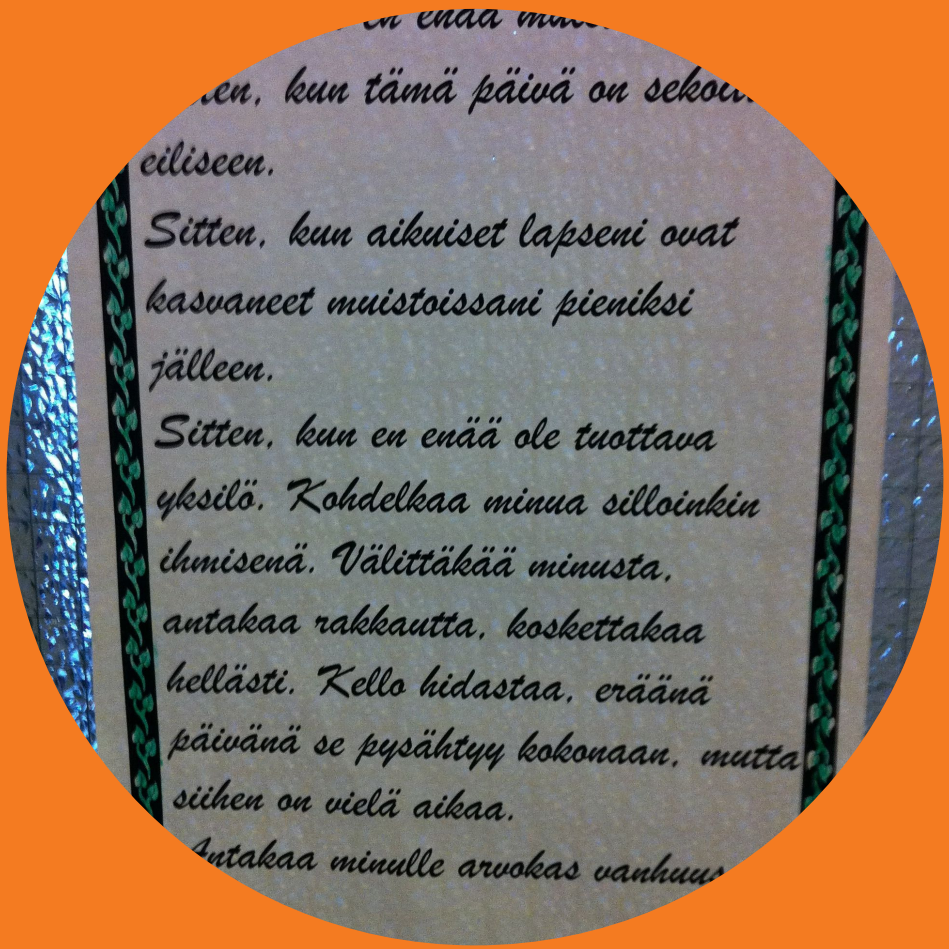
Department of Industrial Engineering and Management

Caring Connections

- Compassionate mutuality in the organizational life of a nursing home

Frank Martela



Aalto University

DOCTORAL DISSERTATIONS

Aalto University publication series
DOCTORAL DISSERTATIONS 144/2012

Caring Connections

- Compassionate mutuality in the organizational life of a nursing home

Frank Martela

A doctoral dissertation completed for the degree of Doctor of Philosophy to be defended, with the permission of the Aalto University School of Science, at a public examination held at the auditorium TU-2 of the school on 30 November 2012 at 12.

Aalto University
School of Science
Department of Industrial Engineering and Management

Supervising professor
Professor Esa Saarinen

Preliminary examiners
Professor Jacoba Lilius, Queen's University, Canada
Docent Merja Miettinen, Tampereen yliopisto

Opponent
Professor Arne Carlsen, BI Norwegian School of Business, Norway

Aalto University publication series
DOCTORAL DISSERTATIONS 144/2012

ISBN 978-952-60-4847-5 (printed)
ISBN 978-952-60-4848-2 (pdf)
ISSN-L 1799-4934
ISSN 1799-4934 (printed)
ISSN 1799-4942 (pdf)
http://urn.fi/URN:ISBN:978-952-60-4848-2

Unigrafia Oy
Helsinki 2012

Finland

Publication orders (printed book):
frank.martela@gmail.com

Author
Frank Martela

Name of the doctoral dissertation
Caring Connections - Compassionate mutuality in the organizational life of a nursing home

Publisher School of Science

Unit Department of Industrial Engineering and Management

Series Aalto University publication series DOCTORAL DISSERTATIONS 144/2012

Field of research Applied Philosophy and Organizational Research

Manuscript submitted 14 May 2012 **Date of the defence** 30 November 2012

Permission to publish granted (date) 21 August 2012 **Language** English

☒ **Monograph** ☐ **Article dissertation (summary + original articles)**

Abstract

Connections with others make up the fabric of daily life within organizations. Caregiving – understood broadly – takes place on a daily basis. Engagement in such caring situations has been found to be highly beneficial for both the caregiver and the cared-for.

A nursing home is an especially good place to study caregiving. Accordingly, the data for this dissertation consists of semi-structured interviews with 26 nurses, five residents, and nine head nurses (altogether 27 hours, transcribed over 400 pages), as well as 13 days of participant observation. In addition, I presented my results to the research subjects in order to receive their feedback as a form of validation. The data was analyzed using a grounded theorizing approach.

My first empirical finding is that in caring situations, both participants can choose to either be emotionally engaged or disengaged. This gives rise to four different types of caring situations: 1) Instrumental caretaking, in which some need is taken care of without either person being engaged in the situation, 2) unmet call for caring, in which the cared-for reaches out to form a connection with the caregiver who remains emotionally detached from the situation, 3) one-sided caregiving, in which the caregiver engages with the cared-for in a warm and tender way but the recipient of care remains disengaged, and 4) caring connection, in which both participants engage emotionally with each other, thus allowing for the formation of a reciprocal, high-quality connection between them.

Focusing on caring connections in particular, I argue that they are composed of six elements that both participants need to display: mutual validation of the distinct worth of the other, being present in the now-moment, opening up towards the other, establishing a shared space, heightened flow of affectivity, and acts of caregiving and displays of gratitude. The connection between the participants is deep and operates to a significant degree through channels related to non-verbal attunement and sensitivities.

This work also makes a few more theoretical contributions. In discussing the ways to improve the possibilities for caring connections, it employs insights from systems intelligence to come up with nine ways through which the nurse can increase the occurence of caring connections. Methodologically, the dissertation makes a contribution by taking a research approach strongly inspired by pragmatist philosophy, and applying it to research in social sciences.

All in all, by emphasizing intersubjectivity and the active contribution of the cared for to the mutually generated encounter, this dissertation contributes equally to two different research traditions: firstly, organizational research and especially positive relationships at work, and secondly, nursing research and especially gerontological nursing.

Keywords caring, caregiving, compassion, intersubjectivity, relationality, nursing, positive relationships

ISBN (printed) 978-952-60-4847-5 **ISBN (pdf)** 978-952-60-4848-2

ISSN-L 1799-4934 **ISSN (printed)** 1799-4934 **ISSN (pdf)** 1799-4942

Location of publisher Espoo **Location of printing** Helsinki **Year** 2012

Pages 334 **urn** http://urn.fi/URN:ISBN:978-952-60-4848-2

Tekijä
Frank Martela

Väitöskirjan nimi
Hoivayhteys – keskeinen inhimillinen voimavara kahdenkeskisessä hoivatyössä

Julkaisija Perustieteiden korkeakoulu

Yksikkö Tuotantotalouden laitos

Sarja Aalto University publication series DOCTORAL DISSERTATIONS 144/2012

Tutkimusala Soveltava filosofia ja organisaatiotutkimus

Käsikirjoituksen pvm 14.05.2012 **Väitöspäivä** 30.11.2012

Julkaisuluvan myöntämispäivä 21.08.2012 **Kieli** Englanti

☒ **Monografia** ☐ **Yhdistelmäväitöskirja (yhteenveto-osa + erillisartikkelit)**

Tiivistelmä

Vuorovaikutustyö sisältää sekä hoitamista että hoivaamista. Hoitaminen tarkoittaa toisen jonkin tarpeen täyttämistä, hoivaamisessa kohdataan lisäksi toinen ihmisenä. On havaittu, että hoivatilanteissa mukanaolo tuottaa hyvää oloa sekä hoidon antajalle että hoidettavalle.

Vanhainkoti on erityisen hyvä paikka havainnoida hoitoa ja hoivaamista. Niinpä tämä väitöskirja perustuu 13 päivään osallistuvaa havainnointia sekä haastatteluihin 26 hoitajan, 5 asukkaan ja 9 osastonhoitajan kanssa, jotka yhteensä kestivät 27 tuntia ja translitteroituina kattoivat 400 sivua. Lisäksi lopussa pidin esitelmän havainnoistani hoitajille vahvistaakseni tuloksiani heidän palautteensa pohjalta. Aineiston analysointi tapahtui grounded theorizing –metodin myötävaikutuksella.

Ensimmäinen empiirinen löydökseni on, että hoitotilanteessa molemmat osallistujat voivat olla emotionaalisesti joko läsnäolevia tai poissaolevia. Tästä vuorovaikutuksesta muodostuu neljä eri hoitotilanteen tyyppiä: 1) asioiden hoitamisessa jokin tarve hoidetaan ilman, että kumpikaan osapuoli on tilanteessa läsnä, 2) hoivan torjutussa hakemisessa hoidettava pyrkii yhteyteen hoitajan kanssa, joka pysyy torjuvana, 3) yksipuolisessa hoivaamisessa hoitaja on lempeän ystävällinen, mutta hoidettava pysyy etäisenä, 4) hoivayhteydessä molemmat ovat läsnäolevia niin, että heidän välilleen muodostuu keskinäinen yhteys.

Tutkimuksessani keskityin erityisesti hoivayhteyksiin ja esitän, että ne koostuvat kuudesta piirteestä, jotka vaaditaan molemmilta osapuolilta: toisen huomioiminen yksilönä, läsnäolo tässä hetkessä, avautuminen toinen toiselle, jaetun tilan muodostaminen, tunnetilojen vahva virtaavuus, ja hoitavat toimenpiteet sekä vastavuoroiset kiitollisuuden osoitukset. Näissä hetkissä keskinäinen yhteys on vahva ja muodostuu pitkälti sanattoman, toiselle herkistyneen viestinnän kautta.

Työ tarjoaa myös muutaman teoreettisen kontribuution. Pohtiessani miten hoitaja voi edistää hoivayhteyksien muodostumista esitän systeemiälyn käsitteen pohjalta yhdeksän tapaa, joilla hoitaja voi keskinäistä vuorovaikutustilannetta viedä kohti hoivayhteyttä. Työ tekee myös metodologisen kontribuution pohjaamalla epistemologiset ja metodologiset valinnat pragmaattisen filosofian traditioon.

Kaiken kaikkiaan työ edistää kahta erillistä tutkimustraditiota korostamalla ihmistenvälisyyttä, intersubjektiivisuutta ja hoidettavan aktiivista roolia vuorovaikutuksessa: Ensinnäkin organisaatiotutkimusta ja erityisesti myönteisen vuorovaikutuksen tutkimusta, ja toiseksi hoitotiedettä ja erityisesti vanhustenhoitoa.

Avainsanat hoiva, myötätunto, ihmistenvälisyys, hoitaja, myönteinen vuorovaikutus

ISBN (painettu) 978-952-60-4847-5 **ISBN (pdf)** 978-952-60-4848-2

ISSN-L 1799-4934 **ISSN (painettu)** 1799-4934 **ISSN (pdf)** 1799-4942

Julkaisupaikka Espoo **Painopaikka** Helsinki **Vuosi** 2012

Sivumäärä 334 **urn** http://urn.fi/URN:ISBN:978-952-60-4848-2

The only value that I have; that I am after here is humaneness.
Humaneness and love are important in elder care.
- Nurse, age 39

Preface

> *"The theory of human caring [- -] emerged from my quest to bring new meaning and dignity to the work and the world of nursing and patient care." "My quest and my work have always been about deepening my own and everyone's understanding of humanity and life itself." (Watson, 1997: 49, 2008: 1)*

This work is my personal attempt to find out what can be accomplished through organizational research in the mission of empowering people to understand and realize those things that ultimately makes their lives good. I am a pragmatist and "the tradition of pragmatism has been guided by the fundamental conviction that philosophy - as well as science or any other practice - is in the service of good life" (Pihlström 1996: 379). My ultimate motivation for engaging in this four-year project of writing a dissertation in organizational research is found in the following question: What can science contribute to the grand task of increasing peoples' abilities to live out good and valuable lives?

The basic tone transcending this work is **humane** – in three senses of the word. This work is humane in describing situations where two human beings connect in a mutually regarding and tender way, encounters in which one person cares for the other. Thus certain humaneness is the central *focus* of attention in this work. But the humaneness in this work goes even deeper than this. The relational paradigm adopted in this work views the basic nature of human being as more connected than the traditional individualistic western paradigm let's us understand. The *outlook* of this work is thus more sensitive to the humane dimensions of human existence. I feel that there is much to be gained from this change of perspective. Given such outlook, if we really want to understand what it is like to be a human being, we need to look at the manifestations of empathy and care, because they reveal to us something fundamental about our true nature. Finally, the *aims* of this work are humane; the guiding motive behind this work is a willingness to validate and promote the soft, affective dimensions of human existence that potentially have a significant positive effect for the well-being of all members of organizational life.

Table of contents

Acknowledgements

> *Whatever a man's achievements, they are unquestionably a product of affectionate people who nurtured his aspirations. Those who hold one in high esteem, who encourage him in moments of confusion and despair, who support his self-confidence by sharing his dreams, and who urge him into the future by their expressed faith in his capacities, are surely the agents of his unfolding.*
>
> - *Harry Levinson, Dedication, (1972: 5)*

This work as a whole emphasizes human interdependence; the fact that we are always embedded within social relations that determine to a large degree what we as individuals are able to – and willing to – achieve. Taking this relational perspective seriously, we must see that a project like PhD is not an individual achievement, but rather produced within a community of practice. This community has given me the practical knowledge of what conducting organizational research is about, it is from this community I have gained many of the central ideas in this document as well as the necessary constructive feedback and critique to develop these ideas further. It is this community that has inspired me, given me emotional support, and shared the values dear to me. It is fair to say that this work is as much an achievement of those around me, as it is my own. Therefore, I want to acknowledge a few of the persons without whom this work would not exist in the current form.

Firstly, I want to extend my gratitude to my supervisor, professor Esa Saarinen, whose dedication into this project has been remarkable. Our discussions have provided a source of inspiration in which many of the most important insights of this work have emerged. I have admired his ability to look at the topic with fresh eyes and bring new perspectives to look at it – and offer me new books that I most definitely should read. His influence has been central in making this dissertation as deep and multilayered as it is now.

Secondly, I want to thank my colleagues at Aalto University and beyond, with whom I have shared this path towards a PhD. We have not only learned together and from each other, but also had some hilarious moments

during this process. Jukka Luoma, Hanna Timonen, Tuukka Kostamo, Riku Ruotsalainen, Tuomas Kuronen, Timo Vuori, Kari Jalonen, Joosef Valli, Jaakko Korhonen, and Peter Kenttä, its been great to grow with you! Also the intellectually engaging atmosphere within Filosofian Akatemia has been important, thus Lauri Järvilehto, Markus Neuvonen, Karoliina Jarenko, Timo Tiuraniemi, and Tapani Riekki all receive my gratitude.

More generally, it has been a privilege to do this research in the department of Industrial Engineering and Management, which provided some excellent PhD courses and seminars about research design, research methods, and academic writing. I want to thank Satu Teerikangas, Mike Manning, Mikko Ketokivi, Juha-Antti Lamberg, Jukka Lipponen, Matti Vartiainen and Jari Hakanen for organizing these excellent courses. For important comments to different versions of my work, I thank, in addition to many of the names already mentioned, Merja Miettinen, Jacoba Lilius, Katri Vehviläinen-Julkunen, Wendelin Küpers, Saku Mantere, Arne Carlsen, and all those people who have attended different conferences and seminars where I have presented my work.

At the same time, I've had the privilege to work according to my own vision and timetable. This lack of external or financial constraints has been crucial for maintaining my intrinsic motivation – or should I say passion – in this project. For this, I want to thank Raimo P. Hämäläinen and Hannele Wallenius who early on saw my potential and wanted to finance its development. More generally, the Finnish educational system has been an essential structural enabler of this work. We Finns are privileged to have free education until the university level, without which explorative career paths and research work that is not of immediate economic benefit, like this one, could not be easily conducted.

Speaking of structural enablers of my work, I want to thank Alvar Aalto for designing the ceiling of Robert's Coffee in Sähkötalo to be high and equipped with big windows that let the light in. That is the place where most of the pages of this document have been typed, and I believe that the high roof has given space for thoughts to fly in a way that a lower roof would not allow (see here Meyers-Levy & Zhu, 2007).

Naturally, the nursing home, where the empirical research was carried out, has an especially warm place in my heart. I want to thank Titi Heikkilä, who directed me into the nursing homes, and director Leena Pohjonen, who welcomed me to do research in Kustaankartano nursing home. Especially I

want to express my gratefulness for all the nurses and head nurses, who I had the privilege to observe and work with. I have to admit that I admired the ability of many nurses to engage with the residents in a simultaneously professional and empathetic way. Through observing their humane attitude and skillful ways of relating, I learned also many personal lessons in life. There are many individual nurses I remember with affection, I hope all the best for them, hopefully our paths cross again in the future!

Finally, I want to thank those people who have shaped my character and made me into the human being who I am at this point. Firstly, there are good friends too many to be mentioned here. You all have a place in my heart and I will find places to thank you more properly in the future. But the intellectually curious and accepting atmosphere of my family, is what nurtured my tendency for this occupational path. In fact, already when I was a kid, my standard answer to the question of what I will become, when I grow up, was 'maailmantutkija', researcher of the world. I am grateful for my parents for providing an atmosphere where questions were asked, reading encouraged and opinions appreciated. More broadly, I want to thank my parents Heikki and Maarit, as well as my brother and sister Eero and Anna, for providing a home to grow up which was filled with love, laughter, and respect for each other and everyone.

This is also the place to acknowledge the heroic part my sister Anna played in securing the empirical research process of this work. When 2.000 people were roaring and jumping in one big chaotic mass, listening to the gypsy-punk beats of Gogol Bordello, I noticed suddenly that my phone was missing from my pocket. And in the phone were the recordings of the lion share of my research interviews – un-backuped of course. It would have been a pity to loose them. In fact, from the research point of view, it would have been a catastrophe. Fortunately, after some desperate searching, my sister was able to pick up the phone from the floor before anyone in the audience was able to stomp it broken. There is luck involved in every research process!

Finally, and most importantly, I want to thank my loved ones, Piret and Vikkeri. When I look at the two of you, I see and feel the most affectionate, touching, and beautiful caring connection I've ever encountered!

PART I: INTRODUCTION

Prelude

> *When I don't remember my own name. When today is mixed up with yesterday. When my grown-up children have grown in my memories to be small again. When I am not a productive individual anymore. Treat me as a human being even then. Care for me, give me love, touch me tenderly. The clock is slowing down, some day it will stop completely, but there is still time until that. Give me a dignified old age. – A poster on the wall of one nursing home unit*

The nurse opens the door and steps into the room. "Good morning Elsa! Are you already awake? It is ten o'clock and it's brisk winter weather outside!" she happily sings out from the doorway. Elsa, a 91-year-old resident in the nursing home whose name has been changed here, lies in bed but her eyes are open. When the nurse steps closer and their eyes meet, she starts to smile and greets the nurse, "Good morning Lisa, good morning!" One can sense mutual affection in their meeting; both seem to be glad that they are here now, with each other. The nurse, whose name has also been changed, allows Elsa some time to adjust to the thought of going through the morning hygiene routine by chit-chatting with her while preparing the room: opening the curtains, taking cloths from the drawers and talking about how we are today. "Are you ready?" she then asks, and Elsa nods. Gently she assists her first into a sitting position, then standing and holding onto the walking frame. "Into the toilet we go" she says, and encourages Elsa to do the walking on her own while she protects her by following immediately behind. There is a lot of tenderness in the way the nurse supports Elsa in her morning hygiene activities: allowing room for her to do the things on her own to the extent that it is possible and then stepping in to fulfill the things that are already beyond her capacity. The activities are so in synchrony that it is sometimes hard to tell where the agency of Elsa stops and the agency of Lisa begins. They are deeply attuned to each other's movements and moods here, and one can tell that it is not the first time that they have gone through the morning bathroom routine together. The emotional sense of the situation is warm and affectionate. When the nurse has assisted Elsa back to the room for dressing and Elsa is

sitting on the bed, she stops for a second and says, “It’s so good that you are here!” Her body language sends the same message: she is clearly enjoying the opportunity to be taken care of and spending time with this one special nurse, Lisa. But Lisa seems to be enjoying the event as much herself. The way she returns Elsa’s smiles and the way the humane warmth radiates from her are so authentic that they seem to be not only about an acquired professional stance, they seem to emanate from what she is as a human being: a person who cares about others. She is sensitive to Elsa’s needs, guessing correctly that today she wants to wear that lilac sweater again. The way Elsa and Lisa move together, the way they touch each other, the way they look at each other, the way they speak to each other – these things show that in the short time they have for one-on-one interaction – before heading to the more hectic common rooms of the nursing home – there is a deep connection between these two people. This is made possible only through the active participation of both parties, both the nurse and the resident, both Elsa and Lisa. The situation is thus not only about a professional service provider taking care of certain issues for her client. It is more about two human beings meeting and sharing a moment together; a moment of caring connection. This dissertation is about this and other, similar moments. It aims to understand what makes this moment special for both Elsa and Lisa, and how they both make this moment possible.

Chapter 1: Introductory remarks

> *"Caring from the heart is a response from the core of each person, a response to the call to be human." (Roach, 1997: 5)*

Connections with others make up the fabric of daily life within organizations (Dutton & Heaphy, 2003). Situations where one person provides some form of care for the other through being personally engaged and connecting with them are one important part of these daily connections (Kahn, 1993). These acts of caregiving can range from support given to a person who is coping with a major life-crisis to just being there and quickly sharing a sympathetic glance when a minor frustration hits during the working day. In these situations – a supervisor listening empathetically to the employee's complaints, a senior worker spontaneously lending a hand to help the newcomer accomplish a challenging task, co-workers sharing their burdens during the coffee break, or an employee going an extra mile for the customer just out of friendliness – organizational actors care for others beyond what is expected of them based solely on their work roles and this is manifested by concrete acts of helping and supporting each other.

This work is about caregiving, caring situations and caring connections. A *caring situation* is any situation where one person takes care of any kind of need of the other person. It included two people – the *care provider* and the *care receiver,* who both have the possibility to be either engaged or disengaged in the situation. When the care provider engages personally in the situation and meets the other as a unique person, I call this *caregiving,* and the things he or she does for the other *acts of caregiving* (cf. Kahn, 1993). When the care receiver responds to this in a personally engaged and affective way, the situation between them can grow into a *caring connection* – the main focus of this study – that requires the mutual openness of both participants for such intimate togetherness. My experience was that these were the situations where the interaction between the care provider and care receiver was most alive and flourishing. Flourishing on an individual level means "to be filled with positive emotion and to be functioning well psychologically and socially" (Keyes, 2002: 210, 2007), and I felt that these situations were about something akin to 'interpersonal flourishing' (see Ryff & Singer, 2000) as both participants seemed to be filled with positive emotions and to function well reciprocally.

In them, a high-quality connection (Dutton & Heaphy, 2003) was established between the caregiver and the one being cared for.

As "social relationships have significant effects on human health" (Heaphy & Dutton, 2008: 139), it can be argued that the strong affective and relational moments that take place when both the care provider and care receiver are open to meeting each other can significantly influence the general atmosphere of the workplace and the well-being of the individual organizational members and clients (Kahn, 1993; Kroth & Keeler, 2009). Therefore caring situations and caring connections offer an important point of view for gaining a deeper understanding of the affectionate, embedded and interconnected nature of organizational life. Despite the fact that acts of caregiving take place on a daily basis in organizations (Kahn, 1993), it is surprising to find that acts of caregiving remain a highly unexplored topic within organizational research (see Kroth & Keeler, 2009: 513). In his classic work, Kahn (1993: 544) talks about caregiving as "a witnessing of others' journeys such that they experience themselves as joined, as seen and felt, as known, and as not alone, which are the core experiences of feeling cared for." In contrast to caretaking, in which the careseekers are perceived merely as passive receivers of care, caregiving sees the careseekers as full participants and collaborators in their own process of healing and growth (Kahn, 1993: 544; Mayeroff, 1972). Through this broad understanding of caring, we see that it is not only a "powerful response to suffering", but also "an ongoing source of strength for all organizational members" (Lawrence & Maitlis, In press). Recent work on compassion in organizations (Lilius et al., 2008, e.g. 2011) has also made some progress in understanding the motivation behind caregiving behavior. But beyond Kahn's work and the work on compassion, there is very little organizational research to be found that looks at individual and concrete one-on-one caregiving situations between organizational members or their clients. By exploring these caring situations, the present work contributes to the recent calls for putting "relationships at the foreground of organizational studies" (Ragins & Dutton, 2007: 5).

Within nursing science, caring and caregiving are more recognized and understood by many to be the heart of the nursing practice (e.g. Boykin & Schoenhofer, 2001; Watson, 2008). Here, caregiving is about sensing the other person's needs – be they physical, relational, emotional, psychosocial, or even spiritual – and responding to them in a considerate way (see e.g. Mayeroff, 1972). Nursing researchers see that acts of caregiving are part of

our nature (e.g. Boykin & Schoenhofer, 2001; Roach, 1987); they arise from "trenchant, intuitive and empathic insight into another's suffering" (Finfgeld-Connett, 2008a: 199). In general, caring is seen as an interpersonal process that is characterized by interpersonal sensitivity, reciprocity and the mastering of an appropriate set of practices from the part of the caregiver (Finfgeld-Connett, 2008a; Gordon et al., 1996a; Mayeroff, 1972). Although some nursing researchers acknowledge the active role of the care receiver in the caring situation (e.g. Boykin & Schoenhofer, 2001), the existing research has not systematically examined this role and its influence on the nature of the caring situation. Thus the present work contributes to nursing research by exploring the role of the care receiver in influencing the mutual encounter more deeply. Thus it sheds new light on the relational nature of the caring situation in which both participants reciprocally contribute to the way the situation unfolds.

In general, my examination contributes to two different research fields: **organizational research** and **nursing science**. It builds on and goes beyond both work on caregiving (e.g., Kahn, 1993, 2005) and compassion (e.g., Lilius et al., 2011; Lilius et al., 2008) in organizations and present discussions in nursing research, by focusing on the caregiving situation from a relational perspective (see Bradbury & Lichtenstein, 2000; Beebe & Lachmann, 2005) that emphasizes the active role of *both* the care provider *and* the care receiver in the development of the process. The **relational perspective** means a view of human beings where one does not look at them as atomistic, separate and sharply 'bounded' (Gergen, 2009) individuals, but rather sees how the human selfhood is embedded within the larger social field and how deeply we are connected to those close to us (see e.g. Markus & Kitayama, 1991; Beebe & Lachmann, 2005; Buber, 1987 [1923]). At the same time, my focus is especially on the positive aspects of such interactions, because I see that there is much to be gained from understanding what characterizes these situations at their best; when they are really flourishing. This connects the present work to the recent movement towards **positive dimensions of human psychology** (Seligman & Csikszentmihalyi, 2000; Sheldon et al., 2011; Dutton & Ragins, 2007b). Thus the research questions I aim to answer through this research are the following:

1) What are the basic types through which a caring situation can unfold, given the active role of both participants?

2) What elements characterize caring situations when the interpersonal dimension between the participants is flourishing – when a caring connection has been established between them?

Caring connections within nursing homes

> *It must all come from the heart! … When friendliness comes from the heart it is good. … That is the most important thing. [Resident 4]*

The chosen empirical context for the present research was a large public nursing home located in Finland. Because of the interrelated, affective and care-emphasizing nature of the work therein (e.g. Caris-Verhallen et al., 1998; Kahn, 2005; Pierson, 1999), nursing homes provide a particularly revealing context to study relational phenomena such as caregiving. As Boykin & Schoenhofer (2001: 19) boldly put it: "The light that nursing shines on the world of person is knowledge of person as caring." Thus, for a researcher, the nursing home provides an extreme case (Yin, 2009: 47) of an environment where caring is especially manifest and visible. It is a context that is unusually revelatory as regards caring relations, and thus an apt place to start an investigation into their characteristics.

The relationship between the nurse and the resident taps into many interesting phenomena and could potentially be approached from a number of different perspectives (see e.g. Dutton & Ragins, 2007b) including, for example, trust (see Pratt & Dirks, 2007), meaningfulness (see Pratt & Ashforth, 2003), compassion (see Lilius et al., 2008), calling orientation (see Wrzesniewski et al., 1997), emotional labor (see Ashforth & Humphrey, 1993), bodily dimensions (see Heaphy & Dutton, 2008), and many other aspects inherent in these relations. My aim has been to reveal some novel and interesting phenomena that are part of these relationships but that have not been captured in the fullest sense in the research up to now. I have particularly focused on **caring situations**: any situations where one person takes care of any kind of need of the other person. I use the **care provider** and **care receiver** as neutral terms to describe the two roles in a caring situation – one taking care of the other and one being taken care of. In the nursing home context this meant that I focused on the caring situations in which the nurse was the care provider and the resident was the care receiver.

The way I have come to see the situation is that in any caring situation, there are two elements that are relatively independent of each other. There is the **functional dimension** of taking care of the problems and physical needs of the care provider. This can be done with varying levels of skill. For example, in the context of nursing, many years of education is required for the nurse to master the necessary technical skills to perform her work. But in addition to that, there is the **emotional dimension** of meeting the other person in a compassionate and emotionally engaged way. Again, this can be done to a greater or lesser extent. Therefore, one can provide care that gives all the functional support necessary and solves all the problems but which can still appear cold and technical from the point of view of the care receiver. On the other hand, there can be warm and empathic support without any functional value that leaves the recipient feeling good but doesn't help her solve her problems. While both dimensions are essential for good caregiving (and good nursing), in this research project I have decided to concentrate exclusively on the emotional dimension of caregiving and caring situations.

Through an analysis of my data acquired through 13 days of participant observation and interviews with 26 nurses, five residents, and nine head nurses (a total of 27 hours of taped recordings that, when transcribed, spanned over 400 pages), I argue that in caring situations both participants can choose to be either emotionally engaged or disengaged. When the care provider is disengaged, I call her actions **caretaking.** Caretaking is about an instrumental and impersonal form of taking care of the needs of the other person. When the care provider is emotionally engaged we can talk about **caregiving**, which implies a more personal involvement with the care receiver in which one acknowledges the unique humaneness of the other and also brings one's own personality into the equation. Accordingly, I define caregiving as behavior in which one person helps the other toward growth and healing, through being personally engaged and connecting with the other person (cf. Kahn, 1993: 544). I will call the provider of such care a **caregiver.** In addition, the care receivers can be actively seeking caregiving – **calling for caring** – or alternatively closing themselves off from a personal connection with the care provider – **closing from caring**. When they are seeking a more personal form of caregiving I call them **careseekers.**

The combination of the two possible attitudes of both participants gives rise to a typology of four different types of caring situation (see Figure 4 on page

148): (**1) Instrumental caretaking**, in which some physical or other need of the care receiver is taken care of without either person being engaged in the situation; (**2) Unmet call for caring**, in which the person being cared for reaches out to form a connection with the care provider, who remains emotionally detached from the situation; (**3) One-sided caregiving**, in which the care provider engages with the cared-for in a warm and tender way but the care receiver remains disengaged. And lastly, the one that particularly captured my attention – or rather my heart – **(4) Caring connection**, in which both participants engage emotionally with each other, thus making the formation of a reciprocal, high-quality connection between them possible. Caring connections were felt by both participants to be deeply meaningful, warm, and tender. The connection between them seemed to be *broad,* and appeared to function to a significant degree through nonverbal channels related to attunement and human sensitivities (Martela & Saarinen, [Forthcoming]).

Caring connections were thus interactive situations where both participants – in this case the nurse and the resident – seemed to be able to be fully present (see Kahn, 1992) in the situation and for each other. They occurred when both the nurse and the resident had enough time and willingness to meet each other and attune to the moods, needs, and the unique characteristics of one another. A sense of authenticity (see Kahn, 1992: 330) characterized these moments, and I saw how participants were able to express themselves more fully than in ordinary moments of interaction (cf. Morris & Feldman, 1996), and experience one another beyond work roles as unique human beings. They seemed to be able to affectively connect to each other and generate a shared space between them into which they could bring their vulnerabilities and personal joys and sorrows. This mutual sense of connection can be seen to be characterized by intimacy, reciprocity, and affection (see Beebe & Lachmann, 2005). The mutuality of these moments was so intimate that it almost felt like the participants were creating and savoring these moments, not as separate individuals, but together as relational human beings.

Based on my analysis, I define caring connections as *caregiving encounters in which both participants – the carer and the cared-for – are both present in the situation, recognizing the uniqueness of the other and opening up towards the other, and in which affections, care and gratitude are able to flow with ease in the systemic dyad formed between them*. My final model relating to these caring connections focuses on the flow of six

different general processes within the dyad (see **Figure 5** on page 166) that seemed to capture the essential elements of the caring connections: **(1) mutual validation** of the distinctive worth of the other, **(2) being present** in the now-moment, **(3) opening up to each other** and the sharing of oneself in a deep way, **(4) establishing a shared space** into which participants can bring their thoughts and emotions and feel that they are shared, **(5) heightened flow of affectivity** and the moments being affectively highly charged, and **(6) acts of caregiving** from the care provider, which are returned by **displays of gratitude** from the care receiver. Of significance against the previous models of the interaction between the care provider and care receiver is the fact that I saw that all these processes were mutual – both participants had to engage in them in order for the caring connection to be established.

I argue that despite their relative rarity, caring connections can significantly deepen the relationship between the nurse and the resident and their affective commitment to each other (see Grant, 2007). They can also have a remarkably positive effect on the work-related well-being of the nurses, because in these moments they get to exercise their calling for caregiving in its full expression, and they get to connect tenderly to another human being. The nurses mentioned how even a brief exposure to such a moment could carry them through the whole day. Similarly, the moments are deeply significant for the residents, as they do not often get so many opportunities for real interaction with others. Therefore, these moments offer them a chance to meet someone at an emotional level and get to be recognized as the unique personality that they are. Because of the prominent positive potential these moments carry for both the employee and the client, I believe that these moments deserve their place in organizational research.

In the latter, more theoretical part of the dissertation, I aim to give preliminary answers to the question of how the nurses and other organizational actors could increase the chances of engaging in caring connections. I suggest that a systems understanding of the unfolding of the situation is especially important here. It means looking at the interactional situation as a system that is generated through the reciprocal moment-by-moment influence of both participants, through a process that is complex, often nonlinear and largely implicit (see Beebe & Lachmann, 2005; Stolorow et al., 2002). Accordingly, a nurse's systems intelligence (see Hämäläinen & Saarinen, 2008; Martela & Saarinen, [Forthcoming]) – her ability to navigate successfully among the relational systems in which she is

embedded – is seen as the key to nursing that takes the other person into account as a particular human being, and engages with her in a compassionate way. I argue that in the context of nursing, this means firstly that the nurse has to manifest certain implicit attitudes through her way of being, and secondly that she has to cognitively take into account certain aspects of the situation. The former category includes *authenticity*, *attitude of appreciation*, *positive attitude* and *letting oneself be attuned to the situation,* while the more cognitive skills include *taking the resident's perspective*, *facilitating the other's process of opening up*, *being on the lookout for positive impact points* and *being sensitive to the other's bids for connection*. On the organizational level, providing room for the *logic of care* amidst the pressures for a more managerial logic is seen as an important cultural enabler of caring connections.

The methodology and ethical aims of the present research

> *What you want is a philosophy [and organizational or nursing research, we may add] that will not only exercise your powers of intellectual abstraction, but that will make some positive connexion with this actual world of finite human lives. (James, 1991 [1907]: 12)*

The roots of the research approach taken in this work are to be found within the pragmatic philosophical tradition (Dewey, 1908; James, 1991 [1907]; Peirce, 1931). Instead of the traditional choice between positivist and interpretivist research paradigms, I thus aim to carve a middle ground that is based on pragmatic ontology, epistemology, and understanding of the nature of scientific inquiry. Pragmatism hasn't been utilized much as a methodological base in the social sciences (see Baert, 2003: 89), and therefore one of the contributions of the present work is methodological. In Chapter 5, the implications of this view will be elaborated on more fully, but in general, pragmatism means a research approach where the existence of multiple perspectives on reality is allowed for, and these perspectives – attitudes, theories, concepts and so forth – are ultimately judged based on their practical utility as instruments for navigating successfully within particular human lives. Accordingly, instead of looking at the organization from the point of view of one specific theoretical framework, I will utilize theoretical perspectives in this work, ranging from organizational and nursing research to infant and therapeutic research.

As regards science, in the abductive spirit pragmatism acknowledges that the results are arrived at in a process, where the data itself and the preunderstanding of the researcher are in a constant interplay (Dubois & Gadde, 2002; Peirce, 1931: 5.181) that aims towards the best available explanation of the phenomenon at hand. Accordingly, the research questions, the theories used, and the insight gained are all "crystallized in an iterative process" (Rundqvist & Severinsson, 1999: 802) in which they feed into each other, deepening the understanding of each, and eventually arriving at a point where they become harmonized enough so that a solid insight into the matter at hand has been formed.

Along with the pragmatist tradition I see knowledge and understanding not as neutral 'mirrors of the nature' (Rorty, 1979), but as tools to enhance certain aims and forms of living (Dewey, 1938; James, 1991 [1907]; Peirce, 1878). The production of scientific knowledge is distinguished from other forms of knowledge production by the rigid standards that the scientific community has set for itself in terms of what is accepted as a part of the scientific corpus. Yet the ultimate aim of organizational research – as well as other scientific disciplines – should be understood as practical: to provide understanding and knowledge that can be pragmatically useful for people within and in interaction with organizational life (see Baert, 2003; Wicks & Freeman, 1998).

Accordingly, in place of the 'positivistic self-understanding of science', with its ideal of 'value freedom' (Habermas, 1978: 302–303), we should understand that behind every knowledge-constitutive activity – such as scientific work – is a "knowledge-constitutive interest", as Habermas (1978: 308) has put it. Values thus enter into the scientific inquiry through two main channels: we always carry out research because of some motives, *and* our inquiry as well as its results always potentially advance the practical goals of some particular agents. Taking these points seriously and understanding that one is ultimately producing knowledge for practical purposes, it becomes the responsibility of the researcher to acknowledge and be explicit about whose perspectives and motives one is advancing through the knowledge one is generating. Even though one might try to be as unbiased as possible during the actual research and analysis process, the choice of research topic, research methodology, and theoretical frameworks already significantly determines what kind of knowledge one will be generating and whose perspectives this knowledge will be advancing. These choices are made by the researcher, who inescapably "speaks from a

particular class, gender, racial, cultural, and ethnic community perspective" (Denzin & Lincoln, 2000: 21). Therefore, although this is a work in science, the ultimate aims of this work – and all scientific work understood pragmatically – are ethical. Therefore, it becomes necessary to be explicit about my personal motives for doing this work.

One immediate motive for this work was simply that of wanting to help. I had read many news articles about poor working conditions in the nursing home industry in particular and the public sector healthcare in general. I wanted to enter into such an organization and see if there is anything I could do, as a researcher, to help these people to cope with their work better. I felt that people in these organizations would be the ones that could potentially benefit the most out of research that inquired into their working conditions. Yet, because of the financing structures of organizational research, the vast majority of research concentrates on researching corporations, with the relevance of the findings being ultimately justified through their connection to the bottom line and economic performance of these corporations. Therefore, I felt it was my responsibility as a researcher to address this imbalance and enter into an organization within the public healthcare sector in order to generate knowledge that would have the potential to increase these employees' ability to feel better about their work.

Secondly, this work is about legitimizing the soft, humane and affective dimensions of organizational life. The current Western cultural epoch has been characterized by an emphasis on reason and rationality, while emotions and other 'soft' dimensions of human life have been seen as something to be managed and subordinated (Sandelands & Boudens, 2000: 47). In particular, organizational administration and organizational research have been dominated by a paradigm of "rational-legal bureaucracy" (Weber, 1946: 216), leading to an "overrationalized" conception of organizational life (Ashforth & Humphrey, 1995: 102) associated with a very narrow and cold view of human nature. The reason for my attempt to stand opposed to this way of thinking is twofold. Firstly, I want to join the movement that attempts to strengthen the position of these soft dimensions in the scientific discourse about organizations. In other words, through this work I want to be part of the 'affective revolution' in organizational research (Barsade et al., 2003). Additionally, by participating in the scientific discourse, I want to legitimate these phenomena for those making decisions about organizations. Scientific knowledge is used by the organizational agents to legitimize certain

decisions, policies and structures (Gabriel, 2002). By bringing the phenomena I have been researching on the scientific radar they will hopefully become more legitimate discussion topics within organizations themselves, and accordingly the organizational actors can feel more justified in taking them into account in their actual decision-making.

In relation to this motive, I also want to strengthen what I see as being the core of work in nursing homes. The nurses I interviewed as well as the theoretical literature (e.g. Kahn, 2005; Clark, 1995) is unanimous in that the ultimate purpose of a caregiving organization such as a nursing home is to provide good quality care for the careseekers – in this case the residents. Meeting the residents as human beings, giving them "the experience that their life is valuable and meaningful right until the end of it" [Nurse 5] is what good elder care is about. However, in the current era of new public management, this basic motivation seems to clash with an institutional logic that emphasizes financial performance and achievement of measurable targets (see e.g. Wilkinson, 1995). In this market-oriented cultural climate, the caregiving, the humane connection, and the tender mutual moments between the nurses and the residents can too easily become downplayed and neglected. From this perspective, this work can be interpreted as my humble attempt to build a counterforce to this development. By emphasizing precisely those humane aspects of caregiving work that cannot be captured in numbers, I hope to strengthen what could be called 'a logic of care' as the natural operational rationale for nursing homes and other caregiving institutions (cf. Reay & Hinings, 2009). As opposed to the present thinking, where the logic of care has to fight for its existence under the pressures of more market-oriented thinking, I see that it should be seen as the ultimate logic for such institutions, with the managerial logic operating as a necessary and subordinate ally. Financial matters are important for caregiving organizations but ultimately only to the extent that they advance the intrinsically valuable humane goals of these institutions.

More broadly, in our society that celebrates self-sufficiency and downplays human dependence, caregiving activities are often deprecated, even though every one of us needs care at certain points in life (Gordon et al., 1996a: xv). The language we use to make sense of our own behavior doesn't always allow us to recognize when we act out of compassion for someone (see Wuthnow, 1991: 45). As a culture we celebrate independence, youth, health, and beauty, trying to suppress from view the fact that ageing, suffering and

dependence are also parts of every human life. We emphasize selfish motives to the extent that people are unable to realize the extent to which their behavior is affected by other-oriented and compassionate motives (Bellah et al., 1985; Wuthnow, 1991). By stepping into a nursing home populated by elderly residents, I wanted to face these parts of human life and make them more visible. I wanted to remind myself and others that within our long life spans we need each other in order to have a dignified life. And that we all have the capacity and motive to care for others.

Another motive for this work was more societal. We live in an era of instrumentalism, where grand values have had to give way to the push for instrumental goals that has got out of hand (see Bellah et al., 1985; Ferry, 2005; Heidegger, 2003). This general way of thinking is also reflected in organizational research. The importance of most of the research results within the field are legitimized through their connection to the financial performance of the organizations. Despite its instrumental usefulness, I am personally not interested in this discourse; instead I want to advance those dimensions within organizations that are good in themselves: well-being, good social relations, or meaningfulness (cf. Seligman, 2011). Thus two things were clear to me from the beginning: Firstly, that I wanted to do my empirical work within a public sector organization in which the *raison d'être* of the organization itself is something more valuable than producing growth for shareholders – caring for the lives of the residents, for example. And secondly, within this institution I wanted to concentrate on the lived experience of the employees therein; inquiring into things that make their working life good and valuable.

Finally, this work is also an 'utterance' (Bakhtin, 1981) within the discourse of proper ways of doing science. Not believing in the neutrality of science and wanting to strengthen the perspective of values in our society at large, through this work I aim to provide an example of scientific work that is conscious of its value base and explicitly aims to advance certain values. This work as a whole is therefore an exploration of the possibilities of doing science in a way that explicitly advances a certain value-laden perspective (for other examples, see e.g., Barkley 1993; Townley et al. 2003, and Grey & Wilmott 2005). It is one small step in the process of transforming the whole way of doing social sciences from supposed value-neutrality towards value-conscious and explicitly value-advancing self-understanding. My hope is that in the future we will see more – and better – examples of how to accomplish such a thing, because I believe that ultimately this value-

conscious way of doing science – especially social sciences – is most advantageous way of conducting research for society at large.

What then is the practical contribution that I am able to deliver through this work? With this being a qualitative study, my aim is not to provide conclusive evidence to 'prove' any hypothesis to be right or wrong. As said, the aim is more to reveal and highlight relational phenomena within organizations that have not been given enough attention in the research literature. The benefit of such research for the actual person operating with and within organizations is primarily about bringing dimensions of organizational life to their attention that they might not have previously noticed or taken seriously enough. It is about increasing the amount of attention and the sense of importance that organizational members give to these issues and – as already discussed – about legitimizing these issues. Ultimately, the degree of success of this research is to be found in the extent to which organizational actors feel more justified and more empowered to base their decisions and actions on soft, relational, care-related and affective issues.

The structure of this work

As is the convention, the next part of this document is dedicated to a literature review, which starts with a chapter where I review the existing literature within organizational research on the topics relevant to my discussions such as affection, well-being, relationality, positivity, compassion and caregiving. In the next chapter I then review what has been said about caring, caregiving and the relationship between the nurse and the client within nursing research, in order to establish how my work contributes to that research stream. Finally, I bring in some insights from infant and therapeutic research that I see as especially useful for the present topic. The rationale for discussing these fields is the fact that they are able to shed light on certain aspects of interaction at the nonverbal level that are important in caring connections, but are not addressed to any great extent in current literature within organizational or nursing research.

Part three of this document is devoted to methodological discussions. In there – building on pragmatic philosophy and relevant methodological discussions within organizational research – I first lay the foundations for a pragmatic approach for doing organizational research. Then, in the next

chapter I outline the data gathering and analysis process of this work. In other words, I review the steps I have taken to arrive at my results.

Part four of this document then presents my account of caring situations and caring connections in full. First I discuss the typology of caring situations and the four different types I identified. Then I describe in detail what I mean by caring connections and what the six relational processes that I see as defining caring connections are. This is followed by a discussion about why caring connections are so important for the well-being of both nurses and residents. After presenting my results I offer some more speculative insights into how nurses can engage with residents in a way that will enhance the possibility of ending up with a caring connection. The way in which the wider organization can increase the probability of these moments through structural and leadership interventions is also discussed. Finally, I will discuss the limitations of this work, possibilities for future research and the theoretical and practical contributions that this work offers, followed by a general conclusion in which I discuss the wider implications of my research.

PART II: LITERATURE REVIEW

Chapter 2: Relationality and caregiving within organizational research

> *In general, the study of organizations tends to engage our minds but fails to engage our hearts. As a result, researchers typically have little to say about the humanity or aliveness of organizations. (Kanov et al., 2004: 810)*

Introduction

With the topic of my work being the caring encounters between a care provider and a care receiver, I turned to organizational research to see what we already know about such encounters. In addition to research that addresses compassion and caregiving more directly, three streams of research proved to be particularly valuable for me in my attempt to understand more deeply what caring connections are about. Firstly, I realized that the most significant aspects within these moments take place on an emotional level, and thus it became essential to understand what has been written about emotions in organizational life (e.g. Ashforth & Humphrey, 1995; Barsade & Gibson, 2007; Dutton et al., 2006). Secondly, it became obvious from my observations that the moments took place on the relational dimension 'in between' the two actors. Therefore I needed to understand more about the research by looking at organizational actors from a relational perspective (see e.g. Bradbury & Lichtenstein, 2000; Ferris et al., 2009; Orlikowski, 2002). And thirdly, the uplifting characteristic of these moments led me to read about positive organizational scholarship, in which some important progress has been made in understanding the capability-building aspects of organizational life (see Bakker & Schaufeli, 2008; Luthans, 2002).

Accordingly, in this chapter I will review organizational research that I see as relevant for my argument within the research streams on affects and emotions, well-being, relationality and the positive side of human relationships. Finally, I look at what have been written thus far about caring and caregiving within organizational research.

Affective revolution in organizational research

Traditionally, organizations and organizational actors have been studied from an individualistic and rationalistic paradigm that downplays and marginalizes the role of feelings and emotions as well as human relationality (Ashforth & Humphrey, 1995; Sandelands & Boudens, 2000; Weber, 1946). There is a long-standing tradition in Western culture to emphasize reason in favor of emotions in explaining human behavior. In this tradition, emotions are often depicted as enemies of reason, something that needs to be managed, subordinated and overcome (Sandelands & Boudens, 2000: 47). This attitude has permeated our culture and it has especially permeated the view of organizations leading to an 'over-rationalized' conception of organizational life in which "phenomena associated with processes, noninstrumentality, qualitativeness, spontaneity, or subjectivity are often viewed pejoratively – as 'irrational' or 'arational' – and therefore to be avoided or controlled" (Ashforth & Humphrey, 1995: 102). The 20th century was dominated by an administrative paradigm calling for "rational-legal bureaucracy" (Weber, 1946: 216). According to it, "the more the bureaucracy is 'dehumanized', the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation" (Weber, 1946: 216). In addition to organizational administration, this paradigm has also preoccupied organizational theorists (Ashforth & Humphrey, 1995: 102), and accordingly, emotions and affections have been discarded from the mainstream organizational research. It has been argued that affective experiences are "the biggest empty space in our prior conceptualizations of organizing" (Hatch, 1999: 88). This led Mowday and Sutton (1993: 300) to warn how this preoccupation with cognitive processes "can lead to theory and research that portrays organization members as cognitive stick figures, whose behavior is unaffected by emotions."

Luckily, in the last few decades there has been a growing trend that sees affections and emotions as important and legitimate research topics in organizational research (see e.g. Brief & Weiss, 2002). This development has even intensified over the last couple of years, and top journals in the field now accept affection as a legitimate research topic. An analysis by an AMJ editor revealed how "recent years also have shown an increasing number of published and accepted papers on affect, providing validation that the field does indeed seem to be experiencing an 'affective revolution'"

(Morrison, 2010: 935–936). Emotions have entered the debate in different domains of organizational research. Huy (2002), for example, explored the emotional balancing that middle managers do to facilitate their work groups' adaptation to organizational change, while Simpson and Marshall (2010) address the mutuality of emotions and learning in organizations. All in all, it has become clear that as human beings, our experience of work is "saturated with emotions" (Ashforth & Humphrey, 1995: 97).

Through this revolution, the mainstream psychological view of emotions has also been challenged. In general, emotions are subjective feeling states that are at the core of our attitudes, color our experience of people and events, motivate us and drive our behavior (Ashforth & Humphrey, 1995; Barsade, 2002; Frijda, 2007).[1] They are "the organized psychobiological responses linking physiological, cognitive, and motivational systems" (Huy, 2002: 34; see also Salovey & Mayer, 1990). Within the more rationalistic paradigm, feelings have been understood to be a special form of reasoning: "as valenced or 'hot' cognition" (Sandelands & Boudens, 2000: 48). They are contained within individuals and are the results "from assessments of the *personal* significance of situations or events" (Sandelands & Boudens, 2000: 48). Essentially, they are understood to be something we experience *after* making a cognitive evaluation of some phenomenon and something *individuals* make for themselves.

Sandelands and Boudens (2000: 46) offer a sharp critique against this kind of understanding of feeling, arguing that 'concepts of feelings' derived from this perspective "are not abstracted from experience, but imposed on it." According to them, "scientific psychology misses feelings by thinking of them too much as static appraisals rather than as ongoing experiences, and by focusing too much on individuals and not enough on groups" (Sandelands & Boudens, 2000: 52). Therefore, they argue both for a more experience-based and social understanding of feelings. Carrying out a meta-examination of three studies that allowed employees to talk about their work in their own voice, and that included around 400 stories related to work, they found that "when asked about their jobs, people do not talk

[1] Although one can make a distinction between the concepts of emotion, mood, affect and feeling (cf. Ekman and Davidson 1994), following the example of Ashforth and Humphrey (1995) and Huy (2002) I use them interchangeably in this paper as their subtler differences are not critical to the present discussion.

much about what they actually do" but rather about other people and about the feelings they experience in their encounters with these people (Sandelands & Boudens, 2000: 48–51). The same result emerged from Hart et al.'s (1995) examination of police officers. They found that the most important negative job events were not related to the characteristics of the work itself (e.g., dealing with victims and danger), but rather with their relations with supervisors and administration.

More generally, it has become increasingly clear that emotions are social in nature, carrying important interpersonal functions and thus have an important role in how organizational life unfolds (Barsade, 2002; Küpers & Weibler, 2008; Niven et al., 2009). Taking a more relational view of feelings, we thus come to see that they are "strongly identified with a person's place and activities in the life of the group and the place of their work in the larger scheme of things" (Sandelands & Boudens, 2000: 52). As humans are social animals, the feelings of an individual are not just personal matters but are strongly influenced by the social context (Barsade, 2002), and carry important interpersonal functions (Niven et al., 2009). Work feelings can be understood as "a property of the group; it is an awareness of its living form" (Sandelands & Boudens, 2000: 53). Accordingly, "researchers have begun to turn their attention towards understanding the processes and outcomes of collective emotion" (Barsade, 2002: 644). Research on topics such as socially embedded models of thriving (Spreitzer et al., 2005), burnout contagion (Bakker et al., 2005), and emotional contagion (Barsade, 2002) have exposed glimpses of how this collective and interrelated emotional dimension works, but a lot of work needs to be done before the functioning of this dimension is adequately understood. Of special interest for our future discussions is recent theoretical work on the effects of positive group affect spirals (see Walter & Bruch, 2008). This will be reviewed in more detail later on.

We should also reconsider the relationship between emotions and reasoning. Recent psychological evidence has revealed how more often than not the 'emotional tail wags the rational dog' (cf. Haidt, 2001); our experience of a feeling is primary, and only afterwards may we cognitively attempt to attribute it to specific entities (Sandelands & Boudens, 2000: 53). Emotions arise "in response to patterns of information that represent the meaning of eliciting situation" and could be characterized as "states of action readiness" that have a bearing on our attitudes towards particular objects or events (Frijda, 2007: 4). By and large, emotions are generated

through an automatic and implicit process that is the result of experiencing the relevant environment holistically rather than through cognitive categorization and assessment. Often, emotions also carry contextual wisdom that can lead to more intelligent behavior than what we are able to grasp cognitively (Martela & Saarinen, [Forthcoming]; Mayer & Salovey, 1993). Thus they represent not so much a challenge to be overcome for intelligent behavior but rather an important ally that enhances our possibilities to successfully coordinate our lives, especially in complex social situations (see Hämäläinen & Saarinen, 2006; Luoma et al., 2011).

All in all, the renewed interest in the emotional dimension of organizational life reviewed here serves an important function in making emotions a legitimate topic of organizational research (e.g. Barsade, 2002; Dutton et al., 2006; Grant et al., 2008). *The present work aims to contribute to this 'affective revolution' within organizational research by increasing our knowledge of the interpersonal dimension of affections through an exploration of an emotionally rich encounter between two persons, in which both persons are emotionally aroused and the emotions seem to flow between them.*

Well-being as collective

Well-being is by and large considered a central indicator of good human life, more often than not it is even considered to be the ultimate target of human life (e.g. Aristotle, 2009 [350 B.C]; Ryan & Deci, 2001). However, as a research topic it has proven to be quite elusive. Within psychology there are wide debates about what it consists of, how it should be measured and is it at all possible to pin it down (e.g. Keyes et al., 2002; Ryan & Deci, 2001). The same variety of perspectives is reflected in organizational research (see Page & Vella-Brodrick, 2009) in which there is much research around various constructs that relate to well-being such as stress (Halbesleben & Buckley 2004), or job demands and resources (Bakker & Demerouti 2007), but surprisingly little research that directly addresses the concept of well-being itself. A search of the top organizational research journals reveals that 'well-being' has appeared in the title of a paper only a handful of times during their history[2]. Hopefully, following the affective

[2] A search carried out through the ISI Web of Science yielded the following statistics (in the 21st century/in all time): 2/4 times in AMJ, 0/1 times in AMR, 0/1 times in ASQ, 0/0

revolution in organizational behavior, we can expect more research on the general topic of well-being as well as wider discussions about its nature within organizational research. The present dissertation aims to be one contribution to this demand.

In terms of the existing organizational research on employee well-being, for a long time there was a near-exclusive focus on the construct of job satisfaction (see Page & Vella-Brodrick, 2009; Brief & Weiss, 2002). Researchers were especially interested in the possible link between employee happiness and employee or organizational performance (see Wright & Cropanzano 2007). Most often within this tradition, the happiness or well-being of employees was measured exclusively by employees' self-reported job satisfaction and the results have revealed – according to an influential meta-analysis (Iaffaldano & Muchinsky, 1985) – an average true score correlation of .17 between job satisfaction and job performance. The results, however, have been somewhat mixed and criticized for various deficiencies in the research design (see Wright & Cropanzano, 2000). More importantly – for reasons I will discuss soon – many contemporary researchers have criticized the usage of job satisfaction as an indicator of employee well-being, and have turned to more broader and affective-based constructs and ways of measuring well-being.

In addition to the job satisfaction school, there have been various and quite independent traditions that have aimed to explain the constituent elements of well-being. Especially within occupational health literature a number of models have been proposed to explain the causes of job strain and burn out. In many models, job strain has been attributed to an imbalance between the demands of work on employees and the resources they have at their disposal (Winnicott, 1965: 310). This is evident in the *demand-control model* (DCM) (Karasek, 1979, 1998), one of the most well-known models in the occupational health literature. According to the DCM, job strain is caused by the combination of high job demands and low job control. The model assumes that high job demands cause job strain but that individuals who have a high level of control over their job are able to buffer this effect by being able to decide for themselves how to meet these job demands. Another model is the *effort-reward imbalance (ERI) model* (Siegrist, 1996) that assumes that job strain is caused by an imbalance of effort put into a

times in Org. Science and Org. Studies. Only specialist journals such as *Work and Stress* (12/ 40) have devoted space to this kind of study.

job and the rewards gained from that job. Here, rewards are defined broadly to include anything from salary to the impact on one's esteem.

Bakker and Demerouti (1965: 311) point out that both of these models operate on a very narrow conception of factors contributing to employee well-being. It might be true – and empirical research seems to support this – that the factors identified by the models really contribute to the job strain of employees. However, at the same time, research on employee well-being has produced a long list of job demands and job resources that potentially contribute to the well-being of an employee (Bakker & Demerouti, 2007; Halbesleben & Buckley, 2004; Kahn & Byosiere, 1991; Lee & Ashforth, 1996). Therefore, it seems fair to say that these models are at best of limited use when attempting to understand the dynamics of employee well-being. In their place, a model called the *job demands-resources model* has been proposed (Bakker & Demerouti, 2007; Bakker et al., 2003; Schaufeli & Bakker, 2004). It aims to offer a more balanced view of employee well-being by postulating – in addition to a process that leads to job strain and burnout – another process that leads to engagement. In the model it is suggested that every job has characteristics related to well-being that can be divided into two groups: resources and demands. Together, these contribute to two independent yet interacting processes which lead to engagement and strain, which in turn contribute to work-related well-being. The model has received much empirical support recently (e.g. Bakker et al., 2006, 2007; Hakanen et al., 2008). It must, however, be noted that while the contributing elements towards well-being are discussed within the model, the nature of well-being itself is not extensively discussed.

As I have already discussed, the last few decades have seen a growing interest in affective dimensions of organizational life, and this has had significant consequences for discussions relating to employee well-being. Most importantly, the usage of job satisfaction as an indicator of employee well-being has been strongly contested. Job satisfaction was classically defined as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (Locke, 1976: 1300). Analogous to the previous discussion on emotions, employee well-being is thus looked at here as an emotionally charged *assessment* of the job characteristics by the employee (see e.g. Hackman & Oldham, 1980). Assessment is a cognitive evaluation and accordingly Brief and Weiss (2002: 283) criticize this stream of research because "job satisfaction generally is construed in affective terms, but typically only its cognitive aspects are measured."

Similarly, Küpers (2005: 222) argues that the focus on job satisfaction gives us only a narrow view on the more comprehensive question of well-being, which is therefore relatively under-researched. What we get from asking about job satisfaction is thus a narrow and mostly cognitive picture of an employee's attitude towards his or her work.

Accordingly, in a number of papers Wright and Cropanzano (2004, 2000; Wright, 2010) have argued that the construct of psychological well-being would better capture what employee well-being is ultimately about. They found that psychological well-being was related to supervisor-rated job performance ratings beyond the effect of job satisfaction, and thus was more predictive of performance than job satisfaction (Wright & Cropanzano, 2000). Interestingly, they suggest that Barbara Fredrickson's Broaden-and-Build model could be used to explain this correlation (Wright & Cropanzano, 2004). The model suggests that "satisfied and psychologically well employees are more likely than those less satisfied and psychologically well to have the necessary resources to initiate, foster, facilitate, and sustain increased levels of job performance-related activities and behaviors" (Wright, 2010: 146).

In addition to the need to expand the notion of employee well-being from cognitive-emphasizing measures towards more affectively-based models, one could argue that the notion of job satisfaction focuses too much on the individual. Taking the previous discussions on affects into account, quite a lot of the affectively loaded states related to one's work are not derived from an appraisal of one's job. Instead, they emerge directly from one's interpersonal relations and other factors. Recent research has shown the great importance of the social dimension for well-being in general (esim. Suh & Sung, 2009) and work-related well-being in particular (see Bakker & Demerouti, 2007: 314; Haines et al., 1991; Johnson & Hall, 1988). For example, Johnson and Hall (1988) found that high levels of co-worker social support decreased the prevalence of cardiovascular disease, particularly when psychological job demands were high. Sinokki (2011), in turn, found that low social support and poor team climate was associated with depressive and anxiety disorders and sleep-related problems. Social well-being – the degree to which individuals function well in their social lives – ought thus to be seen as a central element in discussing employee well-being in organizations, and "events and circumstances of subjective well-being [- -] must be understood in the context of the social lives in which they are experienced" (Küpers, 2005: 223).

Accordingly, in future there is a need for research related to well-being that looks more directly at the relational processes through which the individual organizational members' well-being is constructed. As Küpers (2005: 227) argues, "well-being is not something individuals 'have' but relationships created by engaging in processes and dialogue and corresponding action." It is thus generated in interactions that take place both between organizational members, and in their engagement with their clients. *The present research aims to contribute to this development by focusing on an intensive relational encounter between a employee and a client that contributes positively to the well-being of both.*

Positive relationships at work

Furthermore, there is at present a movement towards an increased focus on positive and capability-building aspects of organizations (e.g. Cameron et al., 2003; Bakker & Schaufeli, 2008; Luthans, 2002). An extension of positive psychology (Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2002) into the organizational domain, this movement focuses on "elevating processes and outcomes in organizations", or more generally, on "that which is positive, flourishing, and life-giving" (Cameron & Caza, 2004: 731). Traditionally, research on the well-being of employees has focused strongly on the negative aspects of work, addressing mainly the question of how what is wrong can be fixed (Bakker et al., 2008; Taris et al., 2008)[3]. As already noted by Ashforth and Humphrey (1995: 98) "the potential dysfunctions of everyday emotion have generally been more salient to management researchers and practitioners than the potential functions." Therefore, this kind of research is not about denying the negative aspects of work experience. Instead, the movement aims to counterbalance the current focus on the negative by giving equal attention to those factors and processes that produce excellence, thriving and human flourishing within organizations. By learning more about the conditions and capabilities that create positively deviant behavior in organizations it is believed that the

[3] Schaufeli and Bakker (2004: 293) report that negative work-related outcomes outnumber positive outcomes by a ratio of 15 to 1 in research articles published in the *Journal of Occupational Health Psychology* between 1996 and 2004. Taris et al. (2008) report similar findings from the *Work & Stress* journal. This is in accordance with the general trend in psychology: According to Myers (2000), negative emotions outnumber positive emotions by a ratio of 14 to 1 in research published in *Psychological Abstracts*.

focus will shift from only "repairing the worst things in life to also building positive qualities" (Seligman & Csikszentmihalyi, 2000: 5).

Thus researchers within the discipline of positive organizational scholarship are convinced that only through focusing on both the fixing of the worst things *and* the generation of most positive qualities can organizations that really flourish be generated. For example, in a survey made by Corporate Leadership Council (2002), it was found that when a supervisor focuses on the strengths of the employees, performance goes up by 36.4%, while a focus on the weaknesses of employees resulted in performance declining by up to 26.8%. Similarly, Miles and Watkins (2007) argued that leadership teams are most effective when they capitalize on the strengths of the team members and connect them to the outcomes that the team needs to deliver. Cameron and Lavine (2006) attributed the success story of a nuclear facility decommissioning process to the leader's 'abundance mindset'. On the practical side, Linley et al. (2011: 371–372) report having used lessons from positive psychology such as strengths-based transition coaching and emotion-focused coping to help organizational members to successfully manage situations of outplacement.

Within the movement, one special interest area is positive relationships at work (see Dutton & Ragins, 2007b). Ragins and Dutton argue that too often work relationships have been looked at from a social exchange theory perspective in which relationships are a mere means for exchanging resources for the purpose of achieving utility or power (Ragins & Dutton, 2007: 6). Instead, we should look beyond that to see how relationships are "both the foundation and theme of the human condition" (Berscheid, 1999: 261), and accordingly work relationships can be generative sources of enrichment, vitality, and meaningfulness at work (Ragins & Dutton, 2007: 3). As Ferris et al. (2009) put it: "There is little about a relationship that can be understood without understanding its affective tone."

This movement towards understanding positive relationships at work was arguably set in motion by the influential article on *high-quality connections* by Dutton & Heaphy (2003), which distinguished high-quality and low-quality connections between two individuals based on "whether the connective tissue between individuals is life-giving or life-depleting" (Dutton & Heaphy, 2003: 263). They set three defining characteristics for a high-quality connection (Dutton & Heaphy, 2003: 266): 1). A higher emotional carrying capacity, meaning that the connection has the capacity

to "withstand the expression of more absolute emotion and more emotion of varying kinds"; 2) A higher *tensility,* meaning the "capacity of the connection to bend and withstand strain and to function in a variety of circumstances"; and 3) A higher *degree of connectivity*, meaning the relationship's "generativity and openness to new ideas and influences." These relations offer people engaged in them three essential subjective experiences (Dutton & Heaphy, 2003: 267): Firstly, *feelings of vitality and aliveness*, secondly, *positive regard* and the feeling of being known or being loved, and thirdly, they are marked by *felt mutuality*, meaning that both people in a connection are engaged and actively participating. Dutton and Heaphy argue that although direct research is still lacking, high-quality connections lead potentially to a number of positive outcomes as regards individual health and well-being as well as organizational outcomes such as performance (Dutton & Heaphy, 2003: 275–276). They see that if organizations create a fertile ground for building high-quality connections, employees "may be able to display authentic identities more often, engage each other more fully, be more vulnerable in the process of learning, and experience more interpersonal valuing through positive regard, all of which cultivate positive meaning about being an organizational member" (Dutton & Heaphy, 2003: 276).

Since that work, positive relationships at work have been addressed in the book titled *Exploring Positive Relationships at Work* (Dutton & Ragins, 2007b). In the introduction, positive work relationships are defined as "reoccurring connections between two people that takes place within the context of work and careers and is experienced as mutually beneficial, where beneficial is defined broadly to include any kind of positive state, process, or outcome in the relationship" (Ragins & Dutton, 2007: 9) and are then explored from various perspectives including identity (Roberts, 2007), body (Heaphy, 2007), and energy (Quinn, 2007). However, despite the number of theoretical lenses offered, almost all chapters highlight the current lack of empirical research and call for more research on the topics presented. Positive relationships at work are "a research frontier that holds promise and possibility", as Dutton and Ragins (2007a: 400) note in the conclusion, but much work remains to be done before the excitement and theoretical explorations turn into empirically explored and validated research. As Ferris et al. comment while referring to the book, "research relevant to the study of dyadic work relationships is limited in scope" (Ferris et al., 2009).

Some interesting empirical work has been done already, though. For example, the importance of positive qualities for work team functioning was demonstrated by research carried out by Losada and Heaphy (2004). In their study on team performance they analyzed communication in 60 management teams and found that the most important variable explaining the difference between high-performing and low-performing teams was the amount of positive compared to negative communication. A speech act was coded as 'positive' "if the person speaking showed support, encouragement or appreciation", and 'negative' "if the person speaking showed disapproval [- -], sarcasm, or cynicism" (Losada & Heaphy, 2004: 745). The differences in this dimension were striking: For high-performance teams, positive communication was 5.6 times more prevalent than negative while the ratio for medium-performance teams was 1.9 and for low-performance teams as low as 0.36 (Losada & Heaphy, 2004: 747).

Similarly, Carmeli et al. (2009) discovered that among university students both the capacities for and the experiences of high-quality relationships are positively associated with psychological safety, which in turn predicts learning behaviors. Other research has suggested that workgroups in which members like one another "may be more flexible, better able to adapt to a changing environment, and higher performing" (see Bolino et al., 2002: 510), while group identification is positively associated with communication and cooperation within groups (Bolino et al., 2002: 511). Perceived organizational support, in turn, has been found to improve positive employee mood, job involvement and performance (Rhoades & Eisenberg, 2002). Together these pieces of research reveal how important positive qualities are for the relational level of work interaction. In the present research these findings will be extended.

However, empirical examinations of positive phenomena are still "vastly underrepresented in organizational science" (Cameron & Caza, 2004), and researchers within positive organizational scholarship are looking for more empirical work on its primary topics (Linley et al., 2011). Therefore, there is a constant call for "studies of affirmative, uplifting, and elevating processes and outcomes" (Cameron & Caza, 2004). *The present work will contribute to this need by exploring the positively affective relational experience between the employee and the client in a nursing home.*

Towards a relational understanding of organizational life

In addition to the above-mentioned shifts in *focus* from rational to affective and negative to positive, there has been a growing trend in organizational research that challenges the traditional individualistic *perspective* and instead aims to look at the employees and key phenomena within organizations from a relational perspective (see Bradbury & Lichtenstein, 2000; Grant, 2007; Kyriakidou & Özbilgin, 2006b). Therefore we need to ask what relationality means in organizational contexts, and what it has revealed to us about organizational life.

Starting with relationality, Bradbury and Lichtenstein (2000: 551) have argued that the "intersubjective and interdependent nature of organizational life" has become the focus of increased scholarly work. Bypassing the dichotomy between individual organizational actors as separate entities and the collective structural level of organizations, this "relational ontology of social reality" (Özbilgin, 2006: 249) focuses on the 'space between' organizational actors, on their relationships with each other (see also Panayiotou, 2008). Thus, this shift in understanding goes deeper than merely focusing on relationships as a research topic. On a deeper level, we must change our basic understanding of human beings to acknowledge the deep interdependency and the ways in which the social environment constructs a human being (Bradbury & Lichtenstein, 2000). Individuals are not functioning independently, "but rather in terms of their interconnections and dynamic relations with other individuals and social systems, namely their work team, their organization, their culture and their global village" (Kyriakidou & Özbilgin, 2006a: 2). In the next chapter I discuss in more detail what this shift of understanding involves in general psychology. Basically it is about transcending the strict boundaries between human beings and accepting their interdependence, interrelatedness, and how much of what is essential is constructed in the intersubjective 'space between' (Buber, 1987 [1923]) two (or more) persons.

In organizational research, this call for putting "relationships to the foreground of organizational studies" (Ragins & Dutton, 2007: 5) has been answered through research on topics such as organizational caregiving (Kahn, 1993), compassion (Kanov et al., 2004; Lilius et al., 2008), dyadic work relationships (Ferris et al., 2009), relational identity (Sluss & Ashforth, 2007), learning as a relational process (Carmeli et al., 2009), relational systems (Kahn, 1998), collective organizing (e.g. Dutton et al.,

2006), collective mind and heedful interrelating (Weick & Roberts, 1993), collective capability (Orlikowski, 2002), collective action (Quinn & Worline, 2008), communities of practice (Wenger, 1999), and interpersonal sensemaking (Wrzesniewski et al., 2003).

For example, in explaining various group-level phenomena, researchers have relied in various ways on an understanding of intelligence as collective. In explaining highly coordinated flight operations on aircraft carriers, Weick and Roberts (1993) build on the concept of group mind (Wegner et al., 1991) and cognitive interdependence to explain the nearly error-free operations of this supremely demanding collective action. Collective mind is "embodied in the interrelating of social activities", in which the mental operations of individuals build on each other in an aggregate manner to produce "heedful interrelating" that is required to perform the activities to operate the aircraft carrier even in demanding times (Weick & Roberts, 1993: 366). Similarly, Orlikowski (2002: 249) analyzes knowing in a high-tech organization not as "a static embedded capability or stable disposition of actors", but rather as an "ongoing social accomplishment, constituted and reconstituted as actors engage the world of practice" together. Thirdly, Etienne Wenger (1999) sees communities of practice rather than individuals as explaining the highly successful behavior of expert organizations. These practices develop on their own and are not dependent on any single individual. One can replace every member of a community of practice one by one with a new individual taking over from the last, and yet the practices will survive because the new members have adopted them as part of their growth to become full members of the group. Social engagement in these practices is the fundamental process by which an individual develops his or her expertise in the field. In all these cases, the organization taken together is capable of intelligent action that far exceeds the intellectual performance of any single member of the group. The intelligence of these organizations thus resides at the relational systems level between organizational actors.

On the other hand, although the focus on the collective level contrasts with the perspective of the atomistic individual, it omits the important relational level in between these two opposite dimensions. Sluss and Ashforth (2007: 9–10) contrast the level of individual identity with its focus on oneself as a unique being, and self-interest as the basic motivation with a form of relational identity in which one has a sense of interdependence and one's basic motivation is related to the dyad's welfare. As regards self-esteem,

individual self-esteem is derived from interpersonal comparison, while relational self-esteem stems from fulfilling one's role-related obligations. They argue that despite the fact that "to work is to relate" (Flum, 2001: 262; quoted in Sluss & Ashforth, 2007: 10), organizational research has focused too much on the individual and collective levels of identity and have thus overlooked the extent to which persons within organizations define themselves through relational identification and particularized role-relationships (Sluss & Ashforth, 2007: 27). Similarly, Ferris et al. (2009: 1379) argue that although work relationships have recently received increased scholarly attention, "few attempts have taken the next important step in more precisely articulating the actual dimensions that underlie work relationships, how they relate to one another, and how, as a contextual background, they frame and influence organizational phenomena." *The present work aims to take exactly these steps by exploring and articulating the underlying dimensions of a caring connection between workers and clients.*

Caregiving

In his classic study, William Kahn (1993) looked at caregivers and how their networks of relationships with other organizational members provided them with emotional resources to be able to provide care for their clients. Making a distinction between caregiving and caretaking, he argues that the latter takes away the others' capacity to care for themselves (Kahn, 1993: 544). Instead, in proper caregiving, caregivers "help others to help themselves toward growth and healing by simultaneously staying in relation with and keeping themselves apart from those others" (Kahn, 1993: 544). Based on his in-depth qualitative inquiry into a caregiving organization, he offers eight behavioral dimensions of caregiving that seem to be mostly about the attitude of the caregiver (Kahn, 1993: 546):

1) Accessibility, remaining in the other person's vicinity
2) Inquiry, ask and probe for other's experiences, thoughts, feelings and other information necessary to provide good care
3) Attention, actively attending to other's experiences, ideas and self-expressions
4) Validation, communicating positive regard, respect, and appreciation to the other
5) Empathy, imaginatively put self in other's place and identify with other's experiences

6) Support, offer information, feedback, insights and protection for the other
7) Compassion, show emotional presence by displaying warmth, affection and kindness
8) Consistency, provide ongoing, steady stream of resources, compassion and physical/emotional/cognitive presence for the other

Since Kahn's work, however, one-on-one caregiving situations haven't received the attention they deserve. Recently, Kroth and Keeler (2009) noticed this gap and attempted in their theoretical review to systematically search for organizational research articles that would address caring and caregiving. Searching through Academy of Management article archives, Sage journals and EBSCO Business Source Premier, they found just a handful of articles that mentioned caring (Kroth & Keeler, 2009: 513), and after further analysis of the articles they found that with the exception of Kahn's work, none of them seemed to address concrete caregiving situations between individuals. Rather, in most of these articles the focus was on structural and organization-level manifestations of caring attitudes. For example, Sewell and Barker (2006) compared two different "discursive formations" of how theorists make sense of organizational surveillance, one of which they named coercive and the other caring. McAllister and Bigley (2002), in turn, discussed how perceived organizational care affects organization-based self-esteem but explicitly note that they are talking about "an organization-level and organization-centered phenomenon, reflecting perceptions regarding the broad provision of care by the organization to all employees" (McAllister & Bigley, 2002: 895) rather than any individual acts of caregiving.

There is also some discussion about the structural and organizational levels of care under the topic 'perceived organizational support', but this is limited to studying the employees' perceptions of how much the organization as a whole cares about their well-being (see Rhoades & Eisenberg, 2002) rather than focusing on concrete acts of caregiving. As Kroth and Keeler (2009: 507) note, this theoretical stream "was not developed from a conceptual framework of caring and since its inception has delved very little into expanding our understanding of managerial caring per se". In other words, although organizational caring is accepted as one element of the theory, the literature does little to clarify or analyze the concept further. It can also be noted that within the field of business ethics, the 'ethics of care' perspective

– inspired by Noddings' (1984) feminist critique of traditional moral philosophy – has gained some ground (e.g. Burton & Dunn, 1996; Wicks et al., 1994). However, as these discussions are relatively theoretical and confined to business ethics and managerial education (see Burton & Dunn, 2005), they are not useful for shedding light on the actual acts of caregiving within organizational contexts.

Recently, Lawrence and Maitlis (In press) took in a theoretical paper Nodding's (1984) idea of ethics of care to see how it could be enacted in organizations through narrative practice. They argue that through an ethic of care a work organization can better acknowledge the fundamental relationality of persons, vulnerability and fragility of everyday life, and growth of the cared for as an essential aim of the caring persons. They see that three narrative practices – constructing histories of sparkling moments, contextualizing struggles, and constructing polyphonic future-oriented stories – could be employed to enhance the perspective of ethic of care within organizations. They believe that through strengthening the ethic of care a work team can increase its resilience.

Kroth and Keeler themselves reviewed the literature on caring within managerial, nursing and educational research, and came to define managerial caring as "a process wherein a manager exhibits inviting, advancing, capacitizing, and connecting behaviors toward an employee or employees" (Kroth & Keeler, 2009: 521). They see managerial caring as a recursive process in which both the manager and the employee must be active agents and thus "care building is the ongoing process of managerial caring, subsequent employee response, and then ensuing managerial response that result in the growth of care between the two parties" (Kroth & Keeler, 2009: 521). Managers' caring behaviors include *inviting* employees by being receptive and fully available, *advancing* employees by having a desire to help the employee to succeed, *capacitizing* employees through seeing individual potential and helping employees grow, and *connecting* with employees by sharing feelings and developing relationships of mutual trust and obligation (Kroth & Keeler, 2009: 522). The employees, in turn, respond to these by rejecting, ignoring, acknowledging, receiving, accepting, or modifying workplace behavior. However, beyond listing these different behaviors and responses, Kroth and Keeler do not offer any further analysis of what they amount to and how they are manifested, nor do they provide any empirical investigation of them. Their theoretical suggestions should thus be seen as preliminary and tentative. As they

themselves note, "our thinking here is exploratory and we believe will evolve as categories are further articulated" (Kroth & Keeler, 2009: 516).

In addition, it might be noted how a recent research stream within organizational research that looks at compassion (e.g. Kanov et al., 2004; Lilius et al., 2011) comes to describe a phenomenon that is quite close to caregiving. According to Kanov et al. (2004: 810), the study of compassion in organizations "acknowledges the realities of pain, suffering, and healing that are part of the human experience, and in so doing, helps to fill in gaps in the organizational literature that often fails to portray organizations as human institutions." They define compassion as an "empathic emotional response elicited by another person's suffering that moves people to act in a way that will ease the person's anguish or make it more tolerable" (Kanov et al., 2004: 812). Within this tradition, compassion is thus comprised of three components: (1) noticing another's suffering, (2) other-regarding feelings that resemble emphatic concern, and (3) responses aimed at easing the suffering of the other (Lilius et al., 2011: 874). By including the action component of responding to other's suffering into the understanding of compassion, the research thus looks at compassionate *responses* to the other person's suffering. This seems to overlap somewhat with the idea of caregiving, which also looks at ways of taking care of the other that are compassionate. Indeed, Lilius et al. (2008: 195) see compassion as "one form of caregiving." Thus it can be argued that compassion and caregiving are somewhat overlapping concepts. Compassionate acts are by their very nature caregiving acts, and proper acts of caregiving involve at least some degree of felt compassion for the one being cared for[4].

These researchers have looked at compassion both as an interpersonal process between two persons (see Lilius et al., 2008) and also as a collective organizational capability (see Dutton et al., 2006; Lilius et al., 2011). For example, Dutton et al. (2006) looked at the mechanisms through which a compassionate response to organizational members' suffering becomes coordinated in an organization, while Lilius et al. (2008) found that experienced compassion at work is related to both increased positive emotions and affective commitment to the organization. In general, the

[4] One might see compassionate acts as one type of caregiving. Compassion – as understood here – requires the other's suffering to which one then reacts, but caregiving can take place without the other having to suffer first, for example when one contributes towards the other's growth.

understanding of compassion that these researchers have seems to be much in line with the research on caregiving that I review in other parts of this literature review.

What can caregiving then accomplish in organizations? Although direct evidence of the relationship of caregiving with different individual and organizational outcomes is still lacking, we can find some indirect evidence that suggests that acts of caregiving can have a positive impact on many such outcomes. Kroth and Keeler suggest that managerial caring behaviors might be linked to productivity, retention, organizational citizenship behavior and job satisfaction (Kroth & Keeler, 2009: 523). For example, in a recent meta-analysis, perceived organizational support – in which organizational caring was one element – was associated with a number of favorable outcomes such as job satisfaction, affective commitment, lessened withdrawal behavior, and increased performance (Rhoades & Eisenberg, 2002). Additionally, in the Gallup organizations survey (reported in Buckingham & Coffman, 1999) of 2,500 business units, they found that the question 'Does my supervisor, or someone at work, seem to care about me as a person?' was one of the questions that was most strongly linked to positive business outcomes, such as employee retention, engagement and business productivity. Lilius et al.'s (2008) study of compassion revealed, in turn, that experienced compassion – an emotion that is communicated in acts of caregiving (see Kahn, 1993) – is associated with positive emotions and affective organizational commitment.

Considering these discussions together reveals how most of them fail to offer any deeper discussions about what caring means or how it is manifested in concrete situations where two human beings meet. Those that do – Kahn (1993), and researchers on compassion (e.g., Lilius et al., 2008) – focus on the caregiver and his or her attitudes and behaviors. My contribution builds on and extends beyond them, by putting the focus on the caring situation and looking at how both the caregiver and the care receiver influence the way it unfolds. *The novel contribution of the present work is the inclusion of the care receiver as an active participant in the process through which the caring situation unfolds. Through this shift of perspective, we are able to see what these situations can grow into when both participants are actively engaging in them.*

Summary

There have been repeated calls for research on affective (e.g. Brief & Weiss, 2002; Sandelands & Boudens, 2000), relational (e.g. Bradbury & Lichtenstein, 2000), and life-giving (e.g. Cameron & Caza, 2004: 731) dimensions of organizational life – and especially high-quality connections (Dutton & Heaphy, 2003). Interest in these dimensions has constantly grown and became more mainstream – two recent examples testify to this: The theme of the Academy of Management Annual Meeting in 2010 was 'Dare to Care: Passion and Compassion in Management Practice and Research', and Academy of Management Review is publishing a special issue on compassion in the end of 2012. Management research has clearly awakened to the fact that the affective dimension of human interaction plays a much bigger role in successful organizations than previously anticipated. However, empirical research on these important topics is still relatively scarce. There are a few important contributions on caregiving (e.g., Kahn, 1993, 2005), and on compassion (e.g., Lilius et al., 2011; Lilius et al., 2008), and the present work builds on them, but goes beyond them by emphasizing the active role of the care receiver in the caring situation. Besides them, little empirical research has tapped directly into the positively affective relational experience between the employee and the client that is especially well manifested in caregiving situations. This is the gap that the present work aims to fill, by focusing on the caring situations between nurses and their clients in a nursing home.

Chapter 3: The nurse-client relationship within nursing and gerontological research

> *In many countries, nurses are being pulled away from patients' sides, both figuratively and literally. This approach to health service obscures the humanness of the health experience and diminishes, even inhibits, the caring relational aspect that is essential to assist people to live life with intricate health predicaments.* (Jonsdottir et al., 2004: 241–242)

As my research taps into the world of nursing homes, I felt it necessary to widen the theoretical base beyond organizational research by asking what is already known about the relationship between the nurse and the client within nursing research and gerontological research. In this chapter I briefly review the central concepts and theoretical positions within these research fields that I see as relevant for the understanding of caring situations and caring connections.

Nursing as a practice has existed for centuries and starting from the middle of 19th century it has grown into a profession with a period of formal training (Edwards, 1999). Despite various attempts to build a more systematic account of the central nursing concepts and principles (the most famous being Nightingale, 1860), nursing as a scientific field can be said to have emerged in the 1970s with the advent of peer-reviewed nursing journals such as *Journal of Advanced Nursing* (which started in 1976) or *Advances in Nursing Science* (1978). Facing pressures from the generally more prestigiously-held and scientific medicine knowledge, the nursing community had an interest in legitimizing the knowledge and practice inherent in nursing (Edwards, 1999: 563; Pierson, 1999: 295). This led many nursing scientists to draw from the conventions of positivistic science as they began "the work of developing a distinct body of empirical knowledge that would describe, explain, predict and control the central phenomena of concern related to professional nursing practice" (Edwards, 1999: 295). This meant that many early models developed within nursing science were steeped in notions of Cartesian duality, in which nurses and clients were strictly separated entities and in which the nurses were seen as authoritative agents making active interventions, while the clients were

viewed as more or less passive "objects of care", whose experiences were reduced to "measurable, observable commodities" (Edwards, 1999: 295–296). These theories aimed to reduce the reality of the nursing experience into clear and separate variables and then, by measuring correlations between these variables, aimed to produce evidence-based knowledge for the use of practicing nurses (Northrup & Purkis, 2001). Additionally, the rationality-emphasizing view of human beings inherent in Cartesianism and mainstream science led to models of nursing that downplayed the emotional dimensions of nursing. The aim was to develop a systematic body of evidence-based knowledge that would enable nurses to 'control human responses' through an unbiased and objective approach (Edwards, 1999: 296). More recently, this development towards the scientification of nursing practice has been especially strongly articulated through the call for evidence-based practice (e.g. Kitson et al., 1998).

However, not all viewed this scientification of nursing as a healthy development. Many criticized this Cartesian view of the human being and the positivistic view of science as generating a practice of nursing that is based on standardized, almost algorithmic, responses to physical problems (e.g. Watson, 1985). They shared Boykin & Schoenhofer's (2001: 53) concern that "the fullness of the nursing situation is not amenable to study by measurement techniques" and thus the expertise required for nursing can't be reduced to positivistic scientific knowledge. For them, nursing was more about the intimate connection between two human beings and thus could only be practiced in a particular situation, being sensitive to the needs and personality of the particular client (see Pierson, 1999). They thought that the move towards science meant for nursing "that for a period of several decades nursing education seemed to reject, either partially or totally, the art of nursing in order to discover a scientific base for practice" (Boykin & Schoenhofer, 2001: 24). Accordingly, they felt that nursing science needs to start "in a new key" (Eriksson, 2002: 61).

Drawing from human sciences, these writers emphasized instead the actively constructed, particular and unique relationship between the nurse and the client (Pierson, 1999: 297). Through more interpretive research approaches, they were able to tap deeper into the felt meanings of the everyday lived experiences of both the nurses and their clients (Pierson, 1999: 297). This allowed for more holistic interpretations of the complex realities of nursing relations that took into account the underlying values, attitudes and ways of being inherent to the profession. Influential books

within this tradition include Jean Watson's (1985) *Nursing: Human science and human care,* Simone Roach's (1984) *Caring: The human mode of being,* and Boykin & Schoenhofer's (2001) *Nursing as caring*. They are reviewed in more detail below.

These two paradigms – the more positivistic and the more humanistic – have co-existed within nursing science with the main journals publishing articles of both types. In observing this situation, Edwards concludes that the field has not achieved any consensus about what the purposes of nursing are , what the nature of nursing is in the first place, or even what good nursing is about (Edwards, 1999). Researchers stemming from different traditions have widely different answers to these questions.

However, in terms of contemporary nursing practice, many have voiced their concern that the former, more technical way of understanding nursing has recently gained more ground because of political and managerial pressures (e.g. Jonsdottir et al., 2004; McAllister, 2003). Policy reforms, government requests for healthcare accountability, and the managerial need to develop more effective instruments to monitor and evaluate nursing care have all contributed to this development so that, according to Jonsdottir et al. (2004: 241), there is an "increasingly expressed apprehension that nursing practice is dominated by a technologically-driven, prescriptive, and outcomes-oriented approach aimed at solving people's health problems." Similarly, Hartrick (1997: 524) was concerned that despite the fact that the limitations of the medical/technological paradigm and behavioristic model of human relating have been expounded upon for over 30 years, they continue "to profoundly influence the conceptualization and enactment of interpersonal nursing practice."

This kind of technical approach to nursing practice is connected to the Cartesian picture of human beings as separate, and nursing as a practice of solving identifiable and diagnosed problems through standardized procedures (McAllister, 2003; see Northrup & Purkis, 2001). The problem is that this mechanicism reduces human phenomena to only those things which are measurable, observable and knowable and thus we lose from sight, for example, the significance of human relating as a foundation of good nursing (Hartrick, 1997: 524). Instead of bearing witness to the lived realities of the people the nurses serve, professional nursing has placed increased emphasis on other priorities such as "the labeling, diagnosing, and documenting tasks or condition in which the nurse as expert informs

and makes judgments regarding the health and quality of life of healthcare recipients" (Milton, 2002: 22). Professional nurses and professional nurse educators appear to emphasize and value "the completion of technical tasks and procedures as their primary obligation" to the extent that good nursing care is sometimes associated with care *done on time* (Milton, 2002: 22). The challenge that contemporary nursing faces is expressed well by Jonsdottir et al. (2004: 242): "The emphasis on expedience for service delivery is directing nurses' attention to the management of treatments, pulling them away [- -] from relating to patients in a caring way, and pushing them into fast-paced, fast-talking health care provision." Similarly, within gerontological nursing, Nolan et al. argue that "the relative failure of modern day health care" has arisen, in no small measure, "from the promotion of an individualistic view of the world in which independence has become 'lionized' [- -] and interdependence and communitarian values neglected" (see also Clark, 1995; Nolan et al., 2004: 47).

The relational, largely nonverbal phenomena I look at in this dissertation are precisely of that type, which are not easily reduced to any objective measures and are thus best captured through a relational and qualitative research paradigm. *Given this situation, the most important contribution of the present work for nursing research is to put the emphasis back on the way of understanding nursing in which the "nursing situation is considered the locus of all that is known and done in nursing" (Boykin & Schoenhofer, 2001; McCance et al., 1999: 1391). The work thus joins forces with the more humanistic and relational tradition of approaching nursing and aims to further the understanding of nursing understood as a practice in which the "relational core of nursing practice" (Jonsdottir et al., 2004) is appreciated.*

After this initial positioning of the present work within the nursing literature, I will review the literature around the key concepts of present work, namely the nurse-patient relationship, and caring and caregiving. The works I review stem mainly from the latter, more interpretive and humanistic paradigm of nursing research, although those positivistic works that are relevant for present discussion have also been included. But before going into these topics I will position my work against the current debates in gerontological nursing.

The purpose of gerontological nursing

The nursing of ageing people as well as the research relating to it has followed the same general trends of nursing reviewed above as regards practices, approaches and theories. However, there are certain challenges specific to gerontological nursing that makes the field special.

One of the challenges is the lack of prestige and status of gerontological nursing in general (Nolan et al., 2004). Among nurses, work with older people is often perceived as lacking status and being less attractive, exciting and important than other areas of nursing (Happell & Brooker, 2001; Standing Nursing and Midwifery Advisory Committee, 2001). At the same time the demographics of industrial countries clearly show how the need for nurses caring for old people will increase significantly in the future. Therefore there is a need for "considerable remedial action if gerontological nursing is to become a more attractive career prospect" (Nolan et al., 2004: 48).

Another challenge is the lack of motivation and sense of purpose within gerontological nursing. Based on in-depth case studies, Nolan et al. (2002, 2004: 51) report that many nursing homes had 'impoverished' environments where "there was little continuity of care, and a pervasive feeling of a general lack of purpose and direction." In addition, "the actions of more permanent staff often demonstrated that older people themselves were not seen as significant, and that the staff did not believe that what they did was accorded value and status." Given such environments it is no wonder that motivation, recruitment and retention of staff is an important challenge nowadays in gerontological nursing (Nolan et al., 2004: 48).

At the same time Nolan et al. (2002, 2004: 49) report that nurses who felt that they 'could make a difference' and have a positive impact on the lives of older people were far more likely to want to work within gerontological nursing. However, they noted that in order to feel that one can make a difference for residents, one must be able to look beyond the cure and physical improvement and instead see the "subtle and less overt forms of 'improvement'" that the nurse can provide for the residents. Therefore, there is a need to articulate more clearly what the purpose of geriatric nursing is – what is the positive impact that the nurses can have in residents' lives and how can it be achieved (Nolan et al., 2004; Wadensten & Carlsson, 2003).

The present work addresses this gap by highlighting a relational connection between the nurse and the client that arguably is especially salient in gerontological nursing. It might be true that in terms of possibilities to cure patients and utilize one's technical knowledge base, gerontological nursing is able to provide fewer challenges than some other forms of nursing. Therefore, to make it a more attractive career option, one needs to build on its positive aspects. And what gerontological nursing provides at its best is long-lasting contact with the clients, where the physical cure is in the background and providing dignity and enhancing the possibilities of living a good life are in the foreground. In this context, caring connections are moments in which this humane side of nursing is particularly visible. *Therefore, by concentrating on this dimension of caring and its significance for the life of the resident, it is possible to provide a sense of purpose for gerontological nursing and make visible what is especially attractive in it*.

Nurse-client relationship

What do we know about the relationship between the nurse and the client? Nursing science has looked at this question from a variety of angles. One common way of understanding the relationship is to look at the different stages it goes through as time unfolds, from the orientation phase through the working phase to the termination phase (see e.g. Hagerty & Patusky, 2003). A more relevant framework for the present work is the discussion around person-centered nursing (e.g. McCormack & McCance, 2006; Nolan et al., 2004) which has been said to constitute the "'essence' of new nursing" (Nolan et al., 2004: 47). Person-centered care has received a great deal of attention, especially in discussions concentrating on geriatric care. The idea has had a "considerable influence on the policy, practice and academic literature" around nursing of aged persons (McCormack, 2004; Nolan et al., 2004: 46).

Person-centeredness means an approach to nursing where the person receiving care is central (McCormack & McCance, 2006) and shares similarities with those humanistic approaches that take caring as central to nursing practice (Boykin & Schoenhofer, 2001; e.g. Watson, 1985). In McCormack & McCance's (2006: 476–477) conceptualization, there are five processes that are essential for person-centered care: (1) working with patient's beliefs and values, i.e., being knowledgeable about what the

patient values and how the patient views the world; (2) sharing decision-making through negotiations with the patient; (3) engagement, the degree to which the patient and nurse are connected in the relationship; (4) having a sympathetic presence, which is about an engagement that "recognizes the uniqueness and value of the individual by appropriately responding to cues"; and finally (5) provision of physical care by a nurse who has the necessary professional competence to do that.

There is some evidence that the clients appreciate such patient-centered care. For example, in their recent qualitative study on the perceptions of patients with cancer about the important elements of their relationship with the nurses, Kvåle & Bondevik (2008) found that patients valued three central themes related to patient-centered care: (1) Empowerment, the experience of being valued, respected and listened to; (2) shared decision-making about their treatment; and (3) partnership in nursing care, understood here as patients' ability "to take part in all decisions about their daily life and care" (Kvåle & Bondevik, 2008: 585)[5]. As of yet, however, person-centered care is in need of further empirical studies that would, for example, highlight its benefits for both nurses and clients (McCormack & McCance, 2006: 478).

However, some have argued that while person-centered care has taken important steps in taking the client's point of view into account, this has taken too long in a sense. For example, Nolan et al. (2004) argue that within geriatric care it is connected to a heroic model of ageing that emphasizes the individual autonomy of the ageing person. Although this can be seen as countering the older deficit model of ageing, it still doesn't capture the experience of most senior citizens (Nolan et al., 2004: 46). This is because it downplays the dependence that is an inevitable part of the existence of residents in nursing homes. Instead of person-centered care, Nolan et al. (2004) suggest that a relationship-centered approach would better serve the nurses' attempts to provide good quality care for the aged persons. They argue that within such an approach it becomes particularly important to ensure that all parties involved in caring – the older person, family carers, and nurses – experience relationships that promote a sense

[5] It must be noted that this understanding of partnership is different from the conceptualizations of partnership that are reviewed below (e.g. Gallant et al., 2002; Jonsdottir et al., 2004) by reducing it to the patient's ability to have a say in decision-making.

of the following six needs: Sense of security, sense of belonging, sense of continuity, sense of purpose, sense of achievement and sense of significance (Nolan et al., 2004: 49–50). They see that only through acknowledging the centrality of the relationship and the needs of all participants of this relationship will we be able to deliver good care.

One interesting recent study examined close care provider-resident relationships in a long-term caring institution for aged people, by interviewing care providers, residents, and their family members (McGilton & Boscart, 2007). They discovered that care providers and residents defined close relationships slightly differently. For care providers, it was about feeling connected, knowing the resident and having some reciprocity in the relationship. For residents, the most important thing was having a confidant; knowing that the care provider has their best interests in heart, is dependable and is able to take initiative and do a little extra for them. Family members saw that the care provider should present a caring attitude conveying genuine concern for the resident and providing personal attention to him or her. To get into a close relationship, the care providers needed to be able to interact and connect with the residents, but this was sometimes inhibited by time limits and by some residents' inability or unwillingness to communicate with them. Residents and family members listed care providers' non-commitment and ways of ignoring the individual as well as displays of non-trustworthiness as the most important barriers to the establishment of close relationships. Both participants saw close relationships with each other as significant sources of well-being.

Another study asked nursing home residents about the quality of care (Bowers et al., 2001). They discovered that they could categorize respondents into three groups based on the way they defined care. *Care-as-service* residents focused on instrumental aspects of care, seeing themselves as customers that want efficient and competent care. *Care-as-relating* residents emphasized the affective aspects of care and looked for friendship and reciprocity in their relations with the care providers. The third group, *care-as-comfort* residents, consisted of frailer and more dependent residents for whom the most important thing was the hands-on care that alleviated pain and provided physical comfort. The study thus emphasizes the fact that residents are different and have different expectations and needs related to the care that is offered to them.

Another way of conceptualizing the relationships between the nurse and the client has been to talk about partnerships. Understanding the nurse-client relationship as a partnership emphasizes the active role of the clients in the relationship and requires the nurses to meet them on equal footing and value the client as a "worthwhile human being with unique needs" (Gallant et al., 2002: 152). It emphasizes respect, trust and authenticity as central values within the partnership and empowers the clients to have more control over their own healing process (Gallant et al., 2002: 152, 155). However, as noted by Gallant et al. (2002), despite the attention given to partnerships, significant gaps remain in the literature. Most of the core papers are theoretical (e.g. Jonsdottir et al., 2004), and the empirical papers do not seem to address the actual nature of such partnerships or address only a narrow aspect of it (Kvåle & Bondevik, 2008; e.g. Lazenbatt et al., 1999). In addition, "the literature does not speak directly about the benefits of partnership for the nurse partner" (Gallant et al., 2002: 155). *The present work addresses these gaps by providing an empirical examination of the nature of the partnership between the nurse and the client, and emphasizing the benefits of such partnership for the nurses.*

Of special note in the context of the present work is the conceptualization of partnership given by Jonsdottir et al. (2004). In their theoretical paper they argue that the relationship process between the nurse and the client should be understood as a partnership in which the nurses "are fully present to patients and relate to them with open attentiveness as they engage in dialogue about whatever is of concern in the patients' health circumstances" (Jonsdottir et al., 2004: 247). This lends support to the present conceptualization of caring connections, while at the same time emphasizing the need for empirical examination of these partnerships. *Thus the present work takes the insights of Jonsdottir et al. (2004) further by examining these partnerships empirically.*

The theory of human relatedness as developed by Hagerty et al. (1993) is also one way to approach the nurse-patient relationship (see Hagerty & Patusky, 2003). From the perspective of this theory, human beings are viewed as relational beings that experience some degree of involvement with other people[6]. Hagerty et al. divide the states of relatedness in a relationship into four parts, based on the involvement-noninvolvement in

[6] The theory itself extends to our relations with persons, objects, groups and environments, but in this context I focus only on human-to-human relations.

the relationship and comfort-discomfort of the person in question. *Disconnectedness* is felt when a person is not actively involved with another person and this causes discomfort in him or her. *Parallelism* occurs when a person's lack of involvement is experienced as comfortable, while *enmeshment* is about being involved with another in a way that is coupled with discomfort and anxiety. Finally, *connectedness* occurs "when a person is actively involved with another person [- -], and that involvement promotes a sense of comfort, well-being and anxiety reduction" (Hagerty et al., 1993: 293). They theorize that four processes or social competencies are involved in establishing and promoting these relatedness states: (1) *sense of belonging* is about people feeling valued, needed and important in a relationship; (2) *reciprocity* as the individual's perception of an "equitable, alternating, interchange with another person [- -] that is accompanied by a sense of complementarity"; (3) *mutuality* as the real or symbolic perception of shared commonalities and shared accepted differences; and (4) *synchrony,* as a person's "experience of congruence with his or her internal rhythms and external interaction" (Hagerty et al., 1993: 294). Hagerty and Patusky see that previous theorizations of the nurse-patient relationship have been limited by assumptions, according to which the relationship progresses linearly through the series of certain 'phases' and requires a certain amount of time to develop. Instead, they argue that the theory of relatedness broadens other conceptualizations of nursing relationships by emphasizing the uniqueness of every interaction between a nurse and a patient, instead of looking at these relations as developing linearly over time (Hagerty & Patusky, 2003: 149). *The present work builds on this understanding of relatedness by focusing on individual caring* situations *between the nurse and the patient instead of the more long-term* relationships *between them. While Hagerty et al. (1993) theorize about the elements of connectedness, the present work goes beyond it, by offering an in-depth empirical examination of the elements that make up connectedness, and by making explicit how the two actors might be seeking connectedness to a different degree.*

We can also have a look at the different forms the nurse-client relationship can take. In her qualitative study, Morse (1991) made a distinction between four types of mutual relationships based on the amount of personal emotional involvement of both participants. In *clinical relationships,* the focus is on the treatment of the patient's needs, with little personal involvement from both sides. The interaction is superficial, the nurse

behaves professionally and efficiently and the patient has no expectations of the nurse beyond that 'things get done'. The next level, the *therapeutic relationships*, is, according to Morse (1991: 458), the most typical and also the one considered as 'ideal' by administrators and educators. The roles are still in place – the nurse is the professional care provider and the patient is the care receiver – but the participants also have some recognition of each other as unique individuals with life 'outside' of the current institution. The patient can test the nurse to see if he or she can trust her and feel secure in her treatment. At the third level, *connected relationship*, the nurse maintains a professional perspective but "views the patient first as a person and second as a patient" (Morse, 1991: 458). The patient, in turn, chooses to trust the nurse and the nurse chooses to enter the relationship and to meet the patient's needs beyond what is considered necessary from a strictly professional point of view. If necessary, she will go the extra mile for the patient, who recognizes this and feels respect and gratefulness for the care he or she receives. This involvement can, however, also go too far as in the case of *over-involved relationships*. In these, the nurse is so committed to the patient as a person that this overrides her commitment to the treatment and her responsibilities as a nurse. The relationship has thus developed beyond professional constraints into a very close personal relationship between the participants, which can continue even after the treatment is terminated. According to Morse (1991: 459), these incidents of over-involvement occur from time to time within nurse-patient relationships.

Morse (1991: 460) also suggests that the participants engage in continuous negotiations about the nature of their relationship. The nurse might demonstrate commitment, show perseverance, and try to become involved in the patient to develop a deeper relationship with the patient. The patient, in turn, can try to determine whether the nurse is a 'good person' and a 'good nurse' through various strategies before deciding whether to trust her and then make different overtures to make her more committed to the relationship. For the relationship to reach a certain depth, both participants are needed and therefore relationships can also be unilateral, meaning that one person is more committed than the other (Morse, 1991: 462). While one person might use different strategies to attempt to involve the other more in the relationship, this other person might try to stop this process in various ways. The nurse can, for example, depersonalize the patient by using formal address, while the patient can refuse to share any personal information about him- or herself and demonstrate that he or she doesn't

trust the nurse. As will be shown later on, the type of relationship between the nurse and the resident as well as the strategies for increasing or decreasing involvement used by them significantly influence whether the nurse and the resident can engage in caring connections or not. *The present research is in accordance with these findings but focuses on the caring situations instead of caring relationships. It takes these insights further by providing a classification of the different ways the caring situation can unfold, depending on the negotiation intentions of both participants and by looking more deeply into the nature of connected caring situations.*

All in all, relationships between care providers and care receivers constitute a research topic that has received much attention recently. Deeper understanding of the partnership "constitutes wisdom about core elements of a practice that is uniquely nursing" (Jonsdottir et al., 2004: 247). However, despite the centrality of nurse-patient relationships for nursing practice and theory, the field is in need of more empirical papers that examine the nature of these relations. As argued by Berg and Danielson (2007: 501), "The phenomenon, caring relationship, has been widely studied in earlier research. Nevertheless, empirical studies in hospital, concerning patients and nurses experiences of the actual phenomenon caring relationship are rare." Similarly, Nolan et al. (2004: 49) argue that "good care is best understood in terms of inter-relationships between those giving and receiving care" and therefore "there is a need to identify the 'fundamental' similarities that characterize such inter-relationships". McGilton and Boscart note that there is evidence that meaningful relationships between care providers and residents exist in long-term care environments, but "research exploring how these relationships are actually defined and measured is only in an early stage of development" (McGilton & Boscart, 2007: 2150). *Therefore, it can be argued that in the current nursing and gerontological research literature there is a call for more research that deepens our understanding of caring relationships. The present research attempts to answer this call by looking at individual caring encounters and the nature of relationships within it rather than focusing on the long-term relationships between nurses and patients, which is the usual approach.*

Caregiving

Caring and caregiving[7] are activities that sustain life and are seen as one of the central topics of nursing research and practice (Benner & Gordon, 1996). In our society, which shuns away from any concept of interdependence and instead views individuals as "independent, self-determined, and self-created" (Gordon et al., 1996a: ix), these activities often suffer a legitimation crisis; people are unwilling to accept the vulnerability and loss of control that being cared for unveils (Gordon et al., 1996a: xv). Seen as lesser valued feminine work and taking place largely in the private sphere or within specific institutions, these activities have not received the research attention they deserve (Waerness, 1996). Yet we are more vulnerable than our culture allows us to see and from cradle to grave – and especially when the person is close to either of these – acts of caregiving and receiving care constitute a significant part of human life. Thus it is important to make "caregivers' invisible work visible" (Gordon et al., 1996a: xv). In essence, caring is about an interpersonal process that is characterized by interpersonal sensitivity, reciprocity and the mastering of an appropriate set of practices from the part of the caregiver (Finfgeld-Connett, 2008a; Gordon et al., 1996a; Mayeroff, 1972).

Within nursing, three theories of caring stand out (see McCance et al., 1999)[8]: Jean Watson's (1985) *theory of human caring*, Simone Roach's (1984) *theory on caring* and Boykin & Schoenhofer's (2001) *nursing as caring theory*. In addition to these, some of the most important works addressing caring and caregiving are Mayeroff's (1972) classic *On Caring*, Nel Nodding's (1984) philosophical *Caring – a feminine approach to ethics & moral education,* and the contributions collected in the edited book *Caregiving: Readings in knowledge, practice, ethics, and politics* (Gordon

[7] I use the terms caring and caregiving as synonymous in this document. Although both have been defined in various ways, they share the common core of attending to the other as a human being, as I will argue below.

[8] McCance et al. (1999) mention Madeleine Leininger's (1991) *theory of culture care* as the fourth important theory of caring. But as it focuses specifically on ways of caring that are sensitive to clients' various cultural backgrounds – providing "culturally congruent care" (Leininger, 1991: 39) – I will not focus on it in the context of this work.

et al., 1996b). In Finland, Katie Eriksson's *theories of caring and suffering* have been influential (Eriksson, 1994, 2002).

I will start by very briefly characterizing each of these approaches (see Table 1), after which I attempt to make a synthesis of what we can understand about caring and caregiving based on them. It might be noted that all these perspectives on caring stem from humanistic and qualitative research approaches. Unfortunately, this means that "quantitative findings about the consequences of caring are minimal", as a meta-analysis on the topic concluded (Swanson, 1999).

Table 1 Definitions of caring and caregiving

"To care for another person, in the most significant sense, is to help him grow and actualize himself."	(Mayeroff, 1972: 1)
"The commitment to act on behalf of the cared-for, a continued interest in his reality throughout the appropriate time span, and the continual renewal of commitment over this span of time are the essential elements of caring from the inner view."	(Noddings, 1984: 16)
"Caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences. All of human caring is related to intersubjective human responses to health-illness conditions."	(Watson, 1985: 29)
"Caring is the human mode of being. [- -] Caring is a total way of being, of relating, of acting; a quality of investment and engagement in the other [- -] in which one expresses the self fully and through which one touches most intimately and authentically what it means to be human."	(Roach, 2002: 38–39)
"Caring is the intentional and authentic presence of the nurse with another who is recognized as a person living, caring and growing in caring."	(Boykin & Schoenhofer, 2001: 13)

Caregiving is "a witnessing of others' journeys such that they experience themselves as joined, as seen and felt, as known, and as not alone, which are the core experiences of feeling cared for."	(Kahn, 1993: 544)
Caregiving is "a set of relational practices that foster mutual recognition and realization, growth, development, protection, empowerment, and human community, culture, and possibility."	(Gordon et al., 1996a: xiii)
"Caring is a concept encompassing that range of human experiences that has to do with feeling concern for and taking care of the well-being of others."	(Waerness, 1996: 234)
"Caring implies alleviating suffering in charity, love, faith, and hope. Natural basic caring is expressed through tending, playing, and teaching in a sustained caring relationship."	(Eriksson, 2002: 62)
"Caring is a context-specific interpersonal process that is characterized by expert nursing practice, interpersonal sensitivity and intimate relationships."	(Finfgeld-Connett, 2008a: 196)

Starting with Mayeroff (1972), he states that caring is "the antithesis of simply using the other person to satisfy one's own needs" (Mayeroff, 1972: 1). Instead, it is a process, a way of relating to someone that aims to help him grow and actualize himself. In caring "I experience the other as an extension of myself", and through caring "a man lives the meaning of his own life" (Mayeroff, 1972: 9, 2). Mayeroff sees that caring is a fruitful way of thinking about the human condition; the general pattern of caring is the same whether we care for our students, patients, children, or even a philosophical or artistic idea (Mayeroff, 1972: 2). For him, the major ingredients of caring are (Mayeroff, 1972: 13–28):

1) Knowing, understanding the other's needs and the right ways to respond to them
2) Alternating rhythms, knowing when to be active and inactive
3) Patience, enabling the other to grow in its own time and in its own way

4) Honesty, being genuine in caring, being open with oneself and the other
5) Trust, giving the other freedom "to grow in its own way"
6) Humility, appreciating my limitations
7) Hope, "an expression of a present alive with possibilities"
8) Courage, to go into the unknown

For Nel Noddings (1984), the traditional approach to moral philosophy, with its emphasis on judgments and logical reasons, makes it seem like a topic that could be approached with the same detached rationality as geometry (Noddings, 1984: 1). In place of this masculine conception of ethics, she offers a feminine approach that is "rooted in receptivity, relatedness, and responsiveness" (Noddings, 1984: 2). All of us have experienced and long for natural caring – a relationship in which "we respond as one – caring out of love or natural inclination" (Noddings, 1984: 5). We have a natural tendency for caring, and we can extend this beyond our natural relations to other relations as well – thus ethical caring arises out of natural caring. For Noddings, the first essential part of caring is "apprehending the other's reality, feeling what he feels as nearly as possible", but this is not enough because in addition "I must act accordingly; that is, I am impelled to act as though in my own behalf, but in behalf of the other" (Noddings, 1984: 16). Caring becomes for her an ethical ideal and she particularly concentrates on discussing how we can make it a reality through the moral education of children.

Jean Watson's (1985, 2008) theory on caring has its roots in humanistic philosophy and has deep ethical and spiritual underpinnings. Caring is a value and an attitude that must become a will and a commitment that manifests itself in concrete acts (Watson, 1985: 32). The actual caring moment is 'transpersonal' and involves "an ideal of intersubjectivity in which both persons [the nurse and the client] are involved" (Watson, 1985: 60). The goal of caring (and consequently nursing) is to "protect, enhance and preserve humanity" by helping people gain a higher degree of harmony within the mind, body and soul (see also McCance et al., 1999: 1389; Watson, 1985: 54). Watson lists ten 'carative' factors that are central to nursing and caring (Watson, 1985: 75):

1) Humanistic-altruistic system of values
2) Faith-hope
3) Sensitivity to self and others
4) Helping-trusting, human care relationship
5) Expressing positive and negative feelings

6) Creative problem-solving caring process
7) Transpersonal teaching-learning
8) Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9) Human needs assistance
10) Existential-phenomenological-spiritual forces

Of special interest to my conceptualization of caring connections is Watson's discussion about an *actual caring occasion*. She sees that when the giving-receiving behaviors of a caring situation allow for a "contact between the subjective world of the experiencing persons" the caring is transpersonal (Watson, 1985: 58). By transpersonal she refers to:

> *an intersubjective human-to-human relationship in which the person of the nurse affects and is affected by the person of the other. Both are fully present in the moment and feel a union with the other. They share a phenomenal field which becomes part of the life history of both and are coparticipants in becoming in the now and the future. (Watson, 1985: 58)*

An actual caring occasion then is an event, a focal point in space and time, in which an actual occasion of human care between two individuals takes place. It presents both people with the choice of how to be in the relationship and what to do in the moment. When the moment becomes transpersonal and "allows for the presence of the geist or spirit of both", then the event expands the limits of openness and expands the human capacities because in these occasions we enter into each other's experience and can learn from each other (Watson, 1985: 59). The values and views of both the nurse and the patient are thus present in the situation. Watson believes that the alternative to this caring as intersubjectivity is a situation in which both the nurse and the patient are reduced to objects (Watson, 1985: 60).

Simone Roach's (1987, 2002) basic conviction and main premise is that caring is the human mode of being. Inspired by Heidegger, she argues that caring is at the core of what it is like to be a human being. Nursing for her is then the professionalization of this capacity we all already have; it is not unique *to* nursing but unique *in* nursing, because it is "the locus of all attributes used to describe nursing" (Roach, 2002: 39). Nursing is about the affirmation of the basic insight about caring as the human mode of being and the development of one's capacity to care through the acquisition

of cognitive, affective, technical, and administrative skills. For her, there are six central attributes to caring (Roach, 2002: 45–48):

1) Compassion, a way of living born out of an awareness of one's relationship to all living creatures
2) Competence, a state of having the necessary knowledge and skills to respond adequately
3) Confidence, the quality that fosters trusting relationships
4) Conscience, a state of moral awareness
5) Commitment, a complex affective response in which one's desires and obligations converge
6) Comportment, being in agreement with the image of one's profession through one's dress, manner and actions

Boykin & Schoenhofer (2001) share the same basic premise about human beings with Roach: "Persons are caring by virtue of their humanness" and "all persons are caring" and therefore caring is essentially an expression of being a human (Boykin & Schoenhofer, 2001: 1, 3). In addition, each person is growing in their capacity to express caring throughout their lives. For them, caring is about the intentional and authentic presence of the caregiver with another who is recognized as being a living and caring person also (Boykin & Schoenhofer, 2001: 13). They place a great deal of emphasis on this acknowledgement of the other as a caring person, and argue that caring is about the caregiver endeavoring "to come to know the other as caring person" and seeking to understand "how that person might be supported, sustained, and strengthened in his or her unique process of living, caring, and growing in caring" (Boykin & Schoenhofer, 2001: 13).

Of special interest to the present work is Boykin & Schoenhofer's (2001) conceptualization of the *nursing situation* which, according to them, is about a "shared lived experience in which the caring between the nurse and the one nursed enhances personhood" (Boykin & Schoenhofer, 2001: 17). The nursing situation comes into being when "the nurse actualizes a personal and professional commitment to the belief that all persons are caring" (Boykin & Schoenhofer, 2001: 17) but it is an interpersonal experience that requires an active ingredient also from the one being cared for: he or she must be "willing to allow the nurse to enter his or her world" and in a way, call for nursing and nurturance (Boykin & Schoenhofer, 2001: 14). They emphasize the nurse's authentic presence in the situation, her openness to know the other as caring as well as the fact that the nurse should engage fully in these situations (Boykin & Schoenhofer, 2001: 18, 20). They also seem to see the situation as a process in stating for example

that "the process for knowing self and other as caring involves a constant and mutual unfolding" (Boykin & Schoenhofer, 2001: 14). I will make use of their insights in deepening my understanding of caring connections but I will show what the essential differences between this understanding of nursing situations and my understanding of caring connections are in the discussion section.

In Finland, Katie Eriksson has been propagating a similar approach to caring. For her, the ontological basis of caring is a conception of the human being as an entity of body, soul, and spirit, which is fundamentally holy (Eriksson, 2002: 63). Human dignity means for her "accepting the human obligation of serving with love, of existing for the sake of others" (Eriksson, 2002: 62). Suffering is the fundamental category of caring (Eriksson, 2002: 62) and all forms of caring aim, in one way or another, to alleviate suffering (Lindholm & Eriksson, 1993: 1354). The basic motives of caring are compassion and love that "arise in meeting a suffering human being" (Eriksson, 2002: 63). These give rise to a caring relationship, the meaningful context of caring, which is about an unselfish relation with another (Eriksson, 2002: 63).

What kind of general understanding of caring emerges from these different conceptualizations of caring and caregiving presented here and in the previous chapter? As we look at them, it is firstly important to distinguish "abstract caring intentions from the practice of caregiving" (Benner & Gordon, 1996: 41). A person can have generalized feelings of benevolence towards others and express these feelings through statements such as 'I really do care about them', but these sentiments alone do not amount to caregiving as it is understood here. Researchers specialized in caregiving rather see it as a special form of behavior (e.g. Gordon et al., 1996a; Mayeroff, 1972; Kahn, 1993) and thus only when these sentiments are transformed into concrete acts will they become caregiving in the proper sense. As Tarlow (1996: 73) points out in her empirical research about the meaning of caring, "the dominant conclusion to be drawn from this research is that caring means doing for others."

Caring is essentially a "particular kind of relation between people" that involves a caregiver and the one being cared for (Noddings, 1996a: 160). This relation can be understood as an interpersonal process that takes place between the participants (Finfgeld-Connett, 2008a) and is defined by a set of relational practices on the part of the caregiver and the appropriate

response to these practices on the part of the cared-for. The participants have different roles – the one cares and the other is cared for – but nevertheless both participants' active contribution is needed for the relation to be a caring one. In coming to understand what this means, a distinction between caretaking and caregiving might be appropriate (Kahn, 1993: 544). In care*taking*, the receiver of care is depicted as a passive object that needs to be taken care of. Caretaking has its time and place, for example doctors doing surgery on a patient do not usually seek the participation of the patient in the process, and might have to objectify the patient to be able to conduct the necessary operations. In care*giving,* however, those being taken care of are seen as full participants and collaborators in their own process of healing and growth (Kahn, 1993: 544; Mayeroff, 1972). As Waerness argues, "good caring should be performed in a way that, as far as possible, reinforces the self-sufficiency and independence of the receiver" (Waerness, 1996: 235). In caregiving, the recipients of care are thus seen as subjects and the caregiver meets them as full human beings.

From the point of view of the caregiver, caregiving is a way of relating to someone in which one aims to contribute to the other's healing and growth (Mayeroff, 1972: 1). The caregiver interacts with the cared-for through a number of relational practices that "foster mutual recognition and realization, growth, development, protection, empowerment, and human community, culture, and possibility" (Gordon et al., 1996a: xiii). These behaviors enable the careseekers "to feel cared for and about" (Kahn, 1993: 544). Caregiving is ultimately a holistic way of relating to the other in which the different behavioral and attitudinal dimensions are woven together in a way that makes them indistinguishable in daily interactions. Nevertheless, one way to make theoretical sense of this holistic practice is to distinguish between the attitudinal and practical characteristics of it. As Benner and Gordon (1996: 44) note, proper caring requires both "sentiment and skills of connection and involvement" as well as "caregiving knowledge and skills."

First of all, it is clear that without the right kind of attitude, acts that aim at taking care of the other do not amount to caregiving in the proper sense. Citing research about accepting and rejecting parents in child rearing, Noddings (1996b: 29) notes that their attitudes contributed to behavioral differences in children. Although on the behavioral level few notable differences were found between accepting and rejecting parents, their attitudes alone somehow communicated themselves to the children and

affected their process of growth. Thus, he claims that "attitude is crucial to an analysis of caring", and proper caregiving is characterized by an attitude of acceptance, embracement and sympathizing (Noddings, 1996b: 29). The 'cared-for' needs to perceive that the one caring is offering an attitude of inclusion and confirmation. This attitude is about seeing the cared-for "as he is and as he might be" (Noddings, 1996b: 28). Through his analysis of the caregiving literature, Kahn (1993: 544) offers eight dimensions of caregiving that seem to be mostly about attitude: accessibility, inquiry, attention, validation, empathy, support, compassion, and consistency. Caregiving thus is about devotion, "committing myself to the other and to a largely unforeseeable future" (Mayeroff, 1972: 8). It is about being sensitive to the other and his or her unique personality. It is about validating and being empathic towards the perspective of the other. It is also simply about 'being there'; giving time to the other, being attentive and accessible to the other (Tarlow, 1996: 61).

Merely the right kind of attitude is not enough for caregiving, however. Benner and Gordon (1996: 43) point out that without an adequate "set of caregiving skills and practices" with which to embody one's attitude of concern for the other, one fails in the task of being a caregiver. According to them, the knowledge and skills required of a caregiver are embodied in a caregiving practice, in which practice is understood as a "culturally constituted, socially embedded way of being in a situation and with others" (Benner & Gordon, 1996: 43–44). One learns to be a caregiver – to master the practice of caregiving – through extensive training and experience. Because every human context and caregiving relation is unique, these practices need to be flexible and sensitive to the unfolding situation. They need to be "situated, particular and responsive to another human being" (Benner & Gordon, 1996: 46). Therefore, practices "cannot be completely objectified or formalized"; they are more than mere isolated techniques or mechanical manufacturing processes (Benner & Gordon, 1996: 45–46). Instead they are more about implicit know-how or the embodied practice-based understanding of how to be in a certain situation. It must also be acknowledged that caregiving is not only about *doing* something for the other, oftentimes it is about simply *being* with that other (Gordon et al., 1996a: xiv). Sometimes "the most liberating, effective caring is based on letting the other be, letting go or allowing the other to show up" (Benner & Gordon, 1996: 47).

Turning to look at the role of the care receiver, it must be acknowledged that having granted the care receiver an active role we need to recognize some form of reciprocity as a necessary condition in the caregiving process (Noddings, 1996a: 161). Naturally, the one caring and the one being cared for are not in equal roles, but nevertheless the cared-for needs to recognize and reciprocate the care he or she receives in some way – otherwise it would not be a caregiving *relation*. Accordingly, Nodding argues that "the recognition of caring by the cared-for is necessary to the caring relation" (Noddings, 1996b: 32). The recipient of care "contributes to the relationship by responding in some positive way to the efforts of the carer" (Noddings, 1996a: 161). These positive responses validate the caring efforts of the caregiver and make it easier for him or her to care. Thus the responsiveness of the cared-for can have a significant role in how the caregiving moment unfolds.

In these accounts of caregiving, it becomes clear that they are connected to a relational view of a human being. For example, Mayeroff (1972: 5–6) states that I experience the one I care for "as an extension of myself and at the same time as something separate from me that I respect in its own right", and that the worth of the other for me is "something over and above any value it may have for me because of its ability to satisfy my own needs." Noddings, in turn, points out how in caregiving "we are, at least momentarily, engrossed in the other's plans, pains, and hopes, not our own" (Noddings, 1996a: 161). These statements capture the expansion of the concept of oneself and the source of one's motivational basis characteristics of the relational self-understanding (see Markus & Kitayama, 1991).

As will become evident when I present my account of *caring connections,* it has important similarities to all these views of caring. They lend important support for different aspects of this account and through them I have been able to significantly deepen my understanding of what happens in the moments of caring connection. *I argue, however, that the concept of caring connections is able to focus and shed new light on certain dimensions of caring that are not adequately addressed by current theories. In particular, I see that although some of them remind us of the role of the care receiver in the caring process, nevertheless this dimension has not received the attention it deserves. The present work therefore extends the current understanding of caregiving by focusing on the*

process through which both participants mutually construct the caring situation and determine its nature.

Summary

In summary, caregiving has been a central topic within nursing research, especially in its more humanistic camp. Accordingly, there exists many detailed descriptions of the nature of caring that emphasize the essential values and attitudes the nurses must have in order to give humane care for their clients. At the same time, researchers have been emphasizing a more person-centered approach to caring, which emphasizes the client's point of view in caring situations. The present work builds on these approaches, but instead of looking at the long-term caring relationships, the focus is on individual caring situations, and the micro-level interactions that take place within them. These haven't received the research attention they deserve. In addition, as compared to most of the current nursing research that looks at the nurses and their attitudes and behaviors towards the clients, more emphasis is given to the role of the care receiver in the mutually generated caring situation.

Chapter 4: Relationality, attunement, and systems view in psychological, therapeutic, and infant research

> *"The analytic situation [is] recognized as a dyadic intersubjective system of reciprocal mutual influence, to which the organizing activites of both participants make ongoing, codetermining contributions" (Orange et al., 1997: 43)*

A new, more relational view of the human being is emerging within contemporary scientific discourse. In fields as varied as neuroscience and neuroimagining (Hari & Kujala, 2009), personality psychology (Andersen & Chen, 2002), organizational research (Bradbury & Lichtenstein, 2000), infant research (Stern, 1985), and psychoanalytic theorizing (Beebe & Lachmann, 2003; Stolorow et al., 2002), there are contemporary researchers who make the case for a more intersubjective understanding of their subject matter. This new research has come to challenge many of the basic assumptions taken as self-evident by modern Western individuals, both inside and outside the scholarly community.

On a fundamental level, the relational paradigm means that one looks at oneself not as "*separate* from others" but has rather a sense of being "*connected* with others" (Markus & Kitayama, 1991: 226). The individualistic Western conceptualization of person has been famously described by anthropologist Clifford Geertz as "a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background" (Geertz, 1993a: 59). Markus & Kitayama, in turn, summarized this "so-called Western view of the individual" as "an independent, self-contained, autonomous entity who (a) comprises a unique configuration of internal attributes (e.g., traits, abilities, motives, and values) and (b) behaves primarily as a consequence of these internal attributes" (Markus & Kitayama, 1991: 224).

Many labels have been used to describe this kind of understanding of subjectivity and personality, including *independent construal of the self* (Markus & Kitayama, 1991)*, idiocentric personality* (Triandis et al., 1988)*, Cartesian mind* (Stolorow et al., 2002) as well as *individualist, egocentric,*

separate, autonomous, and *self-contained* (from Markus & Kitayama, 1991: 226). This cultural *individualism* is simultaneously an account of the Western understanding of *subjectivity, selfhood, mind, individual,* and *personality*. One way to summarize all these accounts is to talk about the Western subject as a '*bounded being*' (Gergen, 2009), emphasizing the fact that these individualistic accounts put a clear boundary around the self. This idea of strict boundaries comes clear for example in Spence's (1985: 1288) definition of individualism as "the belief that each of us is an entity separate from every other and from the group" which leads to "a sense of self with a sharp boundary that stops at one's skin and clearly demarks self from nonself."

The degree of separatedness that we are supposed to have according to this view, however, seems not to fully explain the many ways in which we demonstrate connectedness and care for each other. Sociologists Bellah, Madsen, Sullivan, Swidler, and Tipton (1985), as well as Wuthnow (1991), in their classical analyses of individualism and commitment in American life, noticed how the norm and moral discourse of individualism has come to dominate American thinking to the point where people "have difficulty articulating the richness of their commitments" (Bellah et al., 1985: 20–21). People are in practice more committed to the well-being of others and more altruistic in their behavior than they are able to explain through the current world view, where the moral universe has flattened into the preferences of isolated and self-interested individuals (Bellah et al., 1985: 76). The ideology of individualism can even be detrimental for society: Triandis et al. (1988: 326) suggested that "extreme individualism may be linked to several forms of social pathology, such as high crime, suicide, divorce, child abuse, emotional stress and physical and mental illness rates."

For these and other reasons, many modern researchers have been interested in looking at more relational conceptualizations of the human being. Some have taken the anthropological or historical approach, comparing modern Western culture with alternatives found on other continents as well as in our own past (Triandis et al., 1988: 329.) For as Clifford Geertz puts it: "However incorrigible it may seem to us," the Western conception of a person is "a rather peculiar idea within the context of the world's cultures" (Geertz, 1993a: 59). Others have taken a more philosophical approach, doing a genealogical analysis of the birth of Western individualism (e.g. MacIntyre, 1984; Seigel, 2005; Taylor, 1989) or

reconceptualizing the nature of human condition from a more relational starting point (e.g. Buber, 1987 [1923]; Levinas, 1979; Merleau-Ponty, 2002 [1945]). For example, for Buber "in the beginning is relation", this "relation is mutual" and "all real living is meeting" (Buber, 1987 [1923]: 11, 15, 18).

What these approaches have in common is that instead of human boundedness, human dependence is emphasized; one is highlighting the many different ways our lives are embedded in the close social ties we have towards others. As Markus and Kitayama summarize: "experiencing interdependence entails seeing oneself as part of an encompassing social relationship and recognizing that one's behavior is determined, contingent on, and, to a large extent, organized by what the actor perceives to be the thoughts, feelings, and actions of *others* in relationship" (Markus & Kitayama, 1991: 227).

For our present purposes, however, the most important steps towards this relational understanding of human life have been made in two fields: firstly in the study of infants' relations to their primary caregivers (e.g. Beebe & Lachmann, 2005; Stern, 1985; Trevarthen, 2008) and secondly in the ongoing 'relational turn' in psychoanalytic therapy (e.g. Boston Change Process Study Group, 2002; Seligman, 2005; Stolorow et al., 2002). To my mind these two fields seem highly appropriate sources to describe the dyad between the nurse and the resident, because both depict situations of intimate togetherness between two individuals. The same is true of nursing which is perceived to involve "an intimate relationship-centred partnership between the nurse and the patient" (Finfgeld-Connett, 2008b: 533). More generally, the rationale for using infant research to look at adult interaction is the fact that the "basic processes of interaction at the nonverbal level remain so similar across the life span" (Beebe & Lachmann, 2005: 23).

In the way I come to understand caring connections, I make much use of this emerging view of human relationality and mutual attunement developed therein. The delicate understanding of the micro-level interactions between two people that infant researchers have been able to reveal is able to shed light on the natural ability for attunement that we adults are also equipped with. Utilizing this viewpoint, we can thus enrich and deepen our sense of what takes place in the interaction between a care provider and a care receiver in other contexts as well – in this case the nurse and the resident. It seems appropriate to briefly review what kind of

view of human relationality and mutual attunement we can find within that field.

In their concluding chapter on positive relationships at work, Dutton and Ragins (2007a: 388) particularly welcome approaches that import ideas from other disciplines not typically connected to organizational studies. It can be argued that the view of attunement and relationality developed in infant and therapeutic research is able to capture some important features of human interaction in general that could further our understanding of relations at work and in nursing. Up to this point, however, nursing research and organizational research have not to my knowledge utilized these perspectives in their work. In both fields, I was able to find only one piece of work that would make some suggestions in this direction (Day, 2010; Trout, 2011) and they will be reviewed below. *Therefore, bringing the theoretical insights developed within infant research and therapeutic discourses into organizational and nursing research is a contribution in itself to these discourses.*

Attunement

Consider the interaction of young infants with their primary caregivers. As human beings we have a natural ability to attune to our surroundings – especially to our social environment. This ability is most clearly demonstrated by studying how such infants relate to their primary caregivers – usually their mothers or fathers. Research on the subject has revealed what Bruner calls "extraordinary synchronicity" in the actions of an infant and her caregiver (Bruner, 1997: 175). The bidirectional exchange between the infant and the caregiver shows how the infant plays an active role in co-coordinating the interaction pattern by attuning herself to the rhythmic patterns of interaction and by anticipating the behavior of the caregiver (Beebe & Lachmann, 2005).

In split-second microanalyses through videotaped interactions of babies and their caregivers, it has been revealed that there are coordinated facial and vocal exchanges (Beebe & Lachmann, 2005). The synchrony of these exchanges is only explainable by assuming that both partners in the dyad are anticipating each other's actions on an implicit level instead of the baby simply mimicking her caregiver. These split-second exchanges have also been documented in the facial exchanges of monkeys (Beebe & Lachmann,

2005: 26 referring to Chevalnier-Skolnikoff 1976) as well as on the faces of flirting couples on park benches (Eibl-Eibesfeldt, 1970), which makes a convincing case for this being a skill human beings are equipped with through evolution. Infants thus exhibit agency in their relationship with their social surroundings. There is in infants a "readiness to find or invent systematic ways of dealing with social requirements and linguistic forms" (Bruner, 1983: 28). Infants are naturally inclined to engage in playful and rhythmic proto-dialogues with their parents (Trevarthen, 2008: 16–17). In fact, infant agency as a whole has been conceptualized as a "systems competence" (Beebe & Lachmann, 2005: 31; Sander, 1985, 1995).

In modern infant research, infants are thus no longer depicted as the passive receivers of care. Instead, it is understood that from very early on, the relationship between the infant and the caregiver is "fully bidirectional", in that both participants are contributing "to the organization of the dyad" (Beebe & Lachmann, 2005: 25). The dyadic systems model in infant research (Beebe et al., 1992; Sander, 1977, 1985) sees "the dyadic system to be the basic unit of interest, within which both interactive regulation and self-regulation can be defined, each affecting the other" (Beebe et al., 2003: 752). From very early on, the baby is making her active contribution to this dyad, coordinating her action to the rhythm of behavior of the caregiver. All in all, recent infant research provides significant evidence for a fundamental human ability to read social systems preverbally and unconsciously (see e.g., Beebe & Lachmann 2005; Bruner 1983; Stern 1985).

Additionally, through this infant-caregiver "attunement" (Stern, 1985) children are able to respond not only to the physical world around them but to the world as represented in the mind of the caregiver (Bruner, 1997: 165). Their actions towards external objects are thus strongly shaped by the meanings their caregivers give to these objects, even though the infants themselves do not need to be aware of these meanings. Through this adaptation to the meaning-structures of their caregivers, children are initiated into the cultural knowledge of their tribe, giving them vital means to navigate their way in the world around them. Their ability to interact functionally with their environment is thus more dependent on their attunement to their social surroundings than on their individual understanding of that environment. They exhibit agency towards the surrounding world through the world view of their significant others.

What this infant agency amounts to is a fundamental human ability to be in relation to others, to attune oneself to the social systems one is surrounded with. It is clear that this attunement happens on a preverbal and non-cognitive level (Beebe & Lachmann, 2005; Bruner, 1983; Stern, 1985). The infant is attuned to the changing environment directly, without the mediating effect of the analytic mind. This attunement must be fundamentally seen as an attunement to the wholeness of the social situation, a process of being with the systemic environment in a holistic fashion. As Sander (quoted in Nahum, 2000: 34; 1991) has put it, infants have an "innate capacity for experiencing the complexity of the organism as a whole." It is clear that early on in life the infant is reacting to the gestalt of the whole situation itself, without the ability to consciously split it into parts, but is still able to react to it in meaningful ways. According to Sander (quoted in Nahum, 2000: 34; 1991) this kind of *gestalt perception* is "basic to the way our brains function, to our developmental origins, and to the process of recognition." Infants are thus able to attune to their environment as a wholeness: they possess an inherent capacity to relate to their surrounding systems in a holistic way.

Having come to appreciate infants' tremendous capability to attune and exhibit agency with their social surroundings, we must acknowledge that as grown-ups we still possess this same capability. As Gallese et al. (2007: 145) suggest, "this intersubjective process that begins in infancy normally continues in elaborated and developed ways throughout the life span of the individual in his or her interpersonal interactions." It is just the case that in looking at the interaction of adults this attunement is often overshadowed by our more cognitive skills and ways of interacting – verbal communication especially – and thus is lost from sight. In one recent study, however, it was found how embodied behavioral synchrony – as measured through video-analysis of the simultaneous movements, tempo similarity, and coordination and smoothness – between two strangers in a laboratory setting increased the felt quality of connection between them (Vacharkulksemsuk & Fredrickson, 2012).

Recent advances in neuroscience have found one explanation for this capability in the form of mirror neurons (see Gallese et al., 2007; Iacoboni, 2009). Mirror neurons generate a "mandatory, nonconscious, and prereflective" *embodied simulation* in the observer "of actions, emotions, and sensations carried out and experienced by the observed" and thus

amounts to a "fundamental biological basis for understanding another's mind" (Gallese et al., 2007: 131, 143). The facial expression of another person leads us automatically "to experience that expression as a particular affective state" (Gallese et al., 2007: 144)[9]. Thus we can conclude that "in virtually any interpersonal interaction there is an automatic unconscious 'induction' in each participant of what the other is feeling" (Gallese et al., 2007: 149).

Nonverbal attunement to each other is thus part of all face-to-face interaction, especially when the participants are more involved and personal in this interaction. Despite this, organizational researchers looking at human interaction in organizations have yet to utilize these perspectives derived from infant research. As of now I was able to locate only one recent article that makes explicit reference to infant research in analyzing the relational depths of coaching experience (Day, 2010). In that particular article, Day argues that the 'relational turn' in psychoanalysis and psychotherapy could be utilized to understand the unconscious dynamics that emerge between a coach and client. It thus demonstrates that this relational perspective is coming and can also be used within organizational research. However, as the context of coaching is quite different from the present focus on care providers and care receivers and as the relational theorists used in that paper are different from those utilized here, that work supports the effort of my work but doesn't overlap with it to any great extent. *As there simultaneously is a growing interest in understanding the affective and relational dimension of organizational life (see Chapter 2) there is great potential in taking the views from infant research and applying them to have a deeper understanding of certain organizational phenomena. This is one of the contributions of the present work.*

Similarly, within nursing research in which the perspective of attunement is especially applicable – there is a deep analogy between an infant and its caretaker and a patient and its care provider – I was able to find only one

[9] It is worth noting that Gallese et al. (2007: 144) quote here Merleau-Ponty's writings from 1945, who seemed to grasp the idea of embodied simulation long before their research findings: "The communication or comprehension of gestures come about through the reciprocity of my intentions and the gestures of others, of my gestures and intentions discernible in the conduct of other people. It is as if the other person's intention inhabited my body and mine his" (Merleau-Ponty, 2002 [1945]: 215).

recent article in which the suggestion was made that infant research should be used to understand the interaction between the nurse and the patient. In his recent short article, infant researcher Michael Trout suggests that in nursing there is much to be learned "from the infant's experience of dependency and connection, and from the range of methods – many of them nonverbal – used by parents to deliver reassurance and to contain" (Trout, 2011: 17). He think that as the nature of healthcare is about interacting with people, we need to consider exactly how we do it: "Does it make a difference whether we make the interaction an attuned one or a mis-attuned one?" (Trout, 2011: 18) He thinks it does and therefore strongly urges nurses to utilize their capacity for attunement and for nursing researchers to take this infant research perspective into account. *In this work I aim to do exactly that; to look at the interaction between the nurse and the client utilizing the insights about attunement given us by infant research.*

Systems understanding of the therapeutic encounter

> *Analytic therapists tolerate uncertainty, find meaning in apparently disordered communication, and embrace the unexpected twists and turns that emerge from intimate attention to the ordinary complexities of everyday life. These are hallmarks of a psychoanalytic sensibility that spans various theoretical persuasions. Non-linear dynamic systems embodies the same sensibilities: It emphasizes such descriptions as pattern, complexity, flux and flow, the interplay of ambiguity and order, stability and instability, and the natural value of uncertainty and generative chaos. (Seligman, 2005: 285)*

In modern psychoanalysis, most of the core assumptions of its Freudian origins have been rethought. Psychoanalysis has in recent decades increasingly moved away from the Cartesian isolated minds and from the related 'objectivist, technically rational stance' (Hoffman, 2001: xii) towards a more relational (Beebe & Lachmann, 2003; Mitchell, 1988) and intersubjective (Dunn, 1995; Marzi et al., 2006; Stolorow et al., 2002) understanding of the therapeutic situation. The development goes by many names: 'the relational turn' (Beebe & Lachmann, 2003; Mitchell, 1988),

'intersubjectivity' (Dunn, 1995; Marzi et al., 2006), 'postmodern perspective' (Goldberg, 2001; Rabin, 1995) and 'intersubjectivist-relational turn' (Seligman, 2005: 316). Irrespective of the name, the movement has grown to be a prominent force within psychoanalysis. The relational perspective has highlighted previously neglected dimensions of the analytic field, such as "ambiguity, complexity, epistemological uncertainty, multiperspectivism, and an interest in co-construction and evolving process" (Seligman, 2005: 316). Regarding therapeutic practice, these approaches are advocating a more empathic, attuned and humane way of interrelating with patients instead of an attitude of intellectual disattachment.

An important parallel development is one that conceives of the therapeutic situation as a system. Generally speaking, a systems approach looks at the therapeutic situation as a *dyadic system* within which both intrapsychic and interpsychic *processes* take place (Beebe et al., 2003; Stolorow, 1997). The roots of systems perspective are in the general systems theory of von Bertalanffy (1968), but it is mainly through Louis Sander's (1977, 1985, 1995) work in infant research and through the dynamic systems approach to development of Thelen and Smith (1994: xiii) that the systems view has found its way into psychoanalysis (see Beebe et al., 2000; Nahum, 2000; Sander, 2002; Seligman, 2005; Stolorow, 1997). The influence of this relational systems understanding has been so strong that, according to Seligman (2005: 287), "most contemporary analysts now think of analyst and analysand immersed in ongoing, complex patterns of mutual influence; whatever other assumptions they make, they agree that a psychoanalysis is a dyadic and dynamic system."[10]

What does this systems understanding of the therapeutic encounter then amount to? When applied to psychoanalysis, dynamic systems theory seeks to account for the "messy, fluid, context-sensitive" (Thelen & Smith, 1994: xvi) nature of the therapeutic process through employing concepts from systems theories, such as complexity, nonlinearity, self-organization, dynamic stability, softly assembled patterns and bidirectional interaction (Beebe et al., 2000; Coburn, 2002; Stolorow, 1997; Thelen, 2005). The systems perspective rejects the conceptualization of the analyst and the

[10] Similarly, Stolorow et al. (2002: 33) state that "most contemporary psychoanalytic schools emphasize relatedness, dialogue, and even systems theory."

patient as separate identifiable units with distinct characteristics that exist independently of the therapeutic context. Development and the success of a therapy are viewed as the "outcome of the self-organizing processes of continuously active living systems" (Thelen & Smith, 1994: 44). Stable intrapsychic patterns are replaced by a highly contextualized view of individual subjectivity in which "worlds of inner experience and intersubjective fields mutually constitute one another" (Stolorow, 1997: 339) and where the therapist's actions are embedded in the ongoing living system formed by the "mutual regulatory process" between the patient and the analyst (Nahum, 2000: 39). Order is viewed as growing out of states of dynamic stability that are "emergent and not designed" (Thelen & Smith, 1994: xix). This means that the systems perspective is able to shed light on key aspects of the conduct of therapy that have previously received less attention – such as the emergent and nonlinear aspects of the process (Boston Change Process Study Group, 2005: 696). Recognizing the therapy process as an ongoing emergent structure with directionality and context-specific internal patterns has the potential to heighten the therapist's 'feeling of what happens' (Damasio, 1999; Seligman, 2005) and thus help the therapist to stay heedful of the subtle possibilities of the process for the benefit of the cure.

The systems approaches in the therapeutic context in effect propose that there is a holistic structure at play in the therapeutic process over and above the therapist, the patient and the context. A co-constructed and interpersonally regulated dyad between the therapist and the patient (Beebe & Lachmann, 2005: 25) thus becomes an essential unit and a partner to the therapist in the analysis. The therapist's ability to maneuver with this evolving higher-level dynamic entity, conceptualized as a 'system', is part of her therapeutic expertise.

Thus more than anything, the systems perspective offers a way of seeing the therapeutic situation as an emergent field of ongoing, co-created and reciprocal interplay of two self-organizing (sub)systems – that is, subjects – in a process that has high level unity, shape and direction in spite of being messy, fluid, nonlinear, multidimensional, and context-dependent (Stolorow & Atwood, 1992: 1; Stolorow, 1997: 341). This has led to a new understanding of therapeutic change as stemming from perturbations that are powerful enough to disrupt and redirect the patient's current way of interpreting the world and shifting it into new patterns or attractor states

(Beebe et al., 2000: 105; Stolorow, 1997: 342). In other words, the beneficial development of the system between the analyst and the patient can open up opportunities for novel ways of being and interacting for the patient. As they become an established part of the patient's habitual way of being throughout the therapeutic encounter, it becomes easier for her to apply them in other relational systems through which she engages with other people.

What does this systems view then mean in terms of the therapeutic practice? Here, it is important to recall the enormous complexities and contextual idiosyncrasies that the therapist encounters in her daily work. As noted by Hoffman (2001: xii) "technical rationality" pays insufficient attention to the "analyst's personal, subjective involvement, for partially blinding emotional entanglement, for the uniqueness of each interaction, for uncertainty and ambiguity, for cultural bias, for change" and "for the analyst's creativity." Following Orange et al. (1997: 68–69), the personal experience of the analyst should be seen "as fluid, multidimensional, and exquisitely context-sensitive, with multiple dimensions of experience oscillating between figure and ground, within an ongoing intersubjective system of reciprocal mutual influence." There are thus multiple parallel and mutually interacting processes ongoing within and in between the patient and the analyst on various different levels – some are explicit and verbal, some implicit and latent, some are affective, while others involve attunement to the other and the emerging situation. The processes involve, among others, subtle shifts in physical behavior, gazes, unfulfilled needs, fantasies, self and interactive regulation, feelings of being influenced, resistance, co-construction, transference, and counter-transference (Beebe & Lachmann, 2005). The analyst must have a sense of her own influence on the patient as well as the patient's influence on her, on the influence of the patient's subjective biases on the therapeutic interaction as well as the influence of her own subjective biases. To succeed, the analyst must adopt a way of being with the patient that is responsive and open to all these experiential and intersubjective dimensions.

These contextual intricacies implicitly allude to something bigger – the *system* of therapeutic process, the unfolding therapy as a whole – that constitutes the higher-level entity in relation to which the acts and choices of the therapist gain their significance. The systems perspective demonstrates its significance in that a fundamental cornerstone of any

systems approach is the emphasis of the whole over and above the parts which are considered to have relevance only in the context of a whole (see e.g. Jackson, 2003). Becoming sensitive to and skillful with the largely nonverbal subtleties, patterns, demands and possibilities of such systems is part and parcel of the therapist's experienced expertise.

Stolorow (1998) goes as far as to say that the whole point of intersubjective systems theory is to overcome the traditional conscious and technique-based approach to psychoanalysis. For Stolorow (1997: 341) "the very boundary between conscious and unconscious is revealed to be a fluid and ever-shifting one [- -] assembling within a dynamic, dyadic, intersubjective system". Stolorow, Atwood and Orange abandon the Freudian unconscious as a container of repressed thoughts and feelings, and replace it with *prereflective unconsciousness* or *an experiential horizon*, which consists of "an experiential system of expectations, interpretive patterns, and meanings" that are formed through our constant interaction within the intersubjective systems we are part of (Stolorow et al., 2002: 45). The same emphasis is also evident in the work of other prominent writers, who embrace the system concept in their meta-analysis of the therapeutic situation, for example in the strong emphasis Beebe et al. (2003: 744) place upon the implicit and nonverbal dimensions of intersubjectivity[11] and in the 'implicit relational knowing', which the Boston Group has emphasized as giving rise to "the foundational level of psychodynamic meaning" (Boston Change Process Study Group, 2007; Lyons-Ruth, 1998; Stern et al., 1998).

Note that this will involve attunement not only to the patient but also with respect to the system as a whole – the therapy as a process. The system as a "third party" (Jones & Corner, 2007: 240) will serve the therapist as an ally. Sensing the direction of the system as an all-encompassing dynamic complex, the therapist makes use of its hidden possibilities. The unit that ultimately delivers the cure is the entire co-created system with all its vagaries and subtle complexities and internal logic. Individual moves, gestures, ebbs and flows, alignments and realignments, speech acts and interpretations on the part of the analyst, however appropriate and ingenious, will gain their significance only via the overall structure the therapist co-creates moment-by-moment with her patient. The "fitness"

[11] Elsewhere, Beebe et al. speak of *symbolic representational level* and *perception-action level* (Beebe et al., 2000: 104).

and "directionality" that the Boston Group emphasize as fundamental to the success of the process are dependent on the whole and reflect the system, which in turn arises as a result of the "continuous, reciprocally influenced process, constructed moment to moment by both partners", as Beebe & Lachmann (2005: 207) put it. The therapist draws from elements that reflect the whole, even though the whole is in the process of becoming and cannot be related to explicitly or in objectival terms.

In the midst of the tremendous complexity of the therapeutic situation, the therapist thus has an additional ally: the therapy process itself envisioned as a system. Like any interesting living system, the therapy system "self-organizes" and exhibits "emergence": it exhibits features beyond what the therapist and the patient bring into it as separate individuals. It is with such phenomena of self-organization and emergence, facilitated by the therapist, where breakthroughs in treatments will reveal the therapist's true mastery.

A powerful demonstration of the analyst's implicit skill of attuning to the patient and the therapeutic system is provided by Heller and Haynal (as reported by Beebe et al., 2003: 749; 1997). They videotaped the faces of the doctor and the patient in 59 psychiatric encounters where patients who had recently attempted suicide were interviewed by the same psychiatrist. In the space of one year, ten of these patients had made another suicide attempt. The psychiatrist's own written reports could not predict those who tried again, but "fine-grained microanalyses of the videotapes of the psychiatrist's face identified 81% of the reattempters. When dealing with her patients who would later make another suicide attempt, the psychiatrist frowned more, showed more head and eye orientation, and showed more overall facial activation and increased speech" (Beebe et al., 2003: 749). The psychiatrist was able to detect the potential reattempters on an implicit level, and even behaved differently with them without any awareness of this difference on a conscious level. In other words, on the level of *sensing* the patient's situation, the doctor got it more right than on the level of her rational account of it.

More generally, recent empirical evidence supports the notion that it is the contextual expertise and ability to read subtle cues from the patient rather than restricting oneself to cognitive insights that lie behind effective therapy. Using the Analytic Process Scales, Waldron et al. (2004) demonstrated that the impact of analytic activities was strongly dependent

on the quality of interventions and the ability of "saying the right thing at the right time." Waldron et al. (2004: 1106) state that "we do not dispute the major importance of interpretation, but [- -] we did conclude that the other core analytic activities seem equally important, and that none is very effective unless of high quality." Quality here refers to the aptness of the type of intervention, the usefulness of its content and the skill of presentation, including tact, timing and language appeal. In their recent summary of their work, the Boston Group (2010) go as far as to state that the "qualitative nature of the whole therapeutic relationship appears to be the most important, specific element in the cure, more than any particular technical activity." The nature of the relationship must be understood in therapy contexts from "the vantage point of the moment-to-moment interaction" (Waldron et al., 2004: 1111) where "at every moment, there is the potential to organize expectations of mutuality, intimacy, trust, repair of disruptions, and hope" (Beebe & Lachmann, 2005: 207).

The systems view thus leads to a view where the analyst is judged by her performance within real-life therapeutic processes, not by her skillfulness in capturing in some symbolic form what her therapy consists of. Their expertise is demonstrated as much in having cognitive knowledge of the situation as in having a feel for the situation. Sometimes the analyst might act highly idiosyncratically and on the spur of the moment. What sets this response apart from what "anyone might respond in an ordinary social situation" (Hoffman, 2001: 181) is the analyst's experience he or she has acquired in the course of her practice and the remarkable fact that even trivial gestures and actions have their meaning in the overall context of that particular therapy. Through continuous exposure to various therapeutic processes with an attitude that Hoffman (2001: 181) describes as "a combination of personal openness and a particular kind of perspective on the process", the therapist builds up a growing sense of what it means to be subjected to the influence of a whole in the context of the therapy as a particular kind of complex system. Importantly, the therapist's experienced expertise enables her to act constructively, even in the absence of an explicit justification for the actions and irrespective of what those actions might mean in some other context or as objective phenomena.

Summarizing this discussion about therapeutic situation, we might say that the recognition of the analytic situation as a dyadic intersubjective system of reciprocal mutual influence (Orange et al., 1997: 43) is indeed ground-

breaking. This has enabled analysts to more fruitfully approach the affect-laden and context-bound features of the therapeutic situation, along with its call for reciprocity, complexity, intersubjectivity, sensitivity and possibilities for nonlinear change. It has illuminated the therapeutic situation as a mutually created and unfolding dynamic system that opens up and closes certain possibilities, many of which operate outside cognitive-rational awareness. As part of the "larger theoretical 'movement towards freedom' within psychoanalysis" (Stern, 2009: 145) the relational and systemic perspective has provided a meta-theoretical justification for the sensibilities that enable the analyst to take into account and emphasize the subtle and contextual but crucially important aspects of the therapeutic situation. This has resulted in a "marked liberating impact upon psychoanalytic practice" (Rabin, 1995: 467): a less rule-oriented, less adversarial and more empathic therapeutic perspective. The analyst is more open to "acts of freedom" (Symington, 1983) and "spontaneous and unpremeditated gestures" (Seligman, 2005: 307), is more willing to engage in improvisational relating in which the therapist "exercises his or her latitude for spontaneous, true-self expression without immediate reflection" (Coburn, 2002: 664; see also Ringstrom, 2001) and is open to "spontaneous emergence of new discoveries" that happen 'in the moment' when the analyst and the patient "are fully engaged with each other" (Fogel et al., 2008: 249).

These insights into the systemic nature of human interaction developed within a therapeutic context offer a truly novel perspective through which to understand how two human beings engage with each other. Understanding the mutually co-constructed intersubjective system as a third party in the analytic process that affects both participant's possibilities and ways of behaving in the situation makes us look at one-on-one interaction in a new way. To my knowledge these insights haven't been applied within organizational research or nursing research. Below I offer some initial guidelines about what this system understanding could mean when applied to the relation between care provider and care receiver.

Care provider and care receiver as an intersubjective dyad

How are we to look at the relationship between the care provider and care receiver given the relational and systems insights reviewed above? According to the relational paradigm, psychological and social phenomena should be approached "not as products of isolated intrapsychic mechanisms, but as forming at the interface of reciprocally interacting subjectivities" (Stolorow & Atwood, 1992: 1). The relational theorists within infant research and therapeutic theorizing are quite suspicious about the individualistic, Cartesian perspective of human beings in which the mind is seen "in isolation, radically separated from an external reality that it either accurately apprehends or distorts" (Orange et al., 1997: 41; see also Bradbury & Lichtenstein, 2000: 553). In this view the care provider and the care receiver would be depicted as separate and independent beings that are somehow externally able to interact with each other. A model derived from this perspective (see Figure 1) would depict internal conditions of the nurse and the resident as well as external conditions to both participants as antecedents, characteristics and consequences of the caring situations. In nursing research, this individuality-emphasizing way of thinking could be connected to those ways of understanding the encounter that emphasize the care provider as the active agent of the caring situation, whose activities have an *impact* on the care receiver who is depicted in a passive role of being the recipient of influence in the situation.

However, as I have argued, to really capture what goes on in an intimate situation such as a caring connection, we have to overcome this atomistic view of humanity and opt for a more intersubjective approach in which the focus is on the *relation* between the care provider and the care receiver. Evidence within organizational research suggests that "when employees care about the beneficiaries of their work, they begin to see their identities as overlapping with beneficiaries' identities and they perceive acting in the interest of these beneficiaries as consistent with their core personal values" (Grant, 2007: 404). The relation between the nurse and the resident is a paradigmatic example of such a situation in which the employees really tend to care for the beneficiaries of their work, and thus this relational tendency to have overlapping identities should be especially strong in such work. Additionally, as I will argue later, my observations made it clear that the residents were not merely passive recipients of care, but that their attitude towards the caregiving activities largely influenced whether the

situations developed into a caring connection or not. The residents were active contributors to the caregiving process that therefore must be understood as bidirectional in an important sense. This makes it all the more important to understand the encounters between the nurse and the resident from a relational perspective. Both theoretical insights and my personal observations thus assured me that the relational paradigm is central to understanding what happens in caring situations and especially in caring connections.

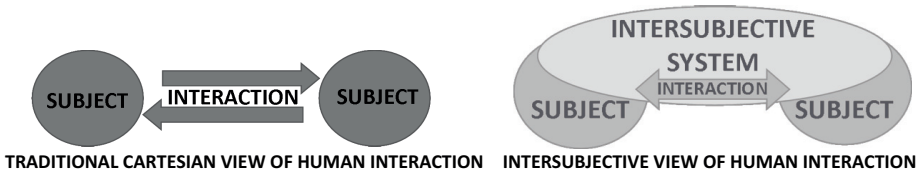


Figure 1 Two perspectives on human interaction.

Applying this relational systems perspective to the caring situation, one could say that the participants – care provider and care receiver – together give rise to an intersubjective dyad within which their interaction takes place. An intersubjective dyad is "an interactive field with a unique organization of its own" (Beebe & Lachmann, 2005: 25). It should be viewed as a higher-order construct that emerges from the interaction of both participants but is not reducible to the individual subjectivities of them (see Figure 1). Instead, it comes into being through a process of co-construction and interpersonal regulation into which both participants bring their subjectivities, their interaction styles and their anticipations of the behavior of the other (Beebe & Lachmann, 2005). More generally, both participants bring their individual life histories that have formed a certain structure of subjectivity for them along to the encounter. When these individual subjectivities come into interaction, this interaction forms the dyad that is unique to their meeting. In this way, the "worlds of inner experience and intersubjective fields mutually constitute one another" (Stolorow, 1997: 339). Behind this perspective is a highly dynamic view of humanity. This means that the intersubjective perspective "stands in direct opposition to a view of the analyst and the patient as separately identifiable and relatively stable units with distinct characteristics that exist independently of the therapeutic context" (Martela & Saarinen, [Forthcoming]). Instead, the "permanence of 'structure'" is replaced with a

"flow of change" (Sander, 2002: 14). The experience, thought and behavior of individual participants are continually co-constructed within the dyad. The forms of being of both participants and their typical patterns of interaction are not static entities but are instead continually enacted in their moment-by-moment interaction.

Through this intersubjective systems perspective, we come to place special emphasis on the affective and nonverbal dimensions of the caring situation. Affectivity is viewed as having a central motivational role (Stolorow et al., 2002: 678). The intersubjective interaction, its regulation and mutuality, happens largely in an implicit, nonverbal dimension (Beebe et al., 2003). This means that "at the nonverbal level, mother and infant, as well as analyst and patient [and nurse and resident, we may add], participate in a moment-by-moment coordination of the rhythms of behavior" (Beebe & Lachmann, 2005: 25). In other words, the coordination of their action occurs through split-second bidirectional interaction in which the participants are implicitly reacting to each other on multiple levels simultaneously, including facial and vocal affect, visual attention, touch, spatial orientation of the body and a more holistic facial-visual engagement in the situation (Beebe et al., 2010: 9–10). When the nature of the relationship is looked at from this "vantage point of the moment-to-moment interaction" (Waldron et al., 2004: 1111) then we must understand how "at every moment, there is the potential to organize expectations of mutuality, intimacy, trust, repair of disruptions, and hope" (Beebe & Lachmann, 2005: 207).

Applying this perspective to our case here we could say that when the nurse enters into interaction with the resident, an implicit bidirectional process of mutual matching of bodily signals is immediately initiated, and this implicit process will to a large extent color the experience they have of the encounter and of each other. In other words, an intersubjective dyad is formed between them. This dyad will influence and regulate the behavior of both participants, and it is within this dyad that their interaction takes place. As indicated before, another way to conceptualize such a dyad is to say that a **system** is formed between the nurse and the resident (cf. Martela & Saarinen, [Forthcoming]). We may follow Weick & Roberts in defining a system as a "joint situation of interrelations among activities" (Weick & Roberts, 1993: 363) and in emphasizing that: "such a system does not reside in the individuals taken separately, though each individual

contributes to it; nor does it reside outside them; it is present in the interrelations between the activities of individuals" (Asch, 1952: 252; Weick & Roberts, 1993: 363). A meeting between a certain nurse and a certain resident can thus be understood from the point of view of the unique system that is formed between them through mutual expectancies and implicitly matched bidirectional affective and bodily signals.

Through this systems perspective we also come to see how the intersubjective dyad unfolds through time. Rather than seeing the interactions between the nurse and the resident as isolated incidents, we must see them as parts of the ongoing process, in which the systems dimension between them is continuously constructed and reconstructed. Through their mutual history, certain habitual interactional patterns and expectations are built into their mutual encounters. Thus the interactive moments between the nurse and the resident are colored from the beginning by their mutual interactional history, the nature of this history defining what kind of interpretive and interactive patterns are triggered in the situation. These systemic effects can make it extremely hard to change the interactional pattern between two participants once it has established itself with due integrity. The system can in effect constitute a relatively independent third dimension of the interactive situation that can to a large extent determine how the two participants will behave in this particular situation.

Summary

In summary, the discourses within infant research, therapeutic research, and other relevant fields is able to bring us a much more nuanced view of one-on-one human interaction. Through a relational view of human beings, which emphasizes our connectedness with others, they show how the interaction between human beings goes much deeper than what an atomistic, individualized and cognitivized view of human beings would reveal. We attune to each other on multiple non-verbal levels simultaneously, and this attunement leads to mutual, implicit adjustments of one's behavior and thinking. When we take into account how both persons' micro-attunements feed into each other below conscious awareness on a split-second basis, this grows into a view of two persons forming an intersubjective dyad that has its unique patterns of unfolding. I

believe that it is through this relational systems view of human interaction that we can best understand what takes place in the tender encounter between a nurse and a resident.

It can be noted that this perspective of the relational dyad between the nurse and the resident connects with the humanistic school of nursing. According to Pierson, researchers within this tradition see relationships in nursing as intersubjective processes, and instead of a Cartesian individualism they rely on a notion of a "mutually constructed understanding of reality constituted through relationships" (Pierson, 1999: 300). For example, Boykin and Schoenhofer argue that "the nursing situation develops when one person presents self in the role of offering the professional service of nursing and the other presents self in the role of seeking, wanting, or accepting nursing service" (Boykin & Schoenhofer, 2001: 17). Therefore, the intersubjective and relational view of the caring situation between the nurse and the patient is nothing new in nursing research. *Within nursing research, however, researchers have not been able to look at these situations with the same depth that has been made possible by infant researchers' analyses of the micro-level interactions between the participants. Therefore, the delicate analysis of the relational and systems dimensions that infant and therapeutic research is able to offer can considerably deepen the ways in which this relationality is conceptualized and understood within nursing*. And as argued, researchers of positive relationships are welcoming research efforts that draw from disciplines not traditionally associated with organizational research (Dutton & Ragins, 2007a: 388). *This is one of the contributions of the present work.*

PART III: METHODOLOGY

Chapter 5: Abductive inquiry – a pragmatic approach for conducting organizational research

> *"What Bacon omitted was the play of a free imagination, controlled by the requirements of coherence and logic. The true method of discovery is like the flight of an aeroplane. It starts from the ground of particular observation; it makes a flight in the thin air of imaginative generalization; and it again lands for renewed observation rendered acute by rational interpretation." – Alfred North Whitehead, 1929 (1979), Process and Reality, pp. 5.*

Introduction

Organizational researchers attempting to start an empirical inquiry face an inescapable choice as regards the chosen ontology, epistemology, and nature of inquiry underlying their research. Whether one makes the choice implicitly or explicitly, these basic assumptions influence what kind of methodological approaches are appropriate, what kind of phenomena one is able to observe and capture, and what kind of results one can expect to find in the first place.

As regards these underlying dimensions, the basic choice has often been framed as one between a positivistic and modern research paradigm on the one hand, and more interpretive and postmodern paradigms on the other hand (see e.g. Hatch & Cunliffe, 2006; Chia, 1995). Without going any deeper into an analysis of the historical developments, it could be stated that traditionally organizational research has been carried through in quite a positivistic spirit. To generalize, in this framework the ontological assumption about there being one objective reality and the epistemological belief in the ability of sciences to capture this reality have contributed to an attitude of inquiry that seeks out "general theories about organizations and their members, which are reminiscent of the powerful universal laws found in the natural sciences" (Donaldson, 2003: 41). These epistemological commitments influence the research process as they require "methods of

collecting and analyzing factual depictions of the world that reveal singular truths or realities and that can be used to evaluate (falsify) hypotheses" (Gephart, 2004: 457).

In recent decades and especially in European contexts, this attitude has been challenged (e.g. Chia, 1995) from a perspective that is based on a more constructivist epistemology and that accordingly emphasizes the "practitioners' lived experiences" (Tsoukas & Knudsen, 2003: 11) and how "models and theories purporting to account for organizational phenomena are not so much reflections of an objective reality as subjective constructions built from a variety of symbolic constructs" (Tsoukas, 1993: 323). This in turn requires research methods that are able to acquire a deep sense and interpret the actual meanings of the actors involved and provide 'thick' descriptions of their social setting (Gephart 2004: 457). The existence of diverse meanings is allowed for and the researchers don't possess any authority to state that their perspective is somewhat better or 'truer' than the other possible perspectives. Thus, the contemporary epistemic odyssey could be characterized as the challenge of "trying to find a passage between Scylla – the rocks of dogmatic modernity – and Caribdis – the whirlpool of dispersed post-modernity" (see Baert, 2003: 89). In here, several authors have suggested that pragmatism could provide the 'third way' through which the research journey could be navigated in beneficial directions while avoiding both extremes (Calori, 2000; Powell, 2001; Wicks & Freeman, 1998).

So, in terms of methodology, the present dissertation aims to make a contribution by offering an alternative to both positivistic and constructivist approaches to organizational research by starting from a pragmatist position as regards ontology, epistemology and the aim of inquiry. The pragmatist tradition has had surprisingly little direct influence on the social sciences (see Baert, 2003: 89), but has recently started to inspire a growing number of organizational scholars (e.g. Wicks & Freeman, 1998; Carlsen, 2006; Simpson, 2009; Simpson & Marshall, 2010). The notion of abduction in particular has provoked interest among organizational researchers (Alvesson & Sköldberg, 2009; Locke et al., 2008; Weick, 2005). Personally I am convinced that this tradition has great potential in influencing our research practices even more in the future. Accordingly, I will start out with a more detailed exploration of what implications the pragmatic philosophical tradition will have for organizational research. The

methodological framework that I come to embrace through this discussion I have chosen to call *abductive mode of inquiry*. As I will argue below, I define it as an approach to research where the researcher proceeds from his own preunderstanding and puts it into an active interplay with the data as well as with various theoretical frameworks, with the aim of constructing the most trustworthy and practically beneficial understanding of the phenomenon under scrutiny.

Pragmatic ontology and epistemology

> *Action ... is the way in which human beings exist in the world. (Joas, 1999)*

As stated, instead of the traditional choice between realist and constructivist options, the ontological and epistemological starting point in this article is pragmatic (Dewey, 1908; James, 1991 [1907]; Peirce, 1931)[12]. At the most basic level this means that experience is taken as primary; as human beings we can never escape our embeddedness within the world of experience into which we are thrown as actors. This means firstly that we are inescapably situated within a stream of experience that constitutes our human condition. "We happen to be humans existing in irreducibly human situations, located in a human world" (Pihlström, 1996: 17) and thus "the only natural starting-point, from which we can proceed in every direction" is the "world of man's experience as it has come to seem to him" (Schiller, 1912: xxi). Secondly, we are engaged with our lives; our relation to the stream of experience is active. Some experiences are more preferable for us than others and our sense of agency places us in a position where we feel that we can influence our future experiences through our choices of action. Ontologically, pragmatism means an attitude of orientation that takes seriously the fact that as human beings we are thrown into a world in which we need to act (see e.g. Putnam, 1994: 152). Accordingly, the world is not primarily something to be observed but something within which we aim to live our lives as best we can.

[12] A note about my relation to these classics: My notion of abduction is greatly inspired by Peirce (1998a), the 19th century founding father of pragmatism, but the relation of my epistemological and ontological account to Peirce's position is complex, and thus on this level I rely more on James and Dewey and the tradition that has followed them.

As regards epistemology, pragmatists believe that all our beliefs are in the final analysis future-oriented "rules for action" (James, 1991 [1907]: 23). As we are within the world primarily as actors and only secondarily as thinkers, knowledge itself is seen as one special form of action, which "like any other action, brings about changes to the world" (Baert, 2003: 97). Anchoring the value of knowledge to the practical life of particular human beings, pragmatists come to embrace fallibilism, the doctrine according to which "we cannot in any way reach perfect certitude nor exactitude. We never can be absolutely sure of anything" (Peirce, 1931: Vol. 1: 147–149). Instead our knowledge "swims, as it were, in a continuum of uncertainty and of indeterminacy" (Peirce, 1931: Vol. 1: 171). The possibility of ever reaching absolutely certain and final knowledge is thus closed for a pragmatist.

On the other hand, not all forms of understanding are of equal value. Some interpretations of reality seem to allow us to better succeed in our projects (James, 1991 [1907]: 23). As a trivial example, there seems to be a strong practical necessity of accommodating our movements to robust physical facts; running against a concrete wall will hurt and not lead us to the place we were heading for (Määttänen, 2006: 13). Accordingly, in pragmatism any idea or theoretical construct is judged by its practical usefulness in advancing the particular projects and goals human beings have in their lives; thus some of them are judged as better in pragmatic terms (James, 1991 [1907]: 88). While this doesn't provide an objective or absolute standard for evaluating beliefs, we do not face full relativism; from the point of view of particular human beings some frameworks are always better than others; they are more suitable as guiding frameworks for our actions in bringing forth the kind of results we are aiming at. Pragmatists thus insist on the "practical, social value of knowledge" (Baert, 2003: 89). In pragmatism, increased knowledge is not about getting the correct "representation of reality in cognition" but is an expression of an "increase of the power to act in relation to an environment" (Joas, 1993: 21).

This does not, however, mean that we can simply start believing in anything we find suitable at any given moment. Single beliefs are tied up with larger belief systems and it is these systems as wholeness that are judged as more or less usable maps to navigate in the world in a suitable way. As Peirce (1877: 14) puts it: "what is more wholesome than any particular belief is integrity of belief." In addition, individuals don't come up with their

believes in isolation, but as parts of a community of inquirers which further sets norms for reasoned justification of one's believes (see Dewey, 1998b; Hildebrand, 1996).

As regards science, pragmatism acknowledges no categorical difference between scientific inquiry and other forms of inquiry: "Sciences themselves are outgrowths of some phase of social culture, from which they derive their instruments, physical and intellectual, and by which their problems and aims are set" (Dewey, 1998c: 311). Science, then, as a *human* enterprise, is also restricted by the same fallibilism as other forms of human inquiry. Despite its sophisticated methods it cannot offer any royal route to truth. So even scientific theories can ultimately be judged on nothing else than with their bearing on the pragmatic challenges of our everyday life. As Dewey (1998a [1938]: 383) states: "Scientific subject-matter and procedures grow out of the direct problems and methods of common sense, of practical uses and enjoyments." What sets science apart from other forms of inquiry are its rigid standards and assessment procedures through which the scientific community aims to assure the accuracy of the gathered knowledge (see Dewey, 1998a [1938]: 383). It is also important to note that science is essentially a collective form of inquiry; individual scientists are tied to the larger community through a variety of mechanics such as the peer review system, which makes the production of scientific knowledge essentially a collective process. Science, then, is a highly sophisticated form of collective inquiry, the procedures of which have been shaped by generations of inquirers attempting to find the most reliable method to make sense of the world together.

Pragmatism acknowledges that science can provide different and seemingly competing explanations of the same phenomena. From the pragmatist point of view these different frameworks are not competing but rather they complement each other: Given certain practical purposes, a certain framework will lead one to take into account the most important factors, while in some other pursuits some other framework can prove to be most useful. Einstein's special theory of relativity might be accurate and sophisticated but Newtonian physics in its simplicity is more useful in most practical purposes. So instead of looking for one right and final theory, one is looking for well-grounded and accurate theories that have their own spheres of application.

This pragmatic understanding of the function of science is found in the writings of many contemporary writers of organizational research and nursing science. The latter especially sees its role as being quite closely connected to the promotion of health, as is evident in the following statement by Jonsdottir et al. (2004: 247): "The essence, purpose and social mandate of the discipline of nursing is the development and use of knowledge for people's health." In organizational research the same practical tendency is found for example in Weick (1989: 524), who contends that "the contribution of social science does not lie in validated knowledge, but rather in the suggestion of relationships and connections that had not previously been suspected, relationships that change actions and perspectives." Powell (2001: 884) declares the same message more boldly: "To a pragmatist, the mandate of science is not to find truth or reality, the existence of which are perpetually in dispute, but to facilitate human problem-solving." Watson, in turn, inspired by pragmatist epistemology, argues that the 'truthfulness' of organizational research papers is fulfilled when they will enable the readers of these studies "to cope more effectively than they otherwise might should they become practically involved in the settings covered in the studies" (Watson, 2011: 207). The pragmatic approach to organizational research thus means an attempt to generate practically useful knowledge for the actors operating in and with organizations.

With the pragmatic emphasis on the practical utility of knowledge, one comes to realize how doing research is always an ethical activity. "*If* it is true (as we surely believe) that inquiry is inevitably value determined, then any given inquiry will necessarily serve *some* value agenda" (Lincoln & Guba, 1985: 9). The ultimate aim of any inquiry is to create knowledge that is useful; understanding that advances the purposes of particular human beings. But realizing this, researchers need "to engage in discussion about which purposes are advanced and why" (Wicks & Freeman, 1998: 129) and this puts an end to the illusion of a value-free science. As noted by Tsoukas and Knudsen (2003: 15), organizational phenomena "do not rest upon invariable social laws, but upon the stability of the beliefs and expectations of the actors involved." Because research influences those beliefs, writing organizational research "is always already an ethical practice in that it entails an active rendering of reality, rather than a passive reporting of it" (Rhodes, 2009: 654). Simpson (2009: 1333) reminds us that "we are all

active participants (practitioners) in our social worlds. It is through our participation that we continuously construct and re-construct the social meanings that shape our thoughts and actions." Because researchers are considered to possess expertise as regards understanding of organizational phenomena, their opinions carry extra weight in this construction process and thus they have great potential to influence and change people's beliefs about organizational reality. From this, a heavy responsibility follows to reflect on the potential beneficiaries of the knowledge created and to be transparent about the values advanced.

To summarize, in pragmatism the aim of scientific inquiry is to create shareable forms of understanding that are fallible, but are nevertheless able to paint for us a picture of the experienced reality that is adequately reliable and most useful in bringing forth the kinds of experiences we are aiming at. Pragmatism suggests that the ultimate justification for all forms of knowledge is their practical usefulness as tools for navigating in this human world. No more, no less. It suggest *no more* because – to quote Powell (2002: 879) – "to claim anything more [- -] reflects a vast overestimate of the veracity of human judgment, rationality, perception, and language, and a futile clinging to the false security of empirical 'certainty'". But it suggest no less, because to suggest less would lead to the post-modern condition where "all metaphors are partial truths" and "there is no way to determine what constitutes 'better' forms of meaning creation" (Wicks & Freeman, 1998: 128). Practical utility and fallibilism are the compasses used by the pragmatist organizational researcher to navigate the inquiry towards generating knowledge that is useful for the actors operating in and with organizations.

Abductive mode of inquiry

Given the general pragmatic outlook outlined above, the traditional choice between inductive and deductive forms of reasoning seems inappropriate. Deductive modes of reasoning in organizational research involves "testing theory against practice using a positivist epistemology", while inductive modes involve "developing theory from practice using an interpretive epistemology" (Hatch & Cunliffe, 2006: 26). Usually – but not necessarily – deductive reasoning is connected to quantitative research where one tests a pre-formed hypothesis against a set of data, while inductive reasoning is

used in qualitative research to draw theory from the richness of pure data. Thus, in ideal form, induction starts from theory-free facts while deduction starts from fact-free theory (Alvesson & Sköldberg, 2009: 4). Both of them have their problems as forms of inference suitable for organizational research. Deductive reasoning as used in organizational research "does not provide selection criteria for choosing between alternative explanations" and thus in effect "sidesteps the question of alternative explanations and focuses instead on testing a single theory for empirical adequacy" (Ketokivi & Mantere, 2010: 318). Additionally, it is not suitable for the generation of new theory from the data. As for inductive reasoning, ever since Hume (1968 [1739]), philosophers of science have realized that in inductive reasoning there is an "unavoidable logical gap between empirical data and theoretical generalizations" (Ketokivi & Mantere, 2010: 316)[13]. Something more than pure induction is always necessary in order to interpret the data. Given that both deductive and inductive reasoning are usually committed to certain epistemologies and given the pragmatic emphasis on the usefulness of knowledge, a more appropriate alternative for pragmatist inquiry is found in abductive reasoning.

Having found both deductive and inductive reasoning lacking, Charles S. Peirce proposed that we need a third form of reasoning to complement these two. This he called abductive reasoning, "the process of forming an explanatory hypothesis" (Peirce, 1998b [1903]: 216), which has sometimes been called *inference to the best explanation* (Josephson & Josephson, 1994: 5; Marcio, 2001: 103). In the classic formulation of abduction, a surprising fact is observed and this initiates a search for a hypothesis that would best explain the surprising fact (Peirce, 1998a: 231). Thus abductive inquiry starts with surprise, wonder, doubt or similar feeling that problematizes one's current way of explaining reality. This initiates a process where the inquirer uses imagination (see here Alexander, 1990) to come up with a novel way of seeing matters that is consistent with the larger context of his or her other experiences and ways of seeing the world,

[13] In addition, it has been argued that both inductive and deductive forms of reasoning in actuality involve abduction at some point of the process (see Marcio, 2001: 103). For example, Josephson and Josephson (1994: 21; quoted from Marcio, 2001: 103) argue that "the whole notion of a 'controlled experiment' is covertly based on abduction. What is being 'controlled for' is always an alternative way of explaining the outcome."

as well as explaining the surprising fact. Abduction thus is a creative process, it is about the insight of "putting together what we had never before dreamed of putting together" (Peirce, 1998c [1903]: 227); making the leap of imagination in order to form the most believable explanation of the matter at hand. Abduction is therefore a learning process – and arguably the only form of inference that can explain how new knowledge comes into being (see Prawat, 1999).

Although it can be argued that all three forms of reasoning – deductive, inductive, and abductive – play some role in all types of research (Mantere & Ketokivi, In Press), some forms of reasoning are more centrally connected to certain research paradigms. Deductive reasoning is especially useful for confirming and disconfirming hypotheses (Mantere & Ketokivi, In Press) and thus is easily connected with a positivistic research paradigm where one seeks out "general theories about organizations and their members, which are reminiscent of the powerful universal laws found in the natural sciences" (Donaldson, 2003: 41). In inductive reasoning, generalizations arise from the data and it has been found especially suitable for post-positivistic inductive case research where the research process produces "surprisingly 'objective'" results (Eisenhardt & Graebner, 2007: 25). Abductive reasoning emphasizes the active interpretive component of the researcher in theoretical inferences and has thus been adopted mostly by researchers working within an interpretive paradigm (e.g. Alvesson & Kärreman, 2007; Wodak, 2004). However, as compared to more interpretive and constructivist epistemologies, pragmatic epistemology gives us better tools at assessing what is a good explanation and what is not (see Wicks & Freeman, 1998). Embracing the constructivist idea that "models and theories purporting to account for organizational phenomena are not so much reflections of an objective reality as subjective constructions built from a variety of symbolic constructs" leads to a situation where different suggested perspectives are not justified by their relation to reality, but grounded merely in "intra-paradigmatic metaphorical lines of reasoning" (Tsoukas, 1993: 323). Against this, pragmatism argues that some theories and explanations are better than others in guiding our behaviour within organizational reality. In other words, even though no theory can claim the status of objectivity, in practical terms some theories are better maps for navigating in the world than others. Thus it can be argued that the pragmatic background paradigm

is especially suitable to be combined with abductive reasoning in organizational research.

In a scientific context and most generally stated, the aim of abductive inference is to arrive at the best available explanation taking all into account – one's observations, one's preunderstanding, and any other material available such as previous theoretical explanations about the phenomenon. 'Best' here thus doesn't refer to any objectively best explanation, but to the best explanation from the point of view of the particular researcher or research community. The way of reasoning found in classical detective stories such as Sherlock Holmes is often used as an example of abductive inference, because in them the detective demonstrates staggering creative capacity in putting together seemingly insignificant facts that become explainable only through the hypothesis generated by the ingenious protagonist (e.g. Paavola & Järvilehto, 2011). Medical diagnostics is another good example of abductive reasoning. The physicians observe certain symptoms, compare them with their previous knowledge, perhaps consult some books or colleagues and take further tests to arrive at their diagnosis (see Alvesson & Sköldberg, 2009: 5). The result is thus neither a logical necessity of the premises, nor a pure induction from the symptoms, and might not always be accurate but it nevertheless gathers together the best possible educated guess of the physician. In order to arrive at this understanding, "a constant movement back and forth between theory and empirical data is necessary" (Wodak, 2004: 200). The result of abductive reasoning is not the final truth about the matter – because of the fallibilism such a thing is unobtainable – but a tentative hypothesis that nevertheless would best explain the evidence and has the most potential to provide practical results.

What abduction could mean as a general model for scientific inquiry is captured best in the following quotation from Dewey[14]: "Inquiry is the controlled or directed transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to

[14] In here, it is appropriate to quote the notion made by Marcio (2001: 102): "Dewey, though acknowledging his intellectual debt to Peirce, does not actually use either the term 'abduction' or 'abductive inference' in any of his writings on logic. Still, the presence of the activity these terms are invoked to represent is unmistakable in Dewey's approach to logic."

convert the elements of the original situation into a unified whole" (Dewey, 1998b: 171). Thus, in scientific inquiry one starts from a situation in need of explanation: Given one's current world view and theoretical understanding, the data represents something surprising, novel or interesting; something one wants to understand better. Through an iterative process of abduction in which one utilizes the existing data and perhaps gathers some new data and makes use of different theoretical perspectives, one aims to reach an appropriate explanation of the puzzling situation. The aim is to reach a situation in which the data to be explained, the theories adopted and one's evolved world view form a "resolved unified situation" (Dewey, 1998b: 174); in other words a wholeness in which one's new way of seeing the matter is able to explain in a satisfactory way what before represented a mystery (cf. Alvesson & Kärreman, 2007).

In organizational research, abductive reasoning has sometimes been labeled *inference to the best explanation*[15] and according to Ketokivi and Mantere, reasoning within it is viewed as a "context-dependent process" with three distinct forms of contextualization (Ketokivi & Mantere, 2010: 323–324): Firstly, the reasoning style of all researchers is influenced by their "idiosyncratic backgrounds and knowledge bases"; their arguments are built upon their existing forms of understanding. Secondly, through 'thick description' (Geertz, 1993b) of the empirical context, the reader is invited to achieve maximal access to the details from which the proposed theory is built. And thirdly, theory "plays an integral role in the reasoning process", and particular theories are allowed to interfere with the inference process and lead it into certain directions.

Gathering together the first and third insights of Ketokivi and Mantere, we see that in abductive reasoning the role of the researcher is active; he makes a leap of imagination to put together the facts to arrive at a novel hypothesis that would best explain what is being explained. In this process the data itself and the preunderstanding of the researcher are in constant interplay (see also Dubois & Gadde, 2002; Peirce, 1998c [1903]: 227). But the researchers are as much 'cultured beings' as the people they study (Watson, 2011: 212). In the pragmatic epistemology, there is no such thing as pure

[15] Although this line of research is often traced back to scientific realist philosophy (Harman, 1965) it has been used also in constructivist approaches (e.g. Locke et al., 2008; Mantere, 2008; Wodak, 2004).

uncontaminated experience, "even so-called *pure* perception – i.e., perception understood as radically distinct in nature from intellectual or cognitive activity – is a species of abduction" (Marcio, 2001: 110), and thus the data the researcher draws upon is always already interpreted in one way or another. Dewey (1998c: 48) states that "experience [- -] is full of inference. There is, apparently, no conscious experience without inference; reflection is native and constant." In modern terms, the same idea of the important role of the researchers' frame of understanding is expressed in the idea of *theory-ladenness of observation,* around which contemporary philosophers of science have attained a wide consensus about (Alvesson & Sköldberg, 2009: 6; Hanson, 1958; Kuhn, 1962). It claims that we "never see single sense-data, but always *interpreted* data, data that are placed in a certain frame of reference" and that "seeing is inseparable from the perspective, *it is perspectival"* (Alvesson & Sköldberg, 2009: 6). Therefore, "how we *know* reality depends upon how we *experience* it, and our experience is in turn determined by our conceptual schemes" (Marcio, 2001: 110). In a way, abduction is thus about evolving the researcher's way of perceiving – his perceptual schemes – to accommodate for novel experiences that disturbed these schemes by seemingly not fitting into them. Actual inquiry thus never starts from a neutral *tabula rasa* position, but it takes place through the actions of the inquirer that are shaped by his or her particular world view, *Weltanschaung*.

To supplement the abductive understanding of the aim of inquiry, we can complete it with a hermeneutical understanding of how this process takes place[16]. Along with Alvesson and Sköldberg (2009: 5–6), I see that applying abductive inference leads to a hermeneutic process "during which the researcher, as it were, eats into the empirical matter with the help of theoretical pre-conceptions, and also keeps developing and elaborating the theory." At the heart of hermeneutics is a view of understanding as a circular movement in which "we must understand the whole in terms of the detail and the detail in terms of the whole" (Gadamer, 2004 [1960]: 291).

[16] Within philosophy, abductive and hermeneutical have usually followed separate paths because they have been embraced within different traditions, but a deeper look at them reveals that there is much that they can offer each other. For example Umberto Eco views the abductive "logic of interpretation" as a model for hermeneutical processes (Eco, 1990: 59).

Hermeneutics emphasizes the historical situatedness of our knowledge; the fact that we always operate from within our own horizon of understanding that restricts our possibilities for interpretation. We make an interpretation based on our present understanding, but this novel interpretation simultaneously shapes and widens our world horizon, thus enhancing our capability for future interpretations. As with Dewey (see Marcio, 2001: 99), the criteria for correct understanding is holistic: "harmonizing all the particulars with the whole" (Gadamer, 1988 [1959]: 68). In organizational research, the hermeneutical has been interpreted to mean that the researcher is

> *deepening his understanding of the meaning of the text in circular movement where the details of a certain text [or any data] are contrasted with emerging, more generalized theoretical thoughts. The aim of the hermeneutical researcher is not to arrive at an 'original meaning' of the text [data] but to seek to enter into a dialogue with it, seeking to 'merge horizons' between the interpreter and the text [data]* (Mantere, 2008: 299).

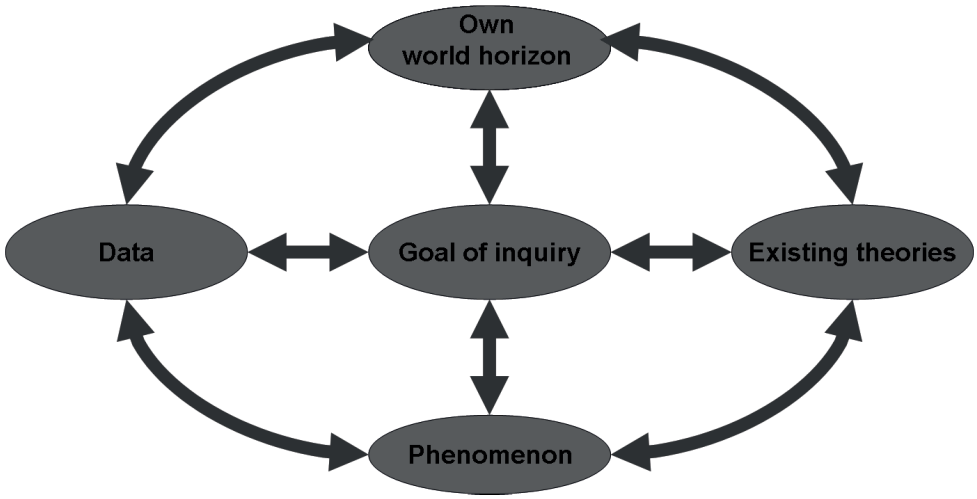


Figure 2 Abductive research process

The abductive mode of inquiry therefore means a continuous circular movement between one's own preunderstanding, the data one has gathered, and existing theories to reach an understanding of the phenomenon under scrutiny that best serves the practical interests one has

chosen to advance. This means that the research questions, the theories used, and the insight gained are all "crystallized in an iterative process" (Mantere, 2008: 299), the main elements of which are the phenomenon under scrutiny, the data available related to the phenomenon[17], existing theories regarding it and the researcher's own world horizon (see Figure 2). The researcher, equipped with his or her preunderstanding, encounters the phenomenon at hand by gathering data about it and familiarizing him or herself with theories about it. When successful, the circular movement is essentially a spiral: At the beginning of the process the preunderstanding of the researcher and the data stand apart from each other; a gap of wonder separates them. In the iterative process the aim is to get them closer to each other; to arrive at a harmonious picture where the data makes full sense, according to one's acquired horizon of understanding and given one's knowledge of different theoretical perspectives.

Five strategies for a researcher wanting to conduct abductive inquiry

Abductive inquiry, as presented here, leads to the embracing of five virtues as part of the research process. These could be thought of as strategies that aid one in bringing forth a fruitful abductive explanation (cf. Paavola, 2004). The first two, *attitude of holding theories lightly* and *reflective self-awareness,* could be seen as general virtues of abductive orientation, while *reflectivity, transparency* and *iterativity* are especially connected to the scientific research process.

Given that the commitment to fallibilism is a central part of the pragmatic framework and subsequently the abductive mode of inquiry, the central virtue of a researcher operating within this paradigm becomes *an attitude of holding theories lightly*[18]. There is namely a paradox in the pragmatic

[17] The concept of data must be understood here broadly to include any material or experience that the researcher is able to capture about the phenomenon and that he or she uses to make sense of it. It can therefore include anything from interviews, participant observation, questionnaires and archival data to physical measurements of some bodily reactions and phenomenological auto-ethnographic sense-making of one's inner experiences.

[18] I borrow the term from Donna Orange (1995). Inspired by Peirce's fallibilism, she proposes *the attitude of holding theories lightly* as part of her attempt to build an

epistemology as a mode for inquiry. On the one hand, we need our current preunderstanding – our concepts, beliefs and theories – to make any sense of our research topic in the first place. They are the "habits of interpretation and action ready for use, and in use, in our transactions with the world" (Locke et al., 2008: 908). On the other hand, the whole point of abductive inquiry is to transcend our current preunderstanding, to expand it so that it can accommodate novel experiences. Metaphorically speaking, we must fix and transform the ship while we are sailing in it. To succeed in this, we must 'unstiffen' (James, 1991 [1907]: 26) our beliefs and theories; they should not 'block the path of inquiry' by blindfolding us from encountering surprising facts and novel events. It becomes our task to find a balance between committing ourselves to certain ways of seeing the world, while at the same time upholding a certain distance to these commitments, and this is not easy to achieve. As Peirce noted, "the pragmatist knows that doubt is an art which has to be acquired with difficulty" (CP 6.498). We must learn to "hold our theories lightly, in a fallibilistic spirit, ready to be surprised and prepared to admit our theoretical [- -] mistakes" (Orange, 1995: 52).

Within organizational research, Miles and Huberman (1994: 11) communicate this attitude in advising how "the competent researcher holds [- -] conclusions lightly, maintaining openness and skepticism", while acknowledging that "the conclusions are still there, inchoate and vague at first, then increasingly explicit and grounded." Similarly, Locke, Golden-Biddle and Feldman (2008) – inspired by Peirce's notion of abduction – have advanced this kind of attitude in proposing that we should *make doubt generative*. They argue that "living doubt is necessary to energize inquiry" (Locke et al., 2008: 908) and look for ways to engage, cultivate and use it in the research process. Instead of fearing doubt and uncertainty, we should embrace the moments and feelings of not knowing something. "Abduction is not just something that we do; it is a consequential process" (Locke et al., 2008: 913) and often needs doubt and surprise of not knowing to initiate. Therefore, in order for anything novel to work, we need to "disrupt the order", to fight against the impulse of thinking that we already know (Locke et al., 2008: 915). Our minds are "powerful rationalizers" that easily jam any unusual fact into an existing category or explain it away with

---

epistemology for psychoanalysis that would best serve the practitioner in her attempt to heal the psychological and emotional life of the patient.

an existing theory before any real sense of doubt and wonder has the time to develop (Abbott, 2004: 244–245; quoted from Locke et al., 2008: 915). We need strategies such as deliberately introducing diversity and contradicting metatheories to one's interpretation process to get rid of the assurance of already knowing and to give room for novel ways of seeing. Additionally, embracing doubt means nurturing hunches, because these felt senses of 'what may be' are what can guide researchers to "feel their way through doubt toward knowing something new" (Locke et al., 2008: 913).

This attitude of doubt is connected to the second virtue of abductive modes of inquiry, *reflective self-awareness*, which means a continuous attempt to become aware of one's own preunderstanding and biases. As has been emphasized, pragmatist epistemology means acknowledging that we always engage with the world from within our "finite human lives", from a perspective that is dependent on "the flux of social and practical life" (Margolis, 2006: 8). This means that acknowledging the tenets of one's current perspective becomes a central strategy to open oneself up to novel ways of seeing the world. This need for self-awareness as a way of understanding what is different is eloquently put by Gadamer:

> *A hermeneutically trained mind must from the start be open to the otherness of the text. But such openness presupposes neither 'neutrality' about the objects of study nor indeed self-obliteration, but rather includes the identifiable appropriation of one's own pre-opinions and prejudices. One has to be aware of one's own bias, so that the text presents itself in its otherness and in this manner has the chance to play off its truth in the matter at hand against the intepreter's pre-opinion. (Gadamer, 1988 [1959]: 73.)*

The abductive mode of inquiry thus means acknowledging the influence of one's own preunderstanding, rather than attempting to hide or downplay its role. Accordingly, the ideal of good research should be transparency, being as reflective and explicit as possible about one's own biases and blind spots. This means a continuous reflective effort on behalf of the researchers to become better aware of their own preunderstandings, because "to bring, as it were, a prejudice to my own attention cannot succeed as long as this prejudice is constantly and inconspicuously in play, but rather only when it is, so to speak, stirred up" (Gadamer, 1988 [1959]: 77). The researcher can

never attain full awareness of his or her blind spots but nevertheless a continuous quest towards widening one's horizon should be a sign of a good researcher. The ideal is not an *a-perspectival researcher,* as this would be impossible, but rather something along the lines of a *reflective perspectivality*. As an example of this quest for increased self-awareness, during the research process I wrote a fifty-page personal essay where I attempted to make sense of the influence of my nationality, family background, personal characteristics and various life events on my present-day self, world view and ways of thinking.

The virtues of holding theories lightly and of reflective self-awareness could be characterized as general virtues of the abductive inquiry. As a mode of inquiry for scientific enterprise, abductive inquiry needs to be supplemented with three additional strategies that should characterize the research process: reflectivity, transparency and iterativity. The need for continuous *reflectivity* about the research process stems from the nature of inquiry in pragmatism: As objective truth is unattainable, the preunderstanding of the researcher matters, the results are measured by their practical bearings, and doing research becomes a question of knowing what kind of knowledge one is producing. In revealing different aspects about the complex social processes at play in organizations, different forms of knowledge advance the point of view of different organizational actors and the realization of different values. Choices regarding research questions, target organizations, data collection methods, analyzing methods and ways of displaying the results all influence what kind of knowledge the researcher is producing (see Miles & Huberman, 1994: 10–12), and should thus be seen as ethical questions. Additionally, as theory is allowed to interfere in the research process (Ketokivi & Mantere, 2010: 324), one also needs to be reflective about what theoretical perspectives one utilizes in different parts of the research process. As there is no correct answer to these choices, the responsibility of the researcher is to be as conscious and reflective as possible about the reasons and consequences of one's choices. Reflection is something one should engage in with every choice about the research process.

In terms of reporting one's research, the obligation to make reflective choices in every stage of the research process turns into an obligation to be as *transparent* as possible about these choices. As Watson argues, the fact that the researcher is a 'cultured being' "necessitates the researcher writing

reflexively so that the readership, or social scientific community (to speak more formally), can situate or 'appreciate in context' the content" of the study (Watson, 2011: 212). One should attempt to state aloud as much as possible what the guiding values and principles have been that have led oneself to making the choices one has made during the research process. Accordingly, the ideal of good research should be transparency, being as reflective and explicit as possible about one's own biases and blind spots. Hence the long discussion about my guiding values in the introduction section of this dissertation. Naturally, one can never be fully transparent about one's preunderstanding, because there are always two kinds of preunderstanding or subjectivity: "the accounted for and the not accounted for, the tamed and the untamed" (Heshusius, 1994: 16). Nevertheless, recognizing that one's choices are based on one's values and beliefs and stating them out loud as much as one is aware of them is a much better option when compared to letting these enter into the research process in disguise and without explicit acknowledgement. Transparency and honesty – and not a "pretense of factuality" (Rhodes, 2009: 654) – becomes the guiding principle of pragmatism-oriented research.

In practice, the required reflectivity is often best attained through doing research in *iterative steps* that allow room for in-between reflections about one's choices as regards different dimensions of the research process. Rather than designing the whole research process at the beginning and sticking to it, an abductive mode of inquiry encourages the researcher to allow for the hermeneutical circle to spin and develop the researcher's insights in order to be able to make even more conscious choices about the research design in the later stages. More often than not, the early encounters with the research topic give rise to novel insights as well as vaguer hunches about what is important and what is valuable. In order to pursue these "notions that may only express themselves as an intuitive feeling of something" (Locke et al., 2008: 913), one should leave enough room in the research design for the hunches one acquires in the early stages of the research process to be explored in the later stages of the process. Being reflective about one's research choices and upholding a fallibilistic attitude towards these choices means that the pragmatic researcher should always stay open to reiterate his or her research choices and thus uphold the iterative ideal as part of the research process.

Conclusion

Adopting the pragmatic background philosophy means that the researcher is no longer reaching for the one verified truth. Instead, all that can be achieved through abductive inquiry "is an intersubjectively constructed and shared *truth"* (Reichertz, 2004: 164). For social scientists, this means that the researchers first have to engage with the data and the existing theoretical perspectives to move their personal understanding to a point in which they are themselves convinced that it adequately explains that which was surprising from their previous point of view. After that they need to communicate their new way of thinking about the matter to the other members of the research community in a way that makes use of the existing theoretical discussions, and that is able to show transparently enough how and why the researcher found the new theoretical insight convincing, given the gathered data and their own preunderstanding about the matter. At the end of the day, these novel theoretical insights are judged based on the practical usability of the proposed views for the particular actors working with and within the phenomena described by the theory.

In the next chapter I link this theoretical account of a pragmatic way of carrying out research into practice by describing what I actually did during the research process and how I justified different choices made during this process.

Chapter 6: The research process

> *In dwelling upon the vital importance of* sound *observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellanous information or curious facts, but for the sake of saving life and increasing health and comfort. – Florence Nightingale, 1859 (1860), Notes on Nursing, pp. 125*

Introduction

Having given the theoretical grounding for my research approach, let us now turn to a discussion of how the empirical research process of this dissertation proceeded in practice. The aim of this dissertation is to make sense of certain phenomena taking place between human beings in the setting of a nursing home through a process of inquiry that conforms to the standards of social sciences. More precisely, I attempt to look at the everyday encounters between the nurses and residents to see what we can learn about human interaction and relationality from there.

The phenomena under scrutiny are relational processes that happen in the 'space between' the organizational actors (see Bradbury & Lichtenstein, 2000). It has been argued that to investigate relational, multilevel processes within organizations it is best to deploy a "qualitative, interpretive, and ethnographic research strategy with a strong situational focus" (Küpers, 2007: 211; Alvesson, 1996). This advice is strengthened by writers in the field of nursing research, who also emphasize the advantages of qualitative research methods when the study object is to uncover the meanings of the intimate and reciprocal caring relationship between the nurse and the client (McCance et al., 1999: 1393; Pierson, 1999: 297).

Additionally, the chosen research strategy should reflect the amount of existing knowledge of the topic. According to Edmondson and McManus (2007: 1162), in a situation where little previous theory exists around one's chosen topic, "rich, detailed, and evocative data are needed to shed light on the phenomenon." Accordingly, they propose the usage of qualitative methods such as observations and interviews with open-ended research questions as the best research strategy in these situations.

Another reason in favor of a qualitative research approach was my own experience as a researcher. As a PhD student with no experience whatsoever of life within nursing homes, and no previous research experience from which to draw any intuitions, I felt that the only meaningful way to conduct research that can really capture something about the organizational realities of the lives of the nurses in a nursing home should involve a deep qualitative encounter with the work itself and the work settings (see also Watson, 2011). As I wanted my insights to also speak to the nurses themselves and not be 'utterances' (see Bakhtin, 1981) within the scientific discourse alone, I felt it necessary to engage qualitatively and deeply with the lives of the nurses before I could feel qualified to say anything meaningful to them about their work realities. To get a *feel* for their lived reality I felt that mere reading of the literature would not serve me right. Thus, a qualitative research approach felt like the only meaningful possibility for me given my research objects, my previous experience and the phenomena I was interested in.

Additionally, the qualitative research approach suited better my underlying wish to make visible and legitimize the soft and humane dimensions of organizational life. As Gephart (2004: 455) has argued, "qualitative research has potential to rehumanize research and theory by highlighting the human interactions and meanings that underlie phenomena and relationships among variables that are often addressed in the field." Different research approaches support different interpretations of the reality, and I felt that in this case the qualitative approach was best in harmony with my personal values. I believed that I could best make justice to the lived experiences of my research subjects through a deep qualitative inquiry into their everyday life.

Accordingly, I chose to gather the data for the study primarily through semi-structured interviews and participant observations. The usage of two different methods was chosen because it allowed for between-method triangulation that would increase the quality and reliability of the data gathering process (Denzin, 1978; Jick, 1979). The combination of interviews and participant observations is often used because they offer good synergy: the observations lead one to be more informed within the interviews to ask the right questions and understand the context from within the interviewees' answers, while the interviews offer an opportunity to ask about the things that one has observed and to validate one's felt senses about what one has seen. On the surface level, the interviews might be

characterized as my primary form of data – it was through the process of interpreting and making sense of their content that most of the research insights crystallized. At the same time I feel that the often tacit sense of how things work in the organization that I developed through participant observation played a major role in this sensemaking process. As Watson (2011: 204) has argued, "interviews carried out in the absence of close observation and workplace interaction with research 'subjects'" are of little use if one really wants to "learn a lot about what 'actually happens' or about 'how things work' in organizations."

Because little previous research employing the relational paradigm to the interaction of the carer and cared-for existed in organizational research, I chose to aim for the development of nascent theory (Edmondson & McManus, 2007: 1158). In developing nascent theory, the main strategy is to use "iterative, exploratory content analysis" to develop new constructs and suggestive models (Edmondson & McManus, 2007: 1164). The aim was thus to identify novel phenomena, connections and patterns from the data to develop "a suggestive theory of the phenomenon that forms a basis for further inquiry" (Edmondson & McManus, 2007: 1163). As I will argue below, grounded theorizing was the methodology that fitted these purposes best and thus it was employed in this research. In general, this dissertation is explorative in nature; it attempts to gather a deep, qualitative understanding of the observed phenomena.

In what follows I will first offer a general description of the site of the research, followed by overall picture of the data collected. After that I will justify my choice of grounded theorizing as the methodology for data analysis, and finally I will provide a sequential description of how the actual research process took place.

The nursing home as the site of the research

Given my willingness to dig into the emotional and relational dimensions of organizational life I could – for reasons given below – think of no better place than a nursing home as the site for my empirical research. Accordingly, the site of the present research was a large nursing home located in Finland that accommodates nearly 600 residents. The organization was divided into 23 units. The units had approximately 24 residents and employed around twenty regular nurses and a head nurse in charge of the whole department. Most of the residents seemed to have some

degree of physical frailty and often also a degree of cognitive frailty (cf. Brown Wilson, 2009). The nurses worked in three shifts so that during the morning and afternoon shifts four nurses were present, and during the night shift only one. In addition there were a number of apprentice nurses, which meant that in many of the shifts there seemed to be at least one or even two of them present. The various units operated quite independently and had some variation in their resident profiles. For example, residents with severe memory problems were gathered in one unit, residents with mental illnesses in another, while short-term residents that were expected to return home after a period of time were gathered in a third unit. To get a wider view of the nursing home work, I familiarized myself with most of the different units at some point in the research process.

The nature of work within the nursing home is very much about human interaction (e.g. Caris-Verhallen et al., 1998; Kahn, 2005; Pierson, 1999). The main core of the work consists of taking the residents through an ordinary day and assisting them in those activities they needed assistance with. As Johnson and Grant (quoted in Foner, 1994: 247; 1985) summarize, the nurses "lift patients out of bed, wash them, brush their teeth, bathe them, groom them, make their beds, change their soiled linen, clean up after them, dress them, escort them to the dining room, help feed them." They also are responsible for the daily treatments of the residents, such as giving them appropriate medicines, tending to possible wounds and alleviating possible pains. In addition, there are some recreational activities for the residents in which the nurses assist them. Although the present work will concentrate mostly on the positive forms of interaction of the nurses, we should remind ourselves that the work of a nurse in a nursing home is by no means a bed of roses filled only with heartfelt moments with the residents. In fact, a certain amount of emotional exhaustion is understood to be an inescapable result of nurses' primary task: "Stress is an inevitable byproduct of the caregiving task" (Kahn, 2005: 21). The everyday work experience of the nurses includes meeting residents that constantly affront them and can even be physically aggressive. Foner reports from her fieldwork how "many patients are bitter and hostile, often because they are so confused" (Foner, 1994: 247) and this was my experience too. Many were the scratches that I saw on the hands and faces of the nurses that had to take care of residents who offered all possible resistance to their caretaking. Being calm, tender and professional when taking care of these residents clearly required a large amount of emotional labor (cf Ashforth &

Humphrey, 1993). Nurses also had to perform necessary but physically painful procedures on the residents and face their suffering (cf. Molinsky & Margolis, 2005). It can be argued that the psychological defenses they have to use in these situations "absent" the nurses psychologically from these situations and thus "reduce the extent to which parts of their selves are fully there in the immediate situation" (Kahn, 1992: 325). In addition, their everyday work includes repeatedly "washing bottoms and changing diapers" [Nurse 17], lifting, feeding and assisting physically disabled residents and consoling disoriented and haunted residents. Illness and death are constantly lurking in the background in their work environment. In general the work of the nurses in a nursing home is considered to be both physically and mentally demanding (e.g. Bakker et al., 2000). On top of this, a global trend of cost-cutting efforts in the public sector (see Wilkinson, 1995) and an international shortage of qualified staff (OECD, 2005) have led to dissatisfaction, absenteeism, burnout, and concerns about quality of care among nurses in different countries (see e.g. Aiken et al., 2002; Petterson et al., 2005). Nurses complain that in the current healthcare environment with fewer financial and personnel resources, it has become increasingly challenging to try to build relationships with patients and their significant others (Hagerty & Patusky, 2003: 147). Unfortunately, when it comes to this trend, elder care in Finland is no exception (e.g. Kröger et al., 2009). In accordance with these general trends the nurses in this study also experienced their workload as being heavy and had a feeling that the cost-cutting and downsizing efforts in recent decades had left them to cope with an increasingly tough work environment.

Despite these hardships, a nursing home provides an appropriate place to study the relational perspective of human life, because the nature of the work offers quite vivid opportunities for relationally deep caregiving moments to occur between nurses and residents. As Pierson (1999: 294) concludes "relationship as an intersubjective process is essential to the practice of professional nursing." In elder care this dimension is even more salient than in other forms of nursing because of the long-term nature of the care and the opportunities for relationship-building that result from the fact that the nurses and residents may interact on a daily bases for many years.

Thus the present work could be stated to employ an extreme case approach to the studied phenomenon of relational dimension of organizational life (Eisenhardt, 1989: 537; Starbuck, 2006: 149–150; Yin, 2009: 47) that aims

to "push the boundaries of our thinking" (Quinn & Worline, 2008: 500). It can be argued that the nature of interaction between the nurses and the residents is "unusually revelatory" (Eisenhardt & Grabner 2007: 27) of the emotional and tender dimensions of human interaction. Therefore, the nursing home as an organization in which these relational phenomena are visible and dominant is an especially good place to start an investigation in which the aim is to get a deep, qualitative understanding of these phenomena that have been researched relatively little in the past.

Gathered data

The data gathering process for this study was implemented in three waves between the spring of 2009 and the summer of 2011 (see Table 2). The gathered data was analyzed in between these waves so that in subsequent gathering phases I was equipped with the insights from the previous stages. This is in accordance with the grounded theorizing principle of theoretical sampling, in which decisions about later data gathering are made based on the theory that is being constructed (Suddaby, 2006: 634). As stated, the primary methods for data gathering were interviews and participant observations. The rule of thumb for grounded theorizing is that at least 25 interviews are needed for theoretical saturation (Suddaby, 2006: 639). The data for this dissertation well exceeds this as I conducted in total 13 days of participant observation and carried out 40 interviews lasting in total around 27 hours.

Starting with the interviews, I personally interviewed 26 nurses. The interviews were semi-structured (Rubin & Rubin, 2005) and lasted on average 38 minutes so altogether I had approximately 17 hours of interview data with the nurses. Transcribed, these interviews amounted to 258 pages of interview data. The interviewed nurses represented all age groups and varied in age from twenty-four to sixty and had been in the field from half a year to thirty years. Of the interviewees, all except for one nurse were female. This reflects the general gender balance in the occupation and the fact that in the units where I carried out the interviews, the interviewed male nurse was the only one that was available during the time of the interviews. To protect his identity, I will refer to all nurses with the feminine pronoun.

Secondly, I wanted to interview some residents in order to capture their perspective on the studied phenomena. As I will explain later, it was

something of a challenge to find residents to be interviewed as most of them were already physically or mentally in such a condition that a fruitful interview with them was not possible. The final resident interviewees numbered five – three women and two men. These interviews were semi-structured and lasted between 10 and 28 minutes with the average being 18 minutes. The interviewed residents varied in age from 78 to 91 and were chosen based on their relatively good condition so as to be able to give meaningful answers to my questions.

Thirdly, to get a slightly different perspective on the studied phenomena, I interviewed nine head nurses. Of the twelve head nurses working in the nursing home, all were women and accordingly also all my interviewees were women. Representative of this, I will use the feminine pronoun in discussing leaders throughout this document. The interviewed head nurses varied in age from twenty-eight to fifty-nine, with most of the head nurses being around fifty years of age. The interviews lasted on average 58 minutes so in total I gathered 8 hours and 44 minutes of interview data (transcribed 133 pages) with the head nurses. Most of the head nurses had extensive work experience as nurses before their current position as supervisors, which they had been in from a couple of months to around twelve years.

It should be noted that during the last set of interviews conducted with the nurses, head nurses and residents, my theoretical models were already quite developed and accordingly I was able to discuss them with the interviewees. Thus we might argue that these interviews amounted to an additional data source as in the case of Dutton et al. (2006: 64), where the responses of the research subjects to their research insights "allowed a comparison of our analysis with their insider experience." Here, however, in the spirit of the iterative nature of the abductive inquiry and grounded theorizing, I will treat the interviews as one data source in total rather than making a separation between initial interviews and the reflective ones. This reflects the fact that interviews were conducted in a number of waves, in between which my theoretical insights gradually matured. Therefore, there is no clear line to be made between the initial interviews and those influenced by my further analysis.

All interviews were recorded with the approval of the interviewees and transcribed verbatim in the language of the interview. One resident refused to allow the interview to be recorded and accordingly my account of this interview is based on the detailed notes I wrote during the interview. The

interview language was Finnish and the quotations from the interviews have been translated by the author. As the nurses and head nurses avoided using the term *patient* and instead preferred to talk about *residents*, this practice has also been adopted in this document. The choice of the word referred to an attitude they spoke of as not seeing the occupants as passive receivers of care but more as human beings living in their final home, where they needed some assistance in their living (cf. Kahn, 1993).

In addition, I conducted thirteen days of participant observation (Spradley & Baker, 1980). During a single day I followed one nurse during her eight-hour daily shift, observing the realities of her working life and listening to her interaction with the residents and other nurses. I also had informal conversations with the nurses during the course of the day where they explained their actions and more general issues about their work to me to varying degrees and in which I inquired about things I saw as interesting, surprising or that I could not understand. I attempted to follow the original idea of ethnography of the Chicago School of sociology[19] in which – according to Watson (2011: 206) – participative observation is best carried out by getting "closely involved with the people being studied in their 'natural' setting [- -] and actively interact and share experiences with them in a manner going beyond simple observation." The level of participation was thus moderate (Spradley & Baker, 1980: 60). This provided the opportunity to experience the realities of the studied nurses' work and considerably deepened my understanding of the nature of the nurses' work in general and about the relational dimension of the work in particular. These experiences were gathered in research notes that I wrote during the day in a small note book and which were supplemented by longer reflections written during the lunch hour or immediately after the observation days.

The observations were conducted with the approval of both the nurses and the residents. Contrary to my initial fear, my presence didn't seem to bother the nurses at all. In fact the nurses seemed to be quite happy that somebody took an interest in their working life and were glad to share their experiences about their work. It might be also noted that to control for the fact that the nurses might 'pose' for me and perform their work differently in my presence, I often asked other nurses in the unit if the nurse I had

[19] It might be noted that Chicago School of sociology was heavily inspired by pragmatist philosophy, especially Mead (see Cook, 2006).

been following behaved any differently from normal in my presence. Most of the time, the nurses stated that the observed nurse seemed to be doing her work in the ordinary manner. On one or two occasions, they reported that the nurse attempted to be especially kind to the residents when compared to her normal behavior. Usually this effect wore off over the long day when the nurse started to become more tired and got more used to my presence. I also attempted to emphasize to the nurses that I was not there to judge them but to observe their work in order to learn more about it.

Similarly to the nurses, the residents also reacted either positively or neutrally to my presence. When the nursing involved more sensitive issues such as going to the toilet or showering, the nurses always asked for the approval of the residents for my presence. Only a few times did a resident refuse my participation and in these situations their will was naturally followed. On many occasions, in these situations I also adopted the habit of voluntarily staying behind while the nurse and the resident went to the bathroom and only listening to their interaction from behind the door in order to not bother the resident too much with my presence. The fact that my presence didn't in general seem to bother the residents at all is most probably related to there being a lot of apprentices within the departments, for whom one of the primary learning methods was to follow and learn from observing the nurses in their daily work. Thus the residents were quite used to someone following and observing the nurses at their work. Additionally, it might be noted that my gender made a positive impression on many residents. They expressed their happiness that there was 'a man in the house' and thus my presence in general was a positive rather than negative impact on the atmosphere of the studied nursing home units.

In addition to interviews and observation, some documentary data was collected and used in the analysis. These included some caretaking manuals, house rules, internal bulletins, etc. that were available on the nursing home premises during the time of the research visits.

Table 2 The gathered data

Time	Gathered data
Mar 2009	5 interviews with the nurses 2 days of ethnographic observation
Oct-Nov 2009	15 interviews with the nurses 4 interviews with the head nurses 5 days of ethnographic observation
Nov-Dec 2010	6 interviews with the nurses 5 interviews with the head nurses 5 days of ethnographic observation
Jul 2011	5 interviews with the residents
Feb 2012	14 feedback forms and oral feedback

Relational observations

Bateson (1972: 314) has argued that the researcher is always "bound within a net of epistemological and ontological premises which – regardless of ultimate truth or falsity – become partially self-validating." This insight can be applied to the debate between the individualistic and relational view of human beings. Approaching our research subjects from either an individualistic or relational paradigm leads to certain research choices as regards valid research questions, chosen methodologies, ways of approaching the subjects and interpreting their actions and words. Through my enculturation into the Western world view I have adopted the dominant individualistic way of looking at human beings. Yet, through this work I have wanted to challenge this by aiming to look at matters from a more relational world view. Accordingly, in this research I have consciously engaged the relational metatheories as regards human nature reviewed above and have thus followed Locke, Golden-Biddle and Feldman's (2008: 915) suggestion that we should use "multiple and various metatheories to disrupt order and stimulate a variety of interpretations of the research context." In particular, I have wanted to commit myself as a researcher to an attitude in which one "continually tests intuitive understandings about social life, [- -] continually challenges conventional wisdoms, and [- -] continually questions taken-for-granted or ideologically-grounded assumptions about the world" (Watson, 2011: 216).

Therefore, to the extent that I have been able, I have let the relational viewpoint influence the basic choices about research subjects, research methods, research questions and the research literature I relate this work to. I hope that through this I am able to observe the things from a different viewpoint as compared to the traditional individualism, and thus be able to

shed light on and highlight certain features that are not so easily seen through more individualistic research lenses. Despite these explicit choices as regards the background paradigm for this research project – choices which are inevitable yet often done implicitly – I have naturally tried to stay as true to the data as possible in the actual data gathering and analysis phases of this research.

This emphasis on relationality also had its impact on the way I observed life in the nursing home. In gaining a deeper understanding of caring connections, I especially felt that my embodied presence in the actual situations was essential. I not only *observed* the caring connections as a researcher, but *felt* them deeply as a human being. Interestingly, my theoretical reading in relationalism enabled me to make more sense of and better utilize these emotional experiences I experienced myself during the research process. The fact that my chosen theoretical perspective influenced my data gathering is in accordance with the iterative characteristic of the abductive research paradigm. Accordingly, the relational paradigm which I adopted during the research process allowed me to also understand the observation process itself in novel ways – or rather it allowed me to see new possibilities within it that a more individualistic paradigm might have concealed. The relational paradigm particularly allowed me to use my implicit and partially bodily senses as well as my capacity for empathy as research instruments.

What I mean by this might come across most clearly by providing an example. When in the interviews I encouraged the nurses to clarify what differentiated an ordinary encounter from the encounter I had started to call caring connections, they were usually quite unable to point to anything concrete. Representative of this confusion of putting these experiences into words is the following quote: “They are not something you really remember that it went like this and this and was like that and that. Because it just happens there…” and “so what just happens to happen at any given time, where it starts going and then it just goes on from that and so on…” [Nurse 17]. Instead of being able to analyze these moments, they stated that it was more something one just sensed: Sometimes they just felt that there was a deep connection between themselves and the resident while at other times this connection was absent, although they were not able to point out any concrete differences between these two occasions. This was also my experience as an observant. On some occasions I could clearly sense that there was something special going on between the nurse and the resident,

while at other times the nurse was just doing her work with the 'regular empathetic touch' that is characteristic of it. Along with the nurses, I felt that I could clearly sense when caring connections occurred, but when pressed to clarify what exactly made me so sure about my judgment, I could not state anything more concrete than 'the tone of her voice', 'the warmth in her eyes' or 'the tenderness in her being.'

This reliance on intuitive, aesthetic, and empathic elements as a central part of the observational work was one reason why Humphrey, Brown and Hatch (2003) employed the metaphor of jazz to describe the ethnographic process. Producing an "in-depth, intuitive, and empathetic understanding of the *other*" is one aspect of the ethnographic work and here "acute social sensitivity" is important (Humphreys et al., 2003: 10). By drawing a parallel to jazz music, they argue that "ethnographers in the field try to interject themselves in others' experiences by joining in their situations and 'jamming' along with them until they get a feel of the *tune* that their subjects are playing" (Humphreys et al., 2003: 13). Although it is important that ethnographers are also able to distance themselves from their subjects and draw more reflective and general conclusions from their experience, this more analytic aspect of the process must be combined with a more intuitive-based attunement to the life of the research subjects. Looking back at my observatory experiences I feel that I can relate to this way of understanding of what happened to me – or rather what happened between me and the research subjects – in the nursing home.

One way to explain how this intuitive level works is to talk about our psychological sensitivities. Recent psychological research has revealed that information processing takes place on two different levels that have been given many names, for example System I and System II (Kahneman, 2003). System II refers to cognitive reasoning, to the realm that is traditionally conceived as thinking. System I is about intuitive, cognitively non-accessible forms of information processing. This kind of processing is fast, parallel and embraces the environment holistically (Dane & Pratt, 2007; Kahneman, 2003.). As social animals, our relational knowledge – our ability to read the faces, poses and other nonverbal signals of others – operates mainly on the System I level. The split-second microanalyses of the synchronized facial and vocal exchanges between a baby and her caregiver have helped to reveal the fundamental human ability to be in relation to others, to attune oneself to the social systems one is surrounded with (see Beebe et al., 2010). The researchers make it clear that this

attunement happens mostly on a preverbal and non-cognitive level (Beebe & Lachmann, 2005; Stern, 1985). In other words, as human beings we are attuned to sense these qualities of interaction on unconscious System I levels, but we are often unable to explicitly pinpoint the sources of our sensing. As an example of this nonverbal attunement, consider this story of a nurse caring for a patient with cancer: "Sometimes a patient will look at me without a single word. I know that the look conveys the message 'I know…that you know' meaning death is near. Sometimes, a touch or simply a look or a feeling will convey the message….but it is there all right." (Jones, 1999: 1300)

During the research process I gradually became more knowledgeable about this dimension of human experience and accordingly I could start to employ it more systematically as one part of my observational capacity. Thus I used my natural sensibility to attune to and empathize with the experience of the other as a research instrument, which enabled me to get a more nuanced picture of the realities I was experiencing in the nursing home. I started to pay more systematic attention to how I felt in the situations I was experiencing and used these sensibilities as cues for my interpretations of the emotional realities playing out in these situations. In ethnography "the major research instrument is the researcher" (Humphreys et al., 2003: 7), and as my main target of observation was the relational dimension of organizational life, it was thus only natural that I as a researcher employed my relational capabilities in order to experience and understand these phenomena.

Grounded theorizing as a pragmatic approach to analyzing the data

Because of the explorative, theory-generating nature of this work, the guiding principle in the choice of the analyzing techniques was to find out how to get the most out of the data. Accordingly, my main methodology for analyzing the interviews was – in accordance with the suggestion of Edmondson and McManus (2007: 1163) – grounded theorizing (Glaser & Strauss, 1967; Suddaby, 2006), especially the more constructivist brand of grounded theorizing (Strauss & Corbin, 1998)[20]. The techniques provided

[20] There are different interpretations of grounded theory, most famously the later divide between the originators, with Strauss favoring a more constructive and creative approach and Glaser advocating a more positivistic and formal approach (see Charmaz, 2006: 129–

by that approach were chosen because they have been widely adopted within social sciences and organizational research (Bryant & Charmaz, 2007; Gephart, 2004), and they offer a reliable and systematic way of moving from particulars of the data into more abstract constructs. Grounded theorizing attempts to stay true to the reality of those researched and allows room for the employees to speak "in their own voices" (Ashforth et al., 2007). It is especially suitable for research that aims to "elicit fresh understandings about the patterned relationship between social actors" and in situations in which the "researchers have an interesting phenomenon without explanation and from which they seek to 'discover theory from data'" (Glaser & Strauss, 1967: 1; Suddaby, 2006: 636). Both of these conditions describe the present research well.

I also saw that grounded theorizing was compatible with the general pragmatic outlook outlined in the previous chapter. In fact, according to Suddaby (2006: 633), Glaser and Strauss originally looked to the pragmatism of Charles Pierce and George Herbert Mead to find an alternative to the strict positivism that permeated social research in the 1960s. Very much in accordance with the pragmatic approach, they offered a compromise "between extreme empiricism and complete relativism by articulating a middle ground in which systematic data collection could be used to develop theories that address the interpretive realities of actors in social settings" (Suddaby, 2006: 634). Grounded theory also walks the pragmatic middle ground between induction and deduction by emphasizing abduction instead (Suddaby, 2006: 639). Although Strauss and Corbin never employ the term 'abduction' themselves, recent scholars have argued that the Peircean spirit of abduction is strongly present in their work (Bryant & Charmaz, 2007: 16), for example when Strauss and Corbin (1998: 137) argue that effective grounded theory requires "an interplay between induction and deduction (as in all science)." In accordance with my interpretation of abduction offered above, grounded theorizing is about "moving between induction and deduction while practicing the constant comparative method" (Suddaby 2006: 639). It is about imaginative

130). Of these alternatives, the interpretation adapted in here is closer to the former *straussian* way of emphasizing the more active and creative role of the researcher conducting grounded theory. Following Gephart (2004: 459), I use the term *grounded theorizing* instead of *grounded theory* because it captures the iterative and process-like characteristic of this approach better.

discovery, but discovery that is grounded in the data and the existing theoretical frameworks.

Of the various interpretations of the core of grounded theorizing, I follow that offered by Suddaby (2006). He argues that grounded theory is "an interpretive process that depends upon the sensitivity of a researcher to tacit elements of the data or meanings and connotations that may not be apparent from a mere superficial reading of denotative content" (Suddaby 2006: 639). For him, the two key concepts of grounded theory are "constant comparison" and "theoretical sampling." The first of these means that data should be collected and analyzed simultaneously, while the second emphasizes that decisions about what data should be collected next are determined by the theory that is being constructed (Suddaby 2006: 634). He also reminds us that the researcher must engage in ongoing self-reflection to ensure that they take "personal biases, world views, and assumptions into account in collecting, interpreting and analyzing data" (Suddaby 2006: 640). All of this is very much in accordance with the pragmatic virtues of iterativity and reflectivity I offered above. In addition, my suggestion about the attitude of holding theories lightly has its counterpart in grounded theorizing in the form of theoretical sensitivity that means among other things that the researcher needs skills to be able to "abstain from forcing preconceived concepts" on the data and to be able to "entertain a range of theoretical possibilities to account for a surprising finding" (Bryant & Charmaz, 2007: 17).

In Suddaby's interpretation, the researcher's role is active: creative input is needed from the researcher in moving from the data into theoretical insights (Suddaby 2006: 638). Such an approach emphasizes the contextuality of one's interpretation and calls for reflectivity about one's presuppositions and their role in the interpretation (Charmaz, 2006: 131). Unlike some more puritanical interpretations of grounded theorizing, Suddaby (2006: 635) also argues that existing theories can be employed in the grounded theorizing process. In successful analysis, one needs to have theoretical sensitivity, which means researchers' "openness to new or unexpected interpretations of the data, the skill with which they combine literature, data, and experience, and their attention to subtleties of meaning" (Suddaby 2006: 640). This is in accordance with the original insight of Glaser and Strauss. They distinguished between *substantive theory,* which is grounded in extant research, and *grounded theory,* but

argued that "substantive theory is a strategic link in the formulation and generation of grounded formal theory" (Glaser & Strauss, 1967: 79):

> *We believe that although formal theory can be generated directly from data, it is more desirable, and usually necessary, to start the formal theory from a substantive one. The latter not only provides a stimulus to a 'good idea' but it also gives an initial direction in developing relevant categories and properties and in choosing possible modes of integration. Indeed it is difficult to find a grounded formal theory that was not in some way stimulated by substantive theory. (Glaser & Strauss, 1967: 79)*

In the same spirit, Dey (2007: 177) argues that validity in grounded theorizing is not about theory testing but rather about "the extent to which a theory is well-grounded empirically *and* conceptually. [- -] When we develop categories, we need to take account of their theoretical underpinnings and implications as much as their efficacy with regard to the data." This again fits well with my attempt to generate new understanding of the relation between the nurse and the resident making use of the relational understanding of human beings.

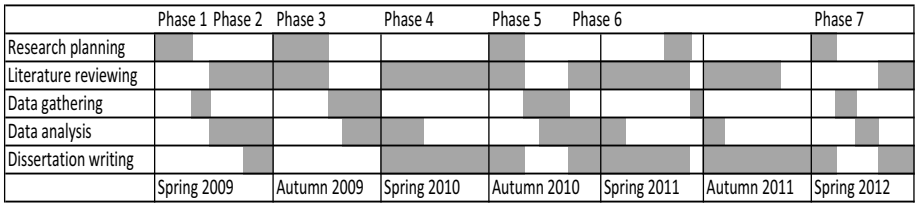
All in all, there is a clear "pragmatic core" in grounded theorizing; it was "founded as a practical approach to help researchers understand complex social processes" (Suddaby 2006: 638). Following Strauss and Corbin's (1998: xi) advice, I've used it not as a set of restricting rules but as enabling tools that have helped me to make the most out of the data. Grounded theorizing has provided the methodology that has allowed me to engage imaginatively (Bryant & Charmaz, 2007: 25) with the data to generate unexpected perspectives that are nevertheless grounded in the data and the existing theoretical literature. It has made it possible to be "systematic and creative simultaneously" (Strauss & Corbin 1998: 13).

Phase 1: Initial encounter

Having given a general description of the chosen research site, types of data and the analysis method, it is time to give a sequential description of the actual steps of the research process (see Table 3). The initial encounter with the nursing home consisted of five interviews and two days of participant observation conducted in parallel in spring 2009. The aim of this pilot study was to get acquainted with the nursing home and the work of the

nurses before choosing the more exact topics for the research. At this point my personal theoretical familiarity with the nursing home work was still relatively limited and thus my preunderstanding was mostly shaped by general images of the nursing home work as low-paid and understaffed, but with employees that 'have their heart in the right place', despite the harsh conditions in which they have to work. The interviews were at this point very explorative, with the questions probing the general dimensions of the nurses' work experience and with me attempting to explore particularly interesting themes emerging from the interviews more deeply. The five general themes I discussed with the interviewees were their current feelings about their work, the meanings they attached to their work, the emotions they experienced in their work, stories about their work history, and the best and worst things about their work. Each theme contained around three to five open-ended main questions, followed by probes and follow-up questions to pursue interesting topics brought up in the interviews. Some representative examples of the questions asked are: "What are the things you like about your job?", "Can you remember a situation when you really had a hard time with your job?", "When have you really felt that you are doing meaningful work?", "Have you ever thought about quitting the job and why?", and "What sort of things help you get along with your work?' Given the semi-structured nature of the interviews, I attempted to explore particularly interesting themes in more detail and didn't feel the necessity to ask every question in the protocol with every interviewee.

Table 3 Flow chart of the phases of the research process



As the aim of the research at this point was to keep the data collection process as open as possible to all emerging themes, the interviewees were chosen through *open sampling* (Strauss & Corbin, 1998: 206), which in this case meant that I interviewed the nurses that were available for interview at the time of the interviews. The five nurses interviewed ranged in age from 35 to 60. One of the interviewees was a trainee nurse. The interviews lasted on average for 35 minutes. All in all, I attempted to keep myself as open as

possible to the themes that would emerge from the interviews and the observation.

The two days of participant observation followed the general description given above and consisted of following one nurse during her daily shift from beginning to end, eight hours later. Participation was moderate (Spradley & Baker, 1980: 60) and I wrote research notes throughout the day and gathered longer reflections written immediately after the observation days. Arriving at the nursing home on the first day, I was quite nervous and didn't really know what to expect. Getting used to responding to the residents in a natural manner took some time. Regarding the nurses' work, it turned out to be quite a lot like what I expected it to be: taking care of the residents in their daily routines. At first I was surprised that the nurses didn't seem to be in as much of a hurry as I expected – they weren't running from one place to another and in the middle of the day they often had time to relax in the coffee room. Gradually I learned that the stress they experienced was not only physical but also emotional exhaustion caused by the responsibility they had in terms of the residents' well-being and life and of having to interact with often intractable residents. In addition to stress and exhaustion, I observed in the nurses a great deal of tenderness, satisfaction from being able to help and commitment to the well-being of the residents.

Phase 2: Analysis and theoretical deepening

The interviews were transcribed and the transcriptions were content analyzed by the author using the grounded theorizing techniques offered by Strauss and Corbin (1998). I felt that the coding procedures they suggested would give me the necessary "analytic tools for handling masses of raw data" as well as help me to "consider alternative meanings of phenomena" (Strauss & Corbin, 1998: 13). At this early stage of the research, my aim was to let the themes emerge from the data itself as much as possible and for this the data-driven approach provided by these techniques was helpful. I thus started to analyze the interviews without any theoretical framework consciously in mind at the outset. I felt that at this pilot stage of the research, this was an appropriate way to start my abductive inquiry, because I wanted to let the reality of the nursing home life guide me towards the most appropriate theoretical framework rather than choosing a theoretical framework from the beginning and attempting to fit the data

into it. I am of course not implying that the way I coded and categorized the data was purely inductive and that it emerged from the data as such. My ways of categorizing were most probably in many ways influenced by my culturization and my values that sensitized me to certain ways of interpreting my experiences, but at least it wasn't directly and consciously influenced by any theoretical frameworks of organizational research. I thus attempted to remain as open as possible to different interpretations of my data at this point. In general, I attempted to follow Saku Mantere's advice in looking at the interviews in a hermeneutic way that "initially involves accepting the position of the interviewee as granted, yet engaging in a critical dialogue, conscious of the researcher's own preconceptions" (Mantere, 2008: 299).

In the first stage of the coding, *the open coding phase*, I assigned *ad hoc* codes to all statements that I felt to be significant in light of my emerging research questions, and I paired these codes together with the original quotations from which they emerged. This approach was chosen as I felt that it would best preserve the nuances of the statements. In addition, it provided the greatest amount of flexibility and the widest pool of potential higher-level codes for the consequent rounds of coding procedure. The underlying idea was to open up the text to expose the relevant meanings, ideas and thoughts contained therein (Strauss & Corbin, 1998: 102). The sizes of the pieces of coded material varied from a few words to a couple of sentences. This procedure resulted in 153 different categories. During the process the understanding gained through participant observations served as a guide to how to make sense and categorize the interview data. The results of the analysis were thus constantly compared with the insights gained from the observations.

In the next stage I started to organize the data into more abstract higher-order categories. Firstly I analyzed the data based on its emotional tone, which resulted in four overarching categories. One category included the items that seemed to describe positively attuned aspects of the work, in another those that described negatively attuned aspects of the work, in the third those items that included suggestions on how things might be improved. Finally I had a neutral category for those items that seemed important but didn't fit into any of the previous categories. After this I started to work with the data in various ways, including drawing different diagrams and displays based on the data (see Miles & Huberman, 1994: 11) with the objective of finding the most meaningful way of categorizing and

making sense of it. This was a highly iterative process in which the categories created were continuously modified and changed to best fit with the data. This stage resulted in the data being categorized into a three-stage hierarchy with 28 different categories at the lowest level.

At this point, I also started to familiarize myself more with the theoretical literature around the topics brought up in the interviews and with the general theoretical discourse around nursing and nursing homes. After reading about such approaches to employee well-being as the demand-control model (Karasek, 1998) and effort-reward imbalance (Siegrist, 1996), I found that the job demands-resources model (e.g. Bakker & Demerouti, 2007) fitted best with my experiences at the nursing home and with my way of making sense of the data. This stage also involved many discussions with my colleagues as well as presenting and getting feedback on some preliminary findings at a couple of Finnish conferences on related topics. The aim was – in the abductive spirit – to make possible a 'fusion of horizons'; to arrive at some synthesis of understanding about the well-being related phenomena going on in the nursing home reality. Thus, my final way of categorizing and understanding the data at this point (see Table 4) was partially inspired by the job demands-resources model as well as with other theoretical literature I read during this iterative process of data analysis. In it I divided the well-being related aspects of the work into two overarching categories: job resources and job demands, both of which had three themes. My theoretical insights were, however, far from saturated at this point and thus these categories should be treated as preliminary. I will not discuss them more deeply here. Their main function was to guide me further in the later stages of the research.

Table 4 The hierarchical ordering of the data at the end of Phase 2

Job resources:	Job demands:
Personal resources	**Work characteristics**
Right kind of attitude to work	Bad conscience
Commitment to work	Unrealistic demands
Clear separation of work and leisure	General work characteristics
Positive resources outside of work	Work settings
Professional pride	Customers
Work community	**Work community**
Good work atmosphere	Bad atmosphere
Support from fellow employees	Lack of support
Appreciation of your work	Bullying
Helping the apprentices	Drawing a veil over problems
Work characteristics	Work avoidance
Good moments with the customers	**Leadership**
Gratitude from the customers	Lack of supervision of work
Feelings of good caretaking	Mistrust and lack of understanding for leaders
	Feeling that leadership doesn't understand the job
	Not interfering in visible problems
	Lack of support and respect from leaders

Phase 3: Main encounter

The second encounter with the nursing home and the people therein occurred in autumn 2009. At this point I had chosen to focus my research on the well-being of the nurses and how it is connected to the relations between the nurses and the residents. My initial research phase had convinced me that this was an important dimension of the nurses' work experience, and as it tapped into dimensions of life that I considered as intrinsically valuable – well-being and human relationality – I felt this to be a worthy topic to explore further. Thus my questions and my observations at this phase focused mainly on these aspects of the work.

At this point I interviewed fifteen nurses working in four different units within the nursing home. The interviews lasted on average 37 minutes. Again, the interviews were semi-structured and the interviewees were chosen through open sampling to allow room for interesting themes to emerge. However, a couple of the interviewees were chosen at this point based on a theoretical sampling (Strauss & Corbin, 1998: 201) in order to get a more representative sample. For example, the only male I interviewed was chosen to balance my sample which at that point consisted exclusively of women.

The themes I explored at this point overlapped quite a lot with the themes discussed in the first phase, but they now concentrated more directly on the

well-being and relational aspects of the nurses' work. The interviews now consisted of seven general themes that I explored with all the interviewees: Current feelings about the work, felt sense of the work, the meanings attached to the work, ways of coping with demanding work, colleagues and workplace atmosphere, relations with supervisors, and especially relations with residents. Each theme contained around three to five open-ended main questions, followed by probes and follow-up questions to pursue themes brought up in the interviews. Some representative examples of the questions asked at this stage are: "Describe the best moments you have had in your work?", "How do you cope with demanding work situations?", "What could be done to improve the atmosphere in your work unit?", "How do your supervisors promote your well-being?" and "What kind of emotions do you experience during a typical work day?"

In addition, I interviewed four head nurses. These interviews were on average 55 minutes long. As supervisors of the work units, I felt that they would be equipped with special insights about the social dynamics of the work community. The questions for the head nurses explored the same themes listed above, but in addition to their own perspective I asked them to reflect on the questions from the point of view of the nurses they were supervising. Additionally, I asked questions about their own relations to their subordinates. Some representative questions are: "In terms of employee well-being, what is the situation in this unit?", "When problems emerge in the work community, how do you handle them?" or "What kind of feedback do you get from your subordinates?"

The six days of participant observation followed the same pattern as before: Each day I followed a different nurse during her whole work shift observing, conversing informally and making notes. As my research focus had now concentrated more on the relational aspects of their work, I accordingly tried to pay extra attention to these aspects of the work. Quite early on in my observations, I started to realize that the nurses' way of relating to each other and to the residents seemed to take place on implicit, relational levels rather than on a verbal and purely rational dimension. The most important things going on between the nurses and the residents seemed not to need any verbal content, but were taking place through emphatic ways of touching, looking at each other and just being with the other. In addition, the dynamics between the nurses themselves seemed to involve a keen sensitivity for this implicit dimension. Thus I started to feel strongly that if I wanted to understand what is going on in a nursing home I

needed to concentrate on and understand more about this relational dimension. At the same time I came to see that this relational dimension had to fight for its existence against the managerial currents that emphasized measurable targets and tangible aspects of the work. I started to sense that the logic of management coming from the organizational structures and the logic of care emanating from the nurses were clashing in many situations.

As I familiarized myself more with the everyday realities of the nurses, I also grew more sympathetic to their well-being at work, as I saw how challenging upholding it sometimes was. This led to me to commit myself to an attempt to produce forms of knowledge that would strengthen the nurses' own capacities to maintain their well-being as the target of my dissertation. The choices regarding methodology and other aspects of the research process were therefore not value-neutral – in abductive understanding of inquiry they never can be – but the explicit aim from this point onwards was to develop knowledge that would be useful *from the point of view* of the well-being of the nurses. As I have argued, the pragmatist research approach involves a commitment to the production of knowledge for certain practical purposes which makes research an ethical activity. I had been interested in the well-being of the nurses from the beginning but it was at this point I decided to make it the explicit value-laden aim of this particular research project.

Phase 4: Analysis and theory-building

It was during these partly overlapping data gathering and analyzing phases that the main insights of this study emerged. During the observations and interviews a relational picture of the organizational life started to paint itself to my understanding, and it was further clarified and strengthened through the analysis. The analysis phase involved analyzing the data from the interviews, again using methods and tools inspired by Strauss and Corbin (1998), comparing them with the insights from the participant observation and, in parallel, focusing and reading a significant amount of theoretical literature around the emerging topics. The result of this process was already quite a rich picture of the relational life within the nursing home.

Quite early on in this process I found that for me the most captivating and important theme to arise from the data involved the 'caring connections'

between the nurses and the residents. Accordingly, I decided to concentrate my analysis on this theme. I started by coding the data by assigning *ad hoc* codes to all statements that I felt to be significant from the point of view of this theme, and paired these codes together with the original quotations from which they emerged. The sizes of the pieces of coded material again varied from a few words to a couple of sentences. At this point I also realized how this theme was deeply related to the fact that in these situations the participants transcended the traditional view of human individualism. Thus a relational view of the human being emerged as the main theme of my dissertation. This led to a significant deepening into the theoretical literature around individualism and relationalism (e.g. Gergen, 2009; Markus & Kitayama, 1991; Taylor, 1989) that is reflected in my literature review (the first version of which was written at this point). To clarify my thinking around these topics, I also wrote some theoretical memos at this point that became the basis upon which I started to structure the results section of this dissertation at a later date.

The initial open coding procedure around the topic of caring connection resulted in 110 different coded excerpts from the interviews and a large number of theoretical memos in which I explored the thoughts and feelings that these excerpts had awakened in me. I also used the notes from my observations to recall moments in which I had had the privilege of observing meetings with humane overtones. At the next stage of analysis, these coded excerpts were categorized into 23 different categories that were further arranged in four themes (see Table 5). This iterative and self-corrective process was halted only after I felt that every account related to caring connections was adequately accounted for by a conceptual category (see Strauss & Corbin, 1998: 158). The emotional loading that different excerpts carried with them proved to be one of the most important clues that guided my categorization. Some comments emanated a sense of connection while some other comments didn't have this sense.

Table 5 The initial categorization of the data around caring connections

Second-order themes	First-order categories	Examples	Informant
Antecedents			
	Organizational support	"Luckily our head nurse spurs us to go and do this [spend time with the residents]"	Nurse 4
	Nurses' willingness for humane interaction	"Q: What do you like about this work? A: These real contacts with the residents.	Nurse 9
	Residents' willingness for humane interaction	"seeing that the resident is smiling"	Nurse 3
	Absence of haste	"[when you have to work too quickly] it makes you stressed and colder"	Nurse 4
	Human relations skills	"you must be able to jump into the particular situation. It's about situational sensitivity."	Nurse 7
Characteristics			
	Meeting the other as a unique being	"proficiency here is about the skill to meet different people"	Nurse 10
	Transcending work roles	"I can't think of it as this caretaker - cared for -arrangement. Rather I see it as normal social interaction, same I have outside with friends or family.	Nurse 17
	Being present in the situation	"Sitting with them, being with them, listening to them"	Nurse 10
	Being able to help the resident	"When one is able to ease the suffering of other, that brings a good feeling"	Nurse 5
	Receiving gratitude from the resident	"The best moments are when you get positive feedback from the residents themselves"	Nurse 9
	Sharing the emotional states	"their joy and their gaze and that they are really moved by some achievement of theirs. It carries you for a long time!	Nurse 8
	Honesty	"This is the kind of work that you have to do with your own personality	Nurse 7
	Leisurely pace	"we have a special room [- -] where the nurse can take the resident to escape the buzz and concentrate on the well-being of her client"	Supervisor 2
	Being emotionally present	"They [residents] like it that I am more present with the heart and follow the feelings of my heart"	Nurse 16
Forms			
	Concrete acts of caregiving	"I have talked quite much with the customers on the side of the caretaking, for example while helping with getting dressed"	Nurse 2
	Sharing the burden of the resident	"In these moments I feel that the most important thing is the art of listening. You don't have to have any answers. But you aim to support the other as well as you can."	Nurse 7
	Just being there for the other Having a casual conversation	"When one finds a topic to talk about then the basic work is done on the side without either even noticing it."	Nurse 3
	Singing or laughing together	"one late resident of ours was very ill-tempered but when you started to sing to him the irritation disapeared"	Nurse 12
Consequences			
	Deepening of the relationship	"You know, this is also a way of becoming friends" [A resident to the nurse during showering]	
	Enhanced well-being for the nurse	“Doesn’t it carry through the whole day? Or perhaps not the whole day but it leaves a good feeling and that enhances the day in some way"	Nurse 18
	Enhanced well-being for the resident	"The most important stimulus that keeps the spirits of the older people lively and for them to have a positive feeling comes simply from conversation. When you are together with someone and can concentrate with that someone.”	Nurse 17
	Opening up to the valuefulness of life	"They are moments that bring us to a halt: how important I am and how important that other is!”	Nurse 2

In analyzing the interviews I realized that a large part of what takes place in caring connections was happening on an implicit level that was hard to put into words. The nurses – and I myself – seemed to be at a loss of words when describing the peculiarities of those moments. Therefore to get deeper with my analysis I felt it important to familiarize myself with research that has already explored these implicit intersubjective levels of interaction that take place between two human beings. Accordingly, I turned to intersubjective research, which has explored these unconscious dimensions of human interaction in a therapeutic context and in infant research (e.g. Beebe & Lachmann, 2005; Boston Change Process Study Group, 2010; Stolorow et al., 2002), and their insights proved to be central to my emerging understanding of caring connections.

Using the theoretical models of the relational dimension of human interaction, my insights gained through participant observation, and the categorized interview data as raw material, I started to 'play with the data', displaying it in various ways, drawing diagrams, searching for connections and emerging themes. This exploration of what different techniques could reveal about the data was carried out in order to enhance my theoretical sensitivity (Suddaby2006) and to be able to be as open as possible to different interpretations of the data. Through this process I started to feel strongly that the intersubjective way of making sense of the meeting between the therapist and the patient (e.g. Stolorow et al., 2002) fitted well with my insight about the caring connections between the nurse and the resident. Therefore, I started to build my interpretation around it. My understanding of caring connections was arrived at through a truly abductive and hermeneutical process, where the empirical data and theoretical insights were matched together in iterative steps that deepened the understanding of them both until I had arrived at a result that I felt satisfactorily explained what I had observed. This was in accordance with my general pragmatic orientation as well as the guidelines of grounded theorizing as I depicted them above. At the end of this process, a theoretical model started to emerge which included four core processes, five enabling conditions and three central consequences of caring connections as depicted in **Figure 3**.

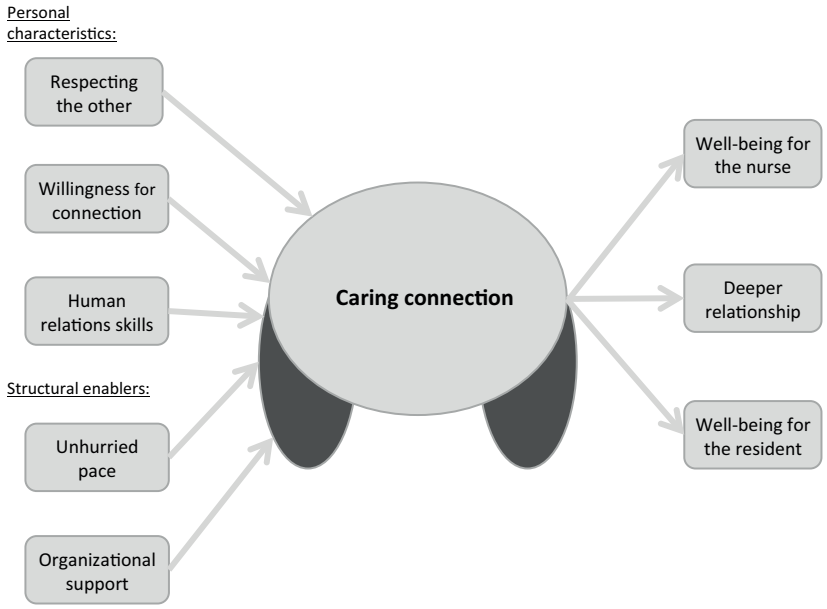


Figure 3. Enablers of caring connections and what caring connections generate based on the analysis at this stage.

Despite having already conducted and analyzed 24 interviews and eight days of participant observation, I felt that theoretical saturation had not been reached. I had a sense that my theoretical model was onto something but that I still needed some more experience of the life within the nursing home to feel convinced about it. Therefore, I decided that I needed to gather some more data. After I had made it clear to myself that a new data gathering period was necessary, I started to prepare myself for the next stage so that I would be as sensitive and open as possible to experiencing and exploring this topic in more detail through my coming observations and interviews with the nurses, the head nurses, and the residents.

Phase 5: Reflective encounter

Autumn 2010 involved a third encounter with the nursing home. This time, my views about the relational dimension of organizational life were already quite crystallized, and I was knowledgeable of a wide spectrum of theoretical lenses through which to look at these matters. I call this visit a reflective encounter, because one of the main points of my visit at this point was to discuss my theoretical insights with the research subjects themselves as well as to observe the interactions between the relevant organizational actors, to see if my insights seemed to make any sense. I already had a clear

sense of the main theme of my dissertation, and this sharpened my ability for observing phenomena related to it. The gathered research experiences and the literature I had been reading enabled me to be sensitized to issues within the nursing home in my participant observations – I was able to pick up on themes and phenomena that would previously have bypassed my attention.

In previous visits I had attempted to explore different units in order to get a more varied picture of the phenomena under study. However, this time I decided that a different research strategy was in place. In order to get a deeper insight into the relational life of one work community and the caring connections taking place there, I decided to spend a whole week in one organizational unit. This turned out to be a good decision as the elapsed time allowed me to establish deeper connections with the research subjects, which made them open up more and reveal things about their way of working that they would have omitted had I only visited them for one or two days. Accordingly, I encountered quite clearly how my understanding of the peculiarities of the organizational life of this particular unit deepened considerably throughout the week.

My observations thus involved spending five days in a row in one work unit. Otherwise they followed the same model as the previous observations: at the beginning of the day I chose one nurse whom I followed throughout the whole workday. However, as I was quite clear at this point what kind of phenomena I was especially interested in, I didn't hesitate to abandon my following of this nurse for a while if something more interesting was happening in another place in the work unit. The week I chose also allowed me to attend two special events that gave me special insights into the nature of their work community. Firstly, the week involved a staff meeting, where the staff and two outside facilitators were supposed to discuss the work atmosphere of the work unit because a conflict between certain members had been escalating already for quite some time. In the meeting it became clear to me who the key players in this conflict were and what roles different people seemed to have in the work community. Secondly, the annual Christmas party of the nursing home staff also happened to be during that week and the nurses of the unit attending the party invited me to join them – an invitation I gladly accepted. The relaxed atmosphere at the party allowed me to have informal conversations with the nurses and they actively shared many interesting insights relating to their work and the work community with me. They also had long discussions amongst

themselves about different residents of the unit and whom they liked and whom they didn't like so much. These discussions were very insightful for my research.

In addition to the observations, I also interviewed six nurses within the same work unit. As my research focus had at this point already concentrated on the caring connections, I could ask quite specific questions about this theme and push the nurses to give rich descriptions of events related to it. So, in addition to the questions used in previous stages, I asked questions such as "Can you describe a moment in which you have felt that you were sharing a special moment with a resident?", "Do you have a special connection with certain residents and how does it manifest itself?" or "Do you sometimes feel that the residents are grateful for the care they receive and if so, in which situations?" I also discussed my emerging insights directly with the nurses themselves to see how much they cohered with their own experiences. These discussions provided an opportunity to get direct confirmation from the research subjects about the accuracy of my analysis as well to further rectify and deepen my insights. These reflective discussions offered an opportunity to make a comparison of my analysis with the "insider experience" (Dutton et al., 2006: 64) of the participants, and thus presented an important form of data triangulation (Denzin, 1978; Jick, 1979) that helped me to get rid of biases and increase the validity of the research findings (Strauss & Corbin, 1998: 161).

This stage of the research also involved interviews with five head nurses, in which I concentrated on the question of how to lead the relational atmosphere within the work unit successfully. The interviews were semi-structured and lasted on average 61 minutes. The head nurses I interviewed varied in age from 28 to 59 and had worked as head nurses for between three months and twelve years. Some representative questions are "What do you feel the nurses are expecting from you as the head nurse?", "What are your ways of influencing the atmosphere in the work unit?" or "Could you provide examples of recent conflicts within the work unit and how you attempted to resolve them?" These interviews allowed me to get information about the wider relational context within which the caring connections took place.

Finally, this stage involved five interviews with residents conducted in summer 2011 in which I attempted to explore caring connections from their perspective. In a sense, the number of interviews was six – three males and

three females – but as one of the men who initially agreed to be interviewed turned out to not give any informative answers but mostly attempted to get me to help him in various tasks before he agreed to answer any questions and then fell asleep immediately after I had helped him, the number of proper interviews is five. Interviewing the residents was quite challenging, as most of the residents in the nursing home were already in a state in which it was hard to perform any longer meaningful interviews with them. Either they were cognitively frail or they had some physical problem such as hearing impairment or reduced ability to speak that made interviewing challenging[21]. Therefore, when choosing the interviewees I had to depend on the nurses' judgment of which people would be in a good enough condition to give some form of meaningful answers to my questions. The final interviewees were three females and two males varying in age from 78 to 91. Some representative questions include: "Is there any particular nurse that you like especially to engage with?", "What do you see as good caregiving?" and "Do you feel that you can speak with the nurses about things that bother or interest you?" The interviews lasted between 10 and 28 minutes with the average being 18 minutes.

In general, I felt that these reflective observations and discussions were a crucial part of the chosen abductive method. As mentioned above, my explicit goal with this research is to create an understanding that enables the nurses to better understand the constituent elements of their well-being in their work. Therefore, discussing the gained insights with the research subjects themselves seemed to be a particularly good way to validate that the insights really could offer something positive for the nurses. Thus I felt these discussions were of vital importance for the kind of research I was attempting to carry out.

Phase 6: Theoretical finalizing

Having made the final round of interviews and participant observation for this dissertation project, I analyzed the results of this phase and compared them with the insights gained from the previous stages of the research

[21] These difficulties in getting into contact with the residents in nursing homes are reflected in other researchers' experiences. For example Foner (1994: 246) reports how "patients are extremely ill and dependent. There were few with whom I could carry on a regular conversation because most were too confused or too weak and ill."

process. The participant observations made at this point proved to be particularly valuable, because with the research topic clearly in my mind, I could concentrate my observations on every encounter in which I saw traces of these caring connections. This provided me with a rich basis of observations around the topic that strengthened my analysis. Moreover, from the interviews with the nurses and residents I was able to gather many touching stories around caring connections as well as inquire deep into the experience of the nurses during these moments. The interviews with the nurses were coded and these coded excerpts were compared to my existing categories. The interviews with the residents were also analyzed and compared with my previous understanding of caring connections.

In the end, the theoretical model of caring connections generated in the previous stage was not altered radically. The biggest change was that the number of core processes increased from four to six as I divided the process of sharing presence into two parts: being present, and opening up to each other, and subsequently the latter again into two: opening up to each other, and establishing a shared space (see Table 6). This was done because a deeper analysis of the characteristics of these dimensions revealed that there actually seemed to be two different issues within one original category. In addition, the theoretical understanding was deepened considerably and I got a much firmer sense about the validity of my theoretical model and a feeling that it really captured something important from the life of the nurses as well as the residents in the nursing home. All in all, while the interviews had initially guided me into looking at caring connections, at this point it was the participant observations that provided most of the essential data through which the model of caring connections was established and deepened.

Table 6 Development of coding categories around caring connections

Preliminary organizing categories	Subsequent organizing categories	Final coding categories
Meeting the other as a unique being Transcending work roles	Mutual recognition	Mutual validation
Being present in the situation Leisured pace	Being present	Being present
Honesty	Opening up to each other	Opening up to each other
Sharing the emotional states		Establishing a shared space
Being emotionally present	Heightened flow of affectivity	Heightened flow of affectivity
Being able to help the resident Receiving gratitude from the resident	Flow of caregiving and gratitude	Flow of caregiving and gratitude

The biggest insight at this point was that I decided to look systematically at the difference between a caring situation in which a caring connection is established, and a caring situation that does not exhibit the characteristics of a caring connection. I had realized early on in the research process that caring connections required the active participation of both the care provider and the care receiver and that both made the choice of engaging or not engaging in the situation independently. Elaborating on this insight, I started to re-examine my data to see what could be said about the interaction of different combinations of engagement or non-engagement by the participants. Based on my observations in particular, I quickly discovered that I could categorize the *caring situations* between the nurses and the residents into four categories based on whether either participant is engaged in the situation or not: one in which both are disengaged, one in which the nurse is engaged while the resident is disengaged, one in which the resident is engaged and the nurse disengaged, and finally caring connections, in which both participants are engaged. This led me to relook at and reanalyze my interview data from this perspective, and therein I found support for this categorization (see Table 7). The model that emerged from this analysis included a distinction between *caretaking* and *caregiving* as regards care provider's attitudes, a distinction between *calling for caring* and *closing from caring* as regards care receiver's attitudes, and the typification of the four possible combinations of them: *instrumental caretaking, unmet call for caring, one-sided caregiving* and *caring connection*. These typifications are elaborated on further in Chapter 7.

Table 7 The different types of care providing attitudes, care receiving attitudes and caring situations

Category	Example	Informant
Caretaking	"some do their work as if they are taking care of some animals"	Nurse 11
	"almost as if we are moving packages, or cattle"	Nurse 17
Caregiving	"meet the resident respectfully and as a human being [- -] and being present for them"	Nurse 9
	"valuing the other as a human being"	Nurse 6
Calling for caring	"I had good moments in that place [previous nursing home]. The nurses were present and helped. I felt that I was myself there."	Resident 4
	"Sometimes they get frustrated for having to spend so much time alone and would want someone there to talk with them but we don't always have time for that"	Nurse 1
Closing from caring	"Nothing is ever good enough for her. She is constantly complaining. [- -] You can try to talk with her but there isn't that something..."	Nurse 18
	"talking with them [the nurses]? I am not particularly interested in that."	Resident 1
Instrumental caretaking	"Some of them like it when you just quickly do your things and that's it"	Nurse 5
	"when doing it in a hurry you don't get into any real contact with the customer [- -] when you just go there and do the things routinely"	Nurse 18
Unmet call for caring	"She [nurse] walked by and I asked could you help me? 'I don't treat you' was the answer"	Resident 5
	"Some just do the work in a routine manner (while others do it with good heart)"	Resident 4
One-sided caregiving	"I enjoy the most challenging clients. [- -] When they scream [- -] But you just respond in a friendly way"	Nurse 4
	"Of course it is heavy when you put yourself 100% there"	Nurse 12
Caring connection	"Best things in work? For example, showering with Lisa makes you feel glad. She is so lovely, we joke around and she has such lovely stories"	Nurse 18
	"My mission is to be good to them and that we could meet on an equal plane"	Nurse 24

Phase 7: Validating my insights with insider experience

At the point where I was finishing my manuscript and where the theoretical insights presented in this work were fully developed, I was invited into the nursing home to present my results to the personnel on two different occasions. In the spirit of Dutton et al. (2006: 64) I saw these encounters with my research subjects as a chance for a "comparison of [my] analysis with their insider experience." In their study of organizing compassionate responses after a fire, Dutton et al. represented their case draft to an audience from the same organization where the original data had been gathered and collected their feedback and responses. For them this was a "key data source" through which to validate the accuracy of their analysis and which provided an "additional check for biases involved in opportunistic case selection" (Dutton et al., 2006: 64). More generally, it has been argued that such member validation "is the most crucial technique for establishing credibility" in qualitative research (Lincoln & Guba, 1985: 314).[22] Accordingly, I decided to use these presentations as opportunities for member validation and prepared a short questionnaire to be distributed to the audiences of my presentations.

[22] Member validation has alternatively been called *member check* or *respondent validation.*

The presentations were given in February 2012 and both lasted for one hour and fifteen minutes with an additional fifteen minutes for questions and comments. In the first of the presentations the audience consisted mostly of head nurses and other nurse supervisors. In total there were fifteen people present. At the end of the presentations I asked for comments on and criticism of my insights from the audience orally, and also gave them the questionnaire to fill in order to provide feedback anonymously and in written form. Seven out of the fifteen returned the form filled. At the end of the designated time, many members of the audience seemed to be in a hurry to get to their next appointment, which might explain why so many didn't return the form. The second presentation conducted two days later took place in one unit of the nursing home and the audience consisted of six nurses and their head nurse. This time all seven members of the audience filled in the feedback forms.

The oral feedback I received at the end of my presentations and the thirteen feedback forms naturally don't amount to a strict validation of my research findings in quantitative terms. Nevertheless, as the feedback was unanimously positive, it strengthens the case that my research has really tapped into something that the nurses and their supervisors see as real and important.

Firstly I asked "Is the division between the four different types of caring situations useful? How do you see it?" All six nurses and most of the supervisors stated that they found it useful. A few of them emphasized that it was especially important the division acknowledged that the residents can be different, and how some of the residents can be very unresponsive to any contact. This answer from one of the nurses summarizes the responses I got quite well: "It is useful and seems to be truthful. For once it has been acknowledged that the resident can be the one isolating herself and does not respond positively to the care she receives." The same point was made orally at the end of both presentations. The nurses and their supervisors attending my presentations strongly expressed their satisfaction with the division, describing it as useful and even "enlightening". They also confirmed that the emphasis on the fact that the residents' attitudes can be different as regards the care they received is not only theoretically novel, but saying it aloud is seen as important from the practitioners' point of view.

Secondly, I asked "Did you understand what I mean by the caring connection? Do you recognize it in your own work?" I also asked them to indicate on a scale from 1 to 5 (with 1 meaning not at all and 5 meaning very well) "How well does the concept of caring connection describe the nursing home reality?" Again, the answers were unanimously positive. All respondents indicated that they recognized the phenomenon in their own work. For example, one nurse answered, "I do understand it. I experience it almost every day in my work," while other stated that, "The concept is clear and it takes place every day in caring work." This was also reflected in the numerical answers they gave. The average score for the nurses was 4.6 on the scale from 1-5, and for the other personnel it was 4.5. In both groups 5 was the most common answer (five out of eight members of the personnel and three out of six nurses with two nurses giving 4 and one 4.5). So both the nurses and other personnel seemed to feel strongly that the concept captured something important from their everyday work environment.

Next, I asked about the six dimensions of caring connections: "Frank suggests that there are six dimensions in caring connections. What do you think of these dimensions, and are there some issues that are not mentioned here?" Once again, the personnel were supportive of my insights. The nurses indicated that "they hit the mark" and "help one to perceive what is meant by caring connection," and similarly the other personnel found them "clear" and indicated that "they all are true and easy to understand." Nurses didn't find anything missing from the descriptions, but two of the supervisors had something to add: One indicated that the importance of right timing should receive more attention, whilst the other said that she would have wanted to see more discussion of the fact that the nurse is in a professional role during the caring connection. The latter, however, added that I talked about this issue in my presentation. So all in all, it can be stated that both the nurses and other personnel attending my presentations were satisfied with the six dimensions of caring connections that I proposed.

In addition, I asked for ideas on how to improve the possibilities for caring connections in their own unit and more general feedback. I will present those ideas that sounded interesting in Chapter 10, where I discuss how to make caring connections happen. All in all, both audiences indicated both orally and in writing that they were pleased with the presentation and found the results accurate and interesting. As one nurse wrote: "Interesting and useful work. It would be good if all the nurses would reflect on these

issues." The feedback from the presentations thus provided additional support for both my taxonomy of four types of caring situations as well as my analysis of caring connections and their six dimensions.

Conclusion

It is notable that the final theoretical insights I am offering in this dissertation make much use of existing theory both within and outside organizational and nursing research. In the spirit of abductive inquiry, I have attempted to reach the best possible understanding by combining my experiences within the nursing home with what I see as the most informative theoretical accounts. The present work thus represents the school of grounded theorizing that emphasizes how researchers' substantial theoretical viewpoints influence the research process (see Suddaby, 2006: 635; Glaser & Strauss, 1967: 79).

Additionally, in some of the questions I have consciously chosen a theory-based approach instead of relying on my empirical material. For example, in looking at the factors contributing towards caring connections, I realized that my empirical material could only give half an answer. Going through the interviews and other empirical data with the techniques of grounded theorizing provided me with a list of three nurse-related factors that contribute to the occurrence of caring connections: *respecting the humanity in the other, openness for connection* and *human relations skills*. In addition, two organizational factors seemed to matter: *unhurried pace* and *organizational support* (see **Figure 3**).

However, as these factors are quite plain and straightforward, I felt that their acknowledgment would not contribute to actual organizational actors' capabilities to enter into caring connections with different care receivers. Thus I felt that in order to provide the potential practitioners with something valuable, I had to go deeper than just saying that "human relations skills are important". Therefore, I chose to discuss the elements that increase the possibility of caring connections more from a theoretical viewpoint than from a perspective directly grounded in my empirical data. I attempted to look at the caring connections from a stance that emphasizes the relational and systemic nature of the caring encounter. I felt that such a theoretical perspective could shed new light on the caring situation and the caring connection, by providing novel theoretical lenses through which to

look at these situations, and which can generate new ways to understand how to improve the possibility of such encounters.

The same choice was made as regards the discussion on the mechanisms of the caring connection. I felt that for the wholeness of my work it is an important topic to discuss, but as I didn't have appropriate empirical data from which to draw my conclusions,[23] I decided to address this question from a theoretical perspective. For the reader's convenience, in Table 8 below I have listed which chapters draw primarily from my empirical material and which from theoretical discussions.

Table 8 The main data source of different chapters

Chapter	Main data source
Chapter 7: Taxonomy of caring situations	Empirical
Chapter 8: The nature of caring connections	Empirical
Chapter 9: The contribution of caring connections	
Why caring connections are so significant	Empirical
Caring connections embedded within caring relations	Empirical
Mechanisms of caring connections	Theoretical
Chapter 10: Making caring connections happen	Theoretical

It must, however, be noted that my empirical material also enters into the more theoretical discussions in three different ways. Firstly, it has guided the choice of theoretical perspectives I draw from here. I have used those theoretical perspectives I have seen to best fit and explain my experiences and observations in the nursing home. Thus the choice of theoretical perspectives has not been arbitrary, but it reflects my empirical encounter with the nurses and residents in the nursing home. Secondly, the theoretical discussions generally build upon the empirical analyses made during the research process. They are inspired and arise from my experiences within the nursing home. One could say that they are anchored in my empirical experiences, but they go beyond them by utilizing different theoretical viewpoints. Thirdly, I try to illustrate the theoretical insights generated through examples drawn from my empirical work.

On the other hand, in my more empirical chapters I have used theoretical insights to enrich and deepen the insights I was able to derive from the

[23] As mentioned in my discussion of future research, to really capture the implicit micro-level interactions that take place during caring connections, one would need to video record such interactions and use frame-by-frame analysis techniques. This kind of data could provide the necessary support for the theoretical suggestions I now make about the mechanisms of caring connections.

empirical observations themselves. As my main contribution in this work is the suggestion of new concepts through which to look at caregiving and caring situations, I felt that the value of such new concepts is partially dependent on the deepness at which I am able to discuss them and connect them to existing theoretical discussions. Therefore, I adopted a research approach where I read broadly to gain knowledge of a wide variety of theoretical insights, which I then used to further discuss issues such as the six elements of caring connections that emerged through my empirical research. In this way I could anchor my novel insights to similar discussions in existing research in a wide variety of fields.

Thus I have attempted to practice what I preach by making the interplay with my chosen theoretical frameworks and my empirical data highly iterative. During the initial interviews and observation I didn't have any particular theoretical framework in mind, but I aimed to look at the phenomena of well-being as open-mindedly as possible. After I had analyzed these results I chose certain theoretical perspectives that I saw as fitting, and immersed myself into them. When I entered the nursing home to do my main empirical data gathering, my observation capabilities and my interview questions were already influenced by certain theoretical frameworks. After the analysis of the results of the main encounter, the job demands-resources framework was abandoned and a relational perspective was chosen as a theoretical paradigm, because it best seemed to fit the data. Therefore, the final round of observations and interviews were no longer in any sense paradigm-independent – they were already largely informed by the chosen framework. This commitment to certain theoretical frameworks that proceeded step-wise and iteratively throughout the research process as it became "progressively more focused" (Bryant & Charmaz, 2007: 1) is much in accordance with the chosen abductive mode of inquiry and has allowed for the interplay of certain theoretical positions with the actual data gathering process to enhance a deeper understanding within the chosen framework. Like the physician who combines empirical observations of the symptoms with theoretical knowledge about the diseases to come up with the most probable diagnosis, I have attempted to combine my observations with the best theoretical knowledge available to come up with the interpretation of organizational life within the nursing home that I see as the most believable. Through such a combination of theoretical discussion with empirical insights, I will thus offer the reader the most advanced understanding of relationality within caregiving organizations I am able to

produce. The legitimation of my results arises ultimately – in addition to the acknowledgement of the relevant literature in the field, the correct usage of research methods in gathering and analyzing the empirical material, and the systematic and transparent way of presenting the results – from them presenting the most informed way of thinking about these matters that I have been able to produce from the empirical and theoretical material I have been exposed to and digested throughout this process.

PART IV: INSIGHTS

Chapter 7: Taxonomy of caring situations

> *An* actual caring occasion *involves action and choice both by the nurse and the individual. The moment of coming together in a caring occasion presents the two persons with the opportunity to decide how to be in the relationship – what to do with the moment (Watson, 1985: 59)*

By a caring situation I mean any situation where one person takes care of any kind of need of the other person. It involves two people: the care provider and the care receiver[24]. In the nursing home I concentrated on the caring situations between the nurse and the resident, focusing especially on the emotional dimension of these situations in contrast to looking at more functional aspects of it. As I will show below, my observations quickly revealed that both participants had the opportunity to either engage in the situation and open up towards the other or alternatively close themselves off from any more personal way of interacting with the other. It is particularly important to note that the resident can also make an active choice here, as this is often left unsaid in the current discussions about caregiving[25]. Both participants therefore have two options – engagement or disengagement – and this choice regarding one's attitude that both persons take determines the nature of their relationship in the caring situation.

A similar observation was made by Mok and Chiu (2004: 479) in their empirical study in palliative care: "Whether a mutual relationship developed was dependent on whether both nurse and patient were willing to enter into the encounter. The involvement of nurses and patients determined the depth of the relationship." Morse (1991: 458) also notes in her depiction of connected relationships how "the patient chooses to trust the nurse", while "the nurse chooses to enter the relationship." Both

[24] There can be caring situations in which one care provider simultaneously takes care of multiple persons, but in this research I have concentrated on what I see as the most typical and prototypical case, that of one-on-one care providing.

[25] See Chapter 3.

participants' engagement is needed for a connected relationship and either participants' non-openness can terminate the process that could otherwise make the caring situation connected (see also McCormack, 2003: 205).

When the care providers engage in the situation I call this *caregiving* and when they close themselves I call this *caretaking* (cf. Kahn, 1993: 544), while care receivers' options are between *calling for caring* or *closing from caring*. From the interaction between these two stances we can derive four different ways in which a caring situation can unfold: *instrumental caretaking, unmet call for caring, one-sided caregiving* and *caring connection* (see Figure 4). Naturally, such polarization of the actual situation into four ideal types somewhat simplifies matters. Certain people – care providers or care receivers – might for example be tender and open to a certain extent but when their limit is reached, they close themselves suddenly and firmly. Nevertheless, this division between different caring situations serves important heuristic purposes in clarifying the different general possibilities which the situation can develop into.

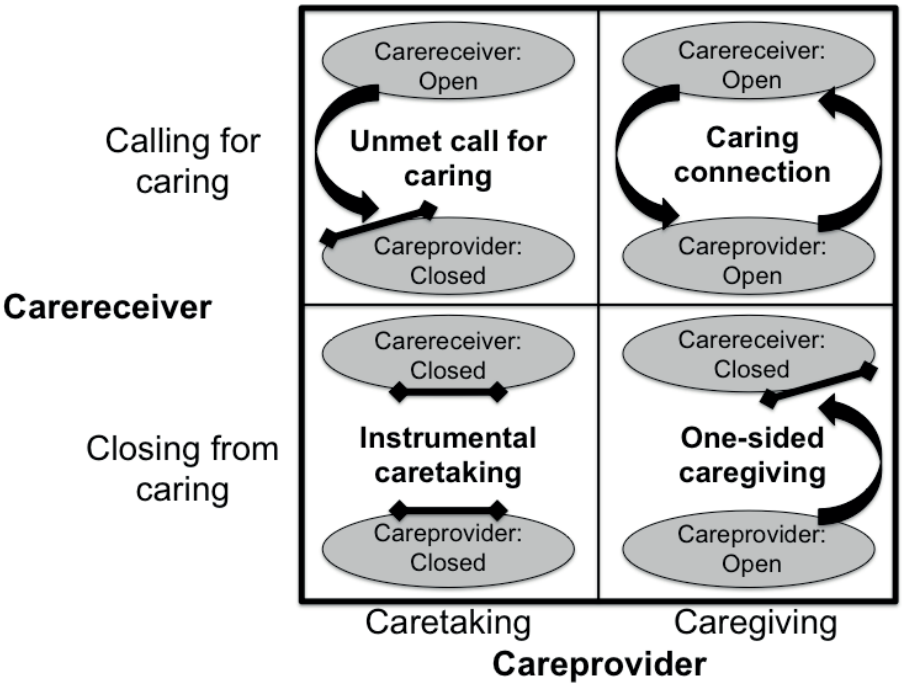


Figure 4 The four different types of caring situations

Caretaking and caregiving

As mentioned previously, by comparing different attitudes the care providers took in their ways of interacting with the care receivers, there was

a distinction to be made between *caretaking* and *caregiving*[26]. In caregiving, the care is *given* to the other who is seen as an active participant in the process. The care provider is thus recognizing and validating the humaneness of the other and open to really meet him or her. In caretaking, the other's needs are *taken care of* without consideration for the other as a person. In turning to caretaking, the care providers essentially close out the possibility for any humane connection to develop between them and the recipients of their care.

In the nursing home I observed many situations in which the nurse's way of relating to the resident was more reserved and failed to validate the resident as a person. Sometimes the nurses gave an impression of busyness and through that attitude were not available for the residents. In these situations they might skip the greetings part of interaction and fail to look into the eyes of the resident. On other occasions they didn't care to explain to the residents what was being done to them and why, thus in effect depersonalizing the resident. They came to signal to the resident that what the resident feels about matters is not relevant, and that the caretaking is a matter between the nurse and the physical need taken care of. My observations were in line with Morse (1991: 463), who reported very similar strategies that the nurse can use to inhibit or decrease the level of involvement in a relationship. This description of a physician about his way of working also provides a clear example of caretaking: "I would continue at a rushed, urgent pace, quickly assessing the problem, never making real contact, prescribing some drug, and moving on to my next task. The result was satisfying neither to the patient nor myself." (Rechtschaffen, 1996: 77; quoted in Trout, 2011: 20)

The nursing literature recognizes several reasons why the nurse might resort to caretaking: For example, many nurses – especially at the beginning of their career – often feel it necessary to distance themselves from the patients to be able to perform necessary but physically painful procedures on them and face their suffering (cf. Molinsky & Margolis,

[26] This distinction was already recognized by Kahn, although for him the main focus was on the dependency of the care receiver: "Caregiving refers to care that is *given* to careseekers, who may do what they wish with it (i.e., receive or deny it); caretaking refers to care that is *taken* of careseekers by administering or ministering to them in ways that deny their abilities to care for themselves and that reduce them to objects" (Kahn, 1993: 544).

2005). They use some psychological defenses to "absent" themselves psychologically from these situations and thus "reduce the extent to which parts of their selves are fully there in the immediate situation" (Kahn, 1992: 325). This might explain why many nurses working in operating room use strategies of depersonalization in which they looked at the care receiver not as a person or even as a patient but as a 'case' (Morse, 1991: 462). On the other hand, some nurses might not want to engage in personal relationships at all with their patients for various personal reasons. They might feel that their job is to take care of the needs of the patients but nobody can obligate them to go beyond that. Certain patients might also "appear so undesirable that the nurse does not want to enter into a close relationship" (Morse, 1991: 462).

The most common reason for nurses not to provide caregiving is arguably, however, the lack of time and emotional energy for it. As Kahn has argued, providing caregiving is emotionally exhausting for the nurses. A nurse who is 'burnt out' or exhausted by the workload can have a very hard time finding the emotional energy that is necessary for these relationships (Morse, 1991: 462). This comes through especially clearly in the following description of a nursing home aide's work given by Foner (1994: 248): "Overwhelmed with work, she had been unable to even squeeze in a few minutes for a morning break. She changed patients' beds in a hurried, distracted way, barely talking to them and muttering to herself about how tired she was. When she got to Mr. Gallo, she virtually threw a shirt on him, not even noticing, or caring, that it was wrinkled, torn, and the wrong size."

Despite these various reasons to settle for caretaking, my experience was that most of the time, most of the nurses at the nursing home who I observed did engage in caregiving. Their tone of voice, willingness for eye contact, openness to listening to the residents' opinions, ways of touching and sensitivity to the rhythm of the resident all communicated that they were willing to meet the resident as a person and were present in the situation in an empathic way. They seemed to carry their tasks with regard for the unique situation, personality and well-being of the resident in question. In fact, the interviews made it clear that this attitude of caregiving was seen by the nurses as a central attitudinal requirement of their profession. As one nurse expressed it, the proficiency in this occupation is about "meeting the resident with respect and as a human being" [Nurse 9].

This insight is also found in the literature about caring, in which caregiving is about relating to the other and entering into an emotionally engaging relationship with the other with the aim of contributing to the others healing and growth (Mayeroff, 1972: 1). In caregiving, the nurse aims to make the other feel that he or she is "cared for and about" (Kahn, 1993: 544), and aims to attend to the others' needs holistically, using both her technical knowledge and intuitive capacity to attune to the other. Foner describes one nurse who is clearly engaging in caregiving: "When she smiled to greet a resident and ask how they were, a real warmth came through. She carefully listened and cared about what residents had to say." (Foner, 1994: 249) My experience was that most of the nurses had internalized this caregiving attitude as part of their way of working with the resident and thus were engaged in caregiving most of the time.

The attitude of the caregiver, in turn, can make all the difference for the experience of the one being cared for, as suggested by Noddings:

> *To the cared-for no act in his behalf is quite as important or influential as the attitude of the one-caring. A major act done grudgingly may be accepted graciously on the surface but resented deeply inwardly, whereas a small act performed generously may be accepted nonchalantly but appreciated inwardly. (Noddings, 1984: 19–20)*

Calling for caring and closing from caring

Taking the care receiver's perspective – in this case the resident's – we can similarly distinguish between two different attitudes towards the care being offered. They can be on the lookout for a human encounter with their care provider. I call this the attitude of *call for caring* (cf. Boykin & Schoenhofer, 2001: 14). Some residents I observed went to great lengths to get a positive and affective response from the nurse: they apologized for having to disturb the nurse with their request, inquired about the nurse's well-being as well as that of her children and pets if she had any, showed gratitude both nonverbally and verbally about everything the nurse did, and generally aimed to be as lovable as possible. I also saw care receivers making all the same overtures towards the nurse that Morse (1991: 461) observed: For example, the care receiver called the nurse by her name, acted in a friendly way, waved to the nurse as she passed by, gave her small gifts such as chocolates or candies, told jokes, or praised the nurse for her work.

When care receivers call for caring they essentially call "for nurturance through personal expressions of caring" (Boykin & Schoenhofer, 2001: 14). They are willing to engage in a relation with the care provider that involves themselves as persons in that relation. In other words, the care receiver can take "the initiative to be part of a caring situation and become well treated" (Berg et al., 2006: 46). This meant an active willingness to be open towards the nurse and allowing her to take care of the receiver. The nurses also sought to be treated as human beings and not merely as instruments of care provision. Thus the nursing aides that Foner (1994: 249) interviewed had favorite patients who were often "those who expressed an interest in, and cared about, their aides as people." As one of her interviewees expressed it: "They show they care for you. They treat you like a human being, know you have a family." (Foner, 1994: 249) This call for caring is perhaps best expressed in the following quote from Jill Bolte Taylor, a neuroanatomist who experienced a massive left hemisphere stroke and here describes her experience as a patient:

> *I wanted to communicate: "Yelling louder does not help me understand you any better! Don't be afraid of me. Come closer to me. Bring me your gentle spirit. Speak more slowly. Enunciate more clearly. Again! Please try again! S-l-o-w down. Be kind to me. Be a safe place for me. See that I am a wounded animal, not a stupid animal. I am vulnerable and confused. Whatever my age, whatever my credentials, reach for me. Respect me. I am here. Come find me." (Taylor, 2008: 72)*

On the other hand, the care receivers could close themselves off completely from any form of humane encounter with their care provider. I call this *closing from caring*. Few residents I interviewed expressed no need for any kind of deeper contact with the nurses. When asked if he ever engages in deeper conversations with the nurses, one resident told me that "I have no need for talking" [Resident 3].[27] This attitude was communicated for example by residents who refused to answer the questions of the nurses or answering them as briefly as possible in an angry voice, or by the residents avoiding eye contact and maintaining a closed body posture. I observed one resident who snapped "shut up" every time a nurse tried to engage him in conversation. In addition to these forms of 'passive resistance' the care

[27] Notably, all three male residents I interviewed or tried to interview expressed no interest whatsoever in caring connections. This is a theme I return to in the discussion section.

receivers could also more actively block the deepening of the mutual relationship by becoming demanding, coercive or manipulative, or by directing mental or physical violence at the care provider. I saw examples of residents who were often quite mean towards the nurses and were thus effectively able to block any positively engaged situation to develop between themselves and the nurses. These observations were in line with Morse's (1991: 463) description of different strategies that care receivers might use to inhibit or decrease the mutual involvement in their relationship with the nurse. The nurses also readily recognized the fact that some residents were very hostile towards the nurses' attempts to connect with them. In fact, when I presented my results to some of the nurses they felt that stating aloud this fact was refreshing and took away some feelings of guilt they might have in these situations.

In closing from caring, the care receivers thus take an attitude towards the care providers where they see them as mere instrumental providers of care without any need to reach out towards the other on any emotional dimension. This can happen for any possible reason. It might be for example that the care receiver has a hard time accepting his or her dependence on other people and thus refuses to meet the nurse as a person. As Morse notes, some patients are "so mortified at their sickness behavior or their loss of control that they are too ashamed to relate to the caregiver" (Morse, 1991: 462). Similarly, Mok and Chiu describe (2004: 476) how in palliative care "some patients prefer to detach themselves from the situation. In such cases, they do not allow nurses to become involved, which makes care more difficult as nurses are then unable to perceive how patients are feeling." For example, one nurse told them how "you would find the patient was suffering and struggling in pain and anger. However, he would choose to control himself and didn't allow you to enter into his inner world." (Mok & Chiu, 2004: 479) It might also be a simple personality issue as seemed to be the case with few of the residents I interviewed. For example, one resident told me, "I am not particularly interested" [Resident 1] when I asked him whether he ever has longer engagements with the nurses. Similarly, one long-term resident told McGilton and Boscart (2007: 2154) that "I'm 94 and not interested in a relationship with anyone anymore" while another stated "I'm not that kind of a person. Not outgoing or looking for companionship." This was also reflected in Bowers et al.'s classification of residents into those who have a 'care-as-service' attitude to the caregiving they received. This type of residents perceived themselves as

purchasers of services and felt that they "had the 'rights' accruing to any consumer" (Bowers et al., 2001: 541). Regardless of the reasons, what was clear was that some care receivers were closing themselves off from the possibility of engaging with the other in a human way, while others were actively seeking such an engagement.

Instrumental caretaking

When neither care provider nor care receiver are willing to invest any personal or emotional energy into the caring situation, I call this *instrumental caretaking*. In these situations the resident had some request that needed to be fulfilled and the nurse took care of it. It took place, for example, when the resident dropped something and the nurse picked it up for him or her when walking by without a second glance at the person in question. Other examples of this are where the nurse changed the diaper of the resident without any communication happening between them or ever touching on anything other than technical details of the operation, and without any smiling or eye contact revealing that something emotional was taking place between them. This kind of task-oriented care providing took place from time to time in the nursing home – especially with residents whom nurses knew from experience were not interested in developing any personal relations with the nurse. It was also required in some more emergency-type situations where time did not allow one to meet the other as a person (see here Berg & Danielson, 2007: 503–504). For example, on one occasion at the dinner table, a resident started to show signs of choking. In the blink of an eye, a nurse was behind him, yanked him up and was ready to perform a heavy-handed Heimlich maneuver on him. There was no time to meet the other as a person but the most important thing – the instrumental and potentially life-saving caretaking task – was fulfilled. More generally, in instrumental caretaking situations, both participants were not looking for anything more than the task being accomplished and thus no harm was done to either participant – although nothing beyond task accomplishment was gained either.

Unmet call for caring

In these situations the care receiver is calling for care and a mutual encounter, but the care provider is in a caretaking mood and either consciously or unconsciously ignores these bids for connection. Therefore,

the care receivers feel that their call for caring is unmet. From my observations I remember one particularly disturbing scene during a meal, where a resident whose speech was almost incomprehensible tried to say something. Instead of allowing her to finish her attempts to communicate, the nurse, who was in a hurry, just stuck a spoonful of food into her mouth. It was evident that she was not at all attuned to the rhythm of the resident. Even though it might have been impossible to understand the resident's message, I still felt that this lack of respect for her attempt to connect and for her personal rhythm was a clear demonstration of a moment where the call for caring and connection was totally unmet.

Some nursing researchers have recognized the negative effects that an unmet call for caring can have on the resident. For example, the long-term residents interviewed by McGilton and Boscart (2007: 2153) stated how they felt being "ignored as individuals" when care providers behaved as if they were not committed to the relationship or when they "did not transmit a feeling of closeness." When care providers failed to listen to their question and never asked them questions that weren't related to care, the residents felt that they were neglected and not given a chance to develop a close relationship with them. When residents felt that care providers were not interested in a close relationship, this was a serious issue for them: "As residents explained this feeling, it became clear that this kind of relationship was very upsetting to them and made them emotionally aware of being 'not wanted'" (McGilton & Boscart, 2007: 2153). Morse, in turn, states that patients complained about how some of the nurses "are cool and brisk and have no eye contact with you, even though everything is done for you physically" (Morse, 1991: 463). These patients felt that the nurses were not interested in them and sometimes had an attitude which says "you're just taking up my time" (Morse, 1991: 463). Berg et al. (2006: 46) argue that when patients feel that their initiatives towards a caring situation go unmet, they are left with feelings of vulnerability. These complaints from residents all stem from the fact that their call for caring remained unmet.

One-sided caregiving

In one-sided caregiving, the care provider engages with the care receiver in a warm way but this emotional involvement remains unmet. This was actually quite a common situation in the nursing home where I was observing. Certain residents were very unresponsive towards any personal

or emotional involvement with the nurses, but nevertheless some nurses met them time after time with the same tireless dedication; greeting them warmly, adjusting to their moods and trying to uphold a smile and eye contact, even if it was not reciprocated. In the interviews, the nurses saw that it was their professional duty to be warm and respectful towards all the residents, regardless of how their warmth was received and whether it was returned. They therefore made an effort to engage in caregiving in most of the situations whether the other participant was emotionally available in the situation or not.

However, it can be argued that the need for reciprocity in human relationships is so deeply seated that "it would be very difficult for professionals *not* to think in terms of reciprocity in the relationship with the recipients of one's care" (Buunk & Schaufeli, 1999: 277). Even though the nurses can't ask for such reciprocity, their experience of the situation is nevertheless different depending on whether it is present or lacking. As Noddings (1984: 72) put it: "To accept the gift of responsiveness from the cared-for is natural for the one caring. To demand such responsiveness is both futile and inconsistent with caring." Particularly when the residents exhibited sheer hostility towards the nurses, it looked as if the nurses were struggling to keep up their good humor. Often after these experiments they needed to calm down for a while and share their bad experience with a colleague in order to get their mood back at where it was before. One-sided caregiving can thus be emotionally exhausting for the nurses.

This is recognized in the nursing literature: When the cared-for doesn't respond to caregiving, there is, according to Noddings, a "constant outward flow of energy that is not replenished by the cared-for" which causes caregivers to lose energy and become burned-out (see also Kroth & Keeler, 2009: 512; Noddings, 2005: 17). Li found that when the nurses encounter undeserving patients who don't reciprocate niceness, the "nurses present themselves as often struggling to maintain their composure. They may sometimes be unable to do so and so niceness may be abandoned in these moments." (Li, 2004: 2576) Hagerty and Patusky, in turn, warn that nurses might be too willing to assume that the patient wants a nurse-patient relationship. If the patient is not willing to take the role of the needy careseeker, the care provider might get frustrated. They refer to a prostate surgery patient who didn't want to connect with the nurses: "Soon, the nurses began to label his behavior as uncooperative and became less

responsive to his requests for pain medication" (Hagerty & Patusky, 2003: 147).

It can thus be argued that in one-sided caregiving situations where the nurse's engagement becomes "an instrument of service work" (Hochschild 1983: 95), the nurses need to exercise some emotional labor (see Ashforth & Humphrey, 1995; Morris & Feldman, 1996) in order to sustain their mood and be able to express the institutionally prescribed emotions. Nurses saw it as their duty to respond to all residents in a warm way, regardless of the way the resident responded and often acted accordingly. Yet it seems clear that one-sided caregiving, where the engagement of the nurse remains unreciprocated, places a burden on the nurses; it is emotionally exhausting in the long run.

Caring connection

Finally, caring connection is the situation in which both participants are open to each other and allow the momentary connection between them to grow deeper. The process that leads to this is reciprocal, it takes place when both participants feed positive engagement with the other in their interaction and thus increases the possibility of a similar response from the other. As these caring connections will be the topic of the next chapter I will discuss them in more detail there.

Chapter 8: The nature of caring connections

> *The best thing in this work is definitely these grannies. They are the best thing in this whole job, those lovely, in their own ways sweet, silly grannies. Just sitting, being with them, listening to the whole cacophony and babble that comes out of their mouths – and then that beaming smile that comes from there. That I didn't understand a single thing but somehow I feel that I can be there as a human being to another human being. [Nurse 10]*

Describe the best moment in your work, I asked. And most of the nurses of the nursing home answered by describing "one-on-one moments with the resident" [Nurse 3]. These were tender moments; moments where they had the time to be present for each other as full human beings with their emotions and vulnerabilities. In these moments, the connection between the nurse and the resident went beyond their institutional roles and they were able to experience each other as particular human beings with a special mutual relationship. As the nurses started to describe these moments, a visible change occurred in their appearance. They became more alive, and their eyes and posture radiated a warm and empathetic tenderness. As a researcher and a human being, I couldn't help but being touched by witnessing and hearing about these moments. The deep emotions that these encounters – and mere descriptions of them – awakened in the resident, the nurse, and me as a researcher suggested that something deeply significant about being a human was contained within them.

The significance of these moments for both the nurses and the residents became evident, both in my observations and in the interviews, and this led me on a journey towards understanding their characteristics more deeply. I first started to call these encounters *humane meetings* because in them the humane dimensions of affectivity, care, and relationality were far more salient than in regular interactions at work. Later on I changed this to *moments of humane caregiving* and subsequently to *caring connections* as I realized that, although all of them didn't involve caretaking in the narrow sense of assisting the other in physical activities, they all were paradigmatic instances of caregiving understood as a caregiver being there for the other

in an intimate and interpersonally sensitive way in order to give to the other the feeling of being recognized, protected, and cared for (Gordon et al., 1996a; Kahn, 1993; Mayeroff, 1972). *Connection,* in turn, has been described as the "dynamic, living tissue [- -] that exists between two people when there is some contact between them involving mutual awareness and social interaction" (Dutton & Heaphy, 2003: 264). One of its defining marks is *mutuality,* "the sense that both people in a connection are engaged and actively participating" (Dutton & Heaphy, 2003: 267). As it involves both "a temporal as well as an emotional dimension", and as the connection can occur "as a result of a momentary encounter, and can also develop and change over a longer time period" (Dutton & Heaphy, 2003: 264), 'connection' as a term seemed to nail down the special nature of these caring situations[28].

As was made clear in the last chapter and will be made more evident in the descriptions below, the essential requirement for caring connections was the mutual engagement of both the care provider and the care receiver in the caring situation. Both needed to be open towards the other and engaged in the situation in order for the shared situation between them to grow into a caring connection. The fact that mutual engagement can lead to something special has been recognized in previous research. Within nursing, McCormack (2003: 205) recognizes that the presence of engagement from both sides leads to the patient and the nurse becoming connected: "The nurse and patient are extensions of each other and a care partnership exists." Within organizational research, Dutton and Heaphy (2003: 267) see felt mutuality – that "both people in a connection are engaged and actively participating" – to be one of the essential characteristics of high-quality connections. Caring connections are also related to Miller & Stiver's (1997: 43) description of mutuality as "a way of relating, a shared activity in which each (or all) of the people involved are participating as fully as possible." For them, felt reciprocity is distinguished

[28] Other writers have used *connection* to refer to experiencing a sense of belonging, reciprocity, mutuality, and synchrony in a relationship (Hagerty et al., 1993: 294) or have defined connection strength in terms of the emotional weight of the attachment (Kahn, 1998), both of which also come close to describing the phenomena I am looking at here. All in all, a consistent definition of connection is still lacking in scientific research (see Dutton & Heaphy, 2003: 265).

from mutuality by the presence of mutual empathy. As we will see, mutual empathy is also one of the characteristics of caring connections.

However, as described in the previous chapter, not all encounters between the nurses and the residents amounted to caring connections, and accordingly, I especially tried to observe the small micro-level differences in the interaction between the nurse and the resident that set caring connections apart from ordinary caring situations. On the surface, there might not be much that differentiated them. Yet the felt sense of these moments seemed to be totally different for both participants and also for an outside observer. What is so special about caring connections and why are they so important? This was the mystery (Alvesson & Kärreman, 2007) I wanted to solve.

Occasions of caring connections

I start with taking a few actual occurrences of caring connections from my observations and describe them in order to provide the reader with a "thicker and more detailed" (Gephart, 2004: 460) account of the observations that provide the basis for my insights. In reporting qualitative research, this is important so that the reader can better appreciate the "members' meaning and in situ social processes" (Gephart, 2004: 460).

As a prototypical example of a caring connection, I observed a nurse feeding a resident whose hands were already too weak for such activity. The atmosphere of the whole scene resembled a mother feeding her baby. Such was the tenderness in her eyes as she looked upon the resident and warmth was in her voice when she asked the resident, "Is it too hot for you?" And such was the satisfaction in the eyes of the resident who received such tender care. Both participants were attuned to each other and fully absorbed in the shared situation. It was not just a professional fulfilling a basic need of her client. It was two human beings in an engaged relationship who cared for each other at that moment. The prototypical caring connection between a mother and a baby was also evident one evening when I observed a nurse putting a resident to bed. She assisted her in her evening toilet routine, tenderly helped her to bed, carefully covered her with a blanket, and asked her, "Is everything good?" All her actions signaled attunement to the mood and slow rhythm of the resident; and the resident was also open in the situation and allowed the nurse to gently guide her through her evening ritual. Putting off the lights in the room, she

said “Good night!” to the resident, who responded by saying “Good night and thank you for the care!” The warmth in the whole scene again signaled that the emotional dimension had gone beyond the roles of client and service provider. Instead, two human beings had met and interacted with each other.

In my observations, it became clear that it was the quality of the interaction between the nurse and the resident that determined whether a certain moment grew into a caring connection. The same basic care-providing activity could sometimes be carried out in a routine manner, but at other times it could amount to a caring connection. For example, one day I had the privilege of following a nurse assisting a resident in her shower. Throughout the showering they were chatting warmly, and the resident expressed her gratitude by saying things like “thank you, thank you,” “we are treated so well here," and "you are good as a human being." Their nonverbal interaction conveyed the same message: their voices were tender, they smiled at each other and laughed, and the resident touched the hand of the nurse as an expression of her gratitude. It was evident that these two individuals had a mutual history together, which had enabled them to create a form of friendship that went beyond their roles as worker and client – and in this moment their friendship had space to blossom. The moment carried on when the nurse was fixing the resident's hair, and now their special relation was explicitly verbalized when the resident said to the nurse, “You know, this is also a way of becoming friends,” and the nurse said, “You are such a temperamental person. Me too, and that’s why we get along so well with each other.” Clearly, both participants were enjoying each other's company and the special moment they shared with each other. About fifteen minutes later, I observed the same nurse shower another resident. She projected a professional caregiving attitude, but the atmosphere of the scene was totally different. This time the resident was quite hostile to the whole idea of showering, and his only line (which he said repeatedly and with anger in his voice) was – pardon the language – ‘Quickly, for fuck’s sake!’ Although the nurse was able to perform the operation with due care and proficiency, it was clear that the situation was experienced by both parties as negative and energy-draining. It must however be noted that the contrast to caring connections need not be this sharp. I also encountered showering sessions where no negative feelings were expressed by either party, but the level of a caring connection was never reached. In these sessions, the showering was done by the nurse in

the careful manner characteristic of professional nurses, but the resident didn't respond with gratitude or other warm feelings. Instead it was taken as 'business as usual.' The resident might enjoy the shower, but no special connection was built between the nurse and the resident. Thus, it was not the activity itself that determined whether an interaction between a nurse and a resident developed into a caring connection, but rather it was the quality of their connection during these moments that mattered. This has been noted by other researchers as well: "The nurse is able to shower a patient with little or no interaction or personal contact, but the same task can become therapeutic purely through the nurse's approach" (Tonuma & Winbolt, 2000: 215; referring to Kitwood, 1997)[29]. When the interaction between the participants radiated a certain sense of a deep and affectionate way of being with each other, a caring connection had emerged.

Given that it was not the physical activity itself, but rather the affective one that made a caregiving moment humane, I was able to observe interactions that carried the characteristics of caring connections across many different situations. Most commonly, they involved a caretaking activity such as assisting in showering or the evening toilet routine, which were carried out in the peace of the resident's room and with enough time to consider both the physical and emotional needs of the resident. Nurses told how they had "discussed quite much with the customers on the side of nursing" [Nurse 2], and often these conversations proved to be important in establishing the humane connection with the resident. For example, one resident told about a nurse with whom she has a special relation, and when asked what were the best moments with this nurse, she told how they discuss all sorts of things, especially about her grandchildren and about the nurse's daughter and dog [Resident 2]. In these conversational kinds of caring connections, the resident might tell the nurse about his or her life, the joys and sorrows of her childhood – and the nurse listens with empathy. Or they might discuss something completely different, such as the characters of a soap opera or the recent developments of the cultural frontier of Finland. The content of the talk was not as important as the extent to which both participants were present in the discussion and were disclosing their true opinions and feelings. In caring connections, both participants were

[29] However, Tonuma and Kitwood seem to recognize only the crucial role of the attitude of the nurse but do not mention the equally crucial role of the attitude of the resident for the felt sense of the situation.

naturally engaged in the discussion. They expressed their authentic opinions, and they really listened to each other instead of just chatting to keep up a conversation[30]. One nurse told how the "most rewarding part of the work is just that you can chat with all the people and if someone is having a bad day, you can cheer her up" [Nurse 4].

Then again, the caring connections might as well occur without any words. The nurse might come and sit next to the resident, and there they sit in silence. Still, one senses that they are present for each other; that on some nonverbal level, just sitting side-by-side signals mutual recognition and caring for each other. Sometimes the nonverbal level might involve physical gestures such as affective touching. The nurse might put her hand on the shoulder of the resident to signal sympathy or perform the caretaking activities in a particularly sensitive way. Or the resident might express her gratitude by touching the nurse in an affectionate way. Touching might be an especially important way of communicating compassion and presence when the physical or mental condition of the residents makes it difficult to make contact verbally or visually. The nurses interviewed by Rundqvist and Severinsson reported how even severely ill patients respond to 'touching'; and thus it can be the best (if not the only) way to get in contact with them (Rundqvist & Severinsson, 1999: 802). So whatever the mode of interaction, "sitting, being, listening" [Nurse 10] or something else, the caring connection is established by both participants being present for each other and communicating this presence through various ways.

One special area of caring connections occurs when the resident is burdened with sadness and anxiety. He or she might have lost someone dear to them, feel sad about their own weakening condition or terrified by the upcoming death. Residents in these situations need someone to confess their sadness to and share their burden. Nurses are often their best option. Although the overarching mood of these moments of confession is sadness, they can still offer particularly strong affective feelings of relationality and can be strongly meaningful for both participants. The importance of offering sufferers opportunities for caring connections in which to share their burden is emphasized by the fact that "recent work with dying people explores how insensitive communications by physicians can engender more suffering than the illness itself or an awareness that the condition is

[30] This difference between authentic and inauthentic speech comes close to Heidegger's (1962 [1927]) discussion about *idle talk*.

terminal" (Kanov et al., 2004: 812). One nurse told me that, although it might sound bizarre, one of the most rewarding parts of her work was end-of-life care because she really felt that she is good in relieving the anxiety of a dying person [Nurse 25]. It is in these moments that she senses that she is able to utilize to the fullest her talent for being with the other in a sensitive manner and that her presence is really important for the other.

Caring connections can even be fleetingly short. At one occasion, the nurses had worked hard to make a pleasant Christmas party for the residents and their relatives. In the beginning moments of the party, I saw a nurse tenderly waving across the room at one of the residents who immediately responded by blowing a kiss in her direction accompanied by a warm smile. The moment itself lasted only a few seconds, but it already contained within itself the warmness characteristic of caring connections. Of course, for these fleeting caring connections to occur, a positive mutual history is required. Caring connections don't happen in isolation but build upon the mutual relational history of the participants, as I will argue later on.

In general, the modes through which a caring connection can occur are quite personal and dependent on the unique characteristics of both the nurse and the resident. For example, while singing is for some nurses very natural and for some residents very nourishing, not all nurses or residents are fond of singing. Additionally there are other, still more personal ways of establishing a caring connection between the nurse and the resident. One nurse [Nurse 12], for example, described vividly how a certain hat and the possibilities for role play that it offered played a central role in her relationship with one special resident who other nurses found hard to deal with. In the end, it is just the imagination of the participants as well as their personal preferences that set the limits for the forms of interaction in which caring connections can occur. As long as both participants are emotionally engaged in the situation and with each other, the caring situations can be called caring connections, whatever the surface level of these moments might be like.

Definition and elements of the caring connections

> *A 'moment of meeting' occurs when the dual goals of complementary fitted actions and intersubjective recognition are suddenly realized. Moments of meeting are jointly constructed, and moments of meeting require the*

> *provision of something unique from each partner. [- -] Each partner grasps and ratifies a similar version of "what is happening now, between us.* (Lyons-Ruth, 1998: 286)

> *A caring occasion occurs whenever the nurse and another come together with their unique life histories and phenomenal fields in a human-to-human transaction. The coming together in a given moment becomes a focal point in space and time. [- -] The process goes beyond itself, yet arises from aspects of it that become part of the life history of each person, as well as part of some larger, more complex pattern of life. [- -] The moment of coming together presents them with the opportunity to decide how to be in the moment, in the relationship – what to do with and in the moment. If the caring moment is transpersonal, each feels a connection with the other at the spirit level, thus it transcends time and space, opening up new possibilities for healing and human connection at a deeper level than physical interaction.* (Watson, 1985: 59–60)

The caregiving instances that I labeled as caring connections were interactive situations where both participants – in this case, the nurse and the resident – seemed to be able to be fully present in the situation and for each other. A sense of authenticity, deep affectivity, and connectedness characterized these moments, and I saw how participants were able to experience one another beyond work roles as unique human beings. As one resident exclaimed, "I felt that I could be myself" [Resident 4]. In these moments, the participants mutually recognized the presence of the other and felt that they were sharing this moment together. In fact, the mutuality of these moments was so intimate that it almost felt as if the participants were creating and savoring these moments, not as separate individuals, but together as relational human beings.

Accordingly, as already argued in the methodology chapter, I saw that we would do best by looking at these caring connections through a relational perspective. Through the relational paradigm, we can better appreciate how the resident is an active participant in the process and how it is co-constructed through reciprocal interaction between the nurse and the resident. Therefore, instead of focusing on the characteristics of the individuals as separate entities, we should be looking at the intersubjective

processes that begin in their meeting and continue throughout the process of the caring connection. It is the flow of these processes within the dyad that is at the heart of what caring connections are about. This way of looking at the matter also goes together with the nursing literature in which nurses presence and caring have been understood as interpersonal processes (Finfgeld-Connett, 2008c). Looking at my empirical material through the lens provided by the perspective of relationality, I attempted to capture the most essential elements of caring connections. My final model focuses on the flow of six different general processes within the dyad (Figure 5) that seemed to capture the essential elements of the caring connection: *mutual validation, being present, opening up to each other, establishing a shared space, heightened flow of affectivity*, and *acts of caregiving and displays of gratitude*. Significantly, in contrast to previous models of the interaction between the care provider and care receiver, I saw that all these processes were mutual. Both participants had to engage in them in order for the caring connection to be established.

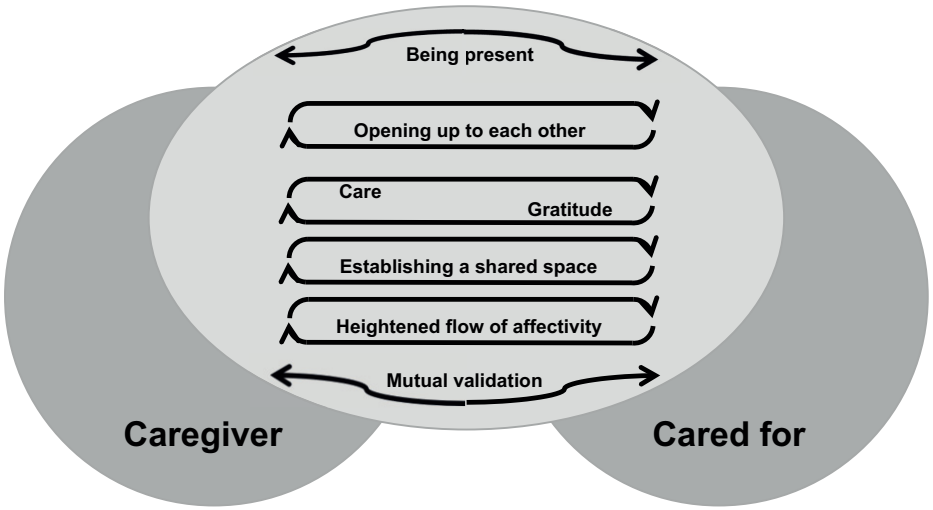


Figure 5. The six processes within the intersubjective dyad between the nurse and the resident

Based on these six elements, I came to define caring connections as *interactive moments in which both participants – the carer and the cared-for – are both present in the situation, recognizing the uniqueness of the other and opening up towards the other, and in which affections, care, and gratitude are able to flow with ease in the systemic dyad formed between them*. In addition to the elements listed above and discussed below, the definition emphasizes the relational and mutual nature of these

encounters. The caring connection takes place within a systemic dyad that is formed between the participants through reciprocal and empathetic attunement. I will discuss more what this means after the following examination of the six elements of caring connections. I present the elements by starting with a description of how I saw the element at the nursing home. Then I will connect my understanding of it to the relevant literature within nursing research, organizational research, infant research, and other relevant fields.

Mutual validation of the distinctive worth of the other

A crucial step towards a caring connection was taken when both participants recognized the distinctive nature of each other and signaled respect and appreciation for the other. The other was seen and treated as someone special – not as just another nurse or resident but as the very person one is. Mutual validation thus means respecting the other, signaling one's appreciation for the unique person that the other is. According to Kahn, validation is about "communicating positive regard, respect, and appreciation to other" (Kahn, 1993: 546). Ideally, the other is viewed "through a lens of unconditional positive regard and acceptance" (Finfgeld-Connett, 2006: 711). This respect for the humanity in the other I see as transcending the whole process of caring connections.

An example of a moment where this validation of the humanness of the other was especially clear was when I saw a nurse putting a special effort (together with the resident) into dressing her up prettily for the Christmas party. Doing her hair and choosing the earrings to match her dress took an especially long time but was greatly appreciated by the resident. "I feel like a queen" she happily proclaimed after thus being recognized by the nurse not only as an old patient with illnesses but as a woman who wants to be pretty at the party.

In the context of the nursing home, this mutual validation was often based on the mutual history of the nurse and the resident – which in the nursing home could be up to ten years. Thus, caring connections were often initiated when the participants, immediately upon seeing each other, signaled that they were aware of each other as a unique and special human being. For example, a nurse walking in the corridor seeing a resident might stop and, concentrating her attention on the resident, ask, "Hi Suzy, how was your dentist yesterday?" or "Hello Rick, is your ankle getting better?" in a warm and validating tone, thus initiating a conversation in which the level

of recognition is acknowledged from the start. But more importantly than the words expressed, this recognition was signaled through nonverbal channels such as the tone of voice, a validating and friendly gaze, or the way they approached each other. In these encounters, it was not hard for an outside observer to see that it was not two strangers that had met each other, but two persons with a mutual and affectionate history.

But validating the worth of the other by no means requires a long mutual history. I saw how stand-in nurses who encountered a resident for the first time were able to signal validation and respect for the resident. This was done by coming to the situation in a respectful way, for example by greeting the resident politely, introducing herself, and asking for his or her name rather than quickly performing the caretaking task before moving on. By being sensitive for the unique personality and needs of the particular resident, the nurse could validate the worth and uniqueness of the resident from the start. Such a nurse asked the resident to make sure that the way she was treating him or her was proper and adjusted her way of communicating and caretaking to this special client. This usually led to the resident also adopting a way of being that signaled that she understood that she was being treated by this one special nurse and not just by anyone.

The nurses saw this validation of clients as a central attitudinal requirement of their profession. As one nurse expressed it, the proficiency in this occupation is about "meeting the resident with respect and as a human being" [Nurse 9]. Another nurse spoke how one of the best things in her occupation was "to realize how one has come to respect the elderly person, despite their sicknesses and everything" [Nurse 10]. The third told how "one always speaks to the residents respectfully and nicely" [Nurse 5]. This respect meant for the nurses that one should never treat the resident as a thing [Nurse 9] or a mere animal [Nurse 11][31]. Some nurses even spoke of the residents in affectionate ways that showed something more than respect, something that almost bordered on pure love for them. The contents of these speeches are hard to account for verbatim as it was more about the affectionate tone of their voice, the tender smile on their face, and

[31] It is hard here not to make a reference to Kant's humanity formula that popularly has been understood to mean that one should never treat another human being as a means but always as an end in itself. McCormack, for example, sees that person-centered nursing practice is partially rooted in the "Kantian ideal of mutual respect and sympathetic benevolence" (McCormack, 2003: 202).

their body language that expressed the warm feelings these nurses had for their residents.

Similarly, the nurses emphasized how the residents had to be met as individuals. This is in accordance with the established view of nursing, which emphasizes that the nurses must "be able to encounter patients as unique individuals" (Hem & Heggen, 2003: 101). The nurses talked about how different people need different forms of care and how one has to be sensitive to this [Nurse 5], or how one has to adapt to the situation that the other can be anywhere from mentally in full condition to seriously demented or in a condition where they understand everything but are unable to formulate clear speech [Nurse 10]. For example, one resident complained to me how she doesn't like nurses who do not speak with her and respond to her stories, while another resident snapped "shut up" if a nurse tried to engage in conversation with him. In the end, no matter what condition the residents were in, the most important thing was to "take these humans as humans" [Nurse 6]. Being recognized and respected as the person one is was thus important for the residents: "You see, even an old person needs respect," as one resident told me as she praised the attitude of one of the nurses.

On the other hand, the resident's validation of the nurse is seen as an equally important ingredient of the caring connection. In my observations, it was evident how some residents reached out towards the nurses by addressing them in a warm tone, thanking them for the care they received, asking about their children, and so forth. They really put in an effort to connect with the caregiver and show that they were appreciated and valued. On the other hand, sometimes some residents seemed to try to avoid validating the humaneness of the nurses by avoiding eye contact and any conversation that was not focused on technical caregiving issues (cf. Morse, 1991). Even residents who physically didn't have many possibilities left still held the power to either validate or not validate the other's unique worth through recognizing them or avoiding any signs of recognition.

In the nursing literature, the need of nurses to validate the worth of the care receivers is recognized. It is already found in the definition of person-centeredness as "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust" (Kitwood, 1997; quoted in McCormack, 2004). Within the gerontological research, there has recently been an

increased appreciation of the value of an older person's biography, and this has been seen to be connected to the Kantian ideal of respect for the intrinsic worth of persons (see McCormack, 2004: 34).

Empirical research has also confirmed how both participants in the relationship highly appreciated this possibility to be recognized. According to Berg and Danielson, for the care receivers, "It was important and highly valued to be seen, validated and to participate in their care" (Berg & Danielson, 2007: 503), while Mok and Chiu found that patients have to feel that the nurses "were genuinely interested in them" (Mok & Chiu, 2004: 480). Similarly, Rundqvist and Severinsson found in their qualitative study how confirmation – "to see and to be seen" – was an important factor for the caring relationship and brought great joy also for the care provider (Rundqvist & Severinsson, 1999: 802). Morse, in turn, argued that in connected relationships, the nurse maintains a professional perspective but "views the patient first as a person and second as a patient" (Morse, 1991: 458). But care providers also needed this validation: One of the results of McGilton and Boscart's (2007: 2154) research was that "care providers need to feel appreciated by residents to develop close relationships with them."

It is important to understand that this validation of the other takes place mainly on an implicit level of facial, bodily, and tonal signals and is connected to processes that are deep within us human beings. In infant research, it is recognized how the responsive parent is through her nonverbal gestures signaling to the baby that "I see you and I'm listening to you and I'll give back to you a reflection of yourself that is valued so you can see and value yourself too" (Siegel & Hartzell, 2004: 80–81; see also Trout, 2011). These words could directly be used to describe what was taking place between the nurse and the resident in the tender moments of a caring connection that I saw at the nursing home. I agree with Trout's suggestion that we can learn much about nursing relationships by looking at those mainly nonverbal methods that are used by parents to attune and connect with the baby (Trout, 2011: 17). Validation thus arguably takes place through the dimensions of attunement discussed in the literature review.

Thus I argue that the foundation of a caring connection is the process of mutual validation. In order to reach the level of openness and tenderness that characterizes caring connections, the participants must start by

showing respect for each other. They need to see the other as a valuable person and appreciate the moment of being in contact with the other.

Being present in the now-moment

The temporal experience of caring connections was that of being present in the moment at hand. Instead of having one's focus in the past or in the future, one concentrated on what was taking place right now. Observing nurses in ordinary caretaking moments, they sometimes were absent-minded, performing their tasks relatively well but at the same time seeming to focus their mental attention on something else – the next task at hand, planning the working day, and so forth. One felt that they were not fully present in the situation. At other moments, when the residents were especially nasty – screaming outright or being aggressive – nurses seemed to consciously attempt to maintain themselves above the situation, keeping their personal irritation in the background and looking at the situation with the calmness of a professional care provider. Similarly, the residents sometimes maintained a clearly absent-minded or ignorant attitude towards the caretaking activity of the nurse. Their focus was not on what was taking place at the moment.

This absent-mindedness from either party resulted in interaction in which caring connections could not emerge. From the intersubjective perspective, we might say that the reciprocal intersubjective system between them is not able to grow towards a caring connection when either party is not 'there' to receive and respond to the bids that the other makes towards emotionally more deep forms of interaction. As has been emphasized, the reciprocal growth of the intersubjective system into a moment of caring connection needs the active contribution of both parties.

On the other hand, sometimes both participants had their focus clearly on the present moment. They concentrated on the moment at hand and this had a clear positive impact on the quality of their interaction. In these situations, their appearance signaled a quality of being present in the situation and attentive towards the other. The temporal experience of both participants was thus that of being present in the here-and-now-moment (cf. Kahn, 1992: 328). Essentially, this meant being present on three levels: in the situation, for each other, and for oneself. Because when one is present in the situation, one is not only more present for the other but also for oneself (Beebe & Lachmann, 2005: 190). One is more aware of oneself and one's current state and actions. But being present also meant that the

participants were more present for each other; they were attentive to the other (cf. Kahn, 1993: 546). This attention was visible through nonverbal gestures such as maintaining eye contact or nodding encouragingly (cf. Kahn, 1993: 546); the nurse is paying attention not only to the words of the resident but also to intonation, body language, facial expressions, and other nonverbal signals (cf. Sahlsten et al., 2009: 493). Being attentive to the other allowed participants to note and become aware of each other's micro-level signals of positive regard and affect (when such signals were present) and respond to them accordingly. It also allowed them to attune to the rhythm of the other's movement. This reciprocal exchange of signals of positive attunement then allowed the transformation of the situation into a caring connection. As argued by Kahn (1992: 323), "it is when people are fully present that they are best able to create connections with one another."

Drawing from Stern (1998: 304), we thus can state that a moment of caring connection is a "moment that pulls the two participants fully into the present."[32] Instead of being directed towards some future outcome or following a path that was determined in the past, the participants experience the present moment as something that they are embedded within. The caring connection might be initiated by either of the participants, but within it, both feel that they are strongly present in the moment at hand.

In the nursing literature, it is widely acknowledged that being present for the other is an important element of good caring[33]. According to Watson (1985: 58), in transpersonal care, both participants are fully present in the moment. McCormack & McCance (2006: 476–477) talk about sympathetic presence as one essential process of person-centered care. Boykin and Schoenhofer (2001: 13, 18) see intentional and authentic presence as part of their definition of caring and as an important nursing asset. And Jonsdottir

[32] This resembles Ladkin's account on leading beautifully, where he describes how vocalist Bobby McFerrin "seemed to work presence in such a way that I experienced *now* as rich ground" and how the quality of engagement that McFerrin was able to create was "nourishing" (Ladkin, 2008: 32–33).

[33] There is less talk about care receivers' presence as such, but the fact that it is important goes together with findings that emphasize the importance of the openness of the patient for caring (see Finfgeld-Connett, 2008a: 200).

et al. (2004: 247) see that in the relationship process between the nurse and the client, the nurses "are fully present to patients and relate to them with open attentiveness." The trouble with these different notions of presence is that they seem to combine many different aspects into the concept and therefore, as concluded by Finfgeld-Connett (2006: 708), presence is "a complex concept that is vague and poorly defined" and which "has been fragmented into numerous types, used indiscriminately and combined with other concepts such as caring." My use of the concept 'being in the present' is narrower and refers only to the temporal experience of focusing on what is at hand now, in this moment[34].

Opening up to each other

When mutual validation and presence in the now-moment were established, the encounter could continue its growth towards a caring connection if and when both the nurse and the resident were able to *open up for each other*. This meant that they became personally more involved; giving more of themselves and bringing increasing depths of themselves into the situation. From the point of view of the nurse, opening up is about "unreserved interaction" [Head nurse 1] with the resident. While mutual validation was about the other and being present also was much about being attentive towards the other, this dimension is about oneself – what one is willing to bring into the shared situation and how much one is willing to open for the other.

In the mutual encounters within the nursing home, opening up meant that the residents felt at ease and could share their personal joys and sorrows with the nurse. In other words, a sense of trust had been established between the nurse and the resident so that the residents felt good at confiding in the nurse. But again, this dimension was more present on the nonverbal level. When the residents opened up, they seemed to be less on guard and were less playing out a certain role. Their appearance signaled certain relaxation. They were able to be more themselves in the situation;

[34] As will be evident in the next paragraph, many aspects that nursing researchers are willing to write under the term 'presence' I take up through the dimension of 'opening up for the other'. I see that one can be temporally present in the situation and attentive towards the other while not revealing anything about oneself. Therefore it is better to treat these two dimensions as independent of each other.

bring more of their personality into the open air. Their body language was more open and less defensive and they were more openly facing the nurse.

Similarly, the opening up of the nurses was shown by them being more relaxed and personal in the situation, less constrained by role requirements of their profession. In the words of Kahn (1992: 324), the nurse was able to bring "increasing depths of herself" into her role performance. She was not only temporally present but *authentically* present, which according to Boykin and Schoenhofer (2001: 18) means "one's intentionally being there with another in the fullness of one's personhood." So for both the nurse and the resident opening up meant being more engaged in the situation; investing more of one's selfhood into the situation they are sharing with the other.

This dimension of opening up of oneself and bringing more of oneself into the nursing situation is again widely acknowledged within nursing literature. In their ethnographic observation of a relation between a nurse and a resident Hem and Heggen (2003: 105) concluded that the nurse's "openness was one of the premises for their interaction." Also in different accounts of nurse's *presence* openness to the other, intimacy and vulnerability play a significant role (see Finfgeld-Connett, 2006); presence "involves being with another person in an intimate way" and is about "engaged availability" (Finfgeld-Connett, 2006: 710).

This is also supported by research on self-disclosure which involves revealing and sharing personal information about oneself to another person (see Greene et al., 2006). Evidence within this research tradition suggests that "self-disclosure promotes relationships through mechanisms of liking and positive affect" (Vacharkulksemsuk & Fredrickson, 2012: 400). Importantly, there is a tendency in human beings for 'disclosure reciprocity', which means that one person's disclosure encourages the other person's disclosure, which in turn may encourage the first person to disclose even more (see Greene et al., 2006: 410). Thus the opening up of the nurse can lead the resident to open up more and vice versa, leading to a reciprocal process of increased openness.

Also the need of the resident to open up is acknowledged in the nursing literature. From the perspective of the resident opening up to the other presumes a need and openness for such an intimate encounter with another human being (Finfgeld-Connett, 2006: 711). One characteristic of connected relationships is, according to Morse (1991: 458), the fact that the

patient chooses to trust the nurse. According to McGilton and Boscart (2007: 2152), "having a confidant" was the primary theme underlying the residents' perspective of having a close relationship with the care provider. More generally, according to Finfgeld-Connett (2006: 711), in nursing literature, it is thought that when the resident is ready for presence, "the nurse is actively invited into the patient's experience." The resident must be willing – or the nurse must be able to awaken this will – to engage in a deep human encounter with the nurse. Otherwise they are not able to deepen their encounter into a caring connection.

In addition, by sharing more of themselves, the participants became more vulnerable in the situation. As noted by Finfgeld-Connett (2006: 711), each individual in the dyad "is compelled to become personally vulnerable." Being vulnerable means being open about one's neediness, suffering, and attachment – about one's fragility as a human being. For this to occur, a level of trust must be established in which the participants feel that they are secure enough to take the risk of being open for the other. This sense of trust is partially established through the previously discussed steps of mutual validation and being present in the situation. In nursing literature, the care receivers' vulnerability is more recognized, but some writers also emphasize the importance of the nurses becoming vulnerable. For example, Hem and Heggen (2003: 105) suggest that "in her interaction with the patient, the nurse experiences and shows her own vulnerability."

We might connect this dimension of opening up with what Kahn (1992) calls psychological presence at work. Through this concept, he attempts to describe "the experiential state enabling organization members to draw deeply on their personal selves in role performances" which is manifested through an "individual's aliveness to and in particular situations" (Kahn, 1992: 321). Looking at it through my categorization, one might say that it is a combination of being present in the moment and opening up. Kahn suggests, for example, that when a person manifests presence, there are "indicators that give the observer the sense that there is someone 'home' in interpersonal and work situations, including physical presence, eye contact, the fullness of the speech that people use in talking with others, the words that are spoken, and the authenticity with which people respond to others in the context of task performance" (Kahn, 1992: 321). So it is about the one being *temporally* fully present there and also that one's whole *personality* is relatively fully present in the situation. Of these, the second dimension describes what I have tried to capture through the concept of opening up. It

is about being able to integrate different aspects of oneself into the situation. Instead of making oneself absent, remaining emotionally detached, or closing off a large part of one's personality, one is able to be in the situation with one's emotions and with different aspects of one's personality (Kahn, 1992).

It must be acknowledged that in this dimension, the difference between the role expectations of the nurse and the resident become visible. Even though the nurse is somewhat able to free herself from the role-related restrictions and bring more of her personality into the situation, her opening up is restricted to only certain dimensions of herself. In opening up, the residents can bring into the situation the happy and empathic dimensions of their personhood, but also their darkest worries and fears. The nurse, however, is mainly able to bring into the situation only those sides of her authentic personality that are warm, positive, and caring. If the nurse would similarly bring forth all her worries and private miseries, this would violate the implicit role expectations that are coded into the situation. This might lead to the termination of the process towards a caring situation as the resident might feel uncomfortable in taking the nurse's burden to carry. Or then the roles would be reversed, with the resident becoming the caregiver and the nurse taking the role of the one needing care. I discuss this possibility later on in the discussion section, but in general in this work I have looked at the ordinary situations where the nurse is in the role of the caregiver. And in that role, she needs to regulate what sides of her personality she can bring into the situation in order to provide the needed care for the resident. As Mok and Chiu (2004: 476) state, "The nurse would always know more about the patient than the patient would know about the nurse." In general, we could say that the nurse can bring herself into the situation as a caring person but not as a care-needing person.

Establishing a shared space

Through the reciprocal process in which the participants both validate and attend to each other on the one hand and open up to the other on the other hand, the connection deepens so that we can talk about a shared space that emerges between them. In other words, through the reciprocity of the relation, a sense of "mutual togetherness" (McGilton & Boscart, 2007: 2152) arises. The participants feel that they are sharing this moment and whatever is brought into it with each other. To use the words of Stern (2004: 172), the situation is "lived-through-together."

Establishing a shared space is therefore first of all about a sense of mutuality and being in the situation together. Mutuality here means "a way of relating, a shared activity in which each (or all) of the people involved are participating as fully as possible" (Miller & Stiver, 1997: 43). Accordingly, Jonsdottir et al. describe how "co-participants [- -] become united" in an evolving dialogue between them (Jonsdottir et al. 2004: 243). We might also describe this as a sense of mutual presence. The participants are actively engaged in the situation and with each other. Secondly, this mutuality is filled with a positive regard for each other. The persons feel that within the intimate situation they share, they are cared about and care for the other. In recognizing each other and acknowledging that this recognition is reciprocal and empathetic, the participants sense that a special form of connection has been established between them. Thirdly, the situation is holistic in the sense that both participants are present for each other through both their more verbal and conscious communication channels as well as the more non-cognitive and intuitive ways of relating. Sharing the presence is made possible by the mutually engaged availability towards the other, a holistic mode of relating, and a sensitive attunement to the moods of the other.

Within the shared space, the participants are able to share their physical, psychological, and even spiritual loads and feel that they are together taking care of them. In the nursing home context, this often meant that the residents could share their worries and feel that the nurse is sharing that burden with them. Through a nurses presence, a resident could feel that he or she was no longer alone in the situation but that there was someone with whom to share the situation with. This makes them feel more secure, and when they feel secure, they feel comfortable to share personal thoughts and feelings in an open and honest manner (Finfgeld-Connett, 2008b: 200). The residents thus must trust the relation enough to become personally involved and vulnerable within it. In return for daring to indulge in such a relation, they get a sense of intimacy – that someone is sharing their thoughts and feelings and the moment with them.

The establishment of a shared space in a way combines the elements discussed before. It takes place only when both the opening up to and being attentive towards each other both take place reciprocally. It is not enough that the one person opens up if the other is not attentive to and validating him or her. And the one attending to the other cannot be there for the other in a deep and authentic way if he or she is not opening up and becoming

vulnerable at least to some degree. As Mok and Chiu (2004: 476) note, "the patient not only wishes to speak, but is also known to the nurse in an intimate and private way." Thus participants of the shared space feel that they are able to give of themselves to the other and that the other is open to receive whatever they are giving. They feel that they are able to share whatever is present in the moment.

This dimension of the caring connection is related to Dutton and Heaphy's (2003) idea that the degree of connectivity in high-quality connections is about "creating expansive emotional spaces that open possibilities for action and creativity" (Dutton & Heaphy, 2003: 266). It is also represented in the nursing literature through different ways. In Watson's (1985: 58–59) discussion about actual caring occasion and transpersonal caring she proposes that the participants share a phenomenal field and enter into each other's experience. Boykin and Schoenhofer (2001: 18) talk about a "shared lived experience" and how the nurse "joins in the life process of the person nursed and brings his or her life process to the relationship as well." They also emphasize that "in order to know the other, the nurse must be willing to risk entering the other's world. For his or her part, the other person must be willing to allow the nurse to enter his or her world. For this to happen, the acceptance of trust and strength of courage needed by person in the nursing situation can be awe-inspiring" (Boykin & Schoenhofer, 2001: 14). Their understanding of the nursing situation as something that involves entering the other's world comes close to the account of shared space where the care provider and the care receiver in a way share their life-worlds for a moment.

Bowers et al. (2001: 542) found that some residents felt it important that they could share their personal identities from their past with the care providers and accordingly described good care providers as those who attended to those identities as they provided care. Pierson (1999: 297), in turn, sums up the constituent elements of caring relationships to include "active sense of engagement, genuine responsiveness, presence, reciprocity and the commitment to foster the well-being of another." All – perhaps with the exception of the last one, which is more about the next dimension, caregiving – could be used to describe what the shared space amounts to. The idea of reciprocity was also important in McGilton and Boscart's (2007: 2152) research on close care provider resident relationships. In the same vein, Hagerty and Patusky emphasize the role of mutuality in the nurse-patient relationship and suggest that "'Small talk' with a patient becomes an

important exchange during which nurses attempt to discover commonalities that facilitate connection" (Hagerty & Patusky, 2003: 149). Finding commonalities could be seen as a way of strengthening the shared space that is forming between the participants. On the other hand, we learn from Jones that this sense of mutuality does not need any words to be established, as is evident in this account of the nurse caring for a patient with cancer: "Sometimes a patient will look at me without a single word. I know that the look conveys the message 'I know…that you know', meaning death is near. Sometimes, a touch or simply a look or a feeling will convey the message….but it is there all right" (Jones, 1999: 1300). Shared space can take place through this kind of exchange of facial expressions through which both participants come to know that 'I know that you know" and thus any words are unnecessary for the experience to be shared.

The discussions about presence in nursing literature also often carry elements of sharing a common space. Milton talks about choosing and affirming "a mutual presence with the other who is viewed as a priority and meaningful" (Milton, 2002: 23). He states that "in choosing to be present and bear witness to the mystery of being human, nurse and person coexist with the known and unknown while constituting the reality that each human lives" (Milton, 2002: 23). In a shared space, the presence is mutual and the participants constitute together the shared reality of the moment.

Another perspective in nursing literature that connects with the idea of a shared space is the one looking at containment (e.g. Jones, 1999; Mok & Chiu, 2004). The term 'containment' was originally used to describe what happens between the infant and the mother when the infant is overwhelmed with emotions and feelings it can't handle and then 'empties' the feelings into the mother who is able to 'contain' them for the infant (Bion, 1962; Jones, 1999: 1299). Analogically, Dutton and Heaphy (2003: 274) argue that "mutual empathy and mutual empowerment provide a relational context to safely navigate and learn about unfamiliar thoughts and feelings." In their qualitative study of nurse-patient relationships in palliative care, Mok and Chiu (2004: 482) came to see that this same "process of containing, in which patients can empty their fears and anxieties into the nurses" can take also place there. Similarly, Jones (1999) looks how nurses dealing with cancer patients are able to contain the anxieties and fears of the patients and thus help them to bear their burden. Watson's description of human care transactions also relates somewhat to the idea of containment. According to her, the nurse – through the unique

use of self – transmits and reflects the person's condition back to that person in a way that "allows for the release and flow of his or her intersubjective feelings and thoughts, and pent-up energy" (Watson, 1985: 58). We can say that shared space means also that the one opening up feels that the thoughts and feelings that he or she shares are received by the other; that the other is able to contain them and perhaps give them back in a more bearable form.

Again we must remember that what is brought into this shared space depends on the roles of the participants. The careseeker is mainly the one who is sharing thoughts and feelings that need to be contained, while the care provider's input is usually more about positive ingredients such as hope and cheerfulness. The nurses are also warned against over-involvement with the other. Pierson reminds that although there must be a space between individuals so that they can come together, the nurse must be able to hold a certain distance in order not to end up in a situation in which the relationship is so intimate that her nursing duties give way to an overwhelmingly unconditional participation and co-unity (Pierson, 1999: 300). Over-involvement in others' suffering might jeopardize one's capacity to be the caregiver in the situation. So although shared space is an important part of the caring connection, the care provider must keep some parts of themselves and their identity outside of it in order to be able to make balanced judgments about what is needed in the situation and thus best serve the careseeker. In this way, we could say that in the shared space, there is partially a "one-sided intimacy."

Despite this dissimilarity of the roles within the caring connection, it can be argued that the nurse and the resident are less constrained by their institutional roles than in more technical caretaking situations. Although it remains a fact that the nurse usually is the one containing and the resident is the one who has something that needs to be contained, these institutional roles are in the background during the unfolding of these situations. When the persons are fully engaged in the mutuality of the situation, their roles flow naturally out of the fact that the one is more in need of support while the other is open to be there for the other. Their roles and behavior thus flow from the demands of the unique situation – although the larger institutional context might have contributed to the fact that the unique situation started to develop in this direction in the first place.

To deepen this understanding theoretically, we might once again borrow from infant research and say that through their interaction, the participants share a common understanding of the ongoing relation they are together creating. There is, in other words, an "intersubjective recognition of a shared subjective reality" (Fonagy, 1998). When the residents feel to be within this intersubjective dyad, this makes them feel more secure in sharing themselves in the situation (cf. Kahn, 1992). Infant researchers have long recognized how even very small infants are equipped with the ability of "sensing the state of the partner, and of sensing whether the state is shared, or not" through implicit monitoring of the correspondences in time, form, and intensity of their bodily signals (Beebe et al., 2010: 103). This innate capacity explains why we are able to 'just know' if the other is sharing the moment with us or not. The experience of shared reality, in turn, leads to the creation of an 'open space' between the participants. This open space is then what enables them to feel that they are sharing the situation and their feelings and emotions within it. As Fonagy (1998: 349) puts it, "in the 'open space' there is a certain disengagement born of confidence of the availability of the other." When participants of the dyad know that the other is available to them, a deepening of their mutuality can happen. This is about "co-creativity and the enlargement of the intersubjective field" (Stern, 2004: xvi). Through their reciprocal and largely implicit interaction, the participants together co-create a situation they feel they are deeply sharing. This can be illustrated by the following passage, which I see as describing the establishment of a shared space between a baby and a parent:

> *"When a baby smiles and makes soft wordless sounds, a nurturing parent responds in like manner by smiling back at the baby and imitating some of the sounds, then pausing and waiting for the baby to respond again. A dialogue is begun which says to the baby, 'I see you and I'm listening to you and I'll give back to you a reflection of yourself that is valued so you can see and value yourself too.' Thus, a connection is made through this simple dialogue, a give-and-take of signals that creates a sense of joining. Our child's emotional well-being is built on this intimate dance of communication" (Siegel & Hartzell, 2004: 80–81).*

In this short passage, both participants are present, and there is a development from mutual recognition through opening up towards creating

a shared space. Commenting on the above passage, Trout makes the statement that this kind of "*co-construction of experience,* based on just such modes of *contingent, collaborative communication,* are seen between adults as well" (Trout, 2011: 18). So it can be argued that both in the relations between infants and their caregivers as well as in relations between adult care providers and care receivers, the creation of mutuality and a shared space is much about the "flow of small moves and moments" (Stern, 2004: xvi).

Heightened flow of affectivity

What was evident from observing the caring connections was that the affective dimension was strong within them. Both participants' way of being within these moments revealed that in these moments their state of mind was emotionally highly charged. As I have tried to describe in the depictions of caring connections given previously in this paper, the appearance, the tone of voice, and the way of interacting of both the nurse and the resident all signaled affective arousal. In fact, the affectivity of these moments was so intense that even in the interview situations, the nurses lightened up and displayed affection when they gave descriptions of these moments.

Additionally, the affectivity seemed to flow from one person to the another within caring connections. When I saw a resident in a good mood engaging in a caring connection with the nurse, many times the nurse couldn't help but be affected by this gladness. For example, one nurse told how she is affected by "their joy and gaze and that they are truly moved by some achievement of theirs" [Nurse 8]. The opposite flow of emotion was also observable. When both participants were open for engagement, the positive affectivity of the nurse was able to flow to the resident and also make him or her feel better. Many times I observed how the residents lightened up when they got into an interaction with a nurse who was in a happy mood. Much of the affective flow within the dyad thus seemed to be immediate and natural – contagion (Barsade, 2002) in its true meaning. Because the nurse and the resident were sharing the presence and thus opened up for each other in a special way, they were responsive to be moved by the other on an emotional level.

Thus caring connections are moments of affectivity. It is as if in these encounters both participants would be taken by an emotionally charged wave that fills their experience of the moment. One could argue that it is not only that the participants enter the moment affectively charged, but

that the moment itself partially creates the heightened mood for both participants. As human beings, we have a basic need for interpersonal attachment (see Baumeister & Leary, 1995), and thus the mere meeting with another is enough to improve our mood – the more the deeper the connection is. This might explain why both participants experienced these moments as so pleasant and energy-giving. The positive affectivity thus often didn't originate in one of the participants but was something that they co-constructed together in their interaction.

This is connected to Dutton & Heaphy's (2003: 266) idea that high-quality connections are characterized by "higher emotional carrying capacity", by which they mean that the connection can include both the expression of more emotion in general and also the expression of both positive and negative emotions. As they state, "we know we are in an HQC [high-quality connection] by the safety we feel in displaying different emotions" (Dutton & Heaphy, 2003: 266). Also, in this sense, caring connections are thus high-quality connections. The idea that the partners of the relation affect each other on an emotional level also resonates well with research on close relationships, which has consistently found that "a person's emotions can affect not only his or her own action tendencies, but also the partner's responses and the resulting quality of the dyadic interaction" (Mikulincer & Shaver, 2005: 149). It is also in accordance with Kahn's (1993: 546) argument that caregiving is partly about displaying emotional presence through showing one's own caring emotions toward the other and expressing warmth and affection nonverbally.

Again, the worlds of infant research and therapy offer us conceptualizations through which to deepen our insight about the shared affective experience of caring connections. Firstly, these moments involve emotional contagion. It is a well-known fact that human beings – as other social animals – automatically mimic and synchronize facial expressions and other bodily signals and consequently converge emotionally (Hatfield et al., 1992, 1993). In organizational research, this flow of emotions between different participants has been conceptualized as emotional contagion (Barsade, 2002; Pugh, 2001). For example, Pugh found empirical support for the hypothesis that "emotional contagion occurs in the service encounter" (Pugh, 2001: 1025). Caring connections provide an especially fertile ground for this phenomenon because of the deep mutual recognition and sharing that makes their relationship open for sensing and feeling the emotions of the other.

Secondly, we can argue that caring connections involve affect attunement. This is the well-documented process in infant research where the mother performs certain behaviors to express "the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state" (Stern, 1985: 142). A more conscious process than the primitive emotional contagion, here the nurse wants to enter into the emotional world of the resident and this is signaled by her resonating with the resident's emotional states. The intention to tune into the resident's emotional experience is thus conscious, but the related attunements occur relatively automatically and out of awareness (Stern, 1985: 145 – 148).

Thirdly, caring connections often involve also the more cognitive level of sharing emotions and emotionally charged stories verbally. The nurse and the resident might express in words how they feel at the moment. The resident might express her gladness for the treatment she gets, she might express how sad she has felt lately, or tell the nurse an emotional story from her past life that she has been thinking about. The nurse, in turn, might express how she is in such a good mood today or share her happiness by telling some happy story about her life[35]. The other then can easier imagine what it must feel like to be the other person and empathically relate to that feeling.

Finally, the moments themselves as deep-going relational encounters bring the participants into an emotionally aroused state. Using Stern's (1998: 304) vocabulary, we can say that caring connections are "affectively charged", they are "'hot' present moment[s]." This raised affectivity should not be seen as contained within the participants. Instead it is affectivity that flows within the dyad. When the connection between the nurse and the resident is deep, the emotions flow freely in both directions through full expressive display of the emotional state one is in. The participants are not holding back their emotions but letting them show and flow. This creates a "heightened affective moment" (Beebe & Lachmann, 2005: 170) in which the affectivity is felt as mutually shared and directed towards the other within the dyad.

[35] The fact that nurses are in a professional role when meeting the residents by and large prohibited them from sharing negative states with the residents. Although they sometimes used happy stories from their personal life to cheer up the residents, it was considered inappropriate to burden the residents with their personal problems. Nevertheless, I also observed this happening at some points.

This heightened affectivity is what explains why these moments are memorized so well and why they so easily lead to the deepening of the relationship between the participants. Being in a state of heightened affectivity and sensing that one is sharing this state with the other are thus central experiences of caring connections. As stated by Stern, "the sharing of affective states is the most pervasive and clinically germane feature of intersubjective relatedness" (Stern, 1998: 138).

Acts of caregiving and displays of gratitude

Finally, as the caring connections were about one person taking care of another, they included acts of caregiving. In the nursing home, it was the nurses who provided these acts of caregiving to the residents. This of course stems from the basic structural nature of their relationship – the nurse is in the nursing home to take care of the residents. Accordingly, most of the interaction between the nurses and the residents I observed in the nursing home involved some form of caregiving. This was also true of most caring connections – they usually emerged within a caregiving situation between the nurse and the resident, most often in situations where the primary task of the nurse was to take care of some physical need of the resident, such as getting out of bed, walking, eating or using the toilet. But as Kahn (1993) and other writers have noticed (Boykin & Schoenhofer, 2001; e.g. Mayeroff, 1972), acts of caregiving must be understood here broadly to include all acts in which the caregiver attends to the needs and personality of the other with the aim of helping his or her healing and growth. As said, it is about sensing the other's needs – be they physical, relational, emotional, psychosocial, or even spiritual – and responding to them in a considerate way. Understood as such, most of the interaction between the nurse and the resident involved the nurse giving some form of care for the resident. In nursing homes, this is much about concrete acts of helping the residents in tasks that are beyond their abilities, such as getting out of bed, walking, eating or using the toilet. But it is also about attending to the loneliness or sorrows of the residents.

Looking at caregiving from the intersubjective perspective, we may understand it as "flowing" (Kahn, 1993: 547) from nurses to residents in caring connections. The nurse and the resident have established a deep relational moment within which there is room to perform the acts of caregiving in a sensitive and considerate manner. Caregiving within caring connections thus goes beyond mere mechanical assistance in certain

functions. For the caregiving to be intersubjectively sensitive, it needs to be about a "trenchant, intuitive and empathic insight into another's suffering" (Finfgeld-Connett, 2008a: 199) as well as an ability to perform the proper kind of nurse interventions in a sensitive and appreciative manner. The nurse is thus not just performing her duties as 'just another job' but identifies accurately the "nuances and meanings [- -] of another's situation" (Finfgeld-Connett, 2008a: 199), feels the others suffering, and performs nursing interventions in order to make the other feel better.

In return for the flow of care from the nurse towards the resident, one can argue that there is in caring connections a flow of gratitude from the resident towards the nurse. As stated by one of the nurses, "The best moments are probably when one gets feedback from the resident herself or when one senses that the resident is feeling good" [Nurse 9]. The resident who receives affectionate care will often, in these heightened affective moments, return the favor partially by manifesting gratitude. As an emotion, gratitude is understood to be triggered precisely by "the perception that one is the beneficiary of another's intentionally provided benefit" (Algoe & Haidt, 2009; see also Emmons & Mishra, 2011). I heard many kind words that residents stated to the nurses that took care of them such as "You are such a wonderful person. Always smiling while working hard." One nurse told me that every time she helps a certain resident to bed in the evening, the complimentary words continue as long as she closes the door. In these examples, the gratitude is outspoken, but being verbal about it is by no means a necessary condition for displaying gratitude. Many times the gratitude was more present in the eyes of the resident as an affectionate gaze or was expressed through other nonverbal means.

The nurses seemed to feel these expressions of gratitude as nourishing. Even though one can argue that the nurses should not expect reciprocity, as they receive financial compensation for their care, the need for reciprocity in human relationships is so deeply seated that "it would be very difficult for professionals *not* to think in terms of reciprocity in the relationship with the recipients of one's care" (Buunk & Schaufeli, 1999: 277). Thus the fact that nurses seem to get much from the gratitude they receive from the residents is only too human.

Research has shown that the function of gratitude in interpersonal relationships is in promoting relationship formation and maintenance through increasing the relationship-enhancing motivations toward the

benefactor (Algoe et al., 2008), and this validated my experiences in the nursing home. By expressing their gratitude, the residents seemed to make the caregiving moment reciprocal and dynamic. Instead of the nurse unilaterally providing care, the flow of gratitude made the moment more mutual and started a dynamic that made the nurse more prone to provide even more care for the resident. Thus the active participation of the residents within the process was a necessary ingredient for the caring connections to evolve. In general, we can state that in caring connections, caregiving is flowing from the nurse towards the resident, and this is returned by a flow of gratitude.

Conclusion

I will close this chapter with one powerful example of a caring connection found in the literature. Morse (1991: 458–459) recounts a story told to her by a nurse that I see as exemplifying how a moment of caring connection can also be established between a nurse and a client when they meet for the first time. In this true story, a woman came to the hospital alone to give birth to her child. Unfortunately, the baby was anacephalic, a rare condition where a baby is born practically without a brain and will die in a few hours after the birth. So there was this woman with her baby in her hands, knowing that in a few hours it would be dead. Examining the situation, the nurse thought , "How am I going to deal with this?"

> *"So I asked her what I could do for her to help her be with this baby while it expired, and she asked me if she could have a rocking chair – she just wanted to get out of bed and rock it till it died. I went to the NICU and got her a chair and helped her out, because she had just had a section 2 hours before that. And she was in the chair. I strapped her in and made her comfortable, and then, in about an hour, the baby died. And so she and I bathed it together and we wrapped it and cried a lot together. I'll never forget her. But I think she appreciated the humanness. The fact that I could cry with her or that it would upset me as much as it upset her. She had no one. I remember staying a couple of hours late with her so she wouldn't have to meet anyone else. And when I left, we hugged one another. And that was meaningful – a hug" (anonymous nurse quoted in Morse, 1991: 458–459).*

This story powerfully demonstrates the many dimensions of a caring connection. First of all, it is clear that it didn't take place on the functional level of taking care of the necessities and formalities of the situation but almost exclusively on the emotional level of connecting with the other. The participants validated the humaneness of each other, and their relation went well beyond that dictated by their institutional roles. Both were focusing on the present moment and on each other – everything outside of it, even the fact that the nurse's shift ended, felt insignificant. Even though they didn't know each other before, they engaged in a connection that was intensive and in which both of them were vulnerable, as was evident in their crying together. The nurse was so committed to the caring of the woman that she even stayed with her after her work period had ended. It was also evident that the moment was highly affective for both participants and that they shared the affective state with each other in crying together and hugging each other. The moment ended with a hug that was felt as meaningful – both were elevated to appreciate the worth of the other. And even though the whole situation – and the relationship between these two persons – lasted only a few hours, both will remember it for the rest of their life. The nurse said this outright: 'I'll never forget her.' And we can derive the meaningfulness of the nurse's act from the patient as well as from the fact that she showed her gratefulness for it when she later donated an IVAC machine to the hospital, with the nurse's name engraved on a brass plaque and an inscription that read 'To ..., for her humanness and caring."

Chapter 9: The contribution of caring connections

> *Transpersonal refers to an intersubjective human-to-human relationship in which the person of the nurse affects and is affected by the person of the other. Both are fully present in the moment and feel a union with the other. They share a phenomenal field which becomes part of the life history of both and are coparticipants in becoming in the now and the future. (Watson, 1985: 58)*

Having explored the nature of caring connections, it is time to look at what caring connections contribute to and what are their consequences. The theme of caring connections first emerged in the research when I asked the nurses to tell about some especially rewarding and significant moments in their work. Sometimes the stories they told were occurrences that had happened some years ago. Yet the mere remembrance of them clearly elevated the mood of the nurses and made them radiate joy. I will argue that caring connections might be rare and short-termed but that they carry significance far beyond their temporal nature. In this chapter, I will first present the benefits of caring connections for the well-being of the nurse and the resident alike, followed by a discussion of how occasions of caring connections are embedded in the longer-term relationships between the participants. Finally, I will say a few words about the mechanisms of caring connections – about how they take place.

Why caring connections are so significant

My investigations made me convinced that caring connections are highly significant moments for both the nurse and the resident alike. These moments themselves are examples of interpersonal flourishing and therefore valuable in themselves. In addition, they are able to improve the well-being of both participants and also to deepen their mutual relationship. In addition, it can be argued that they potentially contribute to human growth, meaningfulness, and other constituent parts of human flourishing.

Moments of interpersonal flourishing

First, as I have already tried to demonstrate, the moments themselves were experienced by both participants as highly significant. As defined, they were moments of affective arousal – moments where both participants were able to bring increasing depths of themselves into the shared situation and engage in it fully. Both participants were highly present in the situation and for each other, and the relational dimension between them seemed to be deep. Both viewed these situations as significant and were glad to be part of them. Based on the nature of caring connections, one could say that they were valuable in themselves.

Caring connections could even be described as moments of relational or interpersonal flourishing (see Ryff & Singer, 2000)[36] because the relational dimension between the persons seemed to function especially well, exhibit vitality, and be filled with positive emotions. As Keyes defines it, flourishing on an individual level means "to be filled with positive emotion and to functioning well psychologically and socially" (Keyes, 2002: 210, 2007). Interpersonal flourishment could thus be seen as a relationship between two (or more) persons that is filled with mutual positive emotions and in which the relational attunement and interaction between the participants is functioning especially well. As I have argued, this is what caring connections are about.

One could also argue that caring connections are examples of what Dutton and Heaphy call high-quality connections and which they see as essentially life-giving. According to Dutton and Heaphy, high-quality connections are associated with mutuality, feelings of vitality, and aliveness for both participants as well as a heightened sense of positive regard for the other (Dutton & Heaphy, 2003: 267). They see that in high-quality connections "employees may be able to display authentic identities more often, engage each other more fully, be more vulnerable in the process of learning, and experience more interpersonal valuing through positive regard, all of which cultivate positive meaning about being an organizational member" (Dutton & Heaphy, 2003: 276). As my description of the elements of caring connection shows, all these descriptions seem to fit well to the caring

[36] Ryff and Singer use in their article the terms 'interpersonal flourishment' and 'relational flourishment' interchangeably, but no definition is offered beyond saying that it is about "quality ties to others" (Ryff & Singer, 2000: 31) – and with a caring connection, the quality of the tie is arguably very high.

connections, and thus it can be argued that caring connections are a subtype of the high-quality connections.

Thus we must acknowledge that the first positive contribution of caring connections are the caring connections themselves, as they happen. They are worthy in themselves, whether or not they have beneficial long-term consequences. They are felt as satisfactory, elevating, and meaningful by the participants. As Hagerty and Patusky (2003: 148) state, "Connection occurs with active involvement with another person or persons along with comfort and increased sense of well being."

Deepening of the relationship between the caregiver and the cared-for

> *Although moments of brief social interaction with a stranger may seem irrelevant in the short-term, we suggest that such moments hold potential as 'building blocks' for social bonds in the long term. (Vacharkulksemsuk & Fredrickson, 2012: 402)*

As was already discussed, the individual situations of caring connections are embedded within the longer-term relations between the ones participating in it. Based on my observations, I argue that they especially contribute to the deepening of these relationships. As one resident put it to the nurse during a caring connection involving hair fixing, 'this is also a way of becoming friends.' In caring connections, participants are present for the other and meeting each other as authentic persons and with their real emotions. They are thus situations that allow the participants to get to know each other more deeply – in fact, almost paradigmatic examples of such situations. My experience was that in these moments, both participants learned to be with the other better, and at the same time the emotional bond between them strengthened. This shouldn't be too surprising as many of the activities within these moments (such as discussions) resembled those activities that people in civil life go through in the path of becoming friends. As the nurses interacted with the same residents on a daily basis, in some cases for many years, nurses reported how they developed relatively deep and affectionate relationships with some of the residents. I came to see that caring connections both build these relationship and – when such relationships have been established – grow out of them.

These insights are backed up by organizational theorists. Drawing on research evidence that shows how increasing the expressiveness of interactions enables people to experience empathy for each other and a

close sense of identification with the other (Batson et al., 1997), Grant suggests that a deep contact between two people is likely to increase their affective commitment to each other (Grant, 2007: 401). Caring connections are, by definition, moments of deep contact between the participants and thus will arguably contribute significantly to the deepening of their relationship. Similarly, in his classical study, Granovetter (1973: 1360) argues that the strength of a tie between two human beings is based on "the amount of time, emotional intensity, intimacy (mutual confiding), and reciprocal services which characterize the tie." Although they can be temporally short, caring connections significantly increase the emotional intensity and intimacy that are part of a certain tie. Dutton and Heaphy, in turn, argue that high-quality connections are characterized by tensility, the "capacity of the connection to bend and withstand strain and to function in a variety of circumstances" (Dutton & Heaphy, 2003: 266).

Similarly, within nursing research there is "emerging evidence that relationships develop through caring processes" (Brown Wilson, 2009: 179), and the importance of creating a positive nurse-patient relationship has recently been more fully acknowledged (McCormack, 2004; Nolan et al., 2004: 47). For example, Mok and Chiu (2004: 480) found that "the nurse-patient relationship evolved into a trusting and connected relationship as patients found that nurses were caring in both action and attitude."

We might also cite some research evidence from research on close relationships that lend support to the notion that the caring connections can lead to a more intimate relationship between the participants. Although research on close relationships has mostly focused on the relation between romantic partners – a man and a woman – many of their basic insights have been found to be applicable also to other, less intimate relationships (see e.g. Shaver & Mikulincer, 2006: 265–266). Firstly, research on self-disclosure has found that increased disclosure – which takes place when participants open up in a caring connection – increases relationship intimacy (see Greene et al., 2006: 416–417). Secondly, *perceived responsiveness* of the significant other is seen as a central aspect of satisfying relationships within many theoretical approaches (see Murray et al., 2006). Perceived responsiveness means that the person feels secure that the other partner is responsive to one's needs. Based on the amount of gratitude that the residents demonstrated in caring connections, one could assume that in these situations the perceived responsiveness is high. In

addition, many times the caring connections involved the resident disclosing some positive events in his or her life to the nurse and the nurse responding supportively to this. According to research on *capitalization* – the sharing of good news with others – such activity leads to increased positive affect and well-being and builds intimacy between the participants (Gable & Gosnell, 2011: 268). Although this research concentrated on the relation between close partners, it can be argued that the same processes might activate in the relation between the nurse and the resident, which in many cases has involved almost daily interaction that has lasted for a number of years.

To get towards a more insightful account of the potential to transform relationships that the caring connections might have, we can borrow from therapeutic literature. In there we find the concept of *moment of meeting* that shares many key elements with caring connections such as mutuality, authenticity, and opening up to the other's subjective experience (Lyons-Ruth, 1998: 286). This kind of moment between two participants in parent-infant interaction as well as in psychotherapy are, according to Lyons-Ruth, catalysts for change. She argues that "these moments of meeting open the way to the elaboration of a more complex and coherent way of being together, with associated change in how relational possibilities are represented in each participant's implicit relational knowing" (Lyons-Ruth, 1998: 288). Implicit relational knowing means a form of procedural knowledge through which we are able to be with and interact with intimate others. The heightened affective characteristic of moments of meeting is thus tied to "a sense of emergent new possibilities in the interactive field" (Lyons-Ruth, 1998: 286). When the interaction between two participants reaches the intimacy of a moment of meeting, this has transformational potential for their mutual relationship.

If this is true of the caregiving relations between a mother and a child or a therapist and a patient, it could also apply to the caregiving relation between the nurse and the resident. Thus it can be argued that caring connections are defining moments in the relationship between the nurse and the resident, moments in which these relations can be transformed to a deeper and more mutually regarding and emphatic connection. In the path towards a deeper relationship of mutual trust and empathy, caring connections thus open up space for both participants to engage with each other on a deeper level, thus strengthening their mutual bond.

Well-being for the nurses

From the interviews with the nurses, it became clear that these moments were important for their own well-being and enjoyment of their work. For example, one nurse commented how "the showering moment with Abigail [name changed] makes me cheerful, as she has such lovely stories" [Nurse 18]. Observing her during and after such a showering, I could tell that this indeed was the case. More generally – and as already mentioned – these moments were considered by many of them to be the best part of their work. They also reported how the good feeling generated by even a short caring connection might last throughout the whole working day. "Doesn't it carry through the whole day? Or perhaps not the whole day but it leaves a good feeling and that enhances the day in some way" [Nurse 18]. They experienced the moments as "extremely rewarding" and as "that something which brings meaningfulness into this work" [Nurse 17]. The satisfaction the nurses got from these moments was not hard to observe either; it was clearly evident in their appearance during and after these moments. The caring connections seemed to have given them emotional energy. They were more light-hearted and generally in a better mood after these occasions. On the other hand, the absence of these moments was seen as having a negative effect on their coping [Nurse 17].

This insight about the positive effect of caring connections on nurses' well-being is backed up by research evidence in nursing research. A meta-analysis on research on caring in nursing research concluded: "Practicing in a caring manner leads to the nurse's wellbeing, both personally and professionally. Personal outcomes of caring include feeling important, accomplished, purposeful, aware, integrated, whole, and confirmed." (Swanson, 1999.) In McGilton and Boscart's (2007) research, both participants – nurse and patient – saw close relationships with each other as significant sources of well-being. When care providers were asked what they liked about their jobs, one of the most common answers was about being appreciated and getting a sense of personal gratification in the work itself (McGilton & Boscart, 2007: 2154; Monahan & McCarthy, 1992). Caring connections arguably provide them with both of these experiences. Several studies have also found that nurses' presence with patients enhances the mental well-being of the nurses (see Finfgeld-Connett, 2006: 708). Waerness reports that in her study on homehelpers, one of the most satisfying features of their work was their personal attachment to the clients (Waerness, 1996: 244), and the same insight emerges from various studies

on nurses' job satisfaction, in which patient contact is found to be one important source of job satisfaction (see Caers et al., 2008). Rundqvist and Severinsson (1999: 802) report how "several care-givers stated great joy over the moments when they were recognized, seen and welcomed by the patient," while Robertson et al. (1994) conclude that interpersonal relationships with residents in nursing homes is what makes aides stay at their jobs. Finally, Mok and Chiu report how nurses in palliative care stated how their encounters with patients provided them with job satisfaction and made them feel enriched (Mok & Chiu, 2004: 479).

Within organizational research, high perceived prosocial impact of one's work has been found to be linked to increased job satisfaction (Grant & Campbell, 2007), and nurses clearly experienced the caring connections as moments of high prosocial impact. On a more physiological level, Dutton and Heaphy (2003: 268) argue that high-quality connections are associated with a release of oxytocin as well as endogenous opiad peptides "which down-regulate the sympathetic and hypothalamic-pituitary-adrenocortical (HPA) response to stress." These anxiety- and stress-reducing mechanisms might prove to be especially important in an occupation such as nursing, which is considered to be inherently stressful with as many as 25% of nurses suffering from some degree of burnout (Freeney & Tiernan, 2009: 1557).

On the other hand, research on the relationships between professional caregivers and their recipients have found that lack of reciprocity is positively associated with emotional exhaustion, depersonalization, and reduced personal accomplishment (Buunk & Schaufeli, 1999: 277–278). Similarly, Berg and Danielson found that the strain of the job was eased "if the patients validated the nurses and if they had confidence in the patient as a person, which in turn promoted her/his participation in care" (Berg & Danielson, 2007: 503). Pines, in turn, found in a quantitative analysis that burnout of hospital nurses was not correlated to their amount of working hours, but it was negatively correlated to the nurses' sense of accomplishment, productivity, and challenge at work (Pines, 2006). The extent to which one feels one is contributing through one's work thus can buffer the worker against burnout. As the caring connections are moments in which the residents are active and validating and from which the nurses 'get' much, it can be argued that they constitute a part of the reciprocity that nurses are able to get from their caring relationship with the residents. Thus, engaging in these moments contributes to the well-being of the

nurses also through protecting them from emotionally demanding feelings that can eventually lead to burnout. All in all, it can be argued that despite their relative rarity and temporal shortness, caring connections are important for the work-related well-being of the nurses.

Well-being for the residents

The residents engaged in caring connections also clearly enjoyed these encounters. Observing them, it was easy to see how these moments improved their spirits. For many residents, the encounters with the nurses were their primary form of interaction with other human beings – indeed for unfortunately many who didn't have any visitors, they were almost the only form of interaction[37]. Thus "we constitute the family for them, we nurses" [Nurse 17]. Accordingly it is easy to see why "these [residents] sometimes get frustrated for being so much alone and of course would want to have a companion with them all the time" [Nurse 1]. It can be argued that "the most important stimulus that keeps the spirits of the residents lively and them to have a good feeling comes simply from conversation. When you are together with someone and can concentrate with that someone." [Nurse 17] Caring connections thus represent for the residents one of the rare occasions for really connecting deeply with another human being and thus their importance for the residents' well-being should not be underestimated[38].

The insight that the high-quality connections that caring connections represent are essential for the well-being of the residents is also backed up

[37] The amount of guests that visited residents varied significantly. While one resident complained how she had received seven different quests in one day, and another told how her daughters visit her every day, there were many residents who the nurses said hadn't had a visitor in many months. Some might not have anyone at all who would visit them. So caring connections might not be as important to some residents as they are for others. Having said this, it still remained a fact that for a large number of residents, these moments seemed to be highly significant.

[38] As I have argued before, there seemed to be big differences in how much the residents longed for emotional engagements such as caring connections with their care providers. So they might be more important for the well-being of some residents and less important for others. I come back to this question in the discussion chapter of this work. Nevertheless, at least for many residents, caring connections seemed to have an important role in their well-being.

by research evidence from various fields. Most importantly, the need to belong and feel connected is a basic human need (Baumeister & Leary, 1995) and "quality ties to others are universally endorsed as central to optimal living" (Ryff & Singer, 2000: 30). For example, Hagerty et al. (1996) proposed that one central attribute of sense of belonging is that of being valued – something that is strongly communicated in caring connections – and found that a sense of belonging is statistically correlated to lower scores on loneliness, depression, anxiety, and suicidal thinking. An overall sense of belonging was closely related to indicators of both social and psychological functioning (Hagerty et al., 1996).

Within nursing research, Huss et al. (1988; reported in McGilton & Boscart, 2007: 2150) found that residents who felt they had an effective relationship with a care provider had a higher life satisfaction. Mok and Chiu (2004: 479) tell how for dying patients, "of utmost importance was that, through their relationships with nurses, they experienced themselves as people who mattered. The relationship was like being refilled with fuel, giving them energy. It enabled them to find meaning in life and eased their suffering." There is also evidence how the process of presence – one of the constituting elements of caring connections – is associated with enhanced mental as well as physical well-being for patients (Finfgeld-Connett, 2006: 708). Even the physical contact and its quality during caring connections can be significant. A recent fMRI study revealed that neural responses to threat were attenuated when the person held somebody's hand, and this effect was stronger the better the quality between the two was (Coan et al., 2006).

Also the compassion that is transmitted through the process has significance. There is evidence on the impact of compassion on reducing patient anxiety (Fogarty et al., 1999) and fostering positive patient health outcomes (Taylor, 1997). (Taylor, 1997). Lindholm and Eriksson (1993: 1359) found through their qualitative study that both patients and nurses felt that one important way to alleviate the suffering of the patients was when nurses showed them "true compassion and love" Similarly, Kanov et al. argue that compassion enables employees "to achieve a deeper level of healing through their treatment of the 'whole person' rather than just illness" (Kanov et al., 2004: 812). As affectionate and compassionate encounters, caring connections can thus be argued to

enable deeper levels of healing to occur than more instrumental moments of caregiving.

Similarly, research on social support has found that perceived support is consistently associated with many dimensions of positive health and well-being (see Gable & Gosnell, 2011 for a review) such as more positive adjustment to diseases (Holahan et al., 1997). It is especially important to notice that these positive effects are more associated with the *perception* that one has supportive of others than with the actual amount of *received* support (Gable & Gosnell, 2011: 266). One explanation for this is that for the support to be effective, it has to be perceived as responsive – understanding, validating, and caring (Maisel & Gable, 2009; Gable & Gosnell, 2011: 266). Caring connections can be seen as especially responsive situations of providing social support, and thus it is easy to believe that they are associated with these positive effects for the well-being of the residents.

The gratitude that the residents displayed during caring connections can also have significance for their own well-being. Feeling grateful has been linked to various positive outcomes such as physical health and psychological well-being (see Emmons & Mishra, 2011 for a review). Especially importantly for the residents plagued by a deteriorating general condition and the prospect of death, gratitude has been shown to facilitate coping with various life difficulties and stress such as the aftermath of a kidney transplant operation (Orr et al. 2007). In addition, opening up and self-disclosure – that take place within caring connections – have been found to be beneficial for a person's health and well-being (see Greene et al., 2006: 421) and can be especially beneficial for those residents who don't have many other contacts whom they could confess to.

Ultimately, the prevalence of caring connections might be connected to the longevity of the residents. A number of studies have shown how social isolation and lack of social support are associated with a detrimental effect on the immune system, increased risk of various diseases, and reduced life span (see Ryff & Singer, 2000: 34–35). As caring connections offer for the residents many of the benefits of social relations, such as a sense of being emotionally supported and recognized, it can be argued that they have the potential to carry a positive effect to the immune system and longevity of the residents. Naturally, it must be borne in mind that residents are individuals and differ significantly in their needs, capacity, and willingness

for engaging in moments of human meetings. In any case, there are various reasons to believe – based both on theory and my observations – that for most of the residents, caring connections are highly important for their well-being.

Other potentially positive effects of caring connections

In addition to the positive effects on well-being of both the nurse and the resident and on their mutual relationship, caring connections can be argued to be connected to a number of other positive factors. These suggestions are more speculative and would need more research to be elaborated, but as they offer important suggestions about the potential benefits of caring connections, I feel that it is important to also represent them here briefly.

Firstly, caregiving has been connected to human growth, understood as a sense of development and realizing one's potential (Kramer, 1997: 230; Mayeroff, 1972), and thus it can be argued that caring connections can contribute to the **human growth** of both the caregiver and the cared-for. For example, Mok and Chiu (2004) found that nurses felt that caregiving contributed to their personal growth, while Dutton and Heaphy (2003: 272) argue that "psychological growth occurs in mutually empathic interactions, where both people engage with authentic thoughts, feelings, and responses." Thus it can be argued that the mutually empathic and empowering caring connections are enablers of human growth (see also Miller & Stiver, 1997).

Secondly, the nurses told in the interviews how they get from caring connections **a sense of being able to help the other**. The nurses described quite widely how one of the best things in their work is seeing that they can create good feelings in the residents. As one nurse explained when asked what she likes about this job: "I have the chance to contribute to what the final times of these people are like, because this is their last home. Somehow I get strong feelings from the fact that through my own actions I can create joy and well-being" [Nurse 5]. Another told how one of the most rewarding things is "when one sees how the customer smiles and is feeling good" [Nurse 3]. A third nurse, in turn, told how she gets a warm feeling "when one gets spontaneous acknowledgement and the customer feels that she has received good care" [Nurse 7]. For the nurses, caring connections are opportunities to feel that they are needed and that they can concretely help the other. As nurses often are highly inclined to care,

opportunities for caregiving can be seen as moments of self-actualization (see Finfgeld-Connett, 2008a: 201).

It is also likely that caring connections contribute to the degree of **meaningfulness** (see Baumeister & Vohs, 2002; Rosso et al., 2010; Wrzesniewski, 2003) that nurses experience in their work. As one nurse expressed it, these moments are "that something which brings meaningfulness into this work" [Nurse 17]. Accordingly, it has been suggested that the experience of caregiving would increase an individual's sense of purpose in life and self-acceptance (Kramer, 1997: 230), and Mok and Chiu (2004: 482) report that palliative care nurses found meaningfulness in their caregiving. Grant, in turn, has argued that the motivation to make a prosocial difference is influenced by the affective commitment to beneficiaries (Grant, 2007), which is arguably increased through caring connections.

Connected to this, it can even be argued that caring connections can lead to an **elevated appreciation of the beauty in life**. At best, "the caring moment can be an existential turning point for the nurse" (Watson, 2008: 5) in which the nurse is able to expand her compassion and caring and find herself more connected to our common humanity. As one nurse remarked, "they are moments that bring us to a halt – how important I am and how important that other is!" [Nurse 2]. Similarly, one nurse in Mok and Chiu's research told how "learning to search for joy and beauty in life" were among the things she had gotten from interactions with patients, and more generally the nurses found "tremendous worth in patients" (Mok & Chiu, 2004: 481). In the midst of the ordinary workday, these moments can suddenly elevate the nurse into seeing the beauty of their work and the dignity in life. This was the impression I also got in a couple of interviews. In the midst of the nurses complaining about their working conditions, my question about the best moments in their work took them by surprise and immediately changed their posture towards an appreciation of what is graceful and dignifying in their work.

For the residents, caring connections could especially contribute to their **sense of dignity**. In these occasions, they were approached as human beings and were able to engage with the other in a way that maintained and respected their human value. Berg and Danielson report how patients want to maintain their dignity and that "it was important and highly valued to be seen, validated and to participate in their care" (Berg & Danielson, 2007:

503). In situations where the residents are simply taken care of, they can have a sense that their human value is ignored, but the mutuality of the caring connections keeps their dignity intact.

All in all, caring connections can be associated with a large number of factors that constitute **human flourishing** or **optimal living** (see Ryff & Singer, 2000). Despite all this research evidence that makes the case for the importance of caring connections for human life in general and nursing home work in particular, the most convincing personal evidence of the power of these moments was the deep satisfaction and tenderness I saw on the faces of the participants of these moments. My observations made me personally convinced that these are the moments that make the work of the nurses worthwhile for both the nurses themselves and for the residents.

Potential drawbacks of caring connections

Having presented the positive outcomes of caring connections, one can ask whether they might have some negative outcomes. Because of their inherently positive characteristic, I didn't find any nurse or resident stating that there would be some negative effects on them. Nevertheless, it can be argued that in some situations, caring connections might contribute to over-involvement with the residents.

In an over-involved situation, the nurse can be so committed to the patient as a person that this overrides her commitment to the treatment and her responsibilities as a nurse (Morse, 1991: 459). Although a certain level of intimacy and involvement is good for the nurse-patient relationship, the nurse must be able to hold a certain distance in order not to end up in a situation in which the relationship is so intimate that her nursing duties give away to an overwhelmingly unconditional participation and co-unity (Pierson, 1999: 300). Through distancing themselves to a certain degree, the nurses are also able to protect themselves from becoming too involved in the patients' suffering (McGilton & Boscart, 2007: 2155). Many nurses had to learn painfully, by trial and error, how to find the right level of involvement in a relationship (Morse, 1991: 465).

As caring connections represent moments of a particularly intimate connection, the risk of over-involvement is present. As one nurse described it: "I think a good nurse-resident relationship is warm and equal but the nurse can't bring her own things and sorrows into it. One must be professional to a certain extent. [- -] I've seen during the years how some nurses take residents to visit their own homes. I wouldn't do that" [Nurse

24]. Therefore, nurses need to hold a certain professional distance in order to be able to make balanced and professional judgments about what is needed in the situation and thus best serve the careseeker.

So from the point of view of the nurse, there is an optimal level of intimacy within a caring connection. Too little intimacy and engagement makes the situation emotionally cold and thus a caring connection is not established. Too much intimacy, in turn, might jeopardize one's capacity to be the caregiver in the situation.

Caring connections embedded within caring relations

The focus of this work has been on the caring connections – the actual moments in which the caregiver and the cared-for are engaged with each other. At the same time, it is clear that these connections do not take place in isolation but as parts of the longer-term relations that have been formed between the caregiver and the cared-for. As I argued in the literature review, most of the nursing research is about these long-term caring relationships between the care providers and care receivers and how they develop over time. The present work differs from them by focusing on the individual instances of caring situations. Thus a word about how these caring situations are related to longer-term caring relationships is in place.

In the nursing home, most caring connections I observed took place in situations where the nurse and the resident already had a long history of mutual interaction behind them. When they met, they communicated immediate and warm recognition of each other through both nonverbal and verbal means. Many times, the instant first reaction of seeing each other was a delighted smile. As they were already familiar with each other and were expecting a warm mutual interaction, their shared encounter often jumped into a caring connection almost instantaneously. In these situations, they clearly had learned how to interact with each other most fruitfully and already had had time to develop an emotional bond and mutual trust in each other. The nurses told me how their relations with some residents could be described as friendships. They knew each other and cared for each other much beyond a pure care provider – client relationship. Of course, even within these warm relationships, the other person might have a bad day or there might be other reasons why an individual caregiving situation between them would not reach a caring connection. But most of the time the caring situations within these caring

relationships seemed to be about a caring connection. Thus based on my observations, I can argue that a warm long-term relationship between the participants significantly paved the way and made more probable the occurrence of caring connections in individual caring situations between them.

But the fact that an affectionate mutual history made it easier to enter a caring connection doesn't mean that the caring connections could not be established without a mutual history. I also observed how stand-ins, who were in the unit for the first day, could develop their engagement with some elders into a caring connection by just being open and empathetic enough in the caring situation. In these situations, it might have taken a bit longer time for both participants to warm up to each other, but still, if the willingness to be warm and open towards the other seemed to be strong enough in both participants, then the situation often developed into a caring connection. Similarly, one occupational therapist who attended one of the presentations of my work stated that "because I represent a different occupational role, my meetings with the clients are different: short-term and occasional. Yet I recognized the issues you were talking about also through my own work." Through a therapeutic attitude and by remembering to take into account the individuality of every client, she felt that she could also experience caring connections through her own work. "Although relationships do evolve over time (when time is available), each interaction is an opportunity for connection and goal achievement," as Hagerty and Patusky (2003: 149) argue. My observations were in line with this insight about every caring situation representing an opportunity for a caring connection.

At the same time, a long mutual history itself was not any guarantee for a caring connection[39]. Some nurses and residents had known each other for years, but still their interaction showed no signs of a caring connection. They might know what to expect from each other, but if this mutual history hadn't made them develop a more personal bond with each other, it didn't seem to contribute much towards a caring connection. This could be for a

[39] In fact, it could be argued that a mutual history can in some situations even prohibit the establishment of a caring connection. This would be the case if the persons had negative expectations about the unfolding of their interaction based on their previous encounters. Blinded by this prejudice, they might miss the bids for connection that the other person might try to signal in a singular caring situation.

number of reasons, including one of the participants not wanting to engage in any personal relationship with the other. As said before, some residents were quite uninterested in engaging personally with any of the nurses. Obviously then, even though they might have been in the nursing home already for years, their interaction with the nurses didn't seem to reach a level of caring connection in any of the caring situations I saw them in.

It can also be argued that the personal chemistry between a certain nurse and a certain resident made it easier or harder to find the path towards a caring connection. I observed how some nurses and residents got along with each other more easily than some others. I sometimes saw how a certain resident was very kind and friendly with one nurse while he or she was quite mean towards another. My observations were in line with Berg and Danielson (2007: 504), who also noted how the "personal chemistry" between certain persons seemed to work better than with others. Similarly, Foner (1994: 249) found out that care providers have "favorite patients" and Morse observed that "patients who 'touch' or appeal to the nurse are more likely to enter a connected relationship" (Morse, 1991: 461). Accordingly, it has been found that some nurse-patient dyads can establish a working relationship in a few weeks, while for others, even a year is not enough (Forchuk et al., 1998).

So it was relatively easy for two persons to enter into a caring connection when they had a long mutual history together in which they had been able to generate mutual familiarity, trust, and empathy for each other. On the other hand, many times the long mutual history hadn't made the participants more engaged and emotionally available towards the other and thus didn't seem to increase the change of a caring connection. And additionally, it was possible to enter a caring connection even the first time two persons met.

Mechanisms of caring connections: A systems understanding of reciprocal growth

Finally, having described *what* takes place in caring connections, a brief note about *how* it takes place might be in order. The question is, in other words, through which mechanisms does an ordinary caring situation grow into a caring connection? As I have been arguing, caring connections are much based on emotional and nonverbal dimensions of human experiencing and thus also the way they take place is highly dependent on

these implicit dimensions. Therefore, to answer this question, we have to focus on the nonverbal and implicit interactive process that takes place between the participants throughout their meeting.

The interpretation of the situation given in this section is speculative and based on theoretical insights derived from the relevant literature, especially from relational and systems-emphasizing infant and therapeutic research (e.g. Beebe & Lachmann, 2005). Accordingly, this is a theoretical chapter rather than an empirical one. To test and confirm these insights, one would need to have an empirical investigation in line with what has been done in infant research in which face-to-face interaction is videotaped and then analyzed sequentially frame-by-frame to see how the micro-levels of mutual engagement feed into each other (see Beebe et al., 2010). Despite being based on theory, this interpretation is nevertheless in harmony with and built upon what I saw in the nursing home. Disregarding their theoretical roots, I feel that it is important to offer these explanations here as they can potentially shed light on the ways through which an ordinary situation can grow into a caring connection.

At the basis of the interpretations given here is a systems understanding of human interaction that leads us to rethink the nature of interaction within the caregiving situation. Stolorow et al. (2002: 24) note how "the residues of subject-object thinking persist most clearly in interpersonal theories, where a therapeutic relationship [or any other relationship, we may add] becomes described as an 'interaction', and the 'interaction' is analyzed in terms of the causal effects that people, understood though usually not acknowledged as essentially separate monads, are having on each other." As people are "fundamentally self-enclosed" in this view (Stolorow et al., 2002: 23), the interaction is something that happens only between their surfaces, people are related to each other "like the collision of billiard balls" (Gergen, 2009: xvi).

In place of this atomistic view of interaction, the more relational view sees that human beings tune in to each other on multiple – and for the most part implicit – levels simultaneously, leading to a situation where a relational field or system is co-constructed between them. In the meeting between the caregiver and the cared-for, both persons' implicit relational knowledge intersect to form an intersubjective system between them (Lyons-Ruth, 1998: 285–286). This intersubjective system arises when the complementary fitted actions and reciprocal intersubjective recognition

start to influence the thoughts and behaviors of both participants. In a sense, the systemic dimension between the participants takes over and has a life of its own. It is constituted by the mutual expectations both parties bring into the situation about the other and about the social interaction in general as well as a "recurrent patterning of mutual regulatory moves" (Lyons-Ruth, 1998: 286) that take place largely out of awareness and can be more or less synchronized and sensitive. Based on their previous interactions and the general interactional patterns acquired in their past, both participants react to and interpret the actions of the other in a unique way. Also, the affective tone of the situation is partially generated through these systemic micro-level interactions. As I argued in discussing the 'heightened flow of affectivity', in caring connections the moment itself partially creates the heightened mood for both participants through mechanisms such as emotional contagion (see Barsade, 2002; Pugh, 2001). It is this mutual dance between both participants' implicit expectations, affections, and expressions that constitute the system within which our cognitive mind then attempts to operate. Therefore the system that the caregiver forms with every cared-for is different; it makes possible certain acts and determines what kind of effects a similar act will have for different intersubjective dyads. Systems understanding of the caregiving situation means that one sees it as an ongoing process in which the mutual interplay between the caregiver and the cared-for "co-creates a systemic higher-level dimension that is based on bi-directional and jointly coordinated, simultaneous forms of interaction that influence the mental processes and regulatory patterns of both of the participants", thus creating possibilities for creative caregiving interventions (Martela & Saarinen, [Forthcoming]).

Expectancies, attunement, and rapport-building micro-acts: key elements in the growth process

When two persons encounter each other in a nursing home or in any other situation, they do not enter the situation empty-handed. Instead, both of them are equipped with certain expectancies about how the situation will unfold and where it might end. Beebe and Lachmann (2005: 13) call these "expectancies of reciprocal exchanges" and argue that already small infants as well as adults have these expectancies, which have an "enormous influence" (Beebe & Lachmann, 2005: 150) in organizing experience and how we approach social situations.

In the meeting between the nurse and the resident, these expectancies are derived from their mutual interactions in the past, from their experiences

with similar social situations, and more generally from the interactional patterns they have come to expect through their upbringing and life history. If the nurse and the resident in the nursing home already have a long mutual history, then their expectancies are largely derived from the way their past interactions have been unfolding. If they have a shorter mutual history, the nurse's expectancies derive from her experiences with other residents, from her education, and from the general interactional patterns she has grown up with. Similarly, the residents' expectancies are based on their experiences with other nurses and on the general interactional patterns they have acquired throughout their long lives. As Mok and Chiu (2004: 479) argue: "At the initial encounter, nurse and patient had their own preconceptions of the meaning of the situation and the roles of each in the encounter", and these had an impact on how the situation unfolded. It might be noted that for some residents suffering from dementia, the images from their own childhood can blend in with the present (see e.g. Feil, 1993). Thus they can see images of their mothers, fathers, and other important childhood figures in the nurses and then behave as reacting to those images.

Thus both participants enter the interactive situation with certain interactional patterns in mind. These expectancies influence what their initial behavior is like and what kind of interactive clues they look for in the other. As Sillars & Vangelisti (2006: 333) put it: "Every act of communication is enacted and interpreted within a particular 'historical' context, including the time and place, relationship history, and history of the immediate encounter." These expectancies also explain why the social situations often unfold towards the direction we expected. If we expect the other to be cheerful and expect that our mutual encounter will bring joy to both of us, then our own initial behavior will most probably be more open and cheerful than if we were to expect the other to be grumpy and that we will end up fighting once again. In such a situation, our own initial way of approaching the other would be more reserved and thus less inviting for the other to show up his or her more cheerful side. Similarly, because of the strong confirmation bias we human beings are prone to (see e.g. Nickerson, 1998), we tend to attend to those signals of the other that confirm our expectations and interpret ambiguous signals according to our initial expectancies. Thus our initial expectancies can easily lock the situation in the direction we expected it to go.

Caring connections are situations that require much openness and emotional engagement from both participants. In order to get there, I believe, there are two possibilities. In the most fortunate situation, both participants have good expectancies of the positive unfolding of the situation and thus they both behave accordingly. As they see that the other lives up to their positive expectancies, they can become increasingly open and emotionally engaged in the situation and the path towards a caring connection is opened. The other option is that one person has such strong positive expectancies of the situation that she is determined to lead it towards a warm and emotionally engaged encounter even though the other participant might not initially be up for that. There are a number of ways she can do that and they are discussed in Chapter 10. If neither party believes in the possibility of a positive mutual encounter, then it is very improbable that they would accidentally find their way towards a caring connection without some outside intervention.

In the process that initiates when the two participants with their expectancies meet, there are two elements that are essential. The first of these is our capability to become aware of each other's bodily movements, both consciously and through nonconscious channels (cf. Beebe & Lachmann, 2005). We are by nature equipped with sophisticated systems through which we are able to make sense of the other's mental state based on subtle physical cues, for example whether we are sharing the attention with the other or not (see Baron-Cohen, 1997). Through these various mechanisms, we then get a feeling about the mental state of the other and whether we are sharing the situation with each other or not. For example, the more our movements are in synchrony in a social situation, the more we experience the relation to be mutual (see Vacharkulksemsuk & Fredrickson, 2012). These mechanisms are activated in social situations and thus the persons feel each other – which means that they automatically pick up cues about each other's moods and intentions through facial, vocal, and bodily signals. These cues and their interpretation – that is by and large implicit – then largely determine how the participants come to experience the situation.

At the same time as the participants are reading and attuning to the signals given out by the other, they are constantly giving out their own attitudes and affections through their own bodily signals. Those nonverbal and verbal signals that contribute positively to the situation in terms of the emotional engagement and caring connections could here be called

rapport-building micro-acts. They are, in other words, small and in themselves insignificant gestures and acts that cumulatively feed positive signals into the interaction that in the end can lift it to levels of mutual emotional engagement that we call caring connections. They can be about a warm look into the eyes, an affectionate touch, a brief, validating nod, a wink of mutual understanding, a kind word, an opening up of one's posture, a stop of one second before walking out of the situation, or whatever. The essential element in these rapport-building micro-acts is that they signal to the other that one cares about the other and is willing to engage with him or her. Most of the time a person gives out these micro-acts without one's conscious awareness. These acts are derived from one's attitude, they are the natural ways to react to the other when one has an appreciative and engaged attitude towards that other. As many of them are rather automatic bodily reactions to one's inner state, they are relatively hard to fake. It is, for example, a well-known fact that there is a difference between a genuine smile that involves certain involuntary muscles and a deliberate smile one is able to produce without the accompanying feeling (see e.g. Ekman et al., 1990). One can of course consciously act out certain rapport-building micro-acts, such as saying a kind word to the other, but if such words are not backed up by body language that signals the same affections, a more sensitive recipient of such words is quick to notice this and might find the words hollow and empty. In other words, we have a rather automatic capability to produce such rapport-building micro-acts when our attitude and emotional state is right. In addition to that, we can also consciously learn to produce certain rapport-building micro-acts to complement and strengthen those produced automatically. By feeding such micro-acts into the mutually generated situation, one is able to make a positive impact into its felt nature.

What is essential to understand is that these processes of attuning to and reading the other's verbal and nonverbal signals on the one hand and projecting one's own verbal and nonverbal signals on the other hand don't take place separately for each person but rather in a bidirectional exchange in which both person's constantly affect each other (see Beebe et al., 2010). In addition to interpreting the other, we are all the time reacting to these interpretations and adjusting our own behavior accordingly. Influences are moving rapidly back and forth in the situation as we unconsciously react to the signals that the other is projecting unconsciously in a reciprocal fashion. In other words, there is a "moment-by-moment coordination of the

rhythms of behavior" (Beebe & Lachmann, 2005: 25) taking place between the participants. This gives rise to a systems understanding of the unfolding of the situation. As participants are making sense of their expectancies and the bodily signals of the other in the situation, their reactions to these is mirrored in the bodily signals that they project. This means that both participants are caught up in a process in which the mutual expectancies, bodily reactions, and their interpretations – which all take place largely implicitly – feed into each other on a moment-by-moment basis. The implicit level of the interactive situation can be enormously rich. Even in a few seconds, these patterns of bidirectional interaction can take many rounds of iteration that then lead the system, and both parties' interpretation of the system, into a certain direction. In a sense, this implicit systems level of interaction is not controlled by either of the participants, as most of it takes place automatically, without the intervention of the more cognitive parts of the mind. This is why it presents itself as a somewhat independent 'third party' to the interaction between two persons. It is co-constructed by their bidirectional and reciprocal interaction on implicit levels but without either of them being able to fully control how it develops.

Self-reinforcing positive gain spirals

The nurse and the resident thus enter into a social situation with each other and immediately a complex, reciprocal, and implicit process of mutual adjustment is initiated between them that has a significant impact on the way they experience and behave in the situation. This process can lead to many directions, but when it leads to a caring connection, I argue that it is because a self-reinforcing positive spiral takes place. In such processes, a positive input from one participant will trigger a positive response in the other, which in turn will further strengthen the first participant's positive inputs into the relationship (cf. Fredrickson, 2003). Research literature on professional caregivers and their recipients have found support for a negative spiral of influence in which harassment on the part of the recipient leads to the caregiver having a sense of lack of reciprocity. This increases her emotional exhaustion, which in turn leads to negative attitudes towards the recipient. Sensing these attitudes, the resident will in turn generate even more harassment (Buunk & Schaufeli, 1999: 280.). On the other hand, it has been suggested that group affect similarity and within-group relationship quality can lead to self-reinforcing spirals of positive group affectivity that both strengthen the group members' positive affect and their

interpersonal relationships in a dynamic process (Walter & Bruch, 2008). I see that something very much akin to this is what happens in caring connections. The process towards caring connections can be understood as a positively reinforcing loop into which both participants' increasingly positive, authentic, and affectionate responses feed into.

There are two ways that this positive spiral could work. Firstly, the more one person shows affection and engagement towards the other, the more this other person is also willing to engage affectionately in the relationship. Thus one person's engagement might increase the engagement of the other, which in turn further increases the engagement of the first person. For example, in systems terms, we may look at the caregiving of the nurse as the input into a self-reinforcing process (Senge, 2006: 94–95) where the received care encourages the resident to display gratitude and the received gratitude encourages the nurse to be even more empathetic in her care. As both elements feed into each other, the system can enter into a positive gain spiral (cf. Salanova et al., 2006) that results in high-quality caregiving and a strong experience of gratitude taking place within a caring connection. Similarly, within research on close relationships, one has found evidence for 'disclosure reciprocity', a process where either person's increased self-disclosure encourages the other to open up, which in turn encourages the first person to open up even more, thus leading to self-reinforcing dynamics (see Greene et al., 2006: 410). In terms of the six elements of the caring connection described earlier, we could say that the situation often involves some increases in one of these dimensions, which then feeds into increases in some other dimensions. For example, if the nurse is able to make the resident feel validated, this might lead the resident to open up more and be pulled more strongly to the present moment. On the other hand, the resident might surprise the nurse by displaying an overwhelming amount of gratitude, which might make the nurse feel validated and make her become more open and affectionate in the situation. The ways in which these different elements could feed into each other are multifold. In general, what was visible in my participant observation and what could also be expected from theory is that they seemed to reciprocally strengthen each other.

But in addition to this, it can be suggested that another self-reinforcing spiral exists. It is related to one's awareness of the other. We might use the metaphor *broadness of channel* to describe what I mean by this. The more intimate and open the connection is between the nurse and the resident, the broader the channel through which they are aware of each other becomes.

It can be said that the channel is narrow when participants avoid eye contact and otherwise do not pay much attention to each other. When the channel is narrow in this way, only the basic physical activities and verbal messages are able to reach the other. But as participants warm up to each other, they increasingly direct their full attention towards the other. Here the channel broadens and the richness of interaction is increased considerably. The more the persons turn their focus towards the other, the better they are able to attune to the other and start to move, feel, and act in synchrony with them. When this takes place, the felt union or bond between the persons grows (see Hagerty et al., 1993) and they have an increasing amount of affections such as compassion towards each other. Their attention can also shift from a more self-directed mode into a more other-directed or relation-directed mode. When this happens, they are not thinking only about themselves as much but they are increasingly looking at the situation as shared between themselves and the other. When they thus grow to become present in the situation with their whole being, the interactive channels will include – in addition to the verbal and physical activities –the nonverbal, intuitive, and non-cognitive dimensions such as gestures, facial expressions, sense of touching, and other hard-to-verbalize dimensions. They also start to be emotionally on the same level, as their close interaction makes them pick up on and relate to the emotional state of the other. Emotional contagion thus takes place more easily in these situations. All in all, they are increasingly aware of each other and are increasingly more present in the situation. Within such a broad channel, the nature of signals that can flow through can be significantly more nuanced and filled with tenderness and affection. The interactive experience of the caregiving situation thus becomes richer, and this richness itself generates possibilities for increased emotional expressiveness in the situation.

It might also be worth noting that the process that leads to caring connections doesn't have to be linear. Instead, there can be nonlinear tipping points through which the mutually generated interactive process enters a new stage. The stability of the interactional system is established through both persons expecting certain things from the interaction and acting accordingly. There is thus context-specific internal patterns in the system – the ways the participants have learned to react and interact with this specific person – that give rise to emergent structures and a dynamic stability (see Boston Change Process Study Group, 2005: 696; Martela &

Saarinen, [Forthcoming]). This means that perturbations strong enough to shift the system into a new stage can take place and instantly change the dynamics of the interactive system[40] (see Beebe et al., 2000: 105; Stolorow, 1997: 342). Thus a system might appear stable for a long time while an internal momentum is growing and then – when a certain tipping point has been reached – it can suddenly change rapidly and permanently. In psychoanalytic literature, there are many descriptions of how the relationship between the analyst and the patient has progressed through such instant shifts that make the relation permanently different and deeper (for one example, see Beebe & Lachmann, 2005: 17–18). Similarly, the relation between the nurse and the resident could develop towards a caring connection partially through a more linear growth of affection and trust and partially through sudden and nonlinear shifts in the nature of their mutual interaction.

I am of course not suggesting that these self-reinforcing mechanisms always take place. For the growth to happen, both participants must remain open to this growth throughout the process; they must remain willing to engage with the other and share of themselves more and more as the relational encounter deepens. They must also come to the situation with enough positive expectations and respect for one another. Otherwise the positive gain spirals can never ignite. And they need to feed enough rapport-building micro-acts into the gain spiral in order for it to continue its growth. Nevertheless, when these three conditions are met – the participants remain open to the growth of engagement, they come to the situation with an adequate amount of initial engagement, and they feed enough rapport-building micro-acts into the situation – then the possibility is open for a self-reinforcing loop that will lead them into the rich experience of a caring connection.

Unsymmetrical reciprocity versus stonewalling

I have thus argued that caring connections require reciprocity and the active involvement of both participants. But it is essential to note that the

[40] These non-linear and sudden shifts in behavioral systems could also be explained through the dynamics of catastrophe theory, which shows how small differences in crucial points of the process can lead to dramatically different outcomes and also how the system might reach certain points beyond which the behavior of the system changes almost catastrophically (see Zeeman, 1976).

way I understand reciprocity here doesn't imply that it should be balanced in terms of equivalence. Often reciprocity is looked at through a social exchange perspective that emphasizes the "equivalence of returns" reflecting the similarity of value of the exchange (see Sparrowe & Liden, 1997; Ferris et al., 2009). But in the context of a nursing home it is essential to note that the residents' capacity to engage in active reciprocity was much dependent on the mental and physical condition of the specific resident. Hence we need to discuss this dimension of caring connections and show how even weakened forms of mutuality differed significantly from situations in which the resident was actively disengaged from the situation and thus blocking the mutual growth of the situation towards a caring connection. This discussion serves as an important illustration of what mutuality in caring connections is about.

As said, in the nursing home some residents were capable of ordinary verbal communication while others had very limited ways of expressing themselves. Thus more often than not the resident was able to respond to the affectionate engagement of the nurse only through nonverbal means. For example, in some situations the gratitude was present only as an affectionate gaze into the eyes of the resident. Even this, however, was enough to make the situation reciprocal and could contribute to the process that led to a caring connection. To understand the importance of even such slight forms of mutuality, we might borrow the concept of stonewalling from Gottman's research on marital interaction. Stonewalling involves "controlling and suppressing verbal and emotional expressive behavior" (Gottman, 1994: 245). Stonewalling thus can be seen as an active withdrawal of responsiveness by the resident. In stonewalling, the person in question refuses to express any form of gratitude or otherwise be emotionally open to the unfolding of the situation. I observed how some residents clearly were involved in stonewalling during caring situations and how such behavior effectively cut off the process towards a caring connection[41]. My interviews revealed that some residents had the attitude that being served and taken care of in the nursing home was their right and

[41] Gottman (1993) notes that in his research on marital interaction, stonewalling was characteristically male behavior. It might be interesting to note that my observations within the nursing home also indicated that typically it was male residents who engaged in stonewalling in their interaction with the nurses. I discuss this more in the discussion section.

something they had paid for through taxes and so forth. Therefore they didn't need to be grateful for it [Resident 2]. They are right in a certain sense, of course, but unfortunately such an attitude deprived them of a change to experience caring connections with their care providers. These relations became, in a sense, "barren" – "They become locked into patterns of relating in which they are distant rather than intimate, with all that that entails: lack of warmth, inability to contribute to one another's learning and growth, and an undermining of task collaboration" (Kahn 1993: 555).

On the other hand, in situations where residents were able to express only a hint of emotional reciprocity through their limited forms of bodily expression, this was enough to initiate the mutuality of the relationship. For example, one nurse described how it was impossible to understand a word of what one resident spoke because her voice was so slurred. "Yet still her responses are such – I can't really explain it – that they make you feel good. When she is in a good mood and smiles, it is nice to chat with her although there is not really any subject in these talks. Perhaps the resident gets a feeling that somebody really cares about her and the discussion is real. That leads to mutual gladness." [Nurse 18] The nurses didn't expect the residents to express reciprocity beyond what they were capable of. Thus the less able the resident was to express him- or herself, the smaller signs of reciprocity were taken by the nurses as acceptable signs of the mutuality of the situation.

Thus there is an important distinction to be made between actively suppressing emotionally expressive behavior and not being physically able to produce emotionally expressive behavior. The former led to non-reciprocal caregiving situations that could not be characterized as connected while the latter was not a hindrance for the evolvement of the moment towards a caring connection. This is also reflected in Li's research findings. She said that nurses could distinguish patients who were troubled and thus unable to be nice and patients who deserved only 'obligatory care' but 'minus niceness' (Li, 2004: 2575–2576). In other words, the nurses saw a difference between those patients who were unable to return warmness because of their personal troubles and those who chose not to return warmness. They felt the latter group also did not deserve any niceness on their part.

All in all, the path towards caring connections can be seen as being built on mutual expectancies, on attunement to the other's bodily signals, and on

doing rapport-building micro-acts. Together they give rise to a self-reinforcing process in which caregiving and other signs of affectionate engagement flows from the nurse to the resident, and this is returned by a flow of gratitude and other signs of mutual engagement on the part of the resident. These positively engaging acts from both sides in turn further strengthen both parties' capacities and efforts to be even more engaged in the situation, and a positive gain spiral is established. This systemic reciprocity makes the process dynamic and can involve nonlinear tipping points. As caring connection is about providing care for the other, no norm of equitable reciprocity is in place, but the care receiver must nevertheless signal that she is at least in some sense engaged and grateful for being part of the process. If, on the other hand, the resident engages in stonewalling, the caregiving is not returned and the process is interrupted. Thus the path towards a caring connection involves both the caregiver and the cared-for – it is co-constructed by them together in a systemic and bidirectional process that mainly takes place on an implicit level and through themselves in insignificant small rapport-building gestures and acts.

Conclusion

Caring connections are powerful occurrences. They seem to reveal to us what is best in us – how we as human beings are deeply engaged with each other and how our capacity for empathy leads us to appreciate the humaneness in the other. As argued by Kanov et al. (2004: 808), "compassion lies at the core of what it means to be human" and caring connections offer a place for compassion to blossom. Thus caring connections offer a direct antidote to the 'rational-legal bureaucracy' that has dominated organizational administration and theory and that argues that bureaucracy progresses "the more the bureaucracy is 'dehumanized', the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation" (Weber, 1946: 216). In the conceptualization of caring connections, it is acknowledged that in caring situations "nurses are both health professionals and fellow human beings" (Hem & Heggen, 2003: 101). Caring connections demonstrate how strongly affective moments are present in organizational life and how they can be beneficial and deeply meaningful for the ones participating in them. In some cases the felt sense of these situations is so strong that there is almost a certain sacredness present in caring connections (cf. Finfgeld-Connett, 2006: 711).

In fact, the primary mission of nursing homes being that of giving a dignified life to the residents, caring connections seems to serve this mission much better than many of the more 'rational' and 'calculable' activities within these organizations. For after all, it is relationships that "makes life worth living" (Ragins & Dutton, 2007: 3) and unfortunately for many residents in a nursing home, the nurses are their primary relationships. Caring connections are potentially very significant events for the participants and can have lasting positive effects on their mental well-being as well as for the atmosphere in the whole organization. Thus, if we want to understand what dimensions of human behavior are especially important for successful elder care, we should look for an answer in the empathetic caregiving and nurses' inner capacity for compassion that lead to caring connections. At least in caretaking organizations (Kahn, 1993), affectively charged moments between the employees and clients seem to be at the heart of their *raison d'être*. Therefore, becoming aware of them and exploring them further is a task that organizational research should take seriously. Through this kind of research, a quest for "that which is positive, flourishing, and life-giving in organizations" (Cameron & Caza, 2004: 731) can be better fulfilled.

Chapter 10: Making caring connections happen

> *Living successfully in a world of systems requires more of us than our ability to calculate. It requires our full humanity – our rationality, our ability to sort out truth from falsehood, our intuition, our compassion, our vision, and our morality. (Meadows, 2008: 170)*

Having discussed extensively the nature and importance of caring connections, the next question to naturally arise is how to advance the occurrence of such warm and tender moments. To be more exact, this question can be divided into two parts: How can individual nurses advance the occurrence of caring connections and how can the organization at large support them?

As discussed in the methodology section, my empirical material could only give half an answer to these questions. Therefore the way I answer these questions in this chapter is more inspired by certain theoretical viewpoints, even though in engaging with theory, I have kept my empirical experiences in mind. Thus this can be viewed as a *theoretical chapter* in which I aim to make speculative suggestions about potential pathways towards caring connections that are anchored in my empirical experiences but go beyond them through the extensive utilization of different theoretical viewpoints.

I will in this chapter first look at how an individual nurse can enhance the occurrence of caring connections through her relational sensibilities and her sense for the social systems that she is engaged in. Then I will broaden the perspective and look how leaders can enhance the occurrence of these encounters and how organizational structures and culture can be designed to support them. The suggestions provided should be treated as preliminary insights that can serve to trigger further discussion about how to advance the possibility for caring connections to happen.

Advancing caring connections through acting systems intelligently

> *The human ability to feel, sense and to resonate, the ability to move and be moved, to enhance and be enchanted, to uplift*

> *and be uplifted are some of those ways holism works within us as our innate systems intelligence.* (Saarinen & Hämäläinen, 2010: 22)

In our quest to learn how caring connections are made possible, the most important insight is to understand that most of what constitutes these situations takes place on implicit, affective, and nonverbal levels of mutually generated intersubjective systems. This insight was already evident in my discussion about the elements of caring connections, but it came through also directly in my observations and interviews. The nurses repeatedly spoke how "human relations skills" [Nurse 15] are central to their vocation and how they have "learned to read [the residents]" [Nurse 6]. Many of the nurses seemed to draw satisfaction from the fact that they had talent in this area. Their work-related sense of accomplishment and mastery seemed to be built upon their sense of being good in dealing with humans. In addition, these skills had a significant effect not only on individual residents but also on the whole group of residents in a single department. As one nurse described it, "the atmosphere [among the residents] changes depending on who is on the working shift". [Nurse 15]. Some nurses seemed to be clearly better in generating a humane atmosphere through their way of being with the residents and through innovative and spontaneous interactive acts. Nevertheless, when pushed to explain why they acted in the way they did, the nurses usually stated that it was not a conscious choice but rather they acted out of intuition. They stated that in many situations they just knew what to do without being able to explain in more detail where this knowledge emerged. In other words, the nurses were often able to act right far beyond what they could explain.

The same is true of my observations. I witnessed many situations in which the nurses were able to turn an ordinary situation into a caring connection through the right kind of attunement to the residents' needs and through being present in the right kind of way for the residents. As an observer, I sometimes was really impressed by the nurses' professionally trained yet naturally flowing ways of winning the hearts of the residents and being with them in a sensitive way. Some nurses really showed how one can treat another with respect and find the humanity inside even the most seriously ill residents. Yet it is hard to give descriptions of these situations that would go beyond saying that they showed 'the right kind of appreciation' for the resident and 'attuned in the right kind of way' to the situation. Thus it is also hard to transform the behavior of the nurses into any specific

techniques through which a caring connection could be called forth. The major part of the skill set they used in these situations seemed to be nonverbal and connected to the way they attuned their movements, voice, and caring style to the individual needs of the resident.

Therefore one could argue that it is important that nurses adapt a perspective on their caregiving that emphasizes these implicit and nonverbal dimensions of their work. As argued in the literature review, within nursing research there is a chasm between those who teach a more scientific, evidence- and technique-based approach and those who argue strongly that "the fullness of the nursing situation is not amenable to study by measurement techniques" (Boykin & Schoenhofer, 2001: 53). For example, McCormack and McCance argue that a person-centered model of nursing makes explicit "the need for nurses to move beyond a focus on technical competence, and requires nurses to engage in authentic humanistic caring practices that embrace all forms of knowing and acting to promote choice and partnership in care decision-making" (McCormack & McCance, 2006: 478). This way of thinking seems to better serve nurses in their quest for connecting with the residents, as it emphasizes the holistic nature of care and the importance of approaching every resident as a unique person and attuning to every situation as one of a kind.

One way to give legitimacy to this appreciation of the holistic and implicit levels of knowing and acting is to use the concept of *rationality of caring* to understand what good nursing – nursing that can lead to caring connections – is about. Contrasting the rationality of caring with the conscious, cognitive, and emotion-downplaying scientific rationality, Kari Waerness argues that to understand good caring, we need to overcome the dichotomy between cognitive and emotional (Waerness, 1996: 240–241). Instead of a choice between the rationality of "bloodless calculators" or emotionality as "blind express[ion] of uncontrolled emotions", she – following Hochschild (1975) – talks about the sentient actor as a social actor who uses both her conscious and emotional capabilities to act fruitfully in a social situation (Waerness, 1996: 241–242). She argues that in order to learn to care in a proper manner, a scientific outsider position is not adequate, but instead, the learning takes place through a position of the insider because "one must learn to think and act on the level of the particular and individual" (Waerness, 1996: 242). She reports about her study of homehelpers in which they reported that they did not find much value in their formal training, but instead "their experience as a housewife

in their own family for many years was the most important prerequisite for being able to do a good job as a homehelper" (Waerness, 1996: 244). In other words, one learns to be a good caregiver by being in contact with and providing care for other individuals. Because the ability to care in a 'proper' way depends on something that can be learned and for which there are 'rules' for proceeding – although not necessarily verbalizeable – this something can be understood as a form of rationality we can call the rationality of caring (Waerness, 1996: 240).

In order to understand more deeply where this rationality of caring arises from, one way to look at it is to see that it is much based on the 'implicit relational knowing' (Lyons-Ruth, 1998) of the nurse. Lyons-Ruth (1998: 282) argues that "interactional processes from birth onwards give rise to a form of procedural knowledge regarding how to do things with intimate others." This knowledge is procedural in the same way as the knowledge to ride a bicycle is. It is about an implicit sense of how to proceed successfully in a certain situation, about how to influence the system formed by oneself and a bicycle or oneself and the other so that it unfolds in the desired direction (Lyons-Ruth, 1998: 284). Similarly, as the procedural knowledge to ride a bike comes about and develops further through the interaction with the bike, the implicit relational knowledge emerges through our constant interaction with intimate others that begins immediately after our birth and is "constantly being updated and 're-cognized' as it is accessed in day-to-day interaction" (Lyons-Ruth, 1998: 285). Every adult person is thus equipped with 'implicit operating procedures in relationships' that determine to a large degree how they act and react in a social situation. Through their training and through their practical experience, the nurses can be argued to be having especially developed implicit relational knowledge of how to proceed with their patients. Therefore one could say that the nurses' ability to turn situations into caring connections much relies on the 'implicit relational knowing' that they have acquired through practicing their trade. The concept of implicit relational knowledge thus can explain where the implicit, non-articulated rationality of caring arises from.

Combining this insight about the implicit rationality of caring with the systems understanding of interaction developed earlier, we come to see that when a caregiver and the cared-for meet – in Lyons-Ruth's case the therapist and the patient, in our case the nurse and the resident – what takes place is that both persons' implicit relational knowledge intersect to form an intersubjective field or system between them (Lyons-Ruth, 1998:

285–286). In other words, the nurse's actions are embedded within a system formed between her and the resident. Whatever she tries to achieve, her action must be suited to take into account this unique system that already exists between herself and the resident, which determines to a large degree what acts and paths are possible and fruitful within this interactive situation. To the degree that the nurses have learned to act in just the right way – in general and with the particular resident – it is to a large degree based on this implicit procedural knowledge combined with their ability to sense the moment-by-moment needs of the unique other. This is what enables them to act intelligently in the caregiving situation.

But having now acknowledged the unique and systemic nature of every situation and the implicit and relational nature of their unfolding the question arises: How can we make sense of the nurse's agency within this intersubjective dyad? How can the nurse make use of this systems understanding of the caregiving situation? Here, the perspective of systems intelligence seems a viable avenue.

The ability to act intelligently within the intersubjective dyad to produce fruitful outcomes for both participants is what can be called an actor's *systems intelligence* (Hämäläinen & Saarinen, 2006, 2008; Saarinen & Hämäläinen, 2004). Along with rationality of caring, the systems intelligence perspective transcends the dichotomy between cognitive and non-cognitive ways of acting fruitfully in a situation and reminds us that our capability for fruitful caregiving much resides on the intuitive level and is acquired through practice rather than through theoretical knowledge. In a previous article, I have argued that systems intelligence could be used to shed light on the ways a therapist can act intelligently in the intersubjective and systemic dyad formed between herself and the patient (Martela & Saarinen, [Forthcoming]). Analogically, I will argue here that the systems intelligence perspective could be used to acknowledge "the tacit and inarticulate, attunement-related aspects" of a nurse's practical acumen (Martela & Saarinen, [Forthcoming]). The construct of systems intelligence thus can assist us in our attempt to conceptualize the ways in which the nurse can increase the occurrence of caring connections.

In general, systems intelligence is about the subject's ability "to act constructively and productively within emergent wholes" – such as the nursing situation – "as they unfold even when lacking objectival knowledge, codes or techniques" (Martela & Saarinen, [Forthcoming]; Hämäläinen &

Saarinen, 2007: 5). It involves the ability "to use the human sensibilities of systems and reasoning about systems in order to adaptively carry out productive actions within and with respect to systems" (Saarinen & Hämäläinen, 2010: 16). It is important here to understand that especially when one is in interaction with social systems such as the intersubjective dyad between the nurse and the resident, one's capabilities for intelligent action are to a large extent implicit, they rely on "non-rational, non-propositional and non-cognitive capabilities, such as instinctual awareness, touch, 'feel', and sensibilities at large, as capabilities that relate the subject intelligently to a system" (Hämäläinen & Saarinen, 2006: 193). These capabilities are often downplayed by traditional conceptions of human intelligence, and hence the concept of systems intelligence is important in legitimizing and enhancing their role in human decision-making and behavior.

Systems intelligence can be divided into nine broad sets of skills or abilities that have been defined as follows:

> (1) *systemic perception* as situational awareness, comprehension and the ability to perceive various types of life situations as identifiable configurations and as entities with dynamic interconnections; (2) *positive attitude* as a way of approaching situations, possibilities, contexts and events in a positive way; (3) *attunement* as the ability to share affects and engage in intersubjectivity (4) *self-reflection* as the ability to reflect on one's motives, behaviors, ways of thinking and values; (5) *perspective-taking* as the ability for reflecting and for adopting new perspectives and interpretations; (6) *long-term systemic orientation* as an ability to recognize and attend to the cumulative and long-term effects of change particularly in the presence of feedback loops; (7) *systems agency with oneself* as abilities of mastering oneself as a systemic whole; (8) *systems agency with people* as abilities of navigating successfully in social situations and of bringing out positive potentials in people; (9) *systems agency with general contexts* as abilities to adapt and act successfully in different situations, contexts and complex environments. (Martela & Saarinen, [Forthcoming])

Hartrick (1997: 526) argues that the nurse needs to acknowledge "complexity and ambiguity as intrinsic characteristics of any human experience." Here, the systems intelligence perspective enables the nurse to be more sensitive to and aware of the influence she has on the intersubjective system formed between her and the resident as well as the influence that this intersubjective system has on her. To borrow the words of Jonsdottir et al. (2004: 241), the systems intelligent nurse "embraces whatever emerges and goes with this conversational flow as new meaning unfolds." Inside the psychoanalytic tradition, Wilma Bucci (1997: 158) perhaps captures this dimension best when she states that "the analyst perceives and responds to his patient on multiple, continuous dimensions, including some that are not explicitly identified. The analyst is able to make fine distinctions among a patient's states [- -] without being able to express those feelings in words." In other words, the analyst has an ability of sensing and experiencing the subtleties of the system. Following these affective and preverbal instincts - gut feelings, if you wish – her actions are often intelligently facilitating the system into the right direction without the analyst having to be fully aware of her action or its rationale. The idea of systems intelligence is "to connect more actively, sensitively and lively" with this competence we already possess (Hämäläinen & Saarinen 2007a: 23) and to act with wit in complex social situations utilizing our implicit relational knowing and other non-cognitive capabilities. Emphasizing the nurse's embeddedness within "the systemic wholeness of the therapeutic situation" and her "sensibilities-based abilities to act intelligently in it", systems intelligence provides a humanly tuned meta-understanding for the systemic aspects of the nurse in action (Martela & Saarinen, [Forthcoming]).

I am thus suggesting that through the perspective of systems intelligence, the nurses can better appreciate the implicit skills in acting correctly that they already have. Thus the mere adaptation of the systems understanding of one's own working situation can already increase the nurses' ability to bring forth caring connections. In addition to these general insights about the rationality of caring, implicit relational knowing and systems intelligence as theoretical lenses through which to better understand a nurse's practical acumen, I will offer nine more specific ways through which the nurse can enhance the occurrence of caring connections. The first four – (1) authenticity, (2) attitude of appreciation, (3) being positive, and (4) attuning to the situation – are related to implicit attitudinal qualities and

are summed up by saying that the nurses should 'follow their heart' in their practice. The last four are more cognitive suggestions for nurses and include (5) attempting to understand the point of view of the resident, (6) facilitating the other's active participation, (7) facilitating the other's process of opening up, (8) being on the lookout for positive impact points, and (9) being sensitive to the other's bids for connection. These suggestions emerged from looking at the nurses' way of working through the perspectives provided by the relational viewpoint, systems intelligence, and other theoretical lenses as well my empirical material. I see these ways of working as growing directly out of the practical proficiency that the nurses become equipped with through practicing their trade. They are also the central elements of the nurse's systems intelligence in this specific context. I have divided them into two parts: the first four are more related to our implicit, attitudinal ways of being in the situation, and the latter four are more cognitive suggestions about what to look for in caring situations.

Implicit attitudinal insights for systems intelligent nursing

I'll start with discussing four attitudes that are about the way the nurse is in the situation rather than about more specific behaviors she might do in the situation. In other words, these are attitudinal qualities the nurse needs to be equipped with in order to be more able to interact with the resident in an emotionally engaged fashion. As argued by Noddings (1984: 67–68, 1996b: 29), attitudes are crucial to caring because they can have an effect on the cared-for even in situations where no behavioral differences can be discerned. Human beings have a remarkable capacity to read each other's intentions and attitudes nonverbally (see e.g. Baron-Cohen, 1997 and chapter 4 of this document). In order to feed correct rapport-building signals into the mutual interaction, one thus has to be equipped with the right attitude towards the other and the situation at hand.

Authenticity

Most importantly, certain authenticity from the part of the nurse is required to establish caring connections. Authenticity can be defined here in terms of "working with one's real emotions within the context of one's role and task situation" (Kahn, 1992: 330). The nurse must show that she really cares about the resident at hand and displays authentic emotions in order to convince the resident to be open and engaged in the situation. As Hartrick (1997: 526) argues, only when the nurse is authentic is she able to

respond to the other in a way that will build a connection with that other. And only when both participants are authentically engaged and present in the situation can a caring connection take place.

Inauthentic technique-based responses would not be enough, because if the other is able to pick up on the inauthenticity, either consciously or unconsciously, this would intercept the process towards a deepened mutual connection, which is an essential part of caring connections. And the residents are often surprisingly good at separating authentic from inauthentic caregiving: "Some [nurses] just do it in a very routine manner. Others do it with a good heart" [Resident 4]. As the participants are moving towards increased openness and vulnerability towards each other, the nurses' responses and ways of being must come from their heart in order to build such a situation in the right direction. As Boykin & Schoenhofer (2001: 19) argue, it is not enough that one is 'providing care'; one must be 'living caring' – in other words, one must be authentically caring. The following quote, in which Stern describes how moments of meeting are established in the therapeutic context, is directly applicable in the nursing context:

> *The response cannot be an application of technique nor an habitual therapeutic move. It must be created on the spot to fit the singularity of the unexpected situation, and it must carry the therapist's signature as coming from his own sensibility and experience, beyond technique and theory. (Stern, 1998: 305)*

One of the residents described essentially the same thing but with less technical terminology: "It all must come from the heart! [- -] When the friendliness comes from the heart it is good. [- -] That is the most important thing" [Resident 4]. A nurse's full engagement means that she must be engaged in the situation with her heart. "In its fullest sense, nursing cannot be rendered impersonally, but must be offered in a spirit of being connected in oneness" (Boykin & Schoenhofer, 2001: 19). To be systems intelligent – to be able to engage with the system in a way that moves it into a desired, more affective direction – the nurse thus must be authentic in her behavior with the resident.

Organizational researchers have broadly explored work roles and how they affect the thoughts, emotions, and behavior of people (e.g. Ashforth & Humphrey, 1993; Martin et al., 1998). Often workers have to do some

emotional labor (Morris & Feldman, 1996; Totterdell & Holman, 2003) to get their mood to fit the requirements of their work role, and this is also supported by my own observations in the nursing home during the study. Against this background, caring connections are remarkable in that in them, the nurses (and the residents for that matter) are better able to express their whole personality and are not hindered by the limits of their assigned roles. To borrow from Kahn (1992: 324), we might state that in these moments, the nurses and residents are more able "to present their full, authentic selves" within the unfolding relationship with each other. They don't meet each other within the confines of the roles that are assigned to them from the outside but as two authentic human beings.

However, it would be wrong to state that the nurses step outside of their work roles and this makes them capable of expressing themselves more fully. The case is more that in these moments, their work roles and their 'true selves' merge together; their authentic way of being is more able to manifest itself within the professional role they find themselves in. Using Kahn's (1992: 328) words, we can say that in caring connections they are able to maintain "the integrity of the person and the integrity of the role simultaneously." This is because as caring professionals, the nurses usually have a strong inclination for being with people and caring for them. The everyday realities of their work sometimes provides them with fewer opportunities for expressing these inclinations and following their calling than they would need (see Vinje & Mittelmark, 2007). Within caring connections, they are able to engage with the residents in a tender manner and thus be professionals and authentic human beings at the same time.

Caring connections thus require the nurse to be authentic, responding to the resident beyond the mask of the work role and displaying her real emotions. On the other hand, caring connections – as situations in which the client engages authentically and warmly with them – are also situations in which it is especially easy for the nurses to go beyond the mere work role and display their true emotions.

Attitude of appreciation

As said, the dyadic system is largely co-constructed through mutual expectations. Meeting the other with appreciation is crucial for the development that can lead to caring connections. One needs to respect the other to be able to attune to the other on a level of openness and tenderness that is necessary for a caring connection to initiate. "To allow nurses to

interact with patients rather than with the tasks that they feel the need to complete, there must be respect for the patient as a person." (Tonuma & Winbolt, 2000: 216). One needs to see the other as a valuable person and appreciate the moment to interact with the other. Attitude is "crucial to an analysis of caring" as Noddings (1996b: 29) argues; the nurse's attitude can make a difference to the patient's experience even when behavioral differences are not visible (Noddings, 1996b: 29). Accordingly, the nursing literature has acknowledged this stance of the nurses where "each individual is viewed through a lens of unconditional positive regard and acceptance" (Finfgeld-Connett, 2006: 711) as a constituent element of what it is to be a nurse. At best, this respect for the other as a human being is unconditional (cf. Levinas, 1979); it stems from the humanity in the other, not from any special characteristics of him or her. Respecting the humanity in others unconditionally, to "truly meet them and be with them" [Nurse 9], is thus at the core of what it is to be a nurse, and it is also at the core of the caring connections between the nurse and the resident.

Based on my observations, the attitude of appreciation seemed to be a characteristic that nurses usually are equipped with quite strongly. One nurse told how respecting the human is something "that I don't have to think about, it just comes out of me" [Nurse 6]. The nurses I observed by and large were equipped with a strong sense of respect for the residents they were caretaking.

It might be noted that the appreciation of certain residents might be more challenging than the appreciation of others. When a resident is sociable, engages with the nurse and is grateful for the care he or she receives, it might be relatively easy to maintain an attitude of appreciation towards him or her. On the other hand, some residents can be very harsh on the nurses, abusing them verbally and sometimes even attempting to physically violate them. To be able to appreciate even these residents can be more challenging. This is in line with Morse's observations according to which "patients who 'touch' or appeal to the nurse are more likely to enter a connected relationship" (Morse, 1991: 461). It should not be denied that certain residents seemed to touch or appeal to the nurses more than the others. Observing the nurses during a social occasion outside of working time I heard them discussing the residents. Some residents were described as 'angels' and the nurses had many tender words for them. Others received less affectionate descriptions like 'a pain in the ass'. Nevertheless, as one nurse I interviewed stated, although one cannot be expected to be friends

with all the residents a certain respect for every resident is a pre-requisition for good nursing [Nurse 7].

Taking a systems perspective, it must finally be noticed how the caring connections themselves are able to build up this sense of respect for the humanity of the other. In the caring connections, the nurse is in touch with and able to feel deeply the humanity in the resident. One nurse spoke how one suddenly stops and realizes "how important I am and how important the other is" [Nurse 2]. In other words, the inherent significance of a human being for another is able to shine through during these moments. This strengthens the affectionate sense the nurses have of the inherent value of every resident.

Being able to respect and appreciate the other is thus important if the nurse wants to engage in a caring connection. In a way, this requirement for appreciation is the other side of the coin of the requirement for authenticity. If one doesn't appreciate a resident – and especially if one's feelings towards the resident are negative – one's authentic way of relating to this resident might not be what is desirable given one's role as a caregiver. In these situations, it might be better that the nurse engages with the resident in a way that hides her true feelings for the resident. So nursing that has the potential to lead towards a caring connection has to be *both* authentic *and* appreciative at the same time. A systems intelligent nurse thus needs to search from within herself the necessary respect towards the other in order to conduct her work in an appropriate way. There is something appealing in everyone, and in order to be able to show real appreciation towards the other, one should try to dig this out. Finding something in everyone through which one can appreciate that specific person is the true skill of a systems intelligent nurse.

Positive attitude

In her meta-analysis of caring studies Swanson identified positive attitude as one of the five caring capacities (Swanson, 1999). This is also visible in my descriptions of caring connections that show how a positive attitude carries a long way. When the nurses are able to approach the encounter with the resident with a positive attitude, looking for uplifting possibilities, they come to bring such an amount of positive energy into the intersubjective system that the possibilities for uplifting mutual encounters is greatly enhanced. As already discussed, how the system between the nurse and the resident will unfold is much influenced by the expectations

that the participants bring into the meeting. If positive encounters are wanted, they usually start with the expectation that such a situation is possible. Positivity also broadens our possibilities to see opportunities within a situation (see Fredrickson, 2003). Therefore, the positive attitude of the nurses is crucial.

This is also connected to the response style of the nurses. Research on close relationships has argued that when one person discloses personal events to the other – be they positive or negative – the way of responding that has most positive effects is an active-constructive one (Gable & Gosnell, 2011: 268–269). An active-constructive response to a positive event disclosure means an attitude where one expresses excitement or enthusiasm about the event, asks questions about it, and elaborates on what the event means for the discloser. Such a reaction – in contrast to a negative or passive reaction – has been found to be associated with increased positive affect, well-being, and intimacy as well as with an increased sense by the discloser that the listener is responsive to her. Especially interesting in the research of Gable et al. (2004) was the fact that a passive-constructive response in which the responding person conveys a positive but relatively passive reaction was consistently negatively correlated with good relationship outcomes such as relationship satisfaction, trust, and intimacy. Extending these findings to the relation between the nurse and the resident, it can be argued that in order to get the most out of their mutual relationship, it is not enough that the nurse reacts positively but passively to the disclosure of positive events by the resident. In terms of systems intelligence, she has to be open to get excited about the personal events of the resident and inquire more about them in a manner that shows that she is really impressed about the event.

Letting oneself be attuned to the situation

As has been argued in my description of caring connections, they are much about both persons attuning to the other and to the situation and being sensitive and open to be moved by the special rhythm and feel of the specific intersubjective dyad. Seligman's point about therapists applies similarly to the nurses. He argues that they "make decisions all the time on the basis of their implicit recognition that the effect of a single factor or intervention depends on the overall situation" (Seligman, 2005: 289). From this, it follows that one of the skills of the nurse that can bring forth caring connections is the ability to let oneself be attuned to the situation. It means that the nurses need to be able to share affects, to be able to attend to the

nonverbal levels of a resident's posture to get a sense of what is happening in the interactive situation and how the resident is feeling. In the words of Jonsdottir et al. (2004: 242), the nurse needs to be "present to the patient in an open caring attentiveness to whatever emerges in their dialogue."

This is connected to current knowledge about relational attentiveness, which is defined as the "capacity to perceive and respond to other people's emotional state" (Heaphy & Dutton, 2008: 154). Heaphy and Dutton have shown how this capacity "fosters the creation of high-quality connections between people in organizations" (Heaphy & Dutton, 2008: 154). It is also consistent with Abrahamsson and Söder's (1977; reported in Waerness, 1996: 244–245) finding that in institutions for the mentally retarded, flexibility in work – the ability to adapt behavior to the individual needs of the cared-for – is an indicator of 'good caring.' Similarly, one resident I interviewed described how she felt gratitude towards one special nurse who was "active in her caregiving and favorable" [Resident 4].

But in addition to being open to the other, one has to be open towards the system itself – towards the possibilities and subtle signals that emerge within the intersubjectively co-constructed interactive field between the participants. One has to *dance with the system*, "stay wide-awake, pay close attention, participate flat out, and respond to feedback" (Meadows, 2002). Newman proposes that "the nurse-client relationship can be thought of as a dance" and notes that moving in synchrony with someone "brings with a feeling of closeness and unity with a greater whole" and makes the participants feel good about what they are doing and about each other (Newman, 1999: 227). Similarly, some nursing researchers emphasize the importance of "creating congruence of rhythms and patterns" in "making connections with patients, including with patients to whom the nurse has difficulty relating" (Hagerty & Patusky, 2003: 149). Synchrony means a congruence of rhythms within the relationship and creates, according to Hartrick (1997: 526), authentic receptivity and "a liveliness together." Hagerty and Patusky suggest that the nurse can facilitate this synchrony even through very straightforward ways such as "changing breath in response to patients breath rhythm" (Hagerty & Patusky, 2003: 149). Being attuned to the system at hand and dancing with it means that one has to stay sensitive and responsive to what is taking place in the situation at hand on a moment-to-moment basis. This is what one nurse called "situational sensitivity" [Nurse 7].

Summary: Listening to one's 'heart'

I have argued that the nurse needs to be authentic, she needs to show appreciation, and she needs to attune to the situation. On the other hand, the idea of implicit relational knowledge and systems intelligence both emphasize that the caregiver can have implicit procedural knowledge about how to influence the situation in the right direction. One way to summarize all of this would be to say that the nurse needs to 'listen to her heart' in the caregiving situation. As human beings, we are equipped with the capacity to attune to the other, to feel compassion for the other, and to offer appropriate care for the other. "Compassion in the face of suffering is a fundamental human response that has a strong evolutionary basis" (Lilius et al., 2011: 874; Goetz et al., 2010). As Trout argues, "the capacity for attunement – for *presence* with our patients – is already in most of us and was from the very beginning" (Trout, 2011: 20).

In addition, my experience was that the persons who had chosen the career of a nurse were persons who had within themselves the capacity to care for others in a tender way. When I asked my interviewees how they ended up being nurses in the first place, the major reason seemed to be the willingness to take care of other people and meet them on a humane level. They told that what they liked about this job is "being together with people" [Nurse 14] or "those human contacts with these residents" [Nurse 9] and how they "liked the people who are here" [Nurse 6]. At least three different nurses independent of each other compared their work with sitting in the office in front of the computer the whole day and told how they could never be in a job like that [Nurse 15, Nurse 4, Head nurse 1]. The willingness to be in "unreserved interaction" [Head nurse 1] with other human beings was clearly one of the major characteristics of people attracted to nursing. This is one of the reasons why nursing homes are such a good place to study caring connections. They are places filled with employees willing to engage in such interaction with their customers[42]. They are thus arguably places

[42] It could be argued that this willingness for connecting with the residents is further increased by the nature of the work. Grant has argued that "people often come to care about others as a result of having contact with them" and "increasing physical proximity between people tends to increase identification and liking" (Grant, 2007: 401). The nature of gerontological nursing is thus almost a paradigmatic example of an occupation in which the workers are exposed to such experiences that will make them identify with and seek contact with the clients.

where the employees are equipped with especially strong capacities for those skills natural for human beings: compassion, attunement, and caregiving.

Therefore, often the best advice that one can give to a nurse is about listening to one's heart, doing what one feels to be right. "Attunement, and its sidekick empathy, will come if we just get out of the way. We get *in* the way of attunement when we sabotage our natural curiosity, our natural empathy, and our natural tendency to hook into the experience of another, by moving too fast, focusing too little" and so forth (Trout, 2011: 19). Often we do this because of wider organizational level norms and demands or because we have through our education learned to trust our technical skills and knowledge more than our gut feelings and other less formal forms of knowledge. However, recent research on intuition has demonstrated that instead of treating it as a 'weak' form of reasoning, it should be understood as "affectively charged judgments that arise through rapid, nonconscious, and holistic associations" that can be "integral to successfully completing tasks that involve high complexity and short time horizons" and are especially accurate in the context of which one has much experience about (Dane & Pratt, 2007: 33). It has become clear that expertise is not restricted to "detached rule-following" but stems from a "more involved and situation-specific" way of acting in the situation (Dreyfus, 2006: 26). As experienced nurses have extensive experience in how to deal with residents, and as human interaction is a prime example of a task that involves high complexity and short time horizons, the intuition of the nurses is quite often prone to lead them to act in the right way. In systems terms, we could state that through practice the nurses have developed an enriched experience of the dynamics of the therapy process and have cultivated their "intersubjective systems sensibility" (Buirski, 2007: xv) that guides them automatically towards the right kind of action in the specific systemic situation. Sometimes the nurse has to trust one's intuition even without being able to provide any rational explanation why one feels that a certain way of acting is right.

Regarding a caring connection, the intuitive ability of the nurses to steer the interactive situation in the right direction explains how the generation of caring connections doesn't have to be a conscious target of the nurse's actions in order for it to take place. In some situations, the nurse might consciously attempt to cheer up the resident or to get into a deeper contact with him or her. In other situations, she just acts in a way that feels natural

for her – she follows her heart, as one might say – and even in these moments of intuition, she is applying her systems intelligence. In many situations I saw how nurses who seemed to act just out of their inner sense of how to be in a situation did precisely the right forms of actions to steer the encounter with the resident into a caring connection. In these situations it seemed evident that the nurse – through her original inclination to want to be in a caregiving occupation and through her training and experience – was naturally equipped with the calling to generate positively affective and sensitively deep moments with her clients. In other words, she might be acting out of her heart, but in acting in such a way, she is relying on her implicit systems intelligence to bring forth something that she might not be aware of but that she in some way feels is right.

The importance of trusting one's gut feelings is powerfully demonstrated by this story where a nurse recounts one of her night shifts (from Boykin & Schoenhofer, 2001: 20–21): "I remember the strange feeling in the pit of my stomach when the evening nurse reviewed the lab tests on Tracy P. Tall, strawberry-blonde, and freckle-faced, Tracy was struggling with the everyday problems of adolescence and fighting a losing battle against leukemia." Talking with Tracy, she suddenly felt "a sense of urgency that her mother be with her". Despite the fact that the mother was a single provider for two small kids and lived several hours away from the hospital, she convinced her to come there immediately. When the mother arrived, the nurse helped her find a sense of intimacy with her daughter. That night, Tracy died. If the nurse had relied on objective knowledge and evidence-based practices, she would have never called the mother. Instead, she trusted her instincts, 'the strange feeling in the pit of her stomach' and was able to allow the child the possibility to face death with her mother close to her. In other words, she demonstrated "courageous acknowledgment of a call for nursing that would be difficult to substantiate empirically" (Boykin & Schoenhofer, 2001: 21).

Cognitive pointers for systems intelligent nursing

The nurses' attitudes and implicit ways of being in the situation are thus essential for bringing forth caring connections. But as noted, systems intelligence doesn't dismiss the more cognitive forms of knowing but argues along with the idea of rationality of caring that both implicit and explicit knowledge should be utilized in order to make the best out of the caring

situation. Accordingly, I will offer five suggestions about what the nurse should aim to look at and make use of in caring situations in order to increase the probability of caring connections.

Taking the residents' perspective

In order to be with the resident in the right way, it is important that the nurse is able to reflect upon and understand the resident's situation. This is called the skill of perspective-taking and is about the ability to look at the situation and world from a perspective other than one's own[43]. For example, while older paradigms of good caretaking of the patients involved the professional defining the need, or the 'problem' that needs to be taken care of, more recent and humane ways of understanding caregiving emphasize how one should fit one's caregiving to the residents' own understanding of life quality and the things they themselves see as important in their situation (Clark, 1995: 404). Good caring is caring that feels good *from the point of view of the resident,* and thus good caring can take very different forms with different residents. In my interviews I saw how some residents might like the nurse to be talkative while others might appreciate that the nurse shuts up and concentrates on the task. Every resident is unique and can have specific needs that can seem trivial from an outsider's perspective but deeply meaningful for the person in question. For example, the late Václav Havel, the beloved author and first president of the Czech Republic, wanted to have gladiolas to look at near his bed in his last months (Wilson, 2012). A nurse concentrating on the functional aspects of nursing might dismiss such a wish as irrelevant but a sensitive nurse who is able to look at the situation from the perspective of the resident might realize that this could potentially be more important to his quality of life than any functional aspect of the caregiving. No one knows what memories these flowers brought to Václav Havel's mind. To be able to provide the kind of care the resident needs, the nurse thus has to understand the situation from the perspective of the resident and make sense of the specific needs of the resident.

Mok and Chiu (2004: 479) found out that one of the things that led to the development of "a trusting and connected relationship" was about

[43] This insight about understanding the other is also connected to one of the four broad areas of emotional intelligence, that of accurately perceiving emotions (Mayer & Salovey, 1997).

"understanding the patient's needs." This is understandable because when one understands more about how the other experiences the situation and what the other needs in the situation, then one is more able to act in ways that are appreciated by the other. And this increases the possibility of getting into a caring connection. Therefore it is important to attend to the clients as wholes, "tending to their physical, psychosocial and spiritual needs, showing awareness of their expressed and unvoiced needs, providing comfort without actually being asked" (Mok & Chiu, 2004: 480).

The importance of understanding and validating the perspective of the other is further emphasized through research on social support. In a recent study, Maisel and Gable (2009) found that it is not the support itself but the responsiveness of support that matters. By responsive support, they meant support that was understanding, validating, and caring (Maisel & Gable, 2009: 928); in other words, support that is about "acts that communicate caring; that validate the other's worth, feelings, or actions" (cited from Gable & Gosnell, 2011: 266). When support was rated as low in responsiveness, it in fact was associated with no benefits or even negative outcomes while high responsiveness of support was associated with less sadness and anxiety and with greater relationship quality (Maisel & Gable, 2009). Extending these findings to the reality of a nursing home, we thus should understand that the mere providing of support for the residents will not lead to positive psychological outcomes if the support is not intended and perceived to be responsive to the needs and nature of the resident. If the nurses want to provide systems intelligent caregiving, they should really make sure that they understand the other and are able to make the other feel that their abilities and opinions are valued (cf. Maisel & Gable, 2009: 929).

Facilitating the other's active participation

As has been emphasized throughout this work, the resident's active participation is a necessary element of the caring connections. At the same time, it has also been emphasized that often the resident's possibilities for interaction are limited by physical and mental impairments. From the point of view of the nurse, this means that she should try to help make possible the forms of active participation that the resident is still capable of. In other words, the nurse should actively support the resident's active participation.

A trivial example is a situation where the resident is not able to speak anymore but is still able to write. The nurse should make sure that the

resident has the necessary equipment for writing in order to enable the resident to continue to communicate verbally to other people. More generally, the nurse should keep an eye on what senses of the resident are still functioning and utilize them in mutual communication (see Feil, 1993). She should encourage the resident to use creative ways to overcome the obstacles that might hinder the resident from communicating with the nurse. For example, one nurse told of a resident with dementia who had altogether stopped talking. Still, when she sang a familiar song to the resident, "she might join the singing in a way in which I sing a part and then she sings the rest. I found it very nice to be again in an interaction with her" [Nurse 5]. By inviting the resident to sing, the nurse thus offered her a channel for active participation in humane interaction even in a situation where many other channels had already been closed. As every resident is an individual with different abilities and disabilities, the nurses should try to creatively find for every individual resident the ways of being active participant in a communicative situation that work for them.

Another way to facilitate the active participation of the resident is to concentrate on the strengths of the resident. Recent research in positive psychology has found that when participants are encouraged to use their character strengths – those strengths of character that are especially salient in them – this increases their reported happiness and decreases their depressiveness (Seligman et al., 2005). As residents of the nursing home are already in many ways physically and mentally fragile – otherwise they would not be there – their own attention as well as the attention of their caregivers can easily be exclusively on their many weaknesses. Through focusing on the remaining strengths of the resident and through helping the resident focus on those things that he or she is still capable of doing instead of what he or she is not capable of doing any more, one could be able to empower the resident to be more active and use the remaining skills to the maximum. For example, in one unit in the nursing home, the nurses had taken a rehabilitating attitude to their heart. They enthusiastically explained to me how they attempted in all their actions to facilitate the active participation of the resident and told how this attitude had been fruitful many times. Residents who came from a hospital where they had became passive and barely capable of anything more than sitting in their beds were back on their feet in a few months and actively participating in their own care.

Thus the systems intelligent nurse should aim to first identify the remaining capabilities of the resident and then to help the residents themselves to recognize their capabilities and aid them in leveraging those capabilities. Through these interventions, she makes the resident more capable of being the active participant in interaction, which in turn makes it more possible for them to find a way to establish a caring connection between them.

Facilitating the other's process of opening up

Through my observations, I saw that more often than not, the occurrence of caring connections was not so much about the nurses' willingness to make a contact with the residents as it was about the residents' willingness to engage in humane interaction with the nurses. Most of the time, most of the nurses engaged with the residents in relatively warm and tender ways. On the other hand, among the residents there was great variability in the capacity and willingness for making contact with the nurses. Many residents seemed to show consistent disengagement with the nurses while other residents were already in such a bad state because of physical or mental illnesses or general deterioration that their capacity for human interaction was seriously compromised. This explained to a large extent why some residents were involved in caring connections on a regular basis while others almost never experienced these with the nurses.

However, I also saw how sometimes the nurses could overcome some of these barriers to engaged interaction and skillfully establish a connection even with quite involuntary or degenerated residents. Some nurses used humor in innovative ways to lower the barriers and reservedness of the residents and thus were able to engage with them more deeply (on the general functions of humor, see Gervais & Wilson, 2005). Nurses had many stories of fun moments with the residents and how small things could cheer up the day for both the nurse and the resident. Some nurses told how they "get enormously" from these moments where they "laugh together with someone" [Nurse 5]. Humor could offer a way of altering the mood of a situation in one swoop and opening up the channel for a caring connection to develop.

The appropriate usage of humor – and, for example, singing as was discussed before – thus represents a few innovative ways to . The more general point here is that because of the unique nature of the residents, the nurses must not settle with existing modes of interaction but must instead

always be on the lookout for novel ways of encouraging the resident to open up that might work together with this specific resident in her specific situation.

Naturally, one must also respect the fact that not all residents were interested in engaging with the nurses. As reported by Morse, there are patients with whom you can try everything yet not be able to establish a connection (Morse, 1991: 462–463). One should not push the resident into opening up, because this kind of pushing can often be counterproductive. For example, for many residents, stonewalling – the "controlling and suppressing verbal and emotional expressive behavior" (Gottman, 1994: 245) already discussed – might be a way of attempting to protect one's dignity. A person for whom independence has been important might not be able to handle the fact that one has ended up being totally dependent on others whom one doesn't even know so well. Asking this kind of person to open up might lead the other to show his or her independence through the only way left – remaining even more closed. Nevertheless, as research has found, concealing personal thoughts and feelings can be stressful and can increase susceptibility to illness (see Greene et al., 2006: 421). Therefore, sometimes helping the reluctant resident to open up can serve the well-being of that resident. Opening up such a patient requires a delicate psychological eye where one makes room for the other to open up in a way in which the other feels in control of the situation at all times. The nurses just have to give time and space for the patients when they are not willing to disclose their deeper feelings (Mok & Chiu, 2004: 479). As a nurse interviewed by Morse remarked: "You don't barge in and take charge. You allow them to invite you in, and you make yourself want to be invited in. You facilitate that connection" (Morse, 1991: 461).

Being on the lookout for positive impact points

It is quite common to assume that a relationship between the nurse and the patient – or more generally between two human beings – progresses linearly. Hagerty and Patusky, however, challenge this common assumption of nursing researchers and instead maintain that even single or short-term encounters can be significant and that "the process of interaction implies multiplicative effects, such that inherently nonlinear processes result rather than additive progressions" (Hagerty & Patusky, 2003: 146). This fits well together with the systems understanding of the human interaction, which emphasizes the complexity and nonlinearity of the patterns of interaction.

Within this nonlinear system. which is based on the expectations of the participants (see Beebe & Lachmann, 2005), a single event can sometimes shift the whole way of interacting between two persons onto a new level. In a therapeutic context, Stern calls such occasions *moments of meeting* and sees that in them the participants are able to "interact in a way that creates a new implicit, intersubjective understanding of their relationship and permits a new 'way-of-being-with-the-other'" (Stern, 1998: 300). The seeds of such moments of meeting are present in many interactive situations and if approached properly, they could lead to moments of meeting that permanently change the affective tone and possibilities of the specific interactive dyad. This means that there often are more possibilities embedded in the interaction than what meets the eye.

Taking this into account, a systems intelligent nurse is one who looks at the situation not only from the perspective of what is present in the situation but also from the perspective of what possibilities might be opening up in the situation if one is able to seize them. More specifically, she should look for *positive impact points,* possibilities that open up within the interactive dyad from time to time and that – if addressed in proper way – could lead the interaction and relationship of the participants to a new level. Hartrick (1997) uses the term *re-imagining* to describe essentially the same capacity. It is about an attitude of "living the question" that "compels nurses to wonder about and to question the structures and experiences that make up their own and other people's lives" (Hartrick, 1997: 527). Thus it is about looking for ways to transform the co-constructed reality, to think anew the structures that constrict the interaction between me and some specific other.

The importance of looking for positive impact points is especially valid in situations where the relationship between a nurse and a resident has ended in a kind of 'deadlock.' In this kind of situation, both participants expect the interaction to turn out negatively, act accordingly and thus confirm each other's prejudices. Thus the mutual expectations feed into each other to generate suboptimal behavior from both participants, and in such a situation, most efforts by either of the party to alter the interactive situation perishes into this general pattern. In order to change the pattern, the nurse needs to be able to somehow generate a situation in which both participants look at each other and their mutual interaction with fresh eyes, being able to see new possibilities in it. Sometimes, for example, the unexpectedness of some 'comic relief' could dissolve the existing patterns enabling the

participants to build up their interactive dialogue anew. Sometimes some unexpected sorrow or joy hitting the resident might make the resident to be less stuck to his or her usual expectations and thus open up the opportunity for the nurse to trigger new patterns of interaction.

The importance of positive impact points could also be approached by talking about positively reinforcing loops that they can give rise to. Such self-reinforcing spirals take place when one positive effect feeds into another, which in turn feeds the first one even more (see Walter & Bruch, 2008 and the discussion in chapter 9 of this document). In our case, this means that a positive gesture from the part of the nurse could lead the resident to return the positivity in a way that would make the nurse again more capable to display more positive behavior within the interaction. A systems intelligent nurse should thus always be on the lookout for the possibility of such reinforcing loops in her everyday interaction with the residents. She should understand that the seeds of such processes could be very trivial and present only as slight hunches but that these trivialities carry enormous life-giving potential in her work. She should look at her work interaction not only from the perspective of what there is now but also from the perspective of possibilities: how the situation could unfold if the level of mutuality could be increased and how the situation could be turned into such a direction. Many momentary opportunities for a small intervention that could lead the interaction into the track towards caring connections will pass unnoticed when the nurse has not sensitized herself to look for them. Nevertheless, the ability to seize these moments can turn an ordinary work interaction into humane and affectively heightened moments of deep interaction that leave both participants feeling elevated, energized, and more alive.

Being sensitive to the other's bids for connection

An especially important dimension of positive impact points is – to borrow a term from Driver and Gottman (2004) – to be able to recognize and respond when the resident makes a *bid for connection*. Bids for connection are small and seemingly insignificant signals through which one person attempts to get the attention of the other. They can be direct and verbal or indirect and nonverbal and can involve anything from an audible grumble as the other passes by to a verbal joke at the dinner table (Gottman, 2011: 197–198). Sometimes these bids do not ask for more in response other than the other to acknowledge you through a nod and brief eye contact. Based on

their data, Driver and Gottman (2004: 313) argue that these "small, seemingly insignificant moments in the couple's daily life" are "an important component to marital stability and health." Most importantly, Gottman (2011: 199) notes that when these bids receive a larger response in which the person enthusiastically turns toward the bidder, "that usually has huge possibilities for emotional connection." Analogously, it can be argued that similar bids for connection by the residents hold the seed for growing into caring connections if the nurse is able to recognize and respond to them enthusiastically enough.

Additionally, taking again into account the process-like unfolding of the relationships between the nurses and the residents, the responsiveness to these bids most probably also affects the long-term development of intimacy and trust within these relationships (cf. Gottman, 2011: 199–200), which in turn are important building blocks upon which caring connections can be built. More generally, the special moments that caring connections represents can happen only if the relationship between the nurse and the resident is on a sound basis. This means that the small moments of everyday interaction count. Although quite minor issues by themselves, as they take place repeatedly during the weeks, months, and years in the nursing home, they set the tone for the relationship and shape the expectations with which the participants enter into interaction. This general tone then by and large determines how much room there is for such heightened interactive encounters such as caring connections. As noted by Beebe & Lachmann (2005: 170), the "heightened moments are organized only if they capture the essence of similar though less intense moments."

As the interactive skills of the residents are often relatively limited, the nurse must remain constantly open to any bids for connection that the resident might give and aim to recognize them even when they are present as only slight hints in the posture of the resident or as a warm smile in her eyes. The systems perspective allows us to understand that although a resident's participation is a necessary condition for the caring connection to emerge, the resident's participation in the system that generates caring connection doesn't have to be very substantial. Sometimes even the slightest effort by the resident to make the tenderness reciprocal can be enough to initiate the processes within the dyad to develop into a caring connection. In systems terms, we could state that the resident's slight act might produce non-linearly big outcomes if the nurse is able to seize and cultivate them through the system she is part of and to which her acts are

contributing to. A systems intelligent nurse nurtures such interactive dyads in which a resident's slight positive interactive signals have room to grow into mutually engaging moments.

In my observations, the importance of approaching the other from this perspective of what-could-be came through especially clear in situations where the residents' capacities for emotional expressiveness were limited and which demonstrated interesting border cases of caring connections. Some residents were already so degenerated that their capacity to discern the situation and express themselves were almost absent. In the caregiving moments with these residents, I sometimes observed how the nurse still seemed to be able to feel some form of reciprocity going on and behaved accordingly. It was impossible for me to discern whether there was actually some expressiveness in the posture of the resident or if it was just imagined. In any case, the nurse was able to behave as if the situation would be a reciprocal caring connection. Thus it seemed that the amount of reciprocity that the nurse needed from the resident was related to the nurse's beliefs about the capacity of the resident to express any form of reciprocity. The less capable the resident was for emotional expressiveness, the less the nurse expected such reciprocity. This demonstrated a way of approaching the residents in which one always believed in the fact that behind the limited expressive capacity of the resident, there was still some ability to receive the empathic forms of care and feel gratitude for them. This I saw as a powerful demonstration of the positive attitude dimension of systems intelligence.

In summary

> *"Sooner or later in the professional life of every agent of change, in every field of human endeavor, there comes an experience of achieving results beyond what theory would have led one to believe was possible."* (O'Hanlon & Wilk, 1987: ix)

Often it seemed that to bring forth a caring connection, not much more was required from the part of the nurse than providing an initial spark to get the interaction going on the right foot – a smile, an empathetic touch, a joke, a small reference to their mutual history, or something similar – and after that, it was enough to be present and attuned to the other and to the moment-by-moment unfolding of the mutually generated situation. The situation almost seemed to generate itself if the nurse just was open to it.

But this image downplays the fact that being open in the right kind of sensitive way and acting in ways that moved the system in the right direction were dependent on certain implicit capabilities of the nurse, such as her ability to attune to and perceive the potentials in the interactive system and practicing her agency in the right kind of way. Thus the sense of a situation generating itself automatically applied only to cases where the nurse was equipped with the right kind of systems intelligent capabilities in the first place. Actually, behind the seeming easiness in these situations was the fact that the nurse was present in the situation authentically, that she showed appreciation for and was attuned towards the resident, and that she had the necessary experience to act naturally in a way that led the intersubjective dyad in the desired direction. Behind the seeming easiness and naturalness of the situation was a professional whose extensive implicit procedural knowledge made her a natural expert at generating caring connections with her clients.

Additionally, this image of the easiness of the generation of caring connections applied only to situations in which the resident was also open, from the beginning, to the emergence of such an intimate encounter and capable of interacting accordingly. As a co-constructor of these moments, the resident's input was much needed in the process. Some of the residents had closed themselves to any form of intimacy to such a degree that I never saw them in a caring connection with any nurse. Other residents were slow to warm, but in the hands of a nurse who could handle them in the right manner, they were able to open up enough for a caring connection to occur. It was especially in these situations that the systems intelligence of the nurses played a central role in turning an ordinary caregiving encounter into a caring connection through reciprocal growth. The nurses needed to be sensitized enough to see the small positive impact points and bids for connection to take advantage of them.

Thus my argument is that in order to be able to generate caring connections – the peak moments of their work – the nurses must find from within themselves the authentic willingness to engage in such encounters as well as the relational sensibilities to lead the intersubjective system into such intimate levels of mutuality. We might use the concept of *systems intelligent nursing* to refer to nursing that is done in a manner where the nurse uses both her cognitive as well as her intuitive capabilities to engage with the specific relational system of the nursing situation in a way that leads it towards humane and warm forms of caregiving. From the nurse's

point of view, generating caring connections is more a form of art than the application of certain techniques. The intersubjectively shared situation is about a "flow of small moves and moments" (Stern, 2004: xvi), in which the proper way to act is about a compassionate attunement into the rhythm and tone of the situation. As Boykin & Schoenhofer describe it:

> *In the situation, the nurse draws on personal, empirical, and ethical knowing to bring to life the artistry of nursing. When the nurse, as artist, creates a unique approach to care based on the dreams and goals of the one cared for, the moment comes to alive with possibilities. Through the aesthetic, the nurse is free to know and express the beauty of the caring moment. (Boykin & Schoenhofer, 2001: 14)*

In order to illustrate what systems intelligence is about, we can make a distinction between three different mindsets that the nurse can have towards the shared situation with the other (see Table 9). Firstly there is the mindset of caretaking where the nurse is oriented towards the fixing of some problems of the client without concentrating either on the other as a person or at the situation that is generated together. This instrumental way of taking care of the needs of the other has been already discussed. But even in a situation where the nurse is engaging with the resident in a more empathetic manner, one can make a distinction between two mindsets. In one case, one is open to meet the other as a distinct and respected human being. But one might still be trapped by the Cartesian dualism and deficit model of psychology and accordingly focus solely on helping the other get rid of the possible negative feelings through being present for the other in a sympathetic way. This we might call deficit-oriented caregiving. On the other hand, one might have a mindset where one not only engages with the other in an open and empathetic way but also takes heed of the system that is generated in between oneself and the other, and is accordingly actively looking for possibilities to bring this system towards a more flourishing direction. This we might call flourishing-oriented caregiving, and that is what systems intelligent nursing is about. A nurse equipped with this mindset believes that a mutual encounter between two participants can, in the best case, generate something that is valuable and goes beyond what either of the participants could achieve alone. Accordingly, she approaches a social encounter with the question: What could this situation generate at best? Her aim is to realize the systemic potentials inherent in any social interaction.

Table 9 Three mindsets of the nurse

	Caretaking	Deficit-oriented caregiving	Flourishing-oriented caregiving
Focus of intervention	Deficit	Deficit	Flourishing
Focus in the situation	Other as a physical being	Other as a person	Other as a person & the system in-between

An example from a therapeutic context is illustrated here. Beatrice Beebe tells how in the course of a late-afternoon session with a patient she calls Burton, "the daylight was beginning to fade. Neither Burton nor I made a move to switch on the light in the room. We entered a slow, near-reverie state, barely talking. We each sensed the other's calming down, and we were both quite content with our silence." (Beebe & Lachmann, 2005: 17.) Beebe notes how this event "marked a shift in our ability to be together in a calmer way" that was "all the more striking in the context of his [Burton's] usually frenetic, urgent, impulsive, wildly emotional state of mind" (Beebe & Lachmann, 2005: 17–18). Utilizing the setting sun to enhance the therapeutic relationship is something one does not learn from books. Instead, a moment of this nature can be seized upon by a positive, systems intelligent, sensitivity-tuned, and other-focused therapist open to the emergence of something significant in the context of the co-constructed system as it unfolds. In systems terms, one might say that the therapist was able to adapt intelligently to the interplay of the co-dependent parts that constituted the therapeutic situation and thus was able to reach with the patient a tipping point in their relation that provided nonlinear results. Instead of intervening in the situation and putting the light back on in order to 'get back to business' and concentrate on the problems of the patient, the therapist was open to see what possibilities the system might generate in this unique situation.

Within the therapeutic situation, I (Martela & Saarinen, [Forthcoming]) have argued that a systems intelligent analyst is aiming towards an "optimal therapeutic interaction" and responsiveness (Bacal & Herzog, 2003: 636) in which one is monitoring patient's cues on both conscious and preconscious levels to be able to choose one's responses based on their "ultimate therapeutic potential" (Bacal & Herzog, 2003: 642). Similarly, systems intelligent nursing is about utilizing both one's cognitive knowledge about the patient and the situation, as well as one's implicit

attunement to the situation in order to be in the caring situation in a way that best advances the possibility of engaging in a caring connection with each other. The nurse is aware that in the caring situation – conceived as a vaguely defined yet from-within identifiable dynamical complex whole – she may sometimes be in a position to apply specific models, representations or techniques in order to act intelligently and sometimes not. She is attuned to the subtle and specific aspects of the multidimensional system she is involved with. Her focus is on *getting it right* with whatever the system is, as opposed to being able to describe how to get it right. The nurse's sensibilities and attunement to the system and with the patient will thus provide a channel for the situation to grow into a caring connection.

One must acknowledge here that the relation of implicit and explicit should not be seen as mutually exclusive. In the best case scenario, the implicit and explicit are both present simultaneously as a "reflection-in-action" (Schön, 1983), where the nurse's action is "immediately experienced by the [nurse] as both a genuine expression of some aspect of his or her personal experience and as theoretically informed," to use the words of Hoffman (2001: 182)[44]. In these situations, the capability for systems intelligent nursing is built up through a dialectic between two elements: firstly, through the nurse's technical skills of providing appropriate care for the specific ailments of the patient, and secondly, through behavior "that is sufficiently self-expressive and spontaneous so that a bond of mutual identification can develop between the participants" (Hoffman, 2001: xxvii).

We could state that through her continuous engagement in nurse-patient systems, the nurse has an ability to sense and experience the subtleties of the system as well as its systemic possibilities, which might involve emergence and points of non-linear progress. Based on her affective sensibilities and nonverbal instincts and guided by her cognitive understanding, her actions are often facilitated intelligently by the system while also facilitating the system intelligently. The unfolding nurse-patient encounter can thus move into the right direction without the nurse knowing the rationale for her actions – much of the time something just feels right and things just seem to fall into place.

[44] Hoffman is talking about an analyst in a therapeutic situation, but the words apply as well to the nurse in a caring situation.

In other words, systems intelligent nursing is about utilizing one's personality and skills in a holistic fashion, putting oneself into the play as a whole: "The nurse responds to each call for nursing in a way that uniquely represents the fullness (wholeness) of the nurse" (Boykin & Schoenhofer, 2001: 18). To be able to do this, we must remember that humans are caring beings from the beginning and the nurses are professionals who have developed strong implicit relational knowing to act in the right way. So more often than not, they already have the ability to act properly. Sometimes this ability might be hidden beneath the surface by the education of the nurses. "Because many nurses were trained to overlook their caring ways instead of attending to them, nurses may now need something similar to, or indeed 'sensitivity training' itself, to rediscover and reown the possibilities of self as caring person" (Boykin & Schoenhofer, 2001: 23). However, many times it is enough that one just reminds oneself about this ability and allows it to work its way:

> *It may take a revolution of the soul to return to core principles of connecting with the patient. Or it may take the mildest of adjustments: just remembering to stop, touch the door jamb before you enter the room, count to five, and get ready to greet and attune to another human being. (Trout, 2011: 20)*

Organizational and leadership implications of caring connections

This dissertation has focused on the relation between the nurses and the residents, how their mutual interaction generates – or doesn't generate – caring connections. Because of this emphasis, the dimension that I have *not focused* on is the issue of how organizational culture, leadership, and organizational structures enable or discourage the occurrence of caring connections.

This is, however, an important topic because the caregiving relations between the nurses and the residents are embedded within the wider organizational relationships (see Kahn, 1993, 2005). For example, McCabe (2004) found out that person-centered care enables nurses to communicate well with the patients, but this ability is heavily influenced by the work and culture of the organization (see also McCormack & McCance, 2006: 475–476). This insight is echoed in McCormack's conclusion: "The context in which care is provided has the greatest potential to enhance or limit the

facilitation of person-centered practice" (McCormack, 2004: 34). Similarly, Nolan et al. (2004: 52) argue that instead of focusing on the relationship between the nurse and the client, one must see how good nursing depends "rather on a network of relationships" surrounding that nucleus.

So one could argue that the one-on-one encounters between nurses and resident are embedded within the larger network of relationships of the different actors within the nursing home. In this wholeness (see **Figure 6**), the interaction between the nurse and the resident – the focus of this study – is affected by how the interactions flow between the nurses themselves and with their direct supervisors, the head nurses (see Kahn, 1993). On the whole, it can be argued that within nursing homes, the relational dimension of our way of being is especially strong. This is because the primary task of such institutions is about taking care of the residents and involves the employees in close and emotion-filled relationships with them (Kahn, 1993, see 2005). In addition, these "caregiving relationships [- -] reverberate throughout the larger systems in which they are embedded" (Kahn, 2005: 1), and thus responding to the emotional needs and taking care of each other are also a central part of the relationships between the nurses themselves and their superiors. These mutual relations of caregiving are further exaggerated through the deeply interconnected nature of the work. To be able to offer good quality care for the residents, the workers are operating as a cooperating, collective, and inter-coordinated whole rather than as separate individuals (see Kahn, 1998; Orlikowski, 2002; Wenger, 1999).

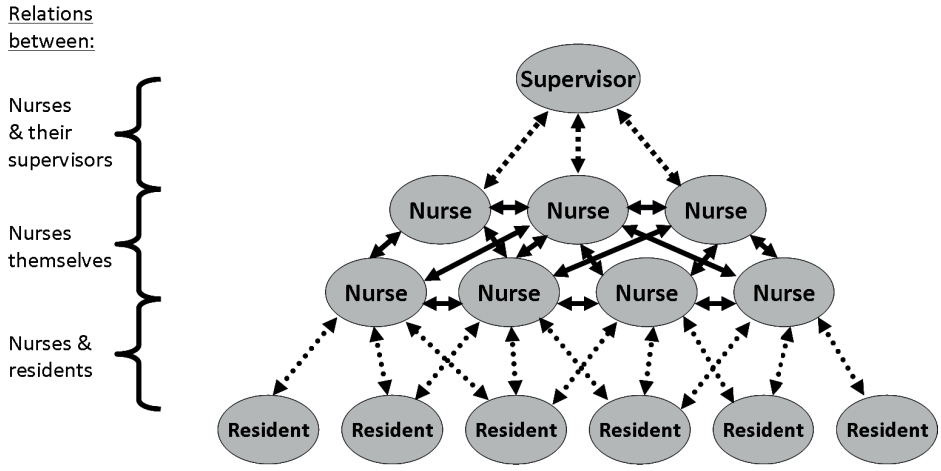


Figure 6 The caregiving unit as a relational system with three primary forms of relations: (1) relations between the nurses and the residents,

(2) relations between the nurses themselves, and (3) relations between the nurses and their supervisor.

Therefore, an important question that this dissertation leaves unanswered is how the larger organizational network can enhance and support the forming of the more positive forms of encounters between the nurse and the resident. This question is left unanswered because the scope of an investigation must be limited, and the relation between the nurse and the resident was a deep enough topic for one research project.

However, based on my empirical experiences and relevant theoretical literature, I will offer a few guidelines about where we should look for an answer to these questions. I see that especially three broad cultural issues emerge that potentially can have a great influence on the occurrence or non-occurrence of caring connections within a single nursing unit: a clash between the logic of care and the logic of new public management, the move from problem-based care to quality of life care, and ways of leading through the logic of care. In addition, the organization can also enhance the possibility of caring connections simply by giving more time and continuity to the nurse-resident relationships.

Providing room for the logic of care within the pressures of logic of new public management

> *"To be treated as 'types' instead of individuals, to have strategies exercised on us, objectifies us. We become 'cases' instead of persons." (Noddings, 1984: 66)*

As of now, the organizational culture within the nursing home under study was often not very supportive of the caring connections. In fact, a few nurses mentioned that after they engage in such a lengthened interaction with a single resident, they have a bad conscience about neglecting the 'more important' work duties. The nurses communicated strongly how they felt that in many situations they had to fight against the organizational-level initiatives that pushed them to deliver more care in less time. However, to provide caregiving in its proper meaning, in which one has the time to recognize the other and tailor the care to the uniqueness and rhythm of the other, often needs more time. In addition, although caring connections were possible even in very brief encounters, the sense of urgency generated by time pressures often made nurses less responsive and thus less prone to be able to engage with the nurses in a manner that would lead to caring connections. Some nurses felt that their superiors were only interested in

numbers and formalities, such as the number of diapers used and completing required paperwork in time, instead of encouraging them to engage with the residents in a humane manner. They thus seemed to have the feeling that the *quantitative* dimension of care had come to dominate the *qualitative* dimension of it. This is indicative of an organizational culture that has put the emphasis on the measurable and tangible goals and thus has come to underemphasize the humane dimension of caregiving that is harder to put into numbers.

More broadly, it has been argued that the international trend of *new public management* (see Wilkinson, 1995) has had a clear influence on how nursing institutions are managed nowadays (e.g. Evans, 1997; Gittell, 2008). New public management is a loose term capturing a set of broadly similar administrative doctrines such as an emphasis on efficiency, imitation of private-sector styles of management, and a focus on explicit standards, targets, and measures of quantifiable outcomes (e.g. Wilkinson, 1995: 981). To put it briefly – and to use the words of Tonuma and Winbolt (2000: 214) – it is about "health care systems" that focus on "getting the most value from the money spent on health care and on outcomes" and which often lead to "rigid hierarchical structures, disempowerment" and routinism of care that reduces care "to a series of tasks." As noted in the literature review, many writers within nursing research have expressed their concern that the recent policy reforms and government requests for healthcare accountability have led to a situation where nurses feel increased pressures to submit to this managerial view of nursing (e.g. Jonsdottir et al., 2004; McAllister, 2003). In the nursing home where I conducted this research, the nurses felt similar pressures coming from above and often had the sense that they themselves, rather than the top management, had a better sense of what is good for the residents. They wanted to concentrate on the primary task of caring for the residents but felt that the recent cost-cutting efforts as well as the increased amount of time they had to spend in front of a computer were eating up time that could otherwise be spent providing high-quality face-to-face care.

One could conceptualize this by saying that the nurses often want to follow a *logic of caring*[45] within their work while facing pressures from the managerial level that seems to operate from a different, more instrumental

[45] Compare this with the discussion about the *rationality of caring* in the previous section on systems intelligence.

perspective, *the logic of new public management*. This struggle between these two perspectives could be interpreted as a rivalry between two institutional logics. Institutional logics are "the organizing principles that shape the behavior of field participants" (Reay & Hinings, 2009: 631). They consist of a set of belief systems and associated practices that focus the attention and behavior of the organizational actors on certain set of issues and ways of resolving them. In other words, they provide "the formal and informal rules of action, interaction, and interpretation that guide and constrain decision-makers" (Thornton & Ocasio, 1999: 804). The logic through which the work in the nursing home is organized can significantly influence how the work is conducted and how relationships between the nurses and their clients are built up. Most relevant study in this regard is Lopez's (2006) qualitative comparison of three nursing homes. He found out that while one of the nursing homes generated an atmosphere where genuine contact with the residents was discouraged, others had highly developed processes of *organized emotional care* that support "the development of caring relationships between service providers and recipients" (Lopez, 2006: 137). As one example, he tells how one nursing home placed a large photograph of each resident as a young, healthy person outside the resident's room door. This he sees as a systematic use of "planned spontaneity", which not only helped the staff to see residents as human beings, but also provided opportunities to ask questions and initiate relaxed conversations with the residents (Lopez, 2006: 145). It is worth mentioning that this was also the custom in all the units I visited in the nursing home under study.

More generally, one could interpret the situation in many nursing homes to be about the nurses attempting to operate by the *logic of care* but feeling that they continuously had to struggle against the *logic of new public management* because that was the dominant logic of the institutional actors in the executive positions of the organization. The logic of care emphasizes humane caregiving and the nurses' implicit ways of knowing how to be with the patients in a caring way. However, "in many settings where nurses find themselves practicing, there is little in the environment to support a commitment to ongoing development of a sense of self as caring person. In fact, many practice environments seem to support knowing self only as instrument, self as technology" (Boykin & Schoenhofer, 2001: 23). Because of the managerial perspective that emphasized efficiency as regards measurable targets, the nurses often had

to balance their behavior between these two goals. As McCormack (2004: 34) argues: "When facilitating person-centredness, nurses find they not only balance competing care values, but often they find it necessary to consider organizational values too [- -]. Nurses are not free to fulfill a moral obligation to the patient without considering organizational and professional implications."

Recent research has shown how two competing institutional logics can coexist (Reay & Hinings, 2009), but compared to Reay and Hinings' study, which looked at a struggle between physicians and their *logic of medical professionalism* against management with their *logic of business-like healthcare*, the nurses possess less power and agency to shape the institution than the physicians, and thus they are less able to fight for their own logic. Tonuma and Winbolt (2000: 214) argue that although many nurses "aspire to achieve individualized holistic care for each of their patients" the "rituals, routines and cultures that have developed in nursing serve to prevent nurses from achieving this ideal model of care." This is unfortunate because submitting oneself to the logic of new public management might constrain the nurse's possibilities to engage in caring connections. For example, Jonsdottir et al. (2004: 247) conceptualize partnerships as the stance between the nurse and client, in which the nurse is able to be fully present to the client, and they argue that in order for such partnerships to form, the nurses must be "free to practice without constraints to achieve outcomes predetermined in relation to the service delivery."

Therefore it can be suggested that in order to strengthen organizational culture within which caring connections can blossom, the logic of care should be given more space. The nurses' capability for caring would be improved if they were part of a culture "where it is believed that people's humanity should be displayed rather than concealed" (Lawrence & Maitlis, In press). Although the monetary pressures can be very real and unavoidable, they shouldn't lead to a situation where they are dominating the thinking patterns and ways of practicing of the nurses. It would be important to generate an atmosphere where the nurses are at least to some extent shielded from these upper-level pressures and can better concentrate on providing care according to the logic that is more natural for them. Lopez's (2006) research shows that it is possible for the top management to commit itself to an approach that more closely aligns with the logic of care, and which leads to better quality interactions between nurses and their

clients, as well as less emotional labor for the nurses. I will turn to the question of how to lead in a way that strengthens the logic of care after discussing another important cultural issue, a clash between problem-based care and quality of life care.

From problem-based care to quality of life care

Another dichotomy within organizational culture that might have a clear impact on the occurrence of caring connections is what could be called a juxtaposition between problem-based caregiving and quality of life caregiving. Problem-based care is tied to the long-prevailing biomedical model of patients, where the emphasis is on "functional abilities, problems, deficits, and special needs determined by assessment methodologies and evaluations by 'experts'" (Clark, 1995: 407). The nurses are encouraged to be problem finders and solvers (McAllister, 2003). Taken to the extreme, this view sees that if there is not anything wrong with a certain resident, one was not supposed to spend time with her. In addition, it discourages nurses from intervening before an appropriate formal diagnosis can be made out of a situation (McAllister, 2003). As summarized by Mitchell, "the values of traditional nursing direct nurses to focus on assessment, prediction, and control of *problems*." (Mitchell, 1992: 105; quoted from Clark, 1995: 407–408).

In recent decades this view of nursing has been challenged by a way of thinking in which one attempts to have a more holistic view of what good life quality means for the residents (e. g. Parse, 1992). Proponents of this approach criticize problem-based care of being too paternalistic. The nurse is seen as the one who decides whether a problem exists and makes a decision about how to solve it (McAllister, 2003). Additionally, it is seen as a reactive approach to caregiving in which nurses are encouraged to intervene only when problems have already occurred instead of focusing on the preventive dimension of care where one builds on the strengths and positive aspects of the client's situation (McAllister, 2003). Most worrisomely, the emphasis on "management of treatments" is pulling the nurses away from "relating to patients in a caring way, and pushing them into fast-paced, fast-talking health care provision" (Jonsdottir et al., 2004: 242). All in all, this kind of approach makes the nurse-client interaction to be problem-oriented and thus downplays the positive, relational, and life-giving dimensions of caregiving that I have attempted to present in this work as central for nursing practice and the quality of life of the residents.

The quality of life approach gives a more active role to the residents to define their own well-being goals and is more ready to acknowledge that life quality means different things to different residents depending on their unique situation and values (Clark, 1995). Instead of working *on* a client, the nurses are encouraged to work *with* them, aiming to support the clients in the pursuit of those issues that they see as valuable (McAllister, 2003: 533). Instead of viewing elderly well-being as a static outcome defined by experts towards which the 'problem-solving' aims at, health and quality of life is understood as a process that involves the individual resident's physical state, self-actualization, development of adaptability, coping skills, and acquisition of wisdom (Clark, 1995: 408). This development parallels the development of positive psychology, which has emphasized that instead of focusing only on deficits of human psychology, one should take a more holistic approach in which the more positive aspects of human functioning are also taken into account (e.g. Seligman & Csikszentmihalyi, 2000; see McAllister, 2003). This way of thinking about nursing emphasizes a solution-focused approach in which problems are not ignored but the focus on them is balanced by a focus on the encouragement of the positive functioning of the resident. Nursing skills such as engagement, resilience-building, giving hope, community development and so forth are valued. Creativity and usage of implicit skills are encouraged (McAllister, 2003: 531). The efforts thus concentrate on improving the quality of life of the residents in a holistic way that takes into account every resident's particular situation and hopes.

Although it was not the main target of my observations, I could see that both approaches to caring were co-existing within the nursing home I visited. Firstly, there were many situations in which the nurses themselves or their supervisors seemed to depict the task of the nurse as that of providing care for the residents when a special problem or need emerged. For example, it came through in formal and less formal meetings between the unit members in which important issues were shared and discussed. These important issues were by and large different problems that needed to be solved, thus communicating the message that these are the truly important parts of the nursing home work. Rarely were positive dimensions of care taken up in formal meetings within the units I attended to.

On the other hand, the nursing home units I visited had taken many important steps towards this quality of life approach to gerontological nursing. In addition to the whole nursing home emphasizing in their

mission statement that their aim is to provide "safe, dignified and good life" for the residents, individual units had done their own projects to define what kind of caregiving they wanted to provide for the residents. Many units had put in visible places mission statement or value declaration posters that usually were the results of some collective process in which the nurses and the head nurse – sometimes with the assistance of an outside consultant – put in the paper the values they thought of as central. One such poster listed "important things to us", and on top of the list was "the well-being of the resident – his/her good life." Especially touching was one poster that – although not written by the nurses themselves – still reflected something of the prevailing mentality, because I saw it on the wall of at least two different units. Written from the perspective of the aged resident, it went as follows:

> *"When I don't remember my own name. When today is mixed up with yesterday. When my grown-up children have grown in my memories to be small again. When I am not a productive individual anymore. Treat me as a human being even then. Care for me, give me love, touch me tenderly. The clock is slowing down, some day it will stop completely, but there is still time until that. Give me a dignified old age."*[46]

Many efforts had thus been taken to transform the work culture of the nursing home units towards one in which the quality of life of the residents is taken as the central focus. The problem was that the positive and individually unique aspects of the quality of life of the residents are easily less quantifiable, and thus the emphasis on new public management and measurable targets easily trumps these good intentions in the busy everyday reality of the nursing home work. One felt that conscious efforts were needed to make sure that the quality of life of the residents really stays in focus, not only in visions, but also in the everyday practice of the work. Thus, this discussion between problem-based care and quality of life care is strongly related to the above discussion about the clash between different institutional logics.

[46] Despite extensive search efforts, I couldn't locate the origins of this piece of poetry. It has been adapted by many Finnish nursing homes but all list the author as anonymous. The translation to English is made by me.

As positive and life-enhancing events, caring connections are something that would remain invisible in a purely problem-based approach to caring, but that should be given a significant role within the quality of life approach to caring. This is because – as I have argued – caring connections have the potential to significantly improve the well-being and meaningfulness of the residents' lives within the nursing home and thus can have a positive impact on their quality of life. Thus it can be argued that the more the quality of life approach dominates over the problem-based approach to caring, the more supportive the nursing environment is to life-enhancing occurrences such as caring connections taking place between the nurse and the resident.

Leading through the logic of care

Having spent time in many different units within the nursing home, I saw how middle managers – the head nurses of the units – were in a key position to influence the atmosphere of the nursing unit and mediate the conflict between the logic of new public management and the logic of care, as well as to promote quality of life caregiving. This is in accordance with Brown Wilson's findings in her examination of care homes: "Leadership created a sense of the 'way we do things around here' and shaped the way relationships across the [nursing] home developed" and "leadership within each [nursing] home appeared to influence the focus staff adopted in their care" (Brown Wilson, 2009: 181, 184). Similarly, Lawrence and Maitlis (In press) argue that "leaders are in a unique position to create legitimacy around displays of humanity."

The head nurses I interviewed felt the pressure to comply with the standards and measurable targets set by the upper management, but how they transformed these pressures to ways of leading the nurses were different. In one unit, the interview with the head nurse revealed how she was very stressed by the targets and paperwork put on her by the upper management, and I observed how this stress transformed into a leadership style in which she hustled the nurses to do their work efficiently. A nurse in her unit told how she likes weekends because then the absence of the head nurse enables one to do the work more leisurely and thus have more opportunities to spend time with the residents instead of just hurriedly taking care of them [Nurse 18]. Although the workload was similar during the week and on the weekends (the residents needed the same care

everyday), she felt the weekends to be much more relaxing because the head nurse was not there creating an atmosphere of hurriedness.

Luckily, opposite examples were also to be found. In a few units, the head nurses clearly encouraged the nurses to make space for moments in which they could spend unhurried time with the residents. For example, when asked about the best moments of the work, one of the nurses answered, "Sometimes when we go out with these patients. When we are one-on-one somewhere… But luckily our head of department always prompts us to go and do such things" [Nurse 4]. In this unit, the head nurse thus encouraged the nurses to take time off to spend it together with the residents. Another department supported the possibility of the nurses to spend time one-on-one with the residents by designating a special therapy room where the nurse can go with the resident and "get rid of this atmosphere of hurry and concentrate on the well-being of her own patient and relax herself at the same time" [Head nurse 2]. This head nurse thus demonstrated keen intuitive appreciation of the importance of caring connections. These examples and my experience of the differences in the atmosphere between different units demonstrated clearly how by supporting the nurses' efforts to spend unhurried time together with the residents either by encouragement or by structural arrangements, the head nurses had the possibility to significantly increase the occurrence of caring connections. This is in line with Heaphy and Dutton's (2008: 154) proposition that when "leaders propagate meaning that evokes collaboration, cooperation, and interdependence between people [- -], they motivate people to connect and ease connection possibilities."

Another key leadership issue for the middle managers was the management of emotions. This was true both generally for caregiving organizations and as relates to caring connections. Through the new public management movement, healthcare and other organizations are connected to the rational administrative paradigm according to which organizations are led through rational and tangible targets. This way of thinking downplays the role of feelings and emotions within organizations that view them as enemies of reason that need to be controlled, if not totally eliminated, in order for the business to succeed (see Ashforth & Humphrey, 1995; Sandelands & Boudens, 2000; Weber, 1946). As my discussion of caring connections hopefully has demonstrated, this kind of approach is not suitable for understanding the reality of nursing home work. The emotional dimensions of leadership that the management of caregiving organizations

need to face have been especially well displayed in William Kahn's work (Kahn, 1993, 2005).

What makes a caregiving organization such as a nursing home special is its primary task in which one group of people directly, face-to-face, cares for another group and thus ends up in close and emotion-filled relationships with them (Kahn, 1993, 2005). The caregivers – in my case, the nurses – need to form "meaningful connections" with careseekers who "may experience any combination of powerful emotions – fear, anger, joy, excitement, nervousness, sadness, terror" and especially anxiety (Kahn, 2005: 177). The caregivers need to be able to receive and manage such strong emotional reactions as part of their everyday work. The emotional exchanges present in these interactions in a way set the tone for the whole organization as the "caregiving relationships [- -] reverberate throughout the larger systems in which they are embedded" (Kahn, 2005: 1). The nature of nurses' work makes it emotionally exhausting, and to be able to manage it, the nurses need to "feel contained and held within the context of their work relations" (Kahn, 2005: 42). They need to feel that there is a "system of supportive relationships" (Likert 1967) in place in the work community so that they can share and discharge their emotional loads when needed. In other words, in their daily interactions the nurses give much emotional support to the residents, and this creates the need to replenish this emotional energy by getting emotional support from one's peers and especially from one's supervisor.

Therefore, when the supervisor was able to value and support the staff in an appropriate way, this increased the emotional engagement that the nurses were able to deliver to the residents. One head nurse wrote in her feedback about my presentation on caring connections that the way to increase their occurrence is about "'Loading emotional energy', open atmosphere, safe work community, support from colleagues. The ability to discuss professionally and freely one's own experiences and different encounters with the residents." This was also recognized by Nolan et al. (2004: 51) in their research; they noted that "several participants felt that if staff were valued and supported themselves they would be better able to value and support older people. There was much talk of the need for strong and visionary leadership and of a supportive culture [- -] The key was seen to be vision and leadership, [- -] a way of realizing a 'vision' of care in which 'fundamental' elements were valued and accorded status." Similarly, McGilton and Boscart (2007: 2154–2155) argue that "it is of paramount

importance that nurse supervisors and administrators take on the responsibility of supporting their staff when they make efforts to get to know individual residents and their family and to develop meaningful relationships with them." In other words, the compassionate acts of the supervisor could trigger "compassion spirals" where "those on the receiving end of compassion are subsequently better able or more likely to direct caring and supportive behaviors toward others" (Lilius et al., [Forthcoming]; see also Goetz et al., 2010). According to Lilius et al., ([Forthcoming]) these kinds of spirals are particularly important in caregiving organizational contexts "where the work itself brings about stress, burnout, and compassion fatigue."

This theme was also strongly present in my interviews. The nurses told how they wanted leaders who are "easily approachable" [Nurse 18] and "empathetic and sympathetic to some degree" [Nurse 22]. In their stories about difficult moments at work, the nurses also constantly told how they in these moments sought to discuss the matter with the head nurse and how they got much needed support from them. They wanted a head nurse to whom they could come and confess their problems and who would listen to their sorrows. The head nurses themselves also felt this pressure to give emotional support to the nurses. This availability they felt to be "quite much the main expectation from personnel" [Head nurse 6]. Few of them even felt that many nurses "think of the head nurse as a kind of mother" [Head nurse 9]. The role of the head nurse thus involved to a significant degree being emotionally available and supporting the nurses with their emotional loads.

My experiences within the nursing home thus confirmed Kahn's (1993, 2005) findings, according to which the generation of a supportive atmosphere within which the nurses can share their emotional loads with their supervisors and colleagues is crucial for the nurses to be able to deliver good quality and tender care. At the same time, I have suggested that caring connections are energy-giving for the nurses, so one might argue that this supportive atmosphere is not so important for the occurrence of these encounters as they are energy-giving by themselves. But this view ignores the fact that caring connections take place within the long-term relationships formed between the nurse and the resident. As argued, such peak moments capture "the essence of similar though less intense moments" (Beebe & Lachmann, 2005: 170), and thus the general tone of the relationship by and large determines the availability of the participants

for caring connections. If the nurse is mostly too stressed and too drained of emotional energy to meet the resident in a sensitive manner when the resident has a bad moment, this already easily indicates that the resident is not willing to open up to the nurse during her better moments. On the other hand, the more emotional energy the nurses have, the more energy they have for transforming even the more difficult moments into humane encounters. Therefore, the emotional support given by the supervisors has an important role in the occurrence of caring connections between the nurses and the residents. As Tonuma and Winbolt (2000: 215) argue, "both nurses and patients can benefit enormously from closer involvement and interaction, if adequate support networks and processes are in place."

This perspective on the importance of emotional support is strengthened through the literature on perceived organizational support and social support that both "tap the extent to which individuals feel they are valued and cared about and have others to turn to who will help them in times of need" (George et al., 1993: 167–168) and which are widely believed to be connected to meeting "the needs for emotional support, affiliation, esteem, and approval" (Rhoades & Eisenberg, 2002: 711). Perceived organizational support has been found to lessen the effect of stressors at work (Rhoades & Eisenberg, 2002: 711), be negatively associated with strains experienced in workplace, with turnover intentions as well as with burnout, and positively associated with job satisfaction and organizational commitment (Cropanzano et al., 1997; Rhoades & Eisenberg, 2002). For example, in a study that examined nurses caring for AIDS patients, it was found that both perceived organizational support and social support lessened the adverse effect on psychological well-being that was caused by caring for this group (George et al., 1993).

Leading in a way that supports the occurrence of caring connections in the nursing home is therefore much about the emotional undercurrents; being able to create a work community where the individual nurses feel that they are psychologically safe and their emotions are contained. As Kahn (2005: 187) put it: "Effective department leaders take seriously the idea that units have emotional lives that must be publicly excavated and tended to." The key question for such an organization and its leadership is how to "deal with the emotions absorbed from careseekers" and those triggered by the work of the caregivers with them (Kahn, 2005: 19.). How can the larger organization make sure that the caregivers are not exhausted by these emotions but can find ways to share and discharge them?

Instead of an organizational culture in which emotions are looked at as something uncontrollable and therefore something that needs to be eliminated as much as possible from the area of work and work-related relationships, we thus need an organizational culture that acknowledges and even embraces the emotional dimension as a necessary and important part of the nursing home work. Positive emotional experiences such as caring connections should be encouraged by the leaders. This can be done, for example, by instituting practices in which such experiences are shared between the nurses. During the meetings in which the nurses discuss their work, there could be a round in which every nurse shares one positive experience with the residents that has happened to her in the last few days[47]. A work culture that respects and embraces these moments could in the best case lead to a more positive work atmosphere, more well-being for the nurses, more positive encounters between the nurses and residents, and ultimately to better quality care.

The role of the organization: Giving time and continuity

Having said all this about the role of the head nurse in generating a supportive atmosphere for caring connections, it must be emphasized that she plays with the cards she has been dealt with, i.e., the resources she has been given. The more nurses there are to take care of the same amount of residents, the more extra time there is from the necessary basic life-supporting tasks. Time is crucial in three ways for caring connections. Firstly, in order to be able to attune for the rhythm of the resident, allow time for the resident to open up and get to know each other, one needs to have enough time to spend with the resident. As Berg and Danielson (2007: 503) note: "The nurses had to use their time with discernment because it was felt to be insufficient. It took time to put themselves into the patients' situation and their meetings were often interrupted. The opportunities to get to know the patient as a person were limited." Similarly, Morse (1991: 465) found that one factor "that prevents the establishment of a connected relationship is the lack of time to spend with the patient." This "gap in the continuity of care is such an important factor that nurses, when explaining

[47] Martin Seligman offers examples of how such practices in a school setting – which is also in many senses a caregiving organization – has led to many positive outcomes (see Seligman, 2011 chapter 5).

how they develop relationships with patients, always mentioned how much time they had together with the patient" (Morse, 1991: 465).

Secondly, time constrains made nurses more stressed and busy and thus less able to maintain a mood in which they were able to engage and connect with the residents. As one resident told me when I asked what is a good nurse: "One that is not in too much hurry" [Resident 2]. For example, one nurse confessed how too much hurry did stress her and thus prevent her from doing the work as she would have wanted to do it [Nurse 4]. When she was asked how the work could be made more meaningful for her, the only thing she came up with was having more time. Similarly, when I represented my results to the nurses and other personnel and asked for suggestions on how to improve the possibility of caring connections, one nurse and one supervisor both indicated that the number of personnel present in the unit was the most important factor. The nurse stated that "more unhurried moments are needed to establish the connection. Unhurriedness is established only by having enough personnel." In addition, in one interview, the resident's first comment when I told her about caring connections was: "When they are in a hurry, they don't have time for anything but to get quickly away" [Resident 2]. In the interview, she continuously returned to the issue that there are too few nurses, and therefore they are too busy to be able to deliver as good care as they could otherwise. In moments of hurry, the nurses are simply not in a mood sensitive enough to engage in the unique situation with the resident[48]. This insight is consistent with research that has shown how transaction busyness decreases employee display of emotion (Pugh, 2001). The same conclusion was also present in interviews conducted by McGilton & Bogart (2007: 2153–2154) in which both nurses and residents named time restraints, workload, and busyness as reasons why the nurses could not "be there" for the residents, connect with them, and establish a relationship with them. The care providers felt that they had no time left to listen to what residents wanted to tell them. A long-term resident concluded: "The nurses cannot be warm, because they are so busy" (McGilton & Boscart, 2007: 2153–2154).

[48] It must be noted that there were few exceptions. Some nurses seemed to be able to operate very swiftly and hurry to the next resident yet at the same time maintain a humane contact with the resident during the short time they were together. In any case, the less the nurses were in a hurry, the more likely it was that they could provide care that was sensitive to the individual needs and personality of the resident.

Of course, one has to be careful not to put too much blame on time constraints. They are also an easy target to blame, even in situations where some other factors more related to the nurse as a person might be the reason for why caring connections do not take place. As one supervisor indicated after one of my presentations of the results: “It is easy to go behind the busyness” when in reality one has not wanted to engage in an empathetic way with the resident for some other, more personal, reason. Some nurses I interviewed seemed to have the habit to always complain about the busyness and the lack of personnel while other nurses in the same unit – and thus operating with the same constraints – were perfectly happy with the situation and stated that lack of personnel is not a problem in their unit. As I relied on the subjective stories of the nurses, it was hard to indicate in which situations the stress was really caused by overload of work that was due to lack of personnel and in which situations some other factors might be more relevant.

Thirdly, time is important also in the sense that often some time is needed for the nurse-resident relationship to develop to a deep enough level within which caring connections could take place. While some residents were so open that they could engage in a caring connection from day one with a new nurse, some others were much more reserved and it took significantly longer time for them to warm up to a new nurse. Especially in one unit that was specialized with residents that had some mental illnesses, the nurses told me how the development of a trusting relationship with certain residents took more than a year to establish. Therefore, from the point of view of the residents, it would be important that they could interact with the same nurses for a long time. Berg et al. (2006: 45) found in their empirical study that patients experienced lack of continuity “due to the fact that they have been confronted with a varying nursing staff” and this had a negative effect on their feeling for caring relationships. The problem is that too often the nurses are considered interchangeable, from the administrator perspective (Morse, 1991: 464): “another nurse will be able to care for the patient without compromising the quality of care.” Morse argues that “in reality, this concept is nonsense. [- -] In the caring relationship, caregivers are not interchangeable” because every nurse has a different relation to the patient (Morse, 1991: 464). And the development of a good relationship often requires time.

Thus the possibility to unhurriedly perform the duties can be argued to be the most important external resource that enables the nurses to have caring

connections. At the same time, there was often a shortage of time. Thus the most important organizational intervention to give nurses unhurried time with the residents could arguably be to improve the ratio of nurses to residents in the nursing home[49]. One resident I interviewed had spent a year in a private nursing home before coming to the unit where she currently was [Resident 5]. During the interview she returned many times to the fact that in that nursing home, the nurses were much more available to the residents; they came immediately when you called them and had time to spend with you. In the current nursing home, you "must scream for help hour after hour," according to her [Resident 5]. It is not hard to find the explanation for this difference, given that the number of residents per nurse was four-fold in the current institution according to the resident.

More generally, the fact that in Finnish nursing homes the nurse-resident ratio is approximately half the amount compared to other Nordic countries (Kröger et al., 2009: 50) doesn't speak in favor of Finnish nursing homes' capacity to provide humane care. By pushing the nurses to their limits, and through different efficiency-increasing strategies, one might be able to produce care that on paper and in terms of certain quantifiable measures looks the same as more resource-consuming caregiving. One might be able to get the same number of residents out of bed, feed them, and change their diapers. What is lost, however, in such cost-cutting and rationalizing efforts are the more intangible dimensions of care. Waerness (1996: 245–246) argues against too formally planned caregiving work, on the basis that it easily leads to routinized, nonflexible care and the devaluation of the informally acquired and intuitive kind of knowledge and skills. One of the key insights of this dissertation is that these dimensions are precisely the dimensions that make the care humane and that are of paramount importance for the quality of life of the residents – and therefore for the real quality of the care.

[49] One might also speculate that this structural dimension influences the organizational culture. When there is a staff shortage and only the most immediately necessary functions can be carried out, it is hard to maintain a logic of care, while the logic of new public management is much more suitable for the realities one has to live with anyway.

PART V: CONCLUSION

Chapter 11: Discussion

> *"To stand in tradition and to heed it is clearly the way of truth that applies in the human sciences." (Gadamer, 1994: 29)*

In this chapter, the standard scientific procedure of discussing the novelty of the research findings, their generalizability, possibilities for future research as well as the theoretical and practical contributions will be carried out.

The novel insight of caring connections

This work set out to explore the caring situations between the nurse and the resident in a nursing home. In so doing, the two major contributions it makes to the existing literature is the introduction of *the taxonomy of caring situations* and the coining of the term *caring connection* and the elaboration of it. As for the first contribution – the taxonomy of caring situations – despite it being elusively simple, it has not been suggested before, as far as I am aware. Some researchers have made remarks about how the involvement of the care receiver also makes a difference in caregiving (e.g. Boykin & Schoenhofer, 2001), but no research I know of has made a systematic comparison of how the different attitudes of the care provider and care receiver play together in a caring situation. Especially the distinction between situations in which the resident is open for connection versus closed from it – in my terminology, one-sided caregiving and caring connection – is something I have been unable to find in existing discussions about caring relations. Therefore the taxonomy makes a quite straightforward contribution to the discussions about the relation between a care provider and a care receiver.

As of the second contribution – the introduction of the idea of *caring connection* into discussions about caregiving – to show that it really is a new construct, it becomes important to show how it differs from existing constructs. Therefore, I will in this section compare it to existing constructs within organizational research, nursing research, therapeutic research, and other relevant fields. The aim is to show that although there are constructs

that bear important resemblances to caring connection, it nevertheless makes an original contribution compared to these constructs.

Caring connections and organizational research

Starting with organizational research, there are four concepts within that tradition that I see as somewhat connected to caring connections: *high-quality connections* (Dutton & Heaphy, 2003), *compassion* (Kanov et al., 2004; Lilius et al., 2008), *caregiving* (Kahn, 1993), and *psychological presence* (Kahn, 1992).

Along with caring connections, high-quality connections involve both "a temporal as well as an emotional dimension" and can occur "as a result of a momentary encounter" (Dutton & Heaphy, 2003: 264). As already discussed in the literature review, high-quality connections (Dutton & Heaphy, 2003) have three defining characteristics: (1) higher emotional carrying capacity, (2) higher tensility, and (3) a higher degree of connectivity. In addition, they include three subjective experiences: (1) feelings of vitality and aliveness, (2) positive regard, and (3) felt mutuality. And as I already noted, all these characteristics could be used to describe caring connections as they are characterized by a high degree of connectivity, heightened affective levels, increased positive regard for one another, and felt mutuality. Through authentic presence, both persons also feel more vital and alive in these situations. Thus it can be argued that caring connections are a prime example of high-quality connections. But whereas high-quality connections aim to be a very general description of what a good relation between any two human beings can be like, caring connections aim to describe a more specific relation – that between a care provider and a care receiver. It aims to describe the special characteristics of high-quality connections within this form of relationship. Caring connections can therefore be seen as one interesting subtype of high-quality connections.

In his study of caregiving in organizations, Kahn (1993) distinguished eight dimensions of caregiving: accessibility, inquiry, attention, validation, empathy, support, compassion, and consistency. For him, caregiving is about a process in which "caregivers help others to help themselves toward growth and healing by simultaneously staying in relation with and keeping themselves apart from those others" (Kahn, 1993: 544). As I have discussed, Kahn's research is able to shed light on caregiving, and his explicit distinction between *caregiving* and *caretaking* has been especially useful

for the present research. The concept of *caring connection* adds the care receiver's contribution to the process. As I have argued, caregiving – the phenomenon that Kahn explores – can lead to *one-sided caregiving* or *caring connections* depending on how responsive the person cared for is in the situation. This is something that Kahn does not explicitly discuss, as his analysis concentrates on the care provider. Thus Kahn's concept of caregiving and caring connections have a different focus. Through focusing on the mutual moment that is built between the participants when both of them are engaged, the concept of caring connections thus expands Kahn's important research.

The same thing could be said about the relation between compassion (Kanov et al., 2004; Lilius et al., 2008) and caring connections. Kanov et al. (2004: 812, 814) define compassion as an "empathic emotional response elicited by another person's suffering that moves people to act in a way that will ease the person's anguish or make it more tolerable", and they suggest that it comprises of three interrelated elements: "'noticing' another's suffering, 'feeling' the other's pain, and 'responding' to that person's suffering." By including the action component as part of compassion instead of treating it as mere affection, this account of compassion bears important resemblances to accounts of caring and caregiving by nursing researchers (see e.g. Finfgeld-Connett, 2008a; Gordon et al., 1996a), and it would be interesting to compare them more. Nevertheless, compassion is about the caregiver's attitudes and ways of behaving, and thus the focus is different from caring connections. The emotional response elicited by compassion might lead the care provider to react to the care receiver's pain in a sensitive way, thus opening up the possibility for a caring connection to occur. But depending on the response of the care receiver, this can lead to either one-sided caregiving or a caring connection. Thus it can again be said that the concepts are related but their focus is different.

Similarly, Kahn's concept of psychological presence comes to describe some important dimensions of caring connections, but again the focus is different. Psychological presence is about the experiential state of being fully present and alive in a situation and involves four dimensions: attentiveness, connection, integration, and focus (Kahn, 1992: 322). In my description of the elements of caring connections, I showed how it relates to many of the dimensions I brought up, such as being present and opening up towards the other. Thus it can be argued that in caring connections, both participants are present in the sense given to the word by Kahn. Yet, while

Kahn focuses on what it is like for *one person* to be present, I focus on a situation when *two persons* are simultaneously present for each other and what emerges through this interaction.

Caring connections and nursing research

Turning to nursing research, we note that the theories of caring developed therein also mainly focus on the attitude and behavior of the care provider (e.g. Roach, 1984; Watson, 1985; see also Finfgeld-Connett, 2008a). For example, in McCormack & McCance's (2006: 476–477) conceptualization, there are five processes essential for person-centered care: (1) working with patient's beliefs and values, i.e. being knowledgeable about what the patient values and how the patient views the world, (2) sharing decision-making through negotiations with the patient, (3) engagement, the degree to which the patient and nurse are connected in the relationship, (4) having sympathetic presence is about an engagement that "recognizes the uniqueness and value of the individual by appropriately responding to cues," and (5) provision of physical care by a nurse who has the necessary professional competence for that. Here we see many of the characteristics of the caring connection (for example, validating the unique value of the other, being sympathetic and present towards the other, and acts of caregiving) discussed *from the point of view of the nurse*. So even though in person-centered care the other person takes the central stage, in conceptualizations of person-centered care the focus is on the care provider and how she takes the other into account.

Mok and Chiu's (2004) description of trusting and connected relationships also has similarities to caring connections. They acknowledge that a relationship can be mutual or unilateral and state that "whether a mutual relationship developed was dependent on whether both nurse and patient were willing to enter into the encounter" and how "the involvement of nurses and patients determined the depth of the relationship" (Mok & Chiu, 2004: 479). Nevertheless, when they describe how these relationships come into being, the focus shifts back to looking only at the nurse: "There were four themes in the development of a trusting and connected relationship: (1) understanding the patient's needs; (2) displaying caring actions and caring attitudes; (3) providing holistic care; and (4) acting as the patient's advocate" (Mok & Chiu, 2004: 479). Patients appear again in the discussion only when it is time to discuss how this relationship can contribute to their well-being. So although they recognize that the patient has a role in the

connected relationship, they fall short of exploring what this role is. As nursing researchers, they follow the usual path of looking at how the actions of the nurse can have a positive effect on the patient. In general, therefore, the present work breaks new ground by focusing especially on a situation where *both* care provider and care receiver are emotionally engaged and active in the situation.

There are, however, few concepts within nursing research that more readily acknowledge the involvement of the care receiver in the situation, and thus in showing the originality of my contribution, we need to focus especially on them. The first of these is the concept of *nursing situation* by Boykin and Schoenhofer (2001). Along with my conceptualization, they see these situations as an intersubjective "shared lived experience" (Boykin & Schoenhofer, 2001: 17). One can also find traces of many of the dimensions of a caring connection in their conceptualization: They talk for example about "authentic presence" and openness to "knowing the other as caring" as the acts of the nurse that initiate these situations (Boykin & Schoenhofer, 2001: 18).

A few important differences remain, however. Firstly, Boykin and Schoenhofer's concept has in many ways a much wider scope than that of caring connections. It is namely entangled with rather strong assumptions about human nature. As Boykin and Schoenhofer repeatedly emphasize, it is based on the assumptions that caring is **the** human mode of being and therefore everyone, including the caregiver and the care receiver, are all the time "living caring" (Boykin & Schoenhofer, 2001: 13). I, on the other hand, see that while caring might be **one** mode of being for humans, I am not willing to commit to a view where it is seen as the only possible way of being with others. Because of this background commitment, Boykin and Schoenhofer also see that every encounter between the nurse and the client is a nursing situation, because in every situation there are two people who are all the time caring in virtue of their humaneness (Boykin & Schoenhofer, 2001: 11). This doesn't seem to allow room for making distinctions between situations that are more characterized by mutual caring and situations in which such caring is quite invisible. Additionally, their account of nursing as caring seems to be simultaneously both a description of the nursing experience as well as an ethical ideal about how

the nurses should experience the nursing situations[50]. As they state, "the belief that all persons, by virtue of their humanness, are caring, establishes the ontological and ethical ground on which this theory is built" (Boykin & Schoenhofer, 2001: 1). Although I also have certain ethical commitments that have led me to choose this kind of research topic (see the introduction) and research approach, I am nevertheless not suggesting that every nurse should see all their encounters with their clients as caring connections.

Additionally, Boykin and Schoenhofer show no sign of sharing my insight that the care receiver can essentially block the establishment of a caring connection. Although they argue that the nursing situation is interpersonal, at the same time they maintain that an unconscious patient or even a deceased patient can be a participant in a nursing situation (Boykin & Schoenhofer, 2001: 18–19). This is because the nurse can still feel "a sense of connectedness" with them; they remain "an active part of **the nurse's experience**" (Boykin & Schoenhofer, 2001: 19 emphasis added). Therefore, as they explicitly state, the nursing situation is for them "a construct held by the nurse," it is "constituted in the mind of the nurse when the nurse conceptualizes or prepares to conceptualize a call for nursing" (Boykin & Schoenhofer, 2001: 17, 13). Thus it is primarily about the nurse's attitude towards, and experience of, the other and the situation they share. I have instead argued that a caring connection requires the active engagement and openness of both partners to the situation and focuses on what happens between them.

All in all, the concept of caring connection and the concept of nursing situation shed light on a similar phenomenon, but approach it from quite different angles. I attempt to describe through the concept of caring connections a certain form of interaction or connection that *sometimes* takes place between a care provider and a care receiver *when certain*

[50] This understanding of the theory as an ethical ideal can actually help to make sense of parts of it that otherwise seem hard to accept. For example, the idea that the client is *always* caring in his or her own life and even growing in this capacity to care (Boykin & Schoenhofer, 2001: 13) is quite hard to accept, as a description of the actual clients, some of whom can be (at least according to my experience) demonstrating quite opposite traits. But if we don't take it as a description of the actual attitude of the client but as a belief or attitude that the nurse should have towards the client, then it becomes much more understandable.

conditions are met. Boykin and Schoenhofer's ambitions are much broader: They aim to offer us a whole worldview that grows out of certain ontological and ethical commitments and within which the concept of nursing situation serves as *an ideal* about the attitude through which the nurse should *always* look at the caring situation.

Another concept of special interest to my conceptualization of the caring connection is Watson's discussion about an *actual caring occasion*. She sees that when the giving-receiving behaviors of a caring situation allow for a "contact between the subjective world of the experiencing persons," the caring is transpersonal (Watson, 1985: 58). By transpersonal, she refers to "an intersubjective human-to-human relationship in which the person of the nurse affects and is affected by the person of the other. Both are fully present in the moment and feel a union with the other. They share a phenomenal field which becomes part of the life history of both and are co-participants in becoming in the now and the future" (Watson, 1985: 58). An actual caring occasion then is an event, a focal point in space and time, in which an actual occasion of human care between two persons takes place. It presents both persons with the choice of how to be in the relationship and what to do in the moment. When the moment becomes transpersonal and "allows for the presence of the geist or spirit of both," then the event expands the limits of openness and expands the human capacities, because in these occasions, we enter into each other's experience and can learn from each other (Watson, 1985: 59). The values and views of both the nurse and the patient are thus present in the situation. Watson sees that the alternative to this caring as intersubjectivity is a situation in which both the nurse and the patient are reduced to objects (Watson, 1985: 60).

Along with my understanding of caring connections, Watson thus emphasizes how the actual caring occasion is co-constructed by the active participation of both the caregiver and the cared-for. She acknowledges the need for both participants to be present in the situation and how a shared space is established within them. For her also, however, the account of caring is more an ethical ideal grounded in certain ontological and ethical principles rather than an empirical description of actual caring situations. She sees how this kind of transpersonal caring relationship "is viewed as the moral ideal of nursing" (Watson, 1985: 63). Accordingly, she does not seem to make a clear distinction between what happens when the resident is non-engaged versus engaged but settles for highlighting in general that the nurse should take into account the active role of the patient. Her concern is

at educating the nurse to take the ideal nursing attitude rather than on offering accurate descriptions of the actual nursing practice. The present work thus aims to take the mutual engagement of the nurse and the patient from the ideological level down to actual practice by looking at when something like that can take place *and when not*.

The distinction between one-sided caregiving and a caring connection could also be useful in extending Noddings' analysis of caring. She struggles with the question of whether caring should be defined so that it necessitates that the cared-for recognizes this caring. In the end, she is forced to conclude that this indeed is the case: "Therefore, sadly, I must admit that, while I feel that I care, X does not perceive that I care and, hence, the relationship cannot be characterized as one of caring" (Noddings, 1984: 68). Instead of making this a crucial question, we could state that caring connections where the care is recognized are of course the most desired situations. But yet there is a significant difference to be made between instrumental caretaking and one-sided caregiving. Instead of an either-or choice between caring and non-caring, we can thus add more options and nuances by distinguishing between situations where either of the party is engaged or disengaged.

Caring connections and infant and therapeutic research

Finally, it must be acknowledged that a caring connection is closely related to three concepts within infant and therapeutic research: *dialogue as moments of real meeting* (Cissna & Anderson, 1998), *moments of meeting* (Stern, 1998), and *heightened affective moments* (Beebe & Lachmann, 2005).

Cissna and Anderson (1998) explore dialogue as moments of real meeting, an account which they derive from a discussion between Martin Buber and Carl Rogers. These moments are characterized by mutuality and permission for the other to be what they are. They are considered to be the instants when real therapeutic personality change occurs. Additionally, Cissna and Anderson (1998: 70) emphasize that the mutuality of these moments can develop even in unequal relationships, such as that between a therapist and a patient. They base their view on Buber's conception of dialogue in which "each of the participants really has in mind the other or others in their present and particular being and turns to them with the intention of establishing a living mutual relation between himself and them" (Buber, 1965: 19). According to Cissna and Anderson (1998: 65), the three

important elements of Buber's account are: "(a) an awareness that others are unique and whole persons, encouraging a turning toward the other and imagining the reality of the other; (b) a genuineness or authenticity that does not mandate full disclosure, but suggests that dialogic partners are not pretending and are not holding back what needs to be said; and (c) a respect for the other that inclines one not to impose but to help the reality and possibility of the other unfold."

Moments of meeting, in turn, are moments "in which the participants interact in a way that creates a new implicit, intersubjective understanding of their relationship and permits a new 'way-of-being-with-the-other'" (Stern, 1998: 300). Conceptualized by the Boston Change Process Study Group [hereafter the Boston Group], they occur when "the dual goals of complementary fitted actions and intersubjective recognition are suddenly realized" (Lyons-Ruth, 1998: 286). They are "jointly constructed" and involve each partner grasping and ratifying a similar version of "what is happening now, between us" (Lyons-Ruth, 1998: 286). For the Boston Group, moments of meeting are the "key element in bringing about change in implicit knowledge" (Stern, 1998: 300). They are partly inspired by Beebe & Lachmann's (2005: 174–175) conception of heightened affective moments – affectively supercharged moments between two participants that can trigger a state transformation in psychic structures of the participants and thus change their way of organizing experience.

Compared to the concepts discussed before, these three constructs more fully acknowledge the equal contribution of both participants to the situation, and caring connections clearly share many elements with these concepts. For example, the emphasis on mutuality, authenticity, permission for the other to be what they are, and respect for the other characteristic of moments of real meeting are directly applicable to caring connections. Similarly, many characteristics of moments of meeting could be used to describe caring connections: both are jointly constructed, affectively supercharged, and involve both participants ratifying a similar version of what is happening between them. Thus it seems that all these concepts have a similar core. The difference between caring connections and the other concepts lies in the nature of the relationship: stemming from an analysis of the therapeutic situation, the moments of real meeting, moments of meeting, and heightened affective moments all emphasize the growth and change of understanding that these moments make possible within the therapeutic relationship. The significance of these moments stems from the

fact that through them the therapeutic relationship can reach new levels and dimensions. As I have argued, caring connections also carry the potential to change and deepen the relationship between the nurse and the resident, but this dimension is not given such a central emphasis as with these concepts.

The main difference between these three concepts and a caring connection is that the experiences they focus on are a bit different. These concepts from the therapeutic context focus on the occasions that signal turning points in the therapeutic relation; situations that make a significant difference to the future unfolding of their relationships and even their lives more generally. Most of the caring connections are not so dramatic situations. They feel significant at the moment they take place and can contribute to the deepening of the relation, but they don't have to be turning points in the relationship of the participants. In addition, the acts of caregiving and displays of gratitude that are essential parts of the caring connections are not discussed within these three concepts, so that is the unique emphasis of caring connections[51]. Thus we could say that caring connections partially overlap these concepts, but not completely. Some occurrences of caring connections can also be moments of meeting (or heightened affective moments or moments of real meeting) in which the mutual relationship shifts to new levels. Some other occurrences of caring connections might not; they are 'only' good everyday moments within a long-term relationship between the caregiver and the cared-for.

So the concept of caring connection seems to bring something new into focus even if we take into account research within infant and therapeutic research. It focuses on a different kind of high point in the relation than what the therapeutic writers highlight. Within organizational and nursing research – the main fields of the present research – it makes a contribution by complementing existing descriptions of phenomena such as compassion, caregiving, psychological presence, person-centered care, and connected

[51] As the therapeutic relationship can also be seen as a caregiving relationship, there can often be acts of caregiving returned by displays of gratitude within these situations. Thus it can be argued that the concepts complement each other. We can learn more about the potential of caring connections for changing the relationship between the participants by reading about the therapeutic relationship. On the other hand, an analysis of caring connections can teach therapeutic writers more about the caregiving that is involved in their work.

relationships with taking the engagement and experience of the cared-for more fully into account and exploring what happens within the mutually constructed relational dimension that emerges when emotional engagement occurs dialectically between two human beings. This has not been done before to the extent it is done here.

Evaluating the credibility of the study

In judging my contribution, it is first important to note that what should be expected from a theory depends on the maturity of the field. In discussing methodological fit in management research, Edmondson and McManus (2007: 1158) argue that with a topic where little previous research exists, it is adequate to aim at a *nascent theory* in which one "proposes tentative answers to novel questions of how and why, often merely suggesting new connections among phenomena." In such research, the research questions are quite open-ended; the data is qualitative, consisting of interviews and observations; and the goal of data analyses are pattern identifications (Edmondson & McManus, 2007: 1160). It is this kind of explorative research that best advances the development of such a nascent field. Accordingly, given the lack of established knowledge about how the attitudes of care providers and care receivers work together, I have concentrated my efforts in suggesting new connections, novel concepts, and fresh ways to interpret existing phenomena. My hope has been that through such efforts, I have been able to generate interesting hypotheses that could intrigue future research efforts in these important yet unexplored topics.

According to Patton (1990, 1999), there are three questions that a qualitative study needs to address in order to be credible. Firstly, one needs to ask what methods and techniques were used to ensure the integrity, validity, and accuracy of the research findings. In addition to doing the analyses in a rigorous manner following the pathways and techniques of grounded theorizing, I used different data sources – 40 interviews and 13 days of observations – to widen the empirical basis upon which my results were built upon. In line with Patton (1999: 1195), I thus triangulated between different qualitative data sources. An additional form of triangulation was acquired through discussing my initial research findings with the research subjects themselves to get their feedback on the credibility and usability of my insights. I believe that through these

measures, the current research is able to fulfill the requirements for validity and accuracy currently in use for qualitative research in our field of study.

Because in qualitative studies, the researcher is the main research instrument, the second question is about the credibility of the researcher himself. What does the researcher bring to the study in terms of qualifications, experience, and perspective? (Patton, 1999: 1198). Here the most important rule is transparency. The reader of the study should become aware of all the possible biases the researcher might have that might influence his or her analysis. Accordingly, I have attempted to give a detailed account of the values and attitudes that have guided my research effort and that got me interested in the phenomena under study in the first place. I have tried to detail my previous knowledge of the research topic and how my knowledge and understanding progressed throughout the research process. And I have tried to be open about the attitudes and affections I have had towards the research subjects. Taking these out in the public allows the reader of the study to evaluate how they can affect the research results. This kind of transparency, rather than apparent objectivity, is under the pragmatic paradigm the best measure to ensure the credibility of the research.

The third question is about the credibility of the underlying research paradigm. This is a question about the underlying philosophical beliefs that provide the rationale for, and make worthwhile, the chosen research methods (Patton, 1999: 1206). According to Patton, much of the controversy around qualitative research stems from this level rather than from more concrete issues about the validated usage of the research methods. To this "paradigm debate" between the advocates for qualitative and quantitative research methods, I can only offer my pragmatically oriented abductive inquiry as a novel alternative, which I see as lending credibility to both ways of doing research. Pragmatic inquiry is about generating knowledge that is useful and, depending on the complexity of the phenomenon, the nature of the question, amount of previous knowledge about the phenomenon (see Edmondson & McManus, 2007), and other issues, in different cases different research strategies are justifiable. In my case, as the relational dimension between care provider and care receiver is complex, quite intangible, and a rather unexplored topic, the qualitative research approach was – as far as I see it – the most credible research strategy.

In terms of methodology, it can be argued that this dissertation has deviated in slight ways from the standard way of doing things within organizational research. Instead of being seemingly neutral, I have already in the introduction explicated the values and attitudes that have been the guiding lights of my research effort. This was made to comply with my basic pragmatic conviction – which I made clear in the methodology section – according to which all organizational research should in the end serve the practical purposes of actual organizational actors. This, combined with the understanding that the neutral viewpoint is an impossibility, leads one to understand that research should be a conscious attempt to steer one's understanding – in close interaction with the data and the theory – towards that route which one expects to be most fruitful in enhancing the life possibilities of the actual people who are the beneficiaries of one's research – in my case, primarily the nurses and other actors within the nursing home and secondarily any organizational actors who engage compassionately with one another.

By explicating and applying the pragmatic abductive method, I thus hope to have made a methodological contribution into organizational research. I personally believe that through the abductive fusing of theory and data, we have gained a deeper understanding of the relational dimension of organizational life within the nursing home than could have been achieved through deriving it solely from either of these sources. If this is true, it speaks in favor of the present research approach. As a whole, this work has been an attempt to apply this pragmatic understanding of organizational research into practice, to see what can be generated through going into a nursing home with this pragmatic research attitude. This work – in its strengths and weaknesses – is thus a demonstration of the usability of the pragmatic method as I have come to understand it. This research project represents my best effort to conduct research in a way that stays true to the tradition of organizational research at the same time it stays true to the basic pragmatic convictions that guide me both in my life and in scientific inquiry.

Generalizability and limitations

The characterizations of caring situations and caring connections have been obtained by observing the relations between nurses and residents in a nursing home context. Thus one can ask how much these results are

relevant outside of this particular environment. I argue that caring situations are not the unique feature of nursing but can take place in all organizations and between all organizational members. For example, Kahn (1993) derived his insights about caregiving by mainly observing the interaction between supervisors and subordinates. Similarly, I myself have in another paper focused on the caregiving relations between supervisors and subordinates on the one hand and on the caring connections between colleagues on the other hand. So although in this dissertation I have not touched upon these relations, during the course of this research, I also observed many encounters between two nurses and between the nurse and her supervisor that could be characterized as caring connections.

More generally, every organization consists of human beings who have human emotions, and thus the affective reality is "an integral and inseparable part of everyday organizational life" (Ashforth & Humphrey, 1995: 98). For example, Lively (2000) has shown how reciprocal emotion management plays an important role in the interaction and the reproduction of status differences between attorneys and paralegals in a law firm – a place that, by the looks of it, would be a haven for the bureaucratic rationality that Weber (1946: 216) looked for. It is thus no surprise that research has revealed "the great variety of ways in which individuals spontaneously reach out to others who are suffering" (Dutton et al., 2006; Kanov et al., 2004: 823). Despite the campaign of organizational administrators and organizational theorists to 'rationalize' the organization (for a discussion, see Ashforth & Humphrey, 1995: 101–108; Weber, 1946), we are human beings, after all, and we respond to one another's needs and suffering in affective ways. As argued by Lilius et al. (2008: 195), compassion – which they see as "one form of caregiving" – is also found "outside organizations designed explicitly for caregiving purposes." Every organization has its functional structure: the patterns of interaction that enable them to get work done. But every organization where human beings interact on a daily basis also has a more humane network of relations. The workers get to know each other personally, share facts about themselves that are not related to work, and become more sympathetic toward each other. These emotional dimensions of work relations might be overshadowed by the more functional aspects of the job, but nevertheless they are there and contribute to how workers relate to their work. For example, in a recent study it was found that employee perceptions of the workplace climate were related to customer perceptions of service quality

(Fischer, 2012). Tender mutual moments that go beyond work roles probably occur in every kind of work that involves face-to-face interaction with another human being. In appropriate situations, caring connections will occur between a supervisor and a subordinate, between two colleagues, between an employee and a client, or between any two human beings in or across organizations.

A special feature of the nurse-resident dyad that needs to be discussed is the roles they are in from the beginning: one is assigned the role of the caregiver and the other is seen as the one cared-for. In ordinary work relations, the one who is needy and the one who is the supporter are not determined from the beginning but emerge as a consequence of the other having a burden that needs to be shared. Although the interaction in caring connections might be more authentic and less role-dependent than in ordinary nursing situations, the roles are always in the background, ready to be applied if the situation would seem to transcend certain boundaries. It would be inappropriate, for example, for the nurse to disclose her own personal problems and expect caregiving and nurturing from the resident[52]. The situation thus is authentic and equal only within certain boundaries. Some other relationships, those between two colleagues, for example, would offer more flexibility in exchanging the roles of the one caring and the one taken care of. Exploring the similarities and differences between caring connections in different contexts would thus offer a natural line for future studies on the subject. It would, for example, be interesting to learn how an encounter between two human beings develops into a caring connection in situations where the relation is more symmetrical, for example between two colleagues, or to see how it works out in situations

[52] Yet even the roles between the nurse and the resident could sometimes be reversed, with the resident becoming the caregiver and the nurse taking the role of the one needing care. In the nursing home, I heard stories about nurses struck by a major misfortune in life who confided in a certain resident and got much needed support from him or her. So caring connections where the nurse is the careseeker and the resident is the caregiver were possible. Sometimes when the relationship of the nurse and the resident is deep enough and the resident is willing to take this role, even this could be acceptable and might even contribute to the well-being of the resident who would feel him- or herself as needed and able to contribute. Naturally, as this deviates much from their institutional roles, nurses would need to be very careful to make sure that the other is in this role out of his or her own will rather than feeling the role forced upon him or her by someone who has more institutional power.

where the relation is asymmetrical in a different way – for example between a superior and a subordinate. My belief is that in these relations, the initial stages towards a caring connection would be different, as participants have to negotiate who will assume the role of the cared-for. However, the latter stages, where the roles have already been established for this particular situation, would unfold in quite similar fashion as caring connections described here. Nevertheless, this needs to be investigated in the future.

In generalizing the results, one must also remember that all human beings do not have an equal craving for emotionally engaged interaction with others. In my empirical observations, I noted that some residents did not seem to have much need for any human contact beyond somebody taking care of the technicalities they couldn't manage themselves, while others were always seeking the attention of the nurses. This relates to Bowers et al.'s (2001: 541–542) distinction between different types of residents: *care-as-relating residents* "saw reciprocity as evidence of good relationships, and thus of good quality care", while *care-as-service residents*[53] felt that they "had the 'rights' accruing to any consumer." Thus one can argue that the benefits of entering a caring connection might be restricted to certain persons while some other persons are more indifferent to its effects.

Of special interest in this question is the influence of the care receiver's gender to the occurrence of caring connections. None of the three male residents I interviewed or attempted to interview expressed any recognition or interest in caring connections. As noted before, they stated that they didn't have a need to talk with the nurses and they otherwise made clear that they were not interested in any kind of humane contact with the nurses. This of course might be a mere coincidence given the small sample size. It might also be a result of some masculine stereotype that these men attempted to fulfill, which meant they were not willing to admit their dependency and their 'soft side' – especially to a younger man they had just met. But in my observations, I also noted that female residents were on average much more prone to engage in caring connections. Some – but definitely not all – men behaved so roughly and indifferently towards the nurses that they most probably never engaged in caring connections. As a personal example, the one resident who agreed to be interviewed but then didn't properly answer my questions yelled at me, "Stop babbling and lift

[53] It might be noted that in Bowers et al.'s (2001) research, the minority (4 out of 26) were in the latter *care-as-service* category.

me into the bed!" and similar replies as answers to my questions [Resident 6]. The nurses told me that this was quite typical behavior of his. More data that would concentrate especially on this issue would be needed to find out how gender-specific caring connections are. In any case, it is not the only case, as I witnessed other such encounters between a male resident and a nurse. This would be an interesting topic for future research. There is some indication in research that the issue of relatedness would be more important for women and that women would have more interdependent self-construals compared to men (see Cross & Madson, 1997). For example, in their large study of the role of culture and gender in individualistic versus relational construal of self, Kashima et al. (1995: 925) found that "gender differences are best summarized by the extent to which people regard themselves as emotionally related to others," and similarly, Hagerty et al. (1996) found in their empirical sample that sense of belonging was more strongly related to both social and psychological functioning of women than of men. In any case, despite the fact that caring connections might be more prevalent among female residents than male residents, I also observed caring connections where the resident was a male. So gender by no means totally determines whether one is interested in caring connections or not, and the potential gender differences don't take away the importance of the topic for a large part of the care receivers. Nevertheless, the influence of gender in caregiving and caring connections would be an interesting topic for future research.

When interpreting the results one, must also remember that the data were collected within one nursing home, and one might speculate that this limits the generalizability of the result. This is naturally a common weakness for this kind of explorative research, but I see this not as a major problem because of the intimate nature of caring connections as happening between two particular human beings makes it quite independent of organizational context. Although organizational culture and procedures might affect how often and how willing the nurses are to enter into such encounters, within these moments the experience is arguably not so much dependent on the organizational context. The encounter is more determined by the characteristics and mutual expectations of individual nurses and residents, and they mostly occur in situations where the organizational pressures are absent. Additionally, as I observed different units during my research, I got some experience how the leadership style and established practices of these different units influence the occurrence of caring connections. Based on

these insights of differences between different units, I would argue that although the larger organizational context might influence how often nurses are able to engage with the residents in a way that leads to a caring connection, the caring connections themselves were not dependent on the unit in which they happened but had the same characteristics in all units.

Future research

The insights about the taxonomy of caring situations and nature of caring connections gained in this research open up many paths for future research. Firstly, having established the concept of caring connections, it would be in place to attempt to explore its causal effects through a more quantitative approach. In their review of research on high-quality connections, Dutton and Heaphy (2003: 275), note how little organizational researchers have explored the effects of social relationships on human health and well-being. Although it seems evident from an understanding of basic human psychology and from the present qualitative study that caring connections will have a number of positive effects on resident well-being, work-related well-being, life satisfaction, work engagement and so on, it remains a task for the future to give empirical support for these hypotheses using quantitative methods.

Secondly, the research made it clear that, especially among residents, there were remarkable differences in the extent to which they engage in caring connections. Thus it would be important to research what personal characteristics predict engagement with the other in client relations and what characteristics are prone to lead the person to not be engaged. For example, attachment theory maintains that the attachment style acquired in childhood – secure, avoidant, or anxious – has an impact on one's interaction also in adulthood, especially in how one reacts to one another's displays of positive or negative emotions (see e.g. Mikulincer & Shaver, 2005). A securely attached person might find it easier to open up even in occupational relations than a person whose basic attachment style is avoidant and who accordingly might have significant problems in support-seeking (see Shaver & Mikulincer, 2006: 260–261). Also, the strategies that the care provider could use to engage a disengaged care receiver might be different depending on whether they are avoidant or anxious about close relationships. Similarly, personal characteristics such as extroversion versus introversion have an impact on a person's close relationship (see

Simpson et al., 2006) and most probably also influences whether a person is able to engage intimately with the care receiver or the care provider. Thus it would be important to investigate this dimension of the impact of personal characteristics of care providers and care receivers for the engagement level in caring situations. Both the individual effects of these characteristics as well as the reciprocal effects of certain characteristic combinations in the dyad deserve to be studied in the future.

Thirdly, significant progress in understanding caring connections and similar relations between nurses and patients as well as other organizational members could be achieved through the use of microanalytic time-series research methods that are currently used in infant research to explore the relation between the mother and the infant. In such research, a common method is to videotape the interaction, which then allows for a frame-by-frame analysis of the facial expressions of both participants, which makes it possible to see how their intersubjective interaction unfolds through reciprocal influence (e.g. Beebe et al., 2010). As I have argued, the relational interaction between the resident and the nurse carries many similarities to the relation between a mother and an infant. Therefore, to gain deeper insight into the intersubjective process that leads into caring connections, such a microanalytic approach could be fruitful. It could reveal how the attunement of the participants feed into the process.

Fourthly, it would be interesting to connect the research insights gained here with the emerging research on intrinsic and prosocial motivation. Intrinsic motivation means the extent to which the individual is motivated by the work itself and the opportunities for self-expression, growth, and enjoyment it offers, rather than by some external rewards or punishments (Amabile, 1993; Gagné & Deci, 2005; Grant, 2008). One special source of intrinsic motivation is the opportunity to have a prosocial impact on others (see Grouzet et al., 2005; Niemiec et al., 2009). Prosocial motivation can be defined as the "desire to expend effort to benefit other people" (Grant, 2008: 49; Batson, 1987). My experience was that the nurses often seemed to be intrinsically motivated to help the residents. Prosocial motivation seems to be especially effective source of work motivation when it is intrinsic in nature, as Grant (2008) found out in recent study. Thus it would be interesting to measure the intrinsic and prosocial motivation of the nurses and see how they connect to the quality of the care given as well as the work-related well-being of the nurses.

Finally, this research has focused on caring connections, moments where one participant is taking care of another. It could, however, be speculated that this situation is an occurrence of a more general form of meeting between two persons. When comparing caring connections with similar concepts (such as moments of meeting) within the therapeutic literature, I felt that despite their differences, they had much common ground. Perhaps both were subtypes of some more general phenomenon. It is not hard to come up with other examples of similar moments in other contexts. For example, when two good friends meet, it is easy to see the presence of five out of six characteristics of caring connections: mutual validation, being present, opening up to each other, establishment of a shared space, and heightened affectivity. Similarly, when I presented the elements of caring connections to one colleague, he immediately saw that the same dimensions could be present when the relation between a lecturer and his or her audience is at their best. He argued that the lecturer needs to be present, to show that one validates the audience, and to open up in order to engage the audience in the right way. This makes possible the flow of affections and the establishment of a shared space between the lecturer and the audience, in which one is able to care for the audience (understood here broadly to mean helping the other to grow), which shows gratitude for this caregiving. This of course is highly speculative at the moment, but one could argue that there is something akin to *humane encounter* that can happen between two or more individuals and of which caring connections are one special occurrence. Exploring this possibility offers one interesting path for future research.

Theoretical and practical contribution

I already discussed above how the introduction of the taxonomy of caring situations as well as the exploration of caring connections are novel contributions both within organizational research and in nursing research. The main contribution of this work is thus already established. However, here I will highlight a few more specific contributions that the present work makes into different discussions within organizational research and nursing research.

Contribution within organizational research

By offering organizational researchers a glimpse of what being humane might mean in relationships in an organizational context, the present

chapter contributes to the growing literature on positive aspects of working life. More specifically, it deepens our understanding of positive relationships at work. As Ragins and Dutton (2007: 3) argue, "scholars have yet to understand the dynamics, mechanisms, and processes that generate, nourish, and sustain positive relationships at work." By employing a relational perspective for understanding relations between care providers and care receivers, the contribution at hand offers a novel way to understand these processes as something happening primarily on the relational level between two individuals.

The present work also contributes to the research stream of compassion at work in many ways. Most importantly, by expanding the research perspective from the compassionate individual to also include the response of the recipient of compassion, it increases understanding of how compassion works in different situations and what kind of dynamics take place between the compassionate person and the recipient of compassion. For example, looking at the relevant research, Lilius et al. (2011: 875) conclude that "compassion is both effortful and potentially draining" for the person providing compassion. The present work argues that compassion might be draining in situations of one-sided caregiving, but when the other person responds warmly to compassion, the compassionate situation can actually be energy-giving and uplifting even for the compassion-provider.

Similarly, the present work makes an important contrast to the concept of emotional labor (Morris & Feldman, 1996; Totterdell & Holman, 2003), which has dominated organizational research on emotions. Emotional labor is seen as coercive and energy-draining (Niven et al., 2009: 220), while caring connections involve expressions of emotion that are energy-giving. Yet, on the surface level, the external expression of the same kinds of positive emotions characterizes both a person participating in a caring connection and a person who puts on the expected emotion through emotional work. The key difference is the authenticity of the positive emotions expressed. In caring connections, one does not have to force oneself to seem positive. The positive mood flows naturally from the situation and from the authentic personality of the employee. So expressing the institutionally prescribed emotions (Ashforth & Humphrey, 1995: 106–107) does not have to be energy-draining when the display of these emotions is authentic and flows naturally from the situation and from the personality of the employee. Along with the important contribution of Lopez (2006), my work thus makes the case for the possibility of non-

coercive organizational support for authentic emotional displays as an important part of caregiving work.

More generally, research on caring connections contributes to understanding how organizational members can be authentic and fully present at work (see Kahn, 1992) – how they can express their full humanity and authentic emotions within their work. Research on this topic looks at situations in which the employees are not just enacting their work roles but are being "fully there" with their various emotions, wishes, vulnerabilities, and values – and able to bring these "increasing depths of their personal selves into role performances" (Kahn, 1992: 324). In addition to Kahn's discussion of psychological presence, this kind of research has involved research on constructs such as personal engagement (Kahn, 1990; May et al., 2004), calling orientation (Hall & Chandler, 2005; Wrzesniewski et al., 1997), or meaningful work (Pratt & Ashforth, 2003). The present research adds to this stream of research by exploring the emergent possibilities of situations where two subjects together are able to more fully express their personalities for each other.

Additionally, one could argue that the present work makes some contribution to our understanding of how to create and maintain work-related well-being in organizations. As argued in the literature review, the research on work-related well-being has increasingly started to understand how social relations at work have a significant effect on the well-being or ill-being at work (see Bakker & Demerouti, 2007: 314; Haines et al., 1991; Johnson & Hall, 1988). This work helps us to understand what forms of relations at work could be contributing positively to well-being and what positive effects they might have.

Similarly, the concept of caring connections contributes to the literature on emotions at work, in turn, by offering a detailed description of a mutually constructed moment of affective arousal. Thus it aligns with those researchers who focus on the importance of the social dimension for the emergence of specific emotions and on the social nature of emotions more generally (see Barsade, 2002; Küpers & Weibler, 2008; Niven et al., 2009). It also shows that instead of viewing emotions as an irrational counterpart to rationality and thus something to be controlled for in organizations (Ashforth & Humphrey, 1995; Küpers & Weibler, 2008), there is a time and place for using one's emotional resources to connect with the client in a better way.

On a more theoretical level, the chapter makes a contribution to organizational research literature by bringing insights about intersubjectivity from therapeutic contexts into organizational research. Thus the chapter follows a similar path as Kahn has followed in some of his classical articles (e.g. Kahn, 1992, 1998) by borrowing insights and concepts from psychological theories and applying them to gain an increased understanding of organizational phenomena. Intersubjectivity offers an important alternative paradigm to the traditional isolated subject psychology, and the present work is a contribution to this growing stream of research that looks at organizational phenomena from this intersubjective perspective. More specifically, many of the representatives of relational psychoanalysis that are used here (e.g. Beebe & Lachmann, 2005; Stolorow et al., 2002) are to my best knowledge applied for the first time in an organizational context. As the relational psychoanalysis that they represent is becoming increasingly dominant in therapeutic contexts, bridging them into organizational research is an important contribution in itself.

Contribution within nursing research

Within nursing research, the present work contributes to the wide discussion about the nature of *caring* (see Finfgeld-Connett, 2008a) by offering an exploration of the relation of nurse's caring to the resident's response. It shows that even though the nurse's attitude and way of engaging might be the same, the situation might unfold in significantly different ways, depending on the resident. Although many theorists have made suggestions in this direction, not many have followed through the full implications of the role of the resident in their research.

Another discussion that caring connection contributes to is about *nurse's presence*. All in all, nurse's presence seems to connect to three elements of caring connections: mutual validation, being present, and opening up towards the other. For example, Doona, Haggerty and Chase (1997: 3) define nursing presence as "an intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to 'spend' herself on his behalf." It requires that the nurse is willing to engage intentionally in such an encounter (Finfgeld-Connett, 2006: 711). Milton describes what presence is about as follows: "In choosing to be present and bear witness to the mystery of being human, nurse and person coexist with the known and unknown

while constituting the reality that each human lives. Within multidimensional realms, the nurse chooses with human presence whether to bear witness–not bear witness and what to disclose–not disclose in the intersubjective nurse-person relationship" (Milton, 2002: 23). As is seen here, the three dimensions mentioned – validating the other, being present, and opening up – are more or less present in these discussions, but often they are not analytically separated from each other. This certain unclearness about the elements of presence makes different conceptualizations of presence hard to analyze and compare. Thus Finfgeld-Connett (2006: 708) was forced to conclude in her meta-analysis that at the moment, presence as a concept is "vague and difficult to delineate" as well as poorly defined and fragmented into numerous types. Through delineating between the validating of *the other,* the opening up of *oneself*, and the *temporal* dimension of being present, the work at hand could clarify our understanding of what different elements constitute a nurse's presence.

The present research also has implications for discussions about the influence of power for nurse-patient relationships (see Kettunen et al., 2002). In caring connections, the participants are in certain caregiving roles from the beginning and not in a symmetrical positions towards each other[54]. This brings the issue of power on the agenda: because of the institutional roles (and in this case also the physical fragility of the resident), it is not two equals who meet, but the resident must rely on the nurse to be able to do things and to get resources he or she wants. Therefore the nurse is from the outset the one equipped with more power to define what happens in the situation and what happens for the other.

Here it can be argued that although the roles and the power distance don't ever disappear completely, it is more in the background in caring connections than in other forms of caring situations. In situations of *calling for caring,* for example, the power distance is especially visible: the

[54] One could, however, argue that there is a certain reversal of the roles also within this asymmetricity. As already discussed, the nurse has usually ended up in the role of caretaker precisely because of her inner craving to take care of her fellow men. In a way, she needs the resident as much as the resident needs her. She needs the one taken care of to fulfill her feelings of caretaking. It could therefore be possible to analyze the situation by comparing it to the relation between a performer and her audience – or more philosophically, to Hegel's master-slave dialectic (see Hegel, 1977 [1807]).

resident longs for an engaged encounter with the nurse but has no means of bringing it forth if the nurse refuses to engage with him or her. In caring connections, however, the intentions of both the nurse and the resident are in harmony; both are looking for an engaged moment of interaction with each other. Thus they can more readily concentrate on being present in the situation beyond their institutional roles and more as the human beings they are. And as human beings, the one is in need of being cared for and seeks caregiving from the other, who in turn is ready to engage in caregiving with this other. The careseekers are thus actively giving the caregivers permission to help them rather than passively submitting to a form of care that is forced upon them. This, in turn, elicits a compassionate reaction in the potential caregiver, who thus responds to this need by providing caregiving. The grip of institutional roles is thus weakened on the persons, and they assume the roles of caregiver and cared-for more out of natural inclination. Thus, although they are not on equal footing because one person needs something that the other can provide, the equal worth of both is acknowledged more in caring connections than in more restricted forms of interaction where the power distance is more outspoken.

This aim towards diminishing the impact of the power distance is in accordance with the aims of humanistic nursing theorists, who argue as follows, for example:

> *The theory of Nursing as Caring proceeds from a frame of reference based on interconnectedness and collegiality rather than on esoteric knowledge, technical expertise, and disempowering hierarchies. In contrast, our emerging theory of nursing is based on an egalitarian model of helping that bears witness to and celebrates the human person in the fullness of his or her being, rather than on some less-than-whole condition of being. (Boykin & Schoenhofer, 2001: 16)*

Similarly, Sahlsten et al. argue that nurses can use the strategies of patient-centered communication – such as 'building close cooperation', 'getting to know the person', and 'reinforcing self-care capacity' as "a way of balancing the asymmetry in the nurse-patient relationship" (Sahlsten et al., 2009: 495). Thus the present work contributes to these discussions by showcasing one form of relation in which the power distance between the nurse and the resident is diminished.

Practical contribution for nursing

What then are the practical takeaways of the present work? Caring connections are moments that can be deeply satisfactory and well-being enhancing for both participants. As of now, the nurses often feel that they must 'steal time' from more important work tasks to have these moments. As I noted, they sometimes even have a bad conscience for following their senses and engaging in these moments. And bad conscience, in turn, has been found to be strongly related to burnout in nursing work (Juthberg et al., 2008). The present organizational structures and culture thus do not often encourage and reward the nurses for engaging in these moments. My hope is that through the present research, these moments can get a place in the vocabulary of the nursing community and thus be more recognized.

For the nurses, the emphasis on affections and caring connections can thus be seen as empowering. By highlighting the soft and affective issues that already are part of their everyday experience of work, I hope to give them vocabularies to talk about these issues and legitimize them to take these issues more seriously. I believe that most of the issues I have been able to represent here are already intuitively clear to the nurses. However, these intuitions easily drown under organizational discourses that emphasize more 'rational' and 'objective' matters. In a way, this research is thus about taking these intuitions, labeling them, and legitimating them through science to empower the nurses to trust them and take them more seriously, and accordingly to use them more in decision-making and in coordinating their behavior.

In addition, the nurses for whom I presented my work seemed to highly appreciate the fact that the work highlighted how some of the residents can be rude or hostile towards them. They felt that usually all descriptions of their work is 'politically correct' in the sense that all residents are described as needy and grateful for the care they receive. Against this, they felt that "it was important to recognize negative residents in addition to negative nurses" and that "for once, it has been acknowledged that the resident can be the one isolating herself and not responding positively to the care she receives." Recognizing that sometimes the patients can be hostile and that "it is not always the nurse's fault" can help the nurses deal with these situations and can mitigate the guilt they sometimes felt after such situations. Even if all the nurses have implicitly known that the residents are very different in terms of their responsiveness, simply the fact that one is allowed to state that aloud can help them in dealing with the different

resident and the negative emotions that an encounter with them might give rise to.

For the political decision-makers and administration of caregiving institutions, the primary message of this work is about reminding that in addition to the measurable targets and financial performance of caregiving organizations, there is a vast and enormously important dimension that cannot be captured in numbers. As of today, there are many organizational structures that discourage and hinder the full blossoming of this relational and affectionate dimension within caregiving organizations. And the trend of the last decades has been to further emphasize and devote time and attention to these measurable dimensions. The quality of caregiving – which is not always the same as the measured quality – would benefit from more initiatives that, instead of pre-empting affections, would encourage and reward caregiving behavior, such as caring connections between the nurses and residents, which I see as essential parts of any good quality caregiving work.

Against the proponents of the new public management, I thus argue that organizations such as nursing homes cannot be managed through an approach that focuses only on the bottom line and the production of the same tangible targets with the same financial input. The most important dimension of caregiving – the humane connection between the care provider and care receiver – is lost in such efforts to rationalize caregiving organizations. If caregiving organizations are to be rationalized, they should be rationalized through the *rationality of caring*.

For the head nurses, who as 'middle managers' have to balance between the institutional demands from above and the everyday realities of their work units, the benefits are a mixture of these both. As policy-makers, these results can assist them in designing ways of working within the work units that better enable the soft and tender dimensions of organizational lives to blossom. As members of the actual work communities, these results can increase their own ability to attend to these dimensions through their everyday interaction with the nurses and their clients.

Additionally, my research has emphasized authenticity as a central building block for caring connections. It can be argued that to be able to authentically display the right kind of emotional tenderness in the caregiving situation, the nurse must from the beginning be equipped with enough emotional sensitivity. Mere technical employment of ready-learned

techniques is not enough, but instead, the right kind of emotional responsiveness must flow from within the nurse. In fact, based on their study of institutions for the mentally retarded, Abrahamsson and Söder (1977; reported in Waerness, 1996: 245) argue that formal training can even promote a tendency to more routinization and thus decrease the nurses' ability to adapt to individual patients in the right kind of way. This carries consequences for nursing education – both in how to select the right candidates for the education and what to teach them. Based on this research, I would suggest that the capacity for empathy should be a central selection criteria in choosing the students in the first place. In addition, teaching the students compassion, empathy, and attunement – instead of socializing them for too much scientific rationality (see Waerness, 1996: 245) – should be given a central place in the curricula.

Practical contribution for organizational actors

Beyond nursing, increased appreciation of caregiving and caring connections is beneficial for a member of any organization because "at any given time, some organizational members will be struggling" with personal challenges that derive from either within or outside of work and appropriately compassionate reactions to these sufferings can be beneficial through a number of ways, including increased commitment to the workplace, better recovery from the suffering, and improved mood of all parties involved (Lilius et al., 2011: 874). So although a nursing home is an extreme case for exploring caring behaviors (Starbuck, 2006: 149–150; Yin, 2009: 47) – an organization in which the relational, affective dimensions of human togetherness are especially visible and therefore a good target for explorative inquiry – it doesn't mean that these caring connections would be restricted to only this kind of organization. Caring situations occur in every kind of organizations in which human beings meet, and wherever they occur, they have the potential to create mutual well-being for both participants. Therefore, the concepts and understanding developed in this research could be used in all kinds of organizations to make sense of the more or less underlying relational and affective currents that always play a prominent role when people come together, interact, and attempt to act together.

Organizational cultures can be understood to consist of symbols (Golden-Biddle et al., 2007: 291), and therefore the words used within them matter. By giving the employees the vocabulary to talk about caring issues, my

attempt is to empower them to make more of these phenomena and to not have bad consciences about them. At the same time, the conceptualization of these moments could in the best case lead to organizations adopting policies that encourage these encounters rather than discourage them. I believe that this form of development would lead to more healthy organizations and improved well-being for all organizational members.

More generally, the movement of positive psychology has highlighted how our understanding of different negative affects is relatively established, but positive affects need still a lot more exploration (see Algoe et al., 2010). This is true even outside of research circles. I feel that we often are still lacking of the vocabulary to talk about and make sense of the positive experiences in our lives. The concept of caring connection can thus help anyone who is in a caring situation to better understand what the situation is about and how to be in it in a way that brings forth positive outcomes. As Wuthnow (1991: 49–50) argues, "having a language to describe our motives for caring is one of the ways in which we make compassion possible in the individualistic society in which we live." The present work contributes to our general understanding of what can take place between me and someone else if we mutually and compassionately engage with each other. Thus it can encourage people to be more caring and engaged with each other in their lives.

Chapter 12: Concluding remarks

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

-T. S. Eliot, Little Gidding

Having discussed the potential for generalizations, limitations, future research as well as the theoretical and practical contributions of caring connections in the last chapter, it is time here to draw the strings together and present some more general conclusions about the research process, share with the reader some personal impressions that the work gave rise to, and set the work in a larger context – as an example of research that aims to strengthen the relational viewpoint within our society.

The research

Conducting research is a journey. Ultimately, it is about moving from one horizon of understanding to a novel one (cf. Gadamer, 2004 [1960]). Ideally, this movement of thought is felt as an advancement. It widens the researcher's world horizon, widens the basis of observations upon which the researcher's worldview is built and is able to make sense of these observations better than the old perspective. Given the pragmatic paradigm, there is no need to claim that the understanding arrived at the end of the journey is somehow more 'objective' or closer to any ultimately correct way of understanding the world[55]. It remains an open question whether there can be any objectively correct way of understanding the world – especially the social reality – and the pragmatist equipped with his or her fallibilistic attitude remains quite skeptical about such a possibility. What pragmatism claims instead is that some perspectives can be better than others in enabling people to live good and meaningful lives. Ultimately, scientific research is about generating such understanding through a process that follows the rigorous standards set out by the scientific community.

[55] Peirce might – but just might – disagree here (see e.g. Peirce, 1878), but let us not go into that debate and stick to the interpretation of pragmatism given in Chapter 4.

The virtues that make the transition to the new perspective sensible are about the new perspective being more tested, more explainable, and more life-enhancing. Living the life through the new perspective should enable people adopting it to live their lives with a better understanding of the ways to make their lives good. And for the new perspective to be scientific, it needs to be accepted by the scientific community. This means that the research process needs to be honest, transparent, and self-corrective. It means that the researcher needs to be aware of the relevant existing literature and should build his or her contribution upon it, standing on the shoulders of giants. The research process and its results need to be reported in the proper way following the standards of reporting of the chosen field. The most important thing in reporting is transparency. The reader should be able to follow the development of the argument – see how the researcher arrived at the results given his or her preunderstanding of the subject, his or her values, the theoretical literature, the empirical data, and the reasoning process. Especially the values and attitudes of the researchers should be seen as an inescapable part of any research project. Explicitness, rather than discretion, should be understood as the best way to cope with this dimension of research that otherwise might be seen to jeopardize the 'objectivity' of the research. These are in brief the virtues that have guided this research process and the writing of the document that you are presently reading.

Personal impressions of the author

On a more personal note, Bradbury & Lichtenstein (2000: 551) argue that a researcher taking intersubjectivity seriously "will be conscious of the impact of her/his research on what is being researched, and too on how that research impacts her/himself." Having now researched relationality and caregiving within a nursing home for roughly three years, I feel how my own sense of appreciation for this humane dimension in all of us has heightened. I feel that through observing these moments, I have acquired a greater appreciation of the humanity within others and the humaneness within myself. In the end, my objectives for doing research have been – and will be – humanistic. My hope is that this kind of research will increase the appreciation of this humane level of our existence against the individualistic and rationalistic currents of today's era. I see that this commitment to the betterment of the human condition for all of us doesn't diminish the scientific value of my contribution.

In entering the nursing home, my deepest wish was that through my research effort I could contribute positively to the peoples' lives for whom that place is everyday reality. The overarching orientation in this work could thus be stated to be that of generating knowledge that moves the nursing homes towards more flourishing. On an individual level, to be flourishing is "to be filled with positive emotion and to be functioning well psychologically and socially" (Keyes, 2002: 210, 2007). Flourishing organizations are then organizations in which these positive qualities are present, both in the individual organizational members' lives as well as in their interactions (cf. Bakker & Schaufeli, 2008). The purpose of elder care is to give elderly persons the possibility to live a life worth living even in their latter years when they become more dependent on outside assistance to achieve this. My observations made me convinced that the well-being of the residents and the nurses – and the organization at large – are intertwined. In addition to the basic fact that human moods spread through interaction, it was easy to see that when the nurses' spirits were high, they had the energy, the motivation, and the talent to give good care to the residents. And when the residents felt good, the sense of satisfaction and achievement as well as the gratitude they received made the nurses feel better. Flourishing nursing homes are therefore about the residents living a worthwhile life and all the organizational members feeling well. In this spirit, the present work has attempted to explore the relational encounter between a caregiver and a care receiver, which has been overlooked by the more individualistic paradigm, but which contributes to this flourishment of nursing homes and accordingly should receive more attention and be the target of more conscious improvement efforts.

What have we then achieved in this research project? As discussed in the previous chapter, this research has highlighted the significance of caring connections for nursing home life and for the well-being of both the nurses and residents. It is my conviction that through giving more attention and encouraging the occurrence of these moments, the well-being and flourishment of both the residents and nurses could be greatly improved. On a larger scale, the research has highlighted what the interaction between two human beings can be at best, when the interpersonal dimension between them is flourishing.

What I have not discussed in this work at any length are the financial and efficacy benefits that could be achieved through advancing the new relational way of understanding organizational life that has been

documented here. This has been a conscious choice. I believe that there is also a case to be made why taking relationality and caregiving more into account in making sense and managing organizational life would benefit the organizations in financial terms[56], and building and examining such a case is a vitally important research topic. Yet I have left it for others to explore this dimension of relationality. The danger is that in the current efficacy-emphasizing thought climate, even a brief concentration on such issues could too easily blind us from seeing and discussing the intrinsic benefits that a more relational understanding of organizational life ought to have for the well-being and sense of meaning of the actors involved. Thus, to counter the balance of overemphasizing the financial and productivity-related benefits in discussing organizations, I have consciously chosen to underemphasize these issues and concentrate almost exclusively on the benefits of relationality for organizational actors' well-being and other similar dimensions. While financial matters are always just a means to something else, the well-being of human beings is intrinsically worthwhile and therefore a justification for this research in itself.

Towards a more relational reality

Finally, as a way of concluding, let's transcend the organizational boundaries and talk briefly about the human condition. I believe that as humans, we are deeply relational beings and the desire for interpersonal attachment is a basic human need (Baumeister & Leary, 1995). We need to belong to a community that accepts us and in which we can feel safe and in which we can securely be ourselves. Aristotle famously acknowledged that we are social animals – an insight that in the 20th century got its expression through Heidegger's (1962 [1927]) idea that one of the essential modes of being for a human is that of *being-with others*. We are beings-in-relationships – to be human is to be among other people and to be embedded in social life. And to be human is to feel compassion in the face of another's suffering and respond with caregiving behavior (Goetz et al., 2010). We should not let our eyes get blinded by the modern individualistic ideology to not see this fundamental fact about the human condition.

[56] One place to start to build such a case are Wright and Cropanzano's (2007) research on the happy/productive worker thesis.

As humans, we thus need to be in relations in which we are acknowledged, appreciated, and accepted. Because of the breakdown of many traditional communities (see Tarlow, 1996: 81), the role of the work community as a fulfiller of this basic human need has increased. More than ever, we need to be embedded in work communities that are more than mere aggregates of people operating together to exchange their labor for a salary. We need work communities that are communities in the true meaning of the word – recognizing us also on the affective and relational levels. Yet the rationalistic-bureaucratic understanding of working life, which ignores and even consciously downplays this dimension, still dominates much of our thinking about organizational reality. Thus research that looks at the work community from the point of view of how it enhances or restrains the maintenance of well-being of individuals understood as relational and affective beings is crucially important for our times.

The present research is one small step that aims to advance this more holistic understanding of individuals at work and working life in general. Research is a way of altering the socially negotiated reality in which our life is embedded. As Ghoshal (2005: 76) has convincingly argued, "many of the worst excesses of recent management practices have their roots in a set of ideas that have emerged from business school academics over the last 30 years." We can change those practices by changing our thinking. Particularly, we need to change our way of understanding the nature of human beings – at work and more generally. Thinking of human beings as individualistic and egoistic creatures interested only in their own, mainly financial, benefit will make us treat them as such – and as people respond to social expectations, they start to behave as such. Thus individualistic egoism is a self-fulfilling prophecy that has started to have a too dominant grip on our societies.

Luckily, an alternative future is possible – a more relational future in which people's natural inclinations for compassion, caregiving, and empathy (see e.g. Goetz et al., 2010) play a central role. This future is made possible by us changing our habituated thought patterns about what it is like to be a human being. Gergen (2009: xvi) expresses his positive vision in stating that "if human connection can become as real to us as the traditional sense of individual separation, so do we enrich our potentials for living." I share his vision that through an acknowledgement of our relational nature, we can generate a more caring society in which people are more considerate about the well-being of others and consequently are more well-being

themselves. In a word, I believe that a society occupied by more relational beings is a more flourishing society than what a society of egoistic individuals can ever be. In this dissertation, I have attempted to reach towards that vision. My purpose has been to show how we can enrich our understanding of human relations within a nursing home through observing caring connections and how an increasing appreciation of them would lead to improved well-being for all organizational actors. Because the atmosphere of the nursing home is more affective and tender than in most other organizations and because the compassion and caregiving are so visible there, the nursing home reality is able to highlight for us many of the qualities that make life worth living. These qualities I would like to carry over to other organizations and other forms of human interaction. For me personally, the most convincing evidence that an alternative future is possible has been to see how an experienced and empathetic nurse meets a resident in a considerate and affectionate way to offer tender and compassionate caring for her in a way that elevates both of them. Accordingly, I will close by the apt words of Wuthnow (1991: 308–309):

> *"Compassion has meaning for us all. It enriches us and ennobles us, even those of us who are neither the care givers nor the recipients, because it holds forth a vision of what a good society can be, provides us with concrete examples of caring that we can emulate, and locates us as members of the diffuse networks of which our society is woven."*

References

Abbott, A. 2004. ***Methods of discovery: Heuristics for the social sciences***. New York: W. W. Norton & Co.

Abrahamsson, B., & Söder, M. 1977. ***Makten och verksamheten: Om villkor och verksamhet vid vårdhemsavdelningar***. Uppsala: Acta Universities Upsaliensis.

Aiken, L. H., Clarke, S. P., & Sloane, D. M. 2002. Hospital staffing, organization, and quality of care: cross-national findings. ***International Journal for Quality in Health Care***, 14(1): 5–13.

Alexander, T. M. 1990. Pragmatic imagination. ***Transactions of the Charles S. Peirce Society***, 26(3): 325–348.

Algoe, S. B., Fredrickson, B., & Chow, S.-M. 2010. The Future of Emotions Research within Positive Psychology. In K. M. Sheldon, T. B. Kashdan, & M. F. Steger (Eds.), ***Designing positive psychology: Taking stock and moving forward***: 115–132. New York: Oxford University Press.

Algoe, S. B., & Haidt, J. 2009. Witnessing excellence in action: the "other-praising" emotions of elevation, gratitude, and admiration. ***The Journal of Positive Psychology***, 4(2): 105–127.

Algoe, S. B., Haidt, J., & Gable, S. L. 2008. Beyond reciprocity: Gratitude and relationships in everyday life. ***Emotion***, 8(3): 425–429.

Alvesson, M. 1996. Leadership studies: from procedure and abstraction to reflexivity and situation. ***The Leadership Quarterly***, 7(4): 455–485.

Alvesson, M., & Kärreman, D. 2007. Constructing mystery: Empirical matters in theory development. ***Academy of Management Review***, 32(4): 1265–1281.

Alvesson, M., & Sköldberg, K. 2009. ***Reflexive Methodology: New Vistas for Qualitative Research: Second Edition***. London: Sage Publications.

Amabile, T. M. 1993. Motivational synergy: Toward new conceptualizations of intrinsic and extrinsic motivation in the workplace. ***Human Resource Management Review***, 3(3): 185–201.

Andersen, S. M., & Chen, S. 2002. The relational self: An interpersonal social-cognitive theory. ***Psychological Review***, 109(4): 619–645.

Aristotle. 2009 [350 B.C]. ***Nicomachean ethics***. (D. Ross & L. Brown, Trans.). Oxford: Oxford University Press.

Asch, S. 1952. ***Social Psychology***. Englewood Cliffs, NJ: Prentice-Hall.

Ashforth, B. E., & Humphrey, R. H. 1993. Emotional Labor in Service Roles: The Influence of Identity. ***The Academy of Management Review***, 18(1): 88–115.

Ashforth, B. E., & Humphrey, R. H. 1995. Emotion in the Workplace: A Reappraisal. ***Human Relations***, 48(2): 97 –125.

Ashforth, B. E., Kreiner, G., Clark, M., & Fugate, M. 2007. Normalizing dirty work: Managerial tactics for countering occupational taint. ***Academy of Management Journal***, 50(1): 149–174.

Bacal, H. A., & Herzog, B. 2003. Specificity theory and optimal responsiveness: An outline. ***Psychoanalytic Psychology***, 20(4): 635–648.

Baert, P. 2003. Pragmatism, realism and hermeneutics. ***Foundations of Science***, 8: 89–106.

Bakhtin, M. 1981. ***The dialogic imagination***. (M. Holquist & C. Emerson, Trans.). Austin: University of Texas Press.

Bakker, A. B., Le Blanc, P., & Schaufeli, W. B. 2005. Burnout contagion among intensive care nurses. ***Journal of Advanced Nursing***, 51(3): 276–287.

Bakker, A. B., & Demerouti, E. 2007. The Job Demands-Resources model: state of the art. ***Journal of Managerial Psychology***, 22(3): 309–328.

Bakker, A. B., Demerouti, E., de Boer, E., & Schaufeli, W. B. 2003. Job demands and job resources as predictors of absence duration and frequency. ***Journal of Vocational Behavior***, 62(2): 341–356.

Bakker, A. B., Emmerik, H., & Euwema, M. C. 2006. Crossover of burnout and engagement in work teams. ***Work and Occupations***, 33(4): 464–489.

Bakker, A. B., Hakanen, J., Demerouti, E., & Xanthopoulou, D. 2007. Job resources boost work engagement, particularly when job demands are high. ***Journal of Educational Psychology***, 99(2): 274–284.

Bakker, A. B., Killmer, C., Siegrist, J., & Schaufeli, W. B. 2000. Effort-reward imbalance and burnout among nurses. ***Journal of Advanced Nursing***, 31(4): 884–891.

Bakker, A. B., & Schaufeli, W. B. 2008. Positive organizational behavior: Engaged employees in flourishing organizations. ***Journal of Organizational Behavior***, 29(2): 147–154.

Bakker, A. B., Schaufeli, W. B., Leiter, M., & Taris, T. W. 2008. Work engagement: An emerging concept in occupational health psychology. ***Work & Stress***, 22(3): 187–200.

Baron-Cohen, S. 1997. ***Mindblindness: As essay on autism and theory of mind***. Cambridge, Mass.: MIT Press.

Barsade, S. G. 2002. The ripple effect: Emotional contagion and its influence on group behavior. ***Administrative Science Quarterly***, 47(4): 644–675.

Barsade, S. G., Brief, A. P., & Spataro, S. E. 2003. The affective revolution in organizational behavior: The emergence of a paradigm. In J. Greenberg (Ed.), ***Organizational behavior: The state of the science***: 3–52. Mahwah, NJ.: Lawrence Erlbaum Associates.

Barsade, S. G., & Gibson, D. E. 2007. Why does affect matter in organizations?. ***The Academy of Management Perspectives***, 21: 36–59.

Batson, C. D. 1987. Prosocial motivation: Is it ever truly altruistic? In L. Berkowitz (Ed.), ***Advances in experimental social psychology, Vol. 20***: 65–122. New York: Academic Press.

Batson, C. D., Sager, K., Garst, E., Kang, M., Rubchinsky, K., & Dawson, K. 1997. Is empathy-induced helping due to self-other merging?. ***Journal of Personality and Social Psychology***, 73(3): 495–509.

Baumeister, R. F., & Leary, M. R. 1995. The need to belong: Desire for interpersonal attachments as a fundamental human motivation. ***Psychological bulletin***, 117(3): 497–497.

Baumeister, R. F., & Vohs, K. D. 2002. The pursuit of meaningfulness in life. In C. R. Snyder & S. J. Lopez (Eds.), ***Handbook of positive psychology***: 608–618.

Beebe, B., Jaffe, J., & Lachmann, F. 1992. A dyadic systems view of communication. ***Relational perspectives in psychoanalysis***, 61–81.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, M. 2000. Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. ***Infant Mental Health Journal***, 21(1-2): 99–122.

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., et al. 2010. The origins of 12-month attachment: A microanalysis of 4-month mother–infant interaction. ***Attachment & human development***, 12(1): 3–141.

Beebe, B., Knoblauch, S., Rustin, J., & Sorter, D. 2003. Introduction: A systems view. ***Psychoanalytic Dialogues***, 13(6): 743–775.

Beebe, B., & Lachmann, F. 2003. The relational turn in psychoanalysis: A dyadic systems view from infant research. ***Contemporary Psychoanalysis***, 39(3): 379–409.

Beebe, B., & Lachmann, F. 2005. ***Infant research and adult treatment: Co-constructing interactions***. New York: The Analytic Press.

Bellah, R. N., Sullivan, W. M., Tipton, S. M., Swidler, A., & Madsen, R. P. 1985. ***Habits of the Heart***. Berkeley, Ca.: University of California Press.

Benner, P., & Gordon, S. 1996. Caring practice. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: 40–55. Philadelphia, Pa.: University of Pennsylvania Press.

Berg, L., & Danielson, E. 2007. Patients' and nurses' experiences of the caring relationship in hospital: an aware striving for trust. ***Scandinavian Journal of Caring Sciences***, 21(4): 500–506.

Berg, L., Skott, C., & Danielson, E. 2006. An interpretive phenomenological method for illuminating the meaning of caring relationship. ***Scandinavian Journal of Caring Sciences***, 20(1): 42–50.

Berscheid, E. 1999. The greening of relationship science. ***American Psychologist***, 54: 260–266.

Bertalanffy, L. von. 1968. ***General systems theory***. New York: Braziller.

Bion, W. R. 1962. ***Learning from experience***. London: Heinemann.

Bolino, M. C., Turnley, W. H., & Bloodgood, J. M. 2002. Citizenship behavior and the creation of social capital in organizations. ***Academy of Management Review***, 27(4): 505–522.

Boston Change Process Study Group. 2002. Explicating the implicit: The local level and the microprocess of change in the analytic situation. ***International Journal of Psycho-Analysis***, 83(5): 1051–1062.

Boston Change Process Study Group. 2005. The "something more" than

interpretation revisited: sloppiness and co-creativity in the psychoanalytic encounter. ***Journal of the American Psychoanalytic Association***, 53(3): 693–729.

Boston Change Process Study Group. 2007. The foundational level of psychodynamic meaning: Implicit process in relation to conflict, defense and the dynamic uncounscious. ***International Journal of Psychoanalysis***, 88: 843–860.

Boston Change Process Study Group. 2010. ***Change in psychotherapy: A unifying paradigm***. New York: Norton.

Bowers, B. J., Fibich, B., & Jacobson, N. 2001. Care-as-service, care-as-relating, care-as-comfort. ***The Gerontologist***, 41(4): 539–545.

Boykin, A., & Schoenhofer, S. O. B. 2001. ***Nursing as caring: A model for transforming practice***. Sudbury, Ma.: Jones & Bartlett Learning.

Bradbury, H., & Lichtenstein, B. M. B. 2000. Relationality in Organizational Research: Exploring The Space Between. ***Organization Science***, 11(5): 551–564.

Brief, A. P., & Weiss, H. M. 2002. Organizational behavior: Affect in the workplace. ***Annual review of psychology***, 53: 279–308.

Brown Wilson, C. 2009. Developing community in care homes through a relationship-centred approach. ***Health & Social Care in the Community***, 17(2): 177–186.

Bruner, J. 1983. ***Child's talk: Learning to use language***. New York: W. W. Norton.

Bruner, J. S. 1997. ***The culture of education***. Cambridge, Mass.: Harvard University Press.

Bryant, A., & Charmaz, K. 2007. Introduction: Grounded Theory Research: Methods and Practices. In K. Charmaz & A. Bryant (Eds.), ***The SAGE Handbook of Grounded Theory.*** 1—28. London: Sage.

Buber, M. 1965. ***Between man and man***. (R. G. Smith, Tran.). New York: MacMillan.

Buber, M. 1987 [1923]. ***I and Thou***. (R. G. Smith, Tran.). New York: Scribner's.

Buckingham, M., & Coffman, C. 1999. ***First, Break All the Rules: What the World's Greatest Managers Do Differently***. New York: Simon & Schuster.

Buirski, P. 2007. ***Practicing intersubjectively***. Plymouth: Jason Aronson.

Burton, B. K., & Dunn, C. P. 1996. Feminist ethics as moral grounding for stakeholder theory. ***Business Ethics Quarterly***, 6(2): 133–147.

Burton, B. K., & Dunn, C. P. 2005. The caring approach and social issues in management education. ***Journal of Management Education***, 29(3): 453–474.

Buunk, B. P., & Schaufeli, W. B. 1999. Reciprocity in interpersonal relationships: An evolutionary perspective on its importance for health and well-being. ***European review of social psychology***, 10(1): 259–291.

Caers, R., Bois, C. D., Jegers, M., Gieter, S. D., Cooman, R. D., & Pepermans, R. 2008. Measuring community nurses' job satisfaction:

literature review. ***Journal of Advanced Nursing***, 62(5): 521–529.

Calori, R. 2000. Ordinary theorists in mixed industries. ***Organization Studies***, 21(6): 1031–1057.

Cameron, K. S., & Caza, A. 2004. Contributions to the discipline of positive organizational scholarship - Introduction. ***American Behavioral Scientist***, 47(6): 731–739.

Cameron, K. S., Dutton, J. E., & Quinn, R. E. 2003. Foundations of positive organizational scholarship. In K. S. Cameron, J. E. Dutton, & R. E. Quinn (Eds.), ***Positive organizational scholarship: Foundations of a new discipline***: 3–13. San Francisco, CA: Berrett-Koehler.

Cameron, K. S., & Lavine, M. 2006. ***Making the impossible possible: Leading extraordinary performance – the Rocky Flats story***. San Francisco, CA: Berrett-Koehler.

Caris-Verhallen, W. M. C. M., Kerkstra, A., van der Heijden, P. G. M., & Bensing, J. M. 1998. Nurse-elderly patient communication in home care and institutional care: an explorative study. ***International Journal of Nursing Studies***, 35(1-2): 95–108.

Carlsen, A. 2006. Organizational becoming as dialogic imagination of practice: The case of the Indomitable Gauls. ***Organization Science***, 17(1): 132–149.

Carmeli, A., Brueller, D., & Dutton, J. E. 2009. Learning behaviours in the workplace: The role of high-quality interpersonal relationships and psychological safety. ***Systems Research and Behavioral Science***, 26: 81–98.

Charmaz, K. 2006. ***Constructing grounded theory: a practical guide through qualitative analysis***. London: Sage.

Chia, R. 1995. From modern to postmodern organizational analysis. ***Organization Studies***, 16(4): 579–604.

Cissna, K. N., & Anderson, R. 1998. Theorizing about dialogic moments: The Buber-Rogers position and postmodern themes. ***Communication Theory***, 8(1): 63–104.

Clark, P. G. 1995. Quality of life, values, and teamwork in geriatric care: Do we communicate what we mean? ***The Gerontologist***, 35(3): 402–411.

Coan, J. A., Schaefer, H. S., & Davidson, R. J. 2006. Lending a Hand. ***Psychological Science***, 17(12): 1032 –1039.

Coburn, W. J. 2002. A world of systems: The role of systemic patterns of experience in the therapeutic process. ***Psychoanalytic Inquiry***, 22(5): 655–677.

Cook, G. A. 2006. Georg Herbert Mead. In J. R. Shook & J. Margolis (Eds.), ***A Companion to Pragmatism***: 67–78. Malden, MA.: Blackwell Publishing.

Corporate Leadership Council. 2002. ***Performance management survey***. Washington D.C.: Author.

Cropanzano, R., Howes, J. C., Grandey, A. A., & Toth, P. 1997. The relationship of organizational politics and support to work behaviors, attitudes, and stress. ***Journal of Organizational Behavior***, 18(2): 159–180.

Cross, S. E., & Madson, L. 1997. Models of the self: Self-construals and

gender. ***Psychological bulletin***, 122(1): 5–37.

Damasio, A. R. 1999. ***The feeling of what happens: Body and emotion in the making of consciousness***. New York: Harcourt.

Dane, E., & Pratt, M. G. 2007. Exploring intuition and its role in managerial decision making. ***The Academy of Management Review***, 32(1): 33–54.

Day, A. 2010. Coaching at relational depth: a case study. ***The Journal of Management Development***, 29(10): 864–876.

Denzin, N. K. 1978. Strategies of multiple triangulation. ***The Research Act in Sociology. Second Edition***. New York: McGraw-Hill.

Denzin, N. K., & Lincoln, Y. S. 2000. Introduction: The discipline and practice of qualitative research. ***Handbook of qualitative research***, 2: 1–28.

Dewey, J. 1908. What Does Pragmatism Mean by Practical? ***The Journal of Philosophy, Psychology and Scientific Methods***, 5(4): 85–99.

Dewey, J. 1938. ***Logic - The Theory of Inquiry***. New York: Holt, Rinehart and Winston.

Dewey, J. 1998a [1938]. Common sense and scientific inquiry. In L. A. Hickman & T. M. Alexander (Eds.), ***The Essential Dewey Volume 1: Pragmatism, Education, Democracy***: 380–390. Bloomington, In.: Indiana University Press.

Dewey, J. 1998b. ***The Essential Dewey Volume 2: Ethics, Logic, Psychology***. (L. A. Hickman & T. M. Alexander, Eds.). Bloomington, In.: Indiana University Press.

Dewey, J. 1998c. ***The Essential Dewey Volume 1: Pragmatism, Education, Democracy***. (L. A. Hickman & T. M. Alexander, Eds.). Bloomington, In.: Indiana University Press.

Dey, I. 2007. Grounding categories. In K. Charmaz & A. Bryant (Eds.), ***The SAGE Handbook of Grounded Theory.*** 167–190. London: Sage.

Donaldson, L. 2003. Organization Theory as a Positive Science. In H. Tsoukas & C. Knudsen (Eds.), ***The Oxford Handbook of Organization Theory***: 39–62. Oxford: Oxford University Press.

Doona, M. E., Haggerty, L. A., & Chase, S. K. 1997. Nursing presence: an existential exploration of the concept. ***Research and Theory for Nursing Practice***, 11(1): 3–16.

Dreyfus, H. L. 2006. Overcoming the myth of the mental. ***Topoi***, 25(1): 43–49.

Driver, J. L., & Gottman, J. M. 2004. Daily marital interactions and positive affect during marital conflict among newlywed couples. ***Family Process***, 43(3): 301–314.

Dubois, A., & Gadde, L. E. 2002. Systematic combining: an abductive approach to case research. ***Journal of business research***, 55(7): 553–560.

Dunn, J. 1995. Intersubjectivity in psychoanalysis: A critical review. ***International Journal of Psycho-Analysis***, 76: 723–738.

Dutton, J. E., & Heaphy, E. D. 2003. The power of high-quality connections. In K. S. Cameron, J. E. Dutton, & R. E. Quinn (Eds.), ***Positive organizational scholarship: Foundations of a new***

discipline: 263–278. San Francisco, CA: Berrett-Koehler.

Dutton, J. E., & Ragins, B. R. 2007a. Moving forward: positive relationships at work as a research frontier. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 387–400. New York: Lawrence Erlbaum Associates.

Dutton, J. E., & Ragins, B. R. (Eds.). 2007b. ***Exploring positive relationships at work: Building a theoretical and research foundation***. New York: Lawrence Erlbaum Associates.

Dutton, J. E., Worline, M. C., Frost, P. J., & Lilius, J. M. 2006. Explaining compassion organizing. ***Administrative Science Quarterly***, 51(1): 59–96.

Eco, U. 1990. ***The limits of interpretation***. Bloomington, In.: Indiana University Press.

Edmondson, A. C., & McManus, S. E. 2007. Methodological fit in management field research. ***Academy of Management Review***, 32(4): 1155–1179.

Edwards, S. D. 1999. The idea of nursing science. ***Journal of Advanced Nursing***, 29(3): 563–569.

Eibl-Eibesfeldt, I. 1970. ***Ethology: The biology of behavior***. New York: Holt, Rinehart and Winston.

Eisenhardt, K. M. 1989. Building theories from case study research. ***Academy of management review***, 14(4): 532–550.

Eisenhardt, K. M., & Graebner, M. E. 2007. Theory building from cases: Opportunities and challenges. ***Academy of Management Journal***, 50(1): 25–32.

Ekman, P., Davidson, R. J., & Friesen, W. V. 1990. The Duchenne smile: Emotional expression and brain physiology: II. ***Journal of personality and Social Psychology***, 58(2): 342–353.

Emmons, R. A., & Mishra, A. 2011. Why gratitude enhances well-being: What we know, what we need to know. In K. M. Sheldon, T. B. Kashdan, & M. F. Steger (Eds.), ***Designing Positive Psychology: Taking Stock and Moving Forward***: 248–262. New York: Oxford University Press.

Eriksson, K. 1994. ***Den lidande människan***. Stockholm: Liber.

Eriksson, K. 2002. Caring science in a new key. ***Nursing science quarterly***, 15(1): 61–65.

Evans, R. G. 1997. Going for the gold: the redistributive agenda behind market-based health care reform. ***Journal of health politics, policy and law***, 22(2): 427–465.

Feil, N. 1993. ***The validation breakthrough: Simple techniques for communicating with people with "Alzheimer"s-type dementia'***. Baltimore, MD.: Health Professions Press.

Ferris, G. R., Liden, R. C., Munyon, T. P., Summers, J. K., Basik, K. J., & Buckley, M. R. 2009. Relationships at Work: Toward a Multidimensional Conceptualization of Dyadic Work Relationships. ***Journal of Management***, 35(6): 1379–1403.

Ferry, L. 2005. ***What Is the Good Life?*** (L. G. Cochrane, Trans.) Chicago: University Of Chicago Press.

Finfgeld-Connett, D. 2006. Meta-synthesis of presence in nursing. ***Journal of Advanced Nursing***, 55(6): 708–714.

Finfgeld-Connett, D. 2008a. Meta-synthesis of caring in nursing. ***Journal of Clinical Nursing***, 17(2): 196–204.

Finfgeld-Connett, D. 2008b. Qualitative convergence of three nursing concepts: art of nursing, presence and caring. ***Journal of Advanced Nursing***, 63(5): 527–534.

Finfgeld-Connett, D. 2008c. Concept synthesis of the art of nursing. ***Journal of Advanced Nursing***, 62(3): 381–388.

Fischer, M. 2012. ***Linkages between employee and customer perceptions in business-to-business services - Towards positively deviant performances***. Aalto University publication series: Doctoral dissertations 7/2012.

Flum, H. 2001. Dialogues and Challenges: The interface between work and relationships in transition. ***The Counseling Psychologist***, 29(2): 259–270.

Fogarty, L. A., Curbow, B. A., Wingard, J. R., McDonnell, K., & Somerfield, M. R. 1999. Can 40 Seconds of Compassion Reduce Patient Anxiety? ***Journal of Clinical Oncology***, 17(1): 371–379.

Fogel, A., King, B. J., & Shanker, S. G. 2008. ***Human development in the twenty-first century: Visionary ideas from systems scientists***. Cambridge: Cambridge University Press.

Fonagy, P. 1998. Moments of change in psychoanalytic theory: Discussion of a new theory of psychic change. ***Infant Mental Health Journal***, 19(3): 346–353.

Foner, N. 1994. Nursing home aides: Saints or monsters? ***The Gerontologist***, 34(2): 245–250.

Forchuk, C., Westwell, J., Martin, M. L., Azzapardi, W. B., Kosterewa-Tolman, D., & Hux, M. 1998. Factors Influencing Movement of Chronic Psychiatric Patients From the Orientation to the Working Phase of the Nurse-Client Relationship on an Inpatient Unit. ***Perspectives in Psychiatric Care***, 34(1): 36–44.

Fredrickson, B. L. 2003. Positive emotions and upward spirals in organizations. In K. S. Cameron, J. E. Dutton, & R. E. Quinn (Eds.), ***Positive organizational scholarship: Foundations of a new discipline***: 163–175. San Francisco, CA: Berrett-Koehler.

Freeney, Y. M., & Tiernan, J. 2009. Exploration of the facilitators of and barriers to work engagement in nursing. ***International Journal of Nursing Studies***, 46(12): 1557–1565.

Frijda, N. H. 2007. ***The laws of emotion***. Mahwah, NJ.: Lawrence Erlbaum Associates.

Gable, S. L., & Gosnell, C. L. 2011. The positive side of close relationships. In K. M. Sheldon, T. B. Kashdan, & M. F. Steger (Eds.), ***Designing Positive Psychology: Taking Stock and Moving Forward***: 265–279. New York: Oxford University Press.

Gable, S. L., Reis, H. T., Impett, E. A., & Asher, E. R. 2004. What do you do when things go right? The intrapersonal and interpersonal benefits of sharing positive events. ***Journal of Personality and Social Psychology***, 87(2): 228–245.

Gabriel, Y. 2002. Essai: On Paragrammatic Uses of Organizational Theory

A Provocation. ***Organization Studies***, 23(1): 133–151.

Gadamer, H. G. 1988 [1959]. On the Circle of Understanding. In J. M. Connolly & T. Keutner (Eds & trans.), ***Hermeneutics versus Science? Three German Views***. Notre Dame, Ind.: University of Notre Dame Press.

Gadamer, H. G. 1994. Truth in the human sciences. In B. R. Wachterhauser (Ed & tran.), ***Hermeneutics and truth***: 25–32. Evanston, Ill.: Northwestern University Press.

Gadamer, H. G. 2004 [1960]. ***Truth and Method***. (J. Weinsheimer & D. Marshall, Trans.). New York: Continuum.

Gagné, M., & Deci, E. L. 2005. Self-determination theory and work motivation. ***Journal of Organizational behavior***, 26(4): 331–362.

Gallant, M. H., Beaulieu, M. C., & Carnevale, F. A. 2002. Partnership: an analysis of the concept within the nurse–client relationship. ***Journal of Advanced Nursing***, 40(2): 149–157.

Gallese, V., Eagle, M. N., & Migone, P. 2007. Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. ***Journal of the American Psychoanalytic Association***, 55(1): 131–176.

Geertz, C. 1993a. " From the Native's Point of View": On the Nature of Anthropological Understanding. ***Local knowledge: Further essays in interpretive anthropology***: 55–70. London: Fontana Press.

Geertz, C. 1993b. ***The Interpretation of Cultures***. London: Fontana Press.

George, J. M., Reed, T. F., Ballard, K. A., Colin, J., & Fielding, J. 1993. Contact with AIDS patients as a source of work-related distress: Effects of organizational and social support. ***Academy of Management Journal***, 36(1): 157–171.

Gephart, R. P. 2004. Qualitative research and the Academy of Management Journal. ***Academy of Management Journal***, 47(4): 454–462.

Gergen, K. J. 2009. ***Relational Being: Beyond Self and Community***. New York: Oxford University Press.

Gervais, M., & Wilson, D. S. 2005. The evolution and functions of laughter and humor: A synthetic approach. ***The Quarterly Review of Biology***, 80(4): 395–430.

Ghoshal, S. 2005. Bad management theories are destroying good management practices. ***Academy of Management Learning & Education***, 4(1): 75–91.

Gittell, J. H. 2008. Relationships and resilience: Care provider responses to pressures from managed care. ***The Journal of Applied Behavioral Science***, 44(1): 25–47.

Glaser, B. G., & Strauss, A. L. 1967. ***The discovery of grounded theory***. New York: Aldine de Gruyter.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. 2010. Compassion: An evolutionary analysis and empirical review. ***Psychological Bulletin***, 136(3): 351–374.

Goldberg, A. 2001. Postmodern psychoanalysis. ***International Journal of Psycho-Analysis***, 82(1): 123–128.

Golden-Biddle, K., GermAnn, K., Reay, T., & Procyshen, G. 2007. Creating

and Sustaining Positive Organizational Relationships: A Cultural Perspective. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 289–305. New York: Lawrence Erlbaum Associates.

Gordon, S., Benner, P., & Noddings, N. 1996a. Introduction. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: vii–xvi. Philadelphia, Pa.: University of Pennsylvania Press.

Gordon, S., Benner, P., & Noddings, N. (Eds.). 1996b. ***Caregiving: Readings in knowledge, practice, ethics, and politics***. Philadelphia, Pa.: University of Pennsylvania Press.

Gottman, J. M. 1993. A theory of marital dissolution and stability. ***Journal of Family Psychology***, 7(1): 57–75.

Gottman, J. M. 1994. ***What predicts divorce?: the relationship between marital processes and marital outcomes***. Hillsdale, NJ.: Lawrence Erlbaum Associates.

Gottman, J. M. 2011. ***The science of trust: Emotional attunement for couples***. New York: W. W. Norton & Company.

Granovetter, M. S. 1973. The strength of weak ties. ***American journal of sociology***, 78: 1360–1380.

Grant, A. M. 2007. Relational job design and the motivation to make a prosocial difference. ***The Academy of Management Review***, 32(2): 393–417.

Grant, A. M. 2008. Does intrinsic motivation fuel the prosocial fire? Motivational synergy in predicting persistence, performance, and productivity. ***Journal of Applied Psychology***, 93(1): 48–58.

Grant, A. M., & Campbell, E. 2007. Doing good, doing harm, being well and burning out: The interactions of perceived prosocial and antisocial impact in service work. ***Journal of Occupational and Organizational Psychology***, 80: 665–691.

Grant, A. M., Dutton, J. E., & Rosso, B. 2008. Giving commitment: Employee support programs and the prosocial sensemaking process. ***Academy of Management Journal***, 51(5): 898–918.

Greene, K., Derlega, V. J., & Mathews, A. 2006. Self-disclosure in personal relationships. In A. L. Vangelisti & D. Perlman (Eds.), ***The Cambridge handbook of personal relationships***: 409–427. New York: Cambridge University Press.

Grouzet, F. M. E., Kasser, T., Ahuvia, A., Dols, J. M. F., Kim, Y., Lau, S., et al. 2005. The structure of goal contents across 15 cultures. ***Journal of Personality and Social Psychology***, 89(5): 800–816.

Habermas, J. 1978. ***Knowledge and Human Interests***. (J. J. Shapiro, Tran.). London: Heinemann.

Hackman, J. R., & Oldham, G. R. 1980. ***Work redesign***. Reading, Ma.: Addison Wesley.

Hagerty, B. M., Lynch-Sauer, J., Patusky, K. L., & Bouwsema, M. 1993. An emerging theory of human relatedness. ***Journal of Nursing Scholarship***, 25(4): 291–296.

Hagerty, B. M., & Patusky, K. L. 2003. Reconceptualizing the Nurse-Patient Relationship. ***Journal of Nursing Scholarship***, 35(2): 145–150.

Hagerty, B. M., Williams, R. A., Coyne, J. C., & Early, M. R. 1996. Sense of belonging and indicators of social and psychological functioning. ***Archives of Psychiatric Nursing***, 10(4): 235–244.

Haidt, J. 2001. The emotional dog and its rational tail: A social intuitionist approach to moral judgment. ***Psychological Review***, 108: 814–834.

Haines, V. A., Hurlbert, J. S., & Zimmer, C. 1991. Occupational Stress, Social Support, and the Buffer Hypothesis. ***Work and Occupations***, 18(2): 212 –235.

Hakanen, J., Schaufeli, W. B., & Ahola, K. 2008. The Job Demands-Resources model: A three-year cross-lagged study of burnout, depression, commitment, and work engagement. ***Work & Stress***, 22(3): 224–241.

Halbesleben, J. R. B., & Buckley, M. R. 2004. Burnout in organizational life. ***Journal of Management***, 30(6): 859–879.

Hall, D. T., & Chandler, D. E. 2005. Psychological success: When the career is a calling. ***Journal of Organizational Behavior***, 26(2): 155–176.

Hanson, N. R. 1958. The logic of discovery. ***The Journal of Philosophy***, 55(25): 1073–1089.

Happell, B., & Brooker, J. 2001. Who will look after my grandmother? Attitudes of student nurses toward the care of older adults. ***Journal of Gerontological Nursing***, 27(12): 12–17.

Hari, R., & Kujala, M. V. 2009. Brain basis of human social interaction: From concepts to brain imaging. ***Physiological reviews***, 89(2): 453–479.

Harman, G. 1965. The inference to the best explanation. ***The Philosophical Review***, 74(1): 88–95.

Hartrick, G. 1997. Relational capacity: the foundation for interpersonal nursing practice. ***Journal of Advanced Nursing***, 26(3): 523–528.

Hatch, M. J. 1999. Exploring the empty spaces of organizing: How improvisational jazz helps redescribe organizational structure. ***Organization Studies***, 20(1): 75–100.

Hatch, M. J., & Cunliffe, A. L. 2006. ***Organization theory: Modern, symbolic, and postmodern perspectives*** (second ed.). Oxford: Oxford University Press.

Hatfield, E., Cacioppo, J. T., & Rapson, R. L. 1992. Primitive emotional contagion. In M. S. Clark (Ed.), ***Review of personality and social psychology: Vol. 14. Emotions and social behavior***: 151–177. Newbury Park, Ca.: Sage.

Hatfield, E., Cacioppo, J. T., & Rapson, R. L. 1993. Emotional contagion. ***Current Directions in Psychological Science***, 2(3): 96–100.

Heaphy, E. D. 2007. Bodily insights: Three lenses on positive organizational relationships. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 47–71. New York: Lawrence Erlbaum Associates.

Heaphy, E. D., & Dutton, J. E. 2008. Positive social interactions and the human body at work: Linking organizations and physiology. ***The Academy of Management Review***, 33(1): 137–162.

Hegel, G. W. F. 1977 [1807]. ***Phenomenology of Spirit***. (A. V. Miller,

Tran.). Oxford: Clarendon Press.

Heidegger, M. 1962 [1927]. ***Being and Time***. (J. Macquarrie & E. Robinson, Trans.). Oxford: Blackwell Publishing.

Heidegger, M. 2003. Overcoming metaphysics. In J. Stambaugh (Tran.), ***The End of Philosophy*** (1st ed.): 84–110. Chicago: University Of Chicago Press.

Heller, M., & Haynal, V. 1997. The doctor's face: A mirror of his patient's suicidal projects. In J. Guimon (Ed.), ***The Body in Psychotherapy***: 46–51. Basel: S. Karger.

Hem, M. H., & Heggen, K. 2003. Being professional and being human: one nurse's relationship with a psychiatric patient. ***Journal of Advanced Nursing***, 43(1): 101–108.

Heshusius, L. 1994. Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? ***Educational Researcher***, 23(3): 15–22.

Hildebrand, D. L. 1996. Genuine Doubt and the Community in Peirce's Theory of Inquiry. ***Southwest Philosophy Review***, 12(1): 33–43.

Hochschild, A. 1975. The sociology of feeling and emotion: Selected possibilities. In M. Millman & R. M. Kanter (Eds.), ***Another voice: Feminist perspectives on social life and social science***: 281-307. New York: Anchor Books.

Hoffman, I. Z. 2001. ***Ritual and spontaneity in the psychoanalytic process - A dialectical-constructivist view***. Hillsdale, NJ.: Analytic Press.

Holahan, C. J., Moos, R. H., Holahan, C. K., & Brennan, P. L. 1997. Social context, coping strategies, and depressive symptoms: An expanded model with cardiac patients. ***Journal of Personality and Social Psychology***, 72(4): 918–928.

Hume, D. 1968 [1739]. ***A treatise of human nature***. Oxford: Clarendon Press.

Humphreys, M., Brown, A. D., & Hatch, M. J. 2003. Is ethnography jazz? ***Organization***, 10(1): 5–31.

Huss, M., Buckwalter, K. C., & Stolley, J. 1988. Nursing's impact on life satisfaction. ***Journal of gerontological nursing***, 14(5): 31.

Huy, Q. N. 2002. Emotional balancing of organizational continuity and radical change: The contribution of middle managers. ***Administrative Science Quarterly***, 47(1): 31–69.

Hämäläinen, R. P., & Saarinen, E. 2006. Systems intelligence: A key competence in human action and organizational life. ***The SoL Journal***, 7(4): 17–28.

Hämäläinen, R. P., & Saarinen, E. 2007. Systems intelligent leadership. In R. P. Hämäläinen & E. Saarinen (Eds.), ***Systems Intelligence in Leadership and Everyday Life***: 3–38. Espoo: Helsinki University of Technology, Systems Analysis Laboratory.

Hämäläinen, R. P., & Saarinen, E. 2008. Systems intelligence - the way forward? A note on Ackoff's' why few organizations adopt systems thinking'. ***Systems Research and Behavioral Science***, 25(6): 821–825.

Iacoboni, M. 2009. Imitation, empathy, and mirror neurons. ***Annual***

Review of Psychology, 60: 653–670.

Iaffaldano, M. T., & Muchinsky, P. M. 1985. Job satisfaction and job performance: A meta-analysis. ***Psychological bulletin***, 97(2): 251–273.

Jackson, M. C. 2003. ***Systems thinking: Creative holism for managers***. Chichester: Wiley.

James, W. 1991 [1907]. ***Pragmatism***. New York: Prometheus Books.

Jick, T. D. 1979. Mixing Qualitative and Quantitative Methods: Triangulation in Action. ***Administrative Science Quarterly***, 24(4): 602–611.

Joas, H. 1993. ***Pragmatism and social theory***. Chicago: University of Chicago Press.

Joas, H. 1999. Action is the way in which human beings exist in the world [Interview by Claus Otto Scharmer, Freie Universität Berlin, Sept. 21, 1999]. ***Presencing Dialogue on Leadership***. http://www.presencing.com/presencing/dol/Joas-1999.shtml, Accessed September 24, 2012.

Johnson, C. L., & Grant, L. A. 1985. ***The nursing home in American society***. Baltimore: Johns Hopkins University Press.

Johnson, J. V., & Hall, E. M. 1988. Job strain, work place social support, and cardiovascular disease: a cross-sectional study of a random sample of the Swedish working population. ***American journal of public health***, 78(10): 1336–1342.

Jones, A. 1999. "A heavy and blessed experience": a psychoanalytic study of community Macmillan nurses and their roles in serious illness and palliative care. ***Journal of advanced nursing***, 30(6): 1297–1303.

Jones, R., & Corner, J. 2007. Systems intelligence and its relationship to communication theories. In R. P. Hämäläinen & E. Saarinen (Eds.), ***Systems Intelligence in Leadership and Everyday Life***: 240–249. Espoo: Helsinki University of Technology, Systems Analysis Laboratory.

Jonsdottir, H., Litchfield, M., & Pharris, M. D. 2004. The relational core of nursing practice as partnership. ***Journal of Advanced Nursing***, 47(3): 241–248.

Josephson, J. R., & Josephson, S. G. 1994. ***Abductive inference: Computation, philosophy, technology***. Cambridge: Cambridge University Press.

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. 2008. Stress of conscience and perceptions of conscience in relation to burnout among care-providers in older people. ***Journal of Clinical Nursing***, 17(14): 1897–1906.

Kahn, R. L., & Byosiere, M. 1991. Stress in organizations. In M. D. Dunnette & L. M. Hough (Eds.), ***Handbook of industrial and organizational psychology***: 571–650. Palo Alto, CA.: Consulting Psychologists Press.

Kahn, W. A. 1990. Psychological conditions of personal engagement and disengagement at work. ***Academy of Management Journal***, 33(4): 692–724.

Kahn, W. A. 1992. To be fully there - Psychological presence at work. ***Human Relations***, 45(4): 321–349.

Kahn, W. A. 1993. Caring for the Caregivers: Patterns of Organizational Caregiving. ***Administrative Science Quarterly***, 38(4): 539–563.

Kahn, W. A. 1998. Relational systems at work. In B. M. Staw & L. L. Cummings (Eds.), ***Research in Organizational Behavior***: 39–76. Greenwich, CT.: JAI Press.

Kahn, W. A. 2005. ***Holding fast: The struggle to create resilient caregiving organizations***. Hove, U.K.: Brunner-Routledge.

Kahneman, D. 2003. A perspective on judgment and choice: Mapping bounded rationality. ***American Psychologist***, 58(9): 697–720.

Kanov, J. M., Maitlis, S., Worline, M. C., Dutton, J. E., Frost, P. J., & Lilius, J. M. 2004. Compassion in organizational life. ***American Behavioral Scientist***, 47(6): 808–827.

Karasek, R. A. 1979. Job demands, job decision latitude, and mental strain: Implications for job redesign. ***Administrative science quarterly***, 24: 285–308.

Karasek, R. A. 1998. Demand/control model: a social, emotional, and physiological approach to stress risk and active behaviour development. In J. M. Stellman (ed.), ***Encyclopaedia of occupational health and safety***, 34.6–34.14. Geneva: ILO.

Kashima, Y., Yamaguchi, S., Kim, U., Choi, S.-C., Gelfand, M. J., & Yuki, M. 1995. Culture, Gender and Self: A Perspective From Individualism-Collectivism Research. ***Journal of Personality and Social Psychology***, 69(5): 925–937.

Ketokivi, M., & Mantere, S. 2010. Two Strategies for Inductive Reasoning in Organizational Research. ***The Academy of Management Review***, 35(2): 315–333.

Kettunen, T., Poskiparta, M., & Gerlander, M. 2002. Nurse–patient power relationship: preliminary evidence of patients' power messages. ***Patient Education and Counseling***, 47(2): 101–113.

Keyes, C. L. . 2002. The mental health continuum: From languishing to flourishing in life. ***Journal of Health and Social Behavior***, 43(2): 207–222.

Keyes, C. L. . 2007. Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. ***American Psychologist***, 62(2): 95–108.

Keyes, C. L. ., Shmotkin, D., & Ryff, C. D. 2002. Optimizing well-being: The empirical encounter of two traditions. ***Journal of Personality and Social Psychology***, 82(6): 1007–1022.

Kitson, A., Harvey, G., & McCormack, B. 1998. Enabling the implementation of evidence based practice: a conceptual framework. ***Quality in Health Care***, 7(3): 149–158.

Kitwood, T. 1997. ***Dementia reconsidered: The person comes first***. Buckingham: Open University Press.

Kramer, B. J. 1997. Gain in the Caregiving Experience: Where Are We? What Next? ***The Gerontologist***, 37(2): 218 –232.

Kroth, M., & Keeler, C. 2009. Caring as a Managerial Strategy. ***Human Resource Development Review***, 8(4): 506 –531.

Kröger, T., Leinonen, A., & Vuorensyrjä, M. 2009. ***Hoivan tekijät - Suomalainen hoivatyö pohjoismaisessa tarkastelussa***.

Jyväskylän yliopisto, Sosiaalityön julkaisusarja.

Kuhn, T. S. 1962. ***The Structure of Scientific Revolutions***. Chicago: University of Chicago press.

Kvåle, K., & Bondevik, M. 2008. What is important for patient centred care? A qualitative study about the perceptions of patients with cancer. ***Scandinavian Journal of Caring Sciences***, 22(4): 582–589.

Küpers, W. 2005. Phenomenology and Integral Pheno-Practice of Embodied Well-Be(com)ing in Organizations. ***Culture and Organization***, 11(3): 221–231.

Küpers, W. 2007. Perspectives on integrating leadership and followership. ***International Journal of Leadership Studies***, 2(3): 194–221.

Küpers, W., & Weibler, J. 2008. Emotions in organisation: an integral perspective. ***International Journal of Work Organisation and Emotion***, 2(3): 256–287.

Kyriakidou, O., & Özbilgin, M. F. 2006a. Introduction. In O. Kyriakidou & M. F. Özbilgin (Eds.), ***Relational perspectives in organizational studies: A research companion***: 1–7. Cheltenham, UK.: Edward Elgar Publishing.

Kyriakidou, O., & Özbilgin, M. F. (Eds.). 2006b. ***Relational perspectives in organizational studies: A research companion***. Cheltenham, UK.: Edward Elgar Publishing.

Ladkin, D. 2008. Leading beautifully: How mastery, congruence and purpose create the aesthetic of embodied leadership practice. ***Leadership Quarterly***, 19(1): 31–41.

Lawrence, T. B., & Maitlis, S. In press. Care and possibility: Enacting an ethic of care through narrative practice. ***Academy of Management Review***.

Lazenbatt, A., Orr, J., Bradley, M., & McWhirter, L. 1999. The role of nursing partnership interventions in improving the health of disadvantaged women. ***Journal of Advanced Nursing***, 30(6): 1280–1288.

Lee, R. T., & Ashforth, B. E. 1996. A meta-analytic examination of the correlates of the three dimensions of job burnout. ***Journal of Applied Psychology***, 81(2): 123–133.

Leininger, M. M. 1991. ***Culture care diversity and universality: A worldwide nursing theory***. New York: National League of Nursing Press.

Levinas, E. 1979. ***Totality and infinity: An essay on exteriority***. (A. Lingis, Tran.). Pittsburgh: Duquesne University Press.

Levinson, H. 1972. ***Organizational diagnosis***. Cambridge, Mass.: Harvard University Press.

Li, S. 2004. “Symbiotic niceness”: constructing a therapeutic relationship in psychosocial palliative care. ***Social science & medicine***, 58(12): 2571–2583.

Lilius, J. M., Kanov, J. M., Dutton, J. E., Worline, M. C., & Maitlis, S. [Forthcoming]. Compassion revealed: What we know about compassion at work (and where we need to know more). In K. S. Cameron & G. M. Spreitzer (Eds.), ***Oxford Handbook of Positive Organizational Scholarship***. Oxford University Press.

Lilius, J. M., Worline, M. C., Dutton, J. E., Kanov, J. M., & Maitlis, S. 2011. Understanding compassion capability. ***Human relations***, 64(7): 873–899.

Lilius, J. M., Worline, M. C., Maitlis, S., Kanov, J. M., Dutton, J. E., & Frost, P. J. 2008. The contours and consequences of compassion at work. ***Journal of Organizational Behavior***, 29(2): 193–218.

Lincoln, Y. S., & Guba, E. G. 1985. ***Naturalistic inquiry***. Beverly Hills, CA.: Sage.

Lindholm, L., & Eriksson, K. 1993. To understand and alleviate suffering in a caring culture. ***Journal of Advanced Nursing***, 18(9): 1354–1361.

Linley, P. A., Garcea, N., Harrington, S., Trenier, E., & Minhas, G. 2011. Organizational Applications of Positive Psychology: Taking Stock and a Research/Practice Roadmap for the Future. In K. M. Sheldon, T. B. Kashdan, & M. F. Steger (Eds.), ***Designing Positive Psychology: Taking Stock and Moving Forward***: 365–381. New York: Oxford University Press.

Lively, K. 2000. Reciprocal emotion management - Working together to maintain stratification in private law firms. ***Work and Occupations***, 27(1): 32–63.

Locke, E. A. 1976. The nature and causes of job satisfaction. In M. D. Dunnette (Ed.), ***Handbook of I/O psychology***: 1297–1349. Chicago: Rand-McNally.

Locke, K., Golden-Biddle, K., & Feldman, M. S. 2008. Making Doubt Generative: Rethinking the Role of Doubt in the Research Process. ***Organization Science***, 19(6): 907–918.

Lopez, S. J. 2006. Emotional labor and organized emotional care. ***Work and Occupations***, 33(2): 133–160.

Losada, M., & Heaphy, E. D. 2004. The role of positivity and connectivity in the performance of business teams - A nonlinear dynamics model. ***American Behavioral Scientist***, 47(6): 740–765.

Luoma, J., Hämäläinen, R. P., & Saarinen, E. 2011. Acting with systems intelligence: Integrating complex responsive processes with the systems perspective. ***Journal of Operational Research Society***, 62: 3–11.

Luthans, F. 2002. The need for and meaning of positive organizational behavior. ***Journal of Organizational Behavior***, 23(6): 695–706.

Lyons-Ruth, K. 1998. Implicit relational knowing: Its role in development and psychoanalytic treatment. ***Infant Mental Health Journal***, 19(3): 282–289.

MacIntyre, A. 1984. ***After Virtue***. Notre Dame, Ind.: University of Notre Dame Press.

Maisel, N. C., & Gable, S. L. 2009. The paradox of received social support: The importance of responsiveness. ***Psychological Science***, 20(8): 928–932.

Mantere, S. 2008. Role expectations and middle manager strategic agency. ***Journal of Management Studies***, 45(2): 294–316.

Mantere, S., & Ketokivi, M. In Press. Reasoning in organization science. ***Academy of Management Review***, 38(1).

Marcio, J. J. 2001. Abductive inference, design science, and Dewey's theory of inquiry. ***Transactions of the Charles S. Peirce Society***, 37(1):

97–121.

Margolis, J. 2006. Introduction: Pragmatism, retrospective, and prospective. In J. R. Shook & J. Margolis (Eds.), ***A Companion to Pragmatism***: 1–10. Malden, MA.: Blackwell Publishing.

Markus, H. R., & Kitayama, S. 1991. Culture and the self: Implications for cognition, emotion, and motivation. ***Psychological review***, 98(2): 224–253.

Martela, F., & Saarinen, E. [Forthcoming]. Systems Metaphor in Therapy Discourse: Introducing Systems Intelligence. ***Psychoanalytic Dialogues***.

Martin, J., Knopoff, K., & Beckman, C. 1998. An alternative to bureaucratic impersonality and emotional labor: Bounded emotionality at The Body Shop. ***Administrative Science Quarterly***, 43(2): 429–469.

Marzi, A., Hautmann, G., & Maestro, S. 2006. Critical reflections on intersubjectivity in psychoanalysis. ***International Journal of Psycho-Analysis***, 87(5): 1297–1314.

May, D. R., Gilson, R. L., & Harter, L. M. 2004. The psychological conditions of meaningfulness, safety and availability and the engagement of the human spirit at work. ***Journal of Occupational and Organizational Psychology***, 77(1): 11–37.

Mayer, J. D., & Salovey, P. 1993. The intelligence of emotional intelligence. ***Intelligence***, 17(4): 433–442.

Mayer, J. D., & Salovey, P. 1997. What is emotional intelligence? In P. Salovey & D. J. Sluyter (Eds.), ***Emotional Development and Emotional Intelligence: Educational Implications***: 3–31. New York: Basic Books.

Mayeroff, M. 1972. ***On Caring***. New York: Harper & Row.

McAllister, D., & Bigley, G. 2002. Work context and the definition of self: How organizational care influences organization-based self-esteem. ***Academy of Management Journal***, 45(5): 894–904.

McAllister, M. 2003. Doing practice differently: solution-focused nursing. ***Journal of Advanced Nursing***, 41(6): 528–535.

McCabe, C. 2004. Nurse–patient communication: an exploration of patients' experiences. ***Journal of Clinical Nursing***, 13(1): 41–49.

McCance, T. V., McKenna, H. P., & Boore, J. R. P. 1999. Caring: theoretical perspectives of relevance to nursing. ***Journal of Advanced Nursing***, 30(6): 1388–1395.

McCormack, B. 2003. A conceptual framework for person-centred practice with older people. ***International Journal of Nursing Practice***, 9(3): 202–209.

McCormack, B. 2004. Person-centredness in gerontological nursing: an overview of the literature. ***Journal of Clinical Nursing***, 13: 31–38.

McCormack, B., & McCance, T. V. 2006. Development of a framework for person-centred nursing. ***Journal of Advanced Nursing***, 56(5): 472–479.

McGilton, K. S., & Boscart, V. M. 2007. Close care provider–resident relationships in long-term care environments. ***Journal of Clinical Nursing***, 16(11): 2149–2157.

Meadows, D. H. 2002. Dancing with systems. ***Systems Thinker***, 13(2):

2–6.

Meadows, D. H. 2008. ***Thinking in systems: A primer***. White River Junction, VT.: Chelsea Green Publishing.

Merleau-Ponty, M. 2002 [1945]. ***Phenomenology of perception***. (C. Smith, Tran.). London: Routledge.

Meyers-Levy, J., & Zhu, R. J. 2007. The influence of ceiling height: The effect of priming on the type of processing that people use. ***Journal of Consumer Research***, 34(2): 174–186.

Mikulincer, M., & Shaver, P. R. 2005. Attachment theory and emotions in close relationships: Exploring the attachment-related dynamics of emotional reactions to relational events. ***Personal Relationships***, 12(2): 149–168.

Miles, M. B., & Huberman, A. M. 1994. ***Qualitative Data Analysis: An Expanded Sourcebook***. Thousand Oaks, CA.: Sage Publications.

Miles, S. A., & Watkins, M. D. 2007. The leadership team: complementary strengths or conflicting agendas? ***Harvard business review***, 85(4): 90–98.

Miller, J. B., & Stiver, I. 1997. ***The Healing Connection: How Women Form Relationships in Therapy and in Life***. Boston: Beacon Press.

Milton, C. L. 2002. Ethical Implications for Acting Faithfully in the Nurse-Person Relationship. ***Nursing Science Quarterly***, 15(1): 21 –24.

Mitchell, G. J. 1992. Parse's theory and the multidisciplinary team: clarifying scientific values. ***Nursing science quarterly***, 5(3): 104–106.

Mitchell, S. A. 1988. ***Relational concepts in psychoanalysis: An integration***. Cambridge, Mass.: Harvard University Press.

Mok, E., & Chiu, P. C. 2004. Nurse–patient relationships in palliative care. ***Journal of advanced Nursing***, 48(5): 475–483.

Molinsky, A., & Margolis, J. 2005. Necessary evils and interpersonal sensitivity in organizations. ***Academy of Management Review***, 30(2): 245–268.

Monahan, R. S., & McCarthy, S. 1992. Nursing home employment: the nurse's aide's perspective. ***Journal of gerontological nursing***, 18(2): 13–16.

Morris, J. A., & Feldman, D. C. 1996. The Dimensions, Antecedents, and Consequences of Emotional Labor. ***The Academy of Management Review***, 21(4): 986–1010.

Morrison, E. 2010. From the editors - OB in AMJ: What is hot and what is not? ***Academy of Management Journal***, 53(5): 932–936.

Morse, J. M. 1991. Negotiating commitment and involvement in the nurse-patient relationship. ***Journal of Advanced Nursing***, 16(4): 455–468.

Mowday, R. T., & Sutton, R. I. 1993. Organizational behavior: Linking individuals and groups to organizational contexts. ***Annual review of psychology***, 44: 195–229.

Murray, S. L., Holmes, J. G., & Collins, N. L. 2006. Optimizing assurance: The risk regulation system in relationships. ***Psychological Bulletin***, 132(5): 641–666.

Myers, D. 2000. The funds, friends, and faith of happy people. ***American Psychologist***, 55(1): 56–67.

Määttänen, P. 2006. Space, time, and interpretation. ***Koht ja Paik / Place and Location***, V: 11–20.

Nahum, J. P. 2000. An overview of Louis Sander's contribution to the field of mental health. ***Infant Mental Health Journal***, 21(1-2): 29–41.

Newman, M. A. 1999. The rhythm of relating in a paradigm of wholeness. ***Journal of Nursing Scholarship***, 31(3): 227–230.

Nickerson, R. S. 1998. Confirmation bias: A ubiquitous phenomenon in many guises. ***Review of General Psychology; Review of General Psychology***, 2(2): 175–220.

Niemiec, C. P., Ryan, R. M., & Deci, E. L. 2009. The path taken: Consequences of attaining intrinsic and extrinsic aspirations in post-college life. ***Journal of Research in Personality***, 43(3): 291–306.

Nightingale, F. 1860. ***Notes on nursing: What it is, and what it is not***. Mineola, NY.: Dover Publications.

Niven, K., Totterdell, P., & Holman, D. 2009. Affect regulation and well-being in the workplace: an interpersonal perspective. In A.-S. G. Antoniou, C. L. Cooper, G. P. Chrousos, C. D. Spielberg, & M. W. Eysenck (Eds.), ***Handbook of Managerial Behavior and Occupational Health***: 218–228. Cheltenham, UK.: Edward Elgar Publishing.

Noddings, N. 1984. ***Caring: A feminine approach to ethics & moral education***. Berkeley, Ca.: University of California Press.

Noddings, N. 1996a. The caring professional. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: 160–172. Philadelphia, Pa.: University of Pennsylvania Press.

Noddings, N. 1996b. The Cared-For. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: 21–39. Philadelphia, Pa.: University of Pennsylvania Press.

Noddings, N. 2005. ***The challenge to care in schools: An alternative approach to education. 2nd edition.*** New York: Teachers College Press.

Nolan, M., Davies, S., Brown, J., Keady, J., & Nolan, J. 2002. ***Longitudinal study of the effectiveness of educational preparation to meet the needs of older people and carers: The AGEIN (Advancing Gerontological Education in Nursing) Project***. London: English National Board for Nursing, Midwifery and Health Visiting.

Nolan, M. R., Davies, S., Brown, J., Keady, J., & Nolan, J. 2004. Beyond "person-centred" care: a new vision for gerontological nursing. ***Journal of Clinical Nursing***, 13: 45–53.

Northrup, D. T., & Purkis, M. E. 2001. Building the science of health promotion practice from a human science perspective. ***Nursing Philosophy***, 2(1): 62–71.

O'Hanlon, B., & Wilk, J. 1987. ***Shifting contexts: The generation of effective psychotherapy***. New York: Guilford Press.

OECD. 2005. Tackling nurse shortages in OECD countries. ***OECD Health***

Working Papers No. 19, Head of Publications Service, Paris.

Orange, D. M. 1995. ***Emotional Understanding: Studies in psychoanalytic epistemology.*** New York: The Guilford Press.

Orange, D. M., Atwood, G. E., & Stolorow, R. D. 1997. ***Working intersubjectively: Contextualism in psychoanalytic practice***. Hillsdale, NJ.: Analytic Press.

Orlikowski, W. J. 2002. Knowing in practice: Enacting a collective capability in distributed organizing. ***Organization Science***, 13(3): 249–273.

Paavola, S. 2004. Abduction as a logic and methodology of discovery: The importance of strategies. ***Foundations of Science***, 9(3): 267–283.

Paavola, S., & Järvilehto, L. 2011. Action Man or Dreamy Detective. In J. Steiff (Ed.), ***Sherlock Holmes and Philosophy. The Footprints of a Gigantic Mind***: 45–54. Chicago: Open Court.

Page, K. M., & Vella-Brodrick, D. A. 2009. The "what","why"and "how"of employee well-being: A new model. ***Social Indicators Research***, 90(3): 441–458.

Panayiotou, A. 2008. Book review: Relational perspectives in organizational studies: A research companion, edited by Olympia Kyriakidou and Mustafa F. Özbilgin. Cheltenham, UK: Edward Elgar, 2006. ***Academy of Management Review***, 33(3): 794–798.

Parse, R. R. 1992. Human Becoming: Parse's Theory of Nursing. ***Nursing Science Quarterly***, 5(1): 35 –42.

Patton, M. Q. 1990. ***Qualitative evaluation and research methods***. Thousand Oaks, CA.: Sage Publications.

Patton, M. Q. 1999. Enhancing the quality and credibility of qualitative analysis. ***Health Services Research***, 34(5): 1189–1208.

Peirce, C. S. 1877. The fixation of belief. ***Popular Science Monthly***, 12: 1–15.

Peirce, C. S. 1878. How to make our ideas clear. ***Popular Science Monthly***, 12: 286–302.

Peirce, C. S. 1931. ***Collected Papers, Vols. 1-6.*** (C. Hartshorne & P. Weiss, Eds.). Cambridge, Mass.: Harvard University Press.

Peirce, C. S. 1998a. ***The Essential Peirce: Selected Philosophical Writings, Volume II, 1893-1913***. (the Peirce Edition Project, Ed.). Bloomington, In.: Indiana University Press.

Peirce, C. S. 1998b [1903]. The Nature of Meaning. In the Peirce Edition Project (Ed.), ***The Essential Peirce: Selected Philosophical Writings, Volume II, 1893-1913***: 208–225. Bloomington, In.: Indiana University Press.

Peirce, C. S. 1998c [1903]. Pragmatism as the Logic of Abduction. In the Peirce Edition Project (Ed.), ***The Essential Peirce: Selected Philosophical Writings, Volume II, 1893-1913***: 226–241. Bloomington, In.: Indiana University Press.

Petterson, I. L., Hertting, A., Hagberg, L., & Theorell, T. 2005. Are trends in work and health conditions interrelated? A study of Swedish hospital employees in the 1990s. ***Journal of Occupational Health Psychology***, 10(2): 110–120.

Pierson, W. 1999. Considering the nature of intersubjectivity within

professional nursing. ***Journal of Advanced Nursing***, 30(2): 294–302.

Pihlström, S. 1996. ***Structuring the world: the issue of realism and the nature of ontological problems in classical and contemporary pragmatism***. Helsinki: Societas Philosophica Fennica.

Pines, A. M. 2006. Stress and burnout: a relational perspective. In O. Kyriakidou & M. F. Özbilgin (Eds.), ***Relational perspectives in organizational studies: A research companion***: 95–111. Cheltenham, UK.: Edward Elgar Publishing.

Powell, T. C. 2001. Competitive advantage: Logical and philosophical considerations. ***Strategic Management Journal***, 22(9): 875–888.

Powell, T. C. 2002. The philosophy of strategy. ***Strategic Management Journal***, 23(9): 873–880.

Pratt, M. G., & Ashforth, B. E. 2003. Fostering meaningfulness in working and at work. In K. S. Cameron, J. E. Dutton, & R. E. Quinn (Eds.), ***Positive organizational scholarship: Foundations of a new discipline***: 309–327. San Francisco, CA: Berrett-Koehler.

Pratt, M. G., & Dirks, K. T. 2007. Rebuilding trust and restoring positive relationships: A commitment-based view of trust. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 117–136. New York: Lawrence Erlbaum Associates.

Prawat, R. S. 1999. Dewey, Peirce, and the learning paradox. ***American Educational Research Journal***, 36(1): 47–76.

Pugh, S. D. 2001. Service with a smile: Emotional contagion in the service encounter. ***The Academy of Management Journal***, 44(5): 1018–1027.

Putnam, H. 1994. ***Words and Life***. (J. Conant, Ed.). Cambridge, Mass.: Harvard University Press.

Quinn, R. E. 2007. Energizing others in work connections. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 73–90. New York: Lawrence Erlbaum Associates.

Quinn, R. W., & Worline, M. C. 2008. Enabling Courageous Collective Action: Conversations from United Airlines Flight 93. ***Organization Science***, 19(4): 497–516.

Rabin, H. M. 1995. The liberating effect on the analyst of the paradigm shift in psychoanalysis. ***Psychoanalytic Psychology***, 12(4): 467–481.

Ragins, B. R., & Dutton, J. E. 2007. Positive Relationships at Work: An Introduction and Invitation. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 3–25. New York: Lawrence Erlbaum Associates.

Reay, T., & Hinings, C. R. 2009. Managing the rivalry of competing institutional logics. ***Organization Studies***, 30(6): 629–652.

Rechtschaffen, S. 1996. ***Time shifting: Creating more time to enjoy your life***. London: Rider Publishing.

Reichertz, J. 2004. Abduction, deduction and induction in qualitative research. In U. Flick, E. von Kardorff, & I. Steinke (Eds.), ***A***

companion to qualitative research: 159–164. London: Sage Publications.

Rhoades, L., & Eisenberg, R. 2002. Perceived organizational support: A review of the literature. ***Journal of Applied Psychology***, 87(4): 698–714.

Rhodes, C. 2009. After reflexivity: ethics, freedom and the writing of organization studies. ***Organization Studies***, 30(6): 653–672.

Ringstrom, P. A. 2001. Cultivating the improvisational in psychoanalytic treatment. ***Psychoanalytic Dialogues***, 11(5): 727–754.

Roach, S. 1984. ***Caring: The human mode of being: Implications for nursing***. Toronto: University of Toronto.

Roach, S. 1987. ***The human act of caring: A blueprint for the health professions***. Ottawa: Canadian Hospital Association.

Roach, S. 1997. Preface. In S. Roach (Ed.), ***Caring from the heart: The convergence of caring and spirituality***: 5–6. Mahwah, NJ.: Paulist Press.

Roach, S. 2002. ***Caring, the human mode of being: A blueprint for the health professions - Second revised edition***. Ottawa: CHA Press.

Roberts, L. M. 2007. From proving to becoming: How positive relationships create a context for self-discovery and self-actualization. In J. E. Dutton & B. R. Ragins (Eds.), ***Exploring positive relationships at work: Building a theoretical and research foundation***: 29–46. New York: Lawrence Erlbaum Associates.

Robertson, J., Herth, K. A., & Cummings, C. C. 1994. Long-term care: retention of nurses. ***Journal of Gerontological Nursing***, 20(11): 4–9.

Rorty, R. 1979. ***Philosophy and the Mirror of Nature***. Princeton, NJ.: Princeton University Press.

Rosso, B. D., Dekas, K. H., & Wrzesniewski, A. 2010. On the meaning of work: A theoretical integration and review. ***Research in Organizational Behavior***, 30: 91–127.

Rubin, H. J., & Rubin, I. 2005. ***Qualitative interviewing: The art of hearing data***. Thousand Oaks, CA.: Sage.

Rundqvist, E. M., & Severinsson, E. 1999. Caring relationships with patients suffering from dementia — an interview study. ***Journal of Advanced Nursing***, 29(4): 800–807.

Ryan, R. M., & Deci, E. L. 2001. On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. ***Annual review of psychology***, 52(1): 141–166.

Ryff, C. D., & Singer, B. 2000. Interpersonal flourishing: A positive health agenda for the new millennium. ***Personality and Social Psychology Review***, 4(1): 30–44.

Saarinen, E., & Hämäläinen, R. P. 2004. Systems intelligence: Connecting engineering thinking with human sensitivity. In R. P. Hämäläinen & E. Saarinen (Eds.), ***Systems Intelligence – Discovering a Hidden Competence in Human Action and Organizational Life***: 9–37. Espoo: Helsinki University of Technology, Systems Analysis Laboratory Research Reports, A88.

Saarinen, E., & Hämäläinen, R. P. 2010. The originality of systems intelligence. In R. P. Hämäläinen & E. Saarinen (Eds.), ***Essays on Systems Intelligence***: 9–28. Espoo: Aalto University, Systems Analysis Laboratory.

Sahlsten, M. J. M., Larsson, I. E., Sjöström, B., & Plos, K. A. E. 2009. Nurse strategies for optimising patient participation in nursing care. ***Scandinavian Journal of Caring Sciences***, 23(3): 490–497.

Salanova, M., Bakker, A. B., & Llorens, S. 2006. Flow at Work: Evidence for an Upward Spiral of Personal and Organizational Resources. ***Journal of Happiness Studies***, 7(1): 1–22.

Salovey, P., & Mayer, J. D. 1990. Emotional intelligence. ***Imagination, Cognition, and Personality***, 9: 185–211.

Sandelands, L. E., & Boudens, C. J. 2000. Feeling at work. In S. Fineman (Ed.), ***Emotion in organizations: Second Edition***: 46–63. London: Sage Publications.

Sander, L. W. 1977. The regulation of exchange in the infant-caretaker system and some aspects of the context-content relationship. In M. Lewis & L. Rosenblum (Eds.), ***Interaction, conversation, and the development of language***: 133–156. New York: Wiley.

Sander, L. W. 1985. Toward a logic of organization in psycho-biological development. In K. Klar & L. Siever (Eds.), ***Biologic response styles: Clinical implications***: 20–36. Washington D.C.: Monographs of the American Psychiatric Association.

Sander, L. W. 1991. Recognition process: Specificity and organization in early human development. Paper presented at the University of Massachusetts conference, The Psychic Life of the Infant.

Sander, L. W. 1995. Identity and the experience of specificity in a process of recognition: Commentary on Seligman and Shanok. ***Psychoanalytic Dialogues***, 5(4): 579–593.

Sander, L. W. 2002. Thinking differently. ***Psychoanalytic Dialogues***, 12(1): 11–42.

Schaufeli, W. B., & Bakker, A. B. 2004. Job demands, job resources, and their relationship with burnout and engagement: a multi-sample study. ***Journal of Organizational Behavior***, 25(3): 293–315.

Schiller, F. C. S. 1912. ***Humanism - Philosophical essays***. London: MacMillan and Co.

Schön, D. A. 1983. ***The Reflective practitioner: How professionals think in action***. New York: Basic Books.

Seigel, J. 2005. ***The idea of the self: Thought and experience in Western Europe since the seventeenth century***. Cambridge: Cambridge University Press.

Seligman, M. E. P. 2011. ***Flourish: A Visionary New Understanding of Happiness and Well-being***. New York: Free Press.

Seligman, M. E. P., & Csikszentmihalyi, M. 2000. Positive psychology - An introduction. ***American Psychologist***, 55(1): 5–14.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. 2005. Positive psychology progress: Empirical validation of interventions. ***American Psychologist***, 60: 410–421.

Seligman, S. 2005. Dynamic systems theories as a metaframework for

psychoanalysis. ***Psychoanalytic Dialogues***, 15(2): 285–319.

Senge, P. M. 2006. ***The Fifth discipline: The art and practice of the learning organization***. New York: Currency Doubleday.

Sewell, G., & Barker, J. R. 2006. Coercion versus care: Using irony to make sense of organizational surveillance. ***The Academy of Management Review***, 31(4): 934–961.

Shaver, P. R., & Mikulincer, M. 2006. Attachment theory, individual psychodynamics, and relationship functioning. In A. L. Vangelisti & D. Perlman (Eds.), ***The Cambridge handbook of personal relationships***: 251–271. New York: Cambridge University Press.

Sheldon, K. M., Kashdan, T. B., & Steger, M. F. 2011. ***Designing Positive Psychology: Taking Stock and Moving Forward***. New York: Oxford University Press.

Siegel, D. J., & Hartzell, M. 2004. ***Parenting from the inside out: How a deeper self-understanding can help you raise children who thrive***. New York: JP Tarcher.

Siegrist, J. 1996. Adverse health effects of high-effort/low-reward conditions. ***Journal of occupational health psychology***, 1(1): 27–41.

Sillars, A. L., & Vangelisti, A. L. 2006. Communication: Basic properties and their relevance to relationship research. In A. L. Vangelisti & D. Perlman (Eds.), ***The Cambridge handbook of personal relationships***: 331–351. New York: Cambridge University Press.

Simpson, B. 2009. Pragmatism, Mead and the Practice Turn. ***Organization Studies***, 30(12): 1329 –1347.

Simpson, B., & Marshall, N. 2010. The mutuality of emotions and learning in organizations. ***Journal of Management Inquiry***, 19(4): 351–365.

Simpson, J. A., Winterheld, H. A., & Chen, J. Y. 2006. Personality and Relationships: A Temperament Perspective. In A. L. Vangelisti & D. Perlman (Eds.), ***The Cambridge handbook of personal relationships***: 231–250. New York: Cambridge University Press.

Sluss, D. M., & Ashforth, B. E. 2007. Relational Identity and Identification: Defining Ourselves Through Work Relationships. ***Academy of Management Review***, 32(1): 9–32.

Snyder, C. R., & Lopez, S. J. 2002. ***Handbook of positive psychology***. Oxford University Press, USA.

Sparrowe, R. T., & Liden, R. C. 1997. Process and structure in leader-member exchange. ***Academy of management Review***, 22(2): 522–552.

Spence, J. T. 1985. Achievement American Style: The Rewards and Costs of Individualism. ***American Psychologist***, 40(12): 1285–1295.

Spradley, J. P., & Baker, K. 1980. ***Participant observation***. New York: Holt, Rinehart and Winston.

Spreitzer, G., Sutcliffe, K., Dutton, J. E., Sonenshein, S., & Grant, A. M. 2005. A socially embedded model of thriving at work. ***Organization Science***, 16(5): 537–549.

Standing Nursing and Midwifery Advisory Committee. 2001. ***Caring for older people - A nursing priority***. London: Department of Health.

Starbuck, W. H. 2006. ***The production of knowledge: the challenge of social science research***. Oxford: Oxford University Press.

Stern, D. N. 1985. ***The interpersonal world of the human infant***. New York: Basic Books.

Stern, D. N. 1998. The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. ***Infant Mental Health Journal***, 19(3): 300–308.

Stern, D. N. 2004. ***The present moment in psychotherapy and everyday life***. New York: Norton.

Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., & Morgan, A. C. 1998. Non interpretative mechanisms in psychoanalytic therapy: the "something more" than interpretation. ***International Journal of Psycho-Analysis***, 79: 903–21.

Stern, S. 2009. The dialectic of empathy and freedom. ***International Journal of Psychoanalytic Self Psychology***, 4(2): 132–164.

Stolorow, R. D. 1997. Dynamic, dyadic, intersubjective systems: An evolving paradigm for psychoanalysis. ***Psychoanalytic Psychology***, 14(3): 337–346.

Stolorow, R. D. 1998. Clarifying the intersubjective perspective: A reply to George Frank. ***Psychoanalytic Psychology***, 15(3): 424–427.

Stolorow, R. D., & Atwood, G. E. 1992. ***Contexts of being: The intersubjective foundations of psychological life***. Hillsdale, NJ.: The Analytic Press.

Stolorow, R. D., Atwood, G. E., & Orange, D. M. 2002. ***Worlds of experience: Interweaving philosophical and clinical dimensions in psychoanalysis***. New York: Basic Books.

Strauss, A. L., & Corbin, J. M. 1998. ***Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd Edition.*** London: Sage Publications.

Suddaby, R. 2006. From the editors: What grounded theory is not. ***Academy of Management Journal***, 49(4): 633–642.

Suh, E. M., & Sung, M. 2009. Collective well-being. In S. J. Lopez (Ed.), ***The Encyclopedia of Positive Psychology***: 197–199. Chichester: Blackwell Publishing.

Swanson, K. M. 1999. What is known about caring in nursing science: A literary meta-analysis. In A. S. Hinshaw, S. L. Feetham, & J. L. F. Shaver (Eds.), ***Handbook of clinical nursing research***: 31–60. Thousand Oaks, CA.: Sage Publications.

Symington, N. 1983. The analyst's act of freedom as agent of therapeutic change. ***International Review of Psycho-analysis***, 10: 283–291.

Taris, T. W., Cox, T., & Tisserand, M. 2008. Engagement at work: An emerging concept. ***Work & Stress***, 22(3): 185–186.

Tarlow, B. 1996. Caring: A negotiated process that varies. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: 56–82. Philadelphia, Pa.: University of Pennsylvania Press.

Taylor, C. 1989. ***Sources of the self: The making of the modern identity***. Cambridge, Mass.: Harvard University Press.

Taylor, J. B. 2008. ***My Stroke of Insight: A Brain Scientist's***

Personal Journey. New York: Viking Penguin.

Taylor, M. B. 1997. Compassion: its neglect and importance. ***The British Journal of General Practice***, 47: 521–523.

Thelen, E. 2005. Dynamic systems theory and the complexity of change. ***Psychoanalytic Dialogues***, 15(2): 255–283.

Thelen, E., & Smith, L. B. 1994. ***A dynamic systems approach to the development of cognition and action***. Cambridge, Mass.: MIT Press.

Thornton, P. H., & Ocasio, W. 1999. Institutional logics and the historical contingency of power in organizations: Executive succession in the higher education publishing industry, 1958-1990. ***American Journal of Sociology***, 105: 801–843.

Tonuma, M., & Winbolt, M. 2000. From rituals to reason: Creating an environment that allows nurses to nurse. ***International Journal of Nursing Practice***, 6(4): 214–218.

Totterdell, P., & Holman, D. 2003. Emotion regulation in customer service roles: Testing a model of emotional labor. ***Journal of Occupational Health Psychology***, 8(1): 55–73.

Trevarthen, C. 2008. The musical art of infant conversation: Narrating in the time of sympathetic experience, without rational interpretation, before words. ***Musicae Scientiae***, 12(1 suppl): 15–46.

Triandis, H. C., Bontempo, R., Villareal, M. J., Asai, M., & Lucca, N. 1988. Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. ***Journal of personality and social psychology***, 54(2): 323–338.

Trout, M. 2011. Presence and Attunement in Health Care: A View From Infancy Research. ***Creative Nursing***, 17(1): 16–21.

Tsoukas, H. 1993. Analogical reasoning and knowledge generation in organization theory. ***Organization studies***, 14(3): 323–346.

Tsoukas, H., & Knudsen, C. 2003. Introduction: The Need for Meta-theoretical Reflection in Organization Theory. In H. Tsoukas & C. Knudsen (Eds.), ***The Oxford Handbook of Organization Theory***: 1–36. Oxford: Oxford University Press.

Vacharkulksemsuk, T., & Fredrickson, B. L. 2012. Strangers in sync: Achieving embodied rapport through shared movements. ***Journal of Experimental Social Psychology***, 48(1): 399–402.

Vinje, H. F., & Mittelmark, M. B. 2007. Job engagement's paradoxical role in nurse burnout. ***Nursing and Health Sciences***, 9(2): 107–111.

Wadensten, B., & Carlsson, M. 2003. Nursing theory views on how to support the process of ageing. ***Journal of advanced nursing***, 42(2): 118–124.

Waerness, K. 1996. The rationality of caring. In S. Gordon, P. Benner, & N. Noddings (Eds.), ***Caregiving: Readings in knowledge, practice, ethics, and politics***: 231–255. Philadelphia, Pa.: University of Pennsylvania Press.

Waldron, S., Scharf, R., Crouse, J., Firestein, S. K., Burton, A., & Hurst, D. 2004. Saying the right thing at the right time: A view through the lens of the Analytic Process Scales (APS). ***Psychoanalytic Quarterly***, 73(4): 1079–1125.

Walter, F., & Bruch, H. 2008. The positive group affect spiral: a dynamic model of the emergence of positive affective similarity in work groups. ***Journal of Organizational Behavior***, 29(2): 239–261.

Watson, J. 1985. ***Nursing: human science and human care, a theory of nursing***. Norwalk, CT.: Appleton-Century-Crofts.

Watson, J. 1997. The Theory of Human Caring: Retrospective and Prospective. ***Nursing Science Quarterly***, 10(1): 49 –52.

Watson, J. 2008. ***Nursing: The philosophy and science of caring. Revised Edition***. Boulder, Colorado: University Press of Colorado.

Watson, T. J. 2011. Ethnography, Reality, and Truth: The Vital Need for Studies of "How Things Work" in Organizations and Management. ***Journal of Management Studies***, 48(1): 202–217.

Weber, M. 1946. Bureaucracy. In H. H. Gerth & C. W. Mills (Eds.), C. W. Mills & H. H. Gerth (Trans.), ***Essays in sociology***: 196–244. New York: Oxford University Press.

Wegner, D. M., Erber, R., & Raymond, P. 1991. Transactive memory in close relationships. ***Journal of Personality and Social Psychology***, 61(6): 923–929.

Weick, K. E. 1989. Theory construction as disciplined imagination. ***Academy of Management Review***, 14(4): 516–531.

Weick, K. E. 2005. Organizing and failures of imagination. ***International Public Management Journal***, 8(3): 425–438.

Weick, K. E., & Roberts, K. H. 1993. Collective Mind in Organizations: Heedful Interrelating on Flight Decks. ***Administrative Science Quarterly***, 38(3): 357–381.

Wenger, E. 1999. ***Communities of practice: Learning, meaning, and identity***. New York: Cambridge University Press.

Whitehead, A. N. 1979. ***Process and reality - Corrected edition***. New York: The Free Press.

Wicks, A. C., & Freeman, R. E. 1998. Organization studies and the new pragmatism: Positivism, anti-positivism, and the search for ethics. ***Organization Science***, 9(2): 123–140.

Wicks, A. C., Gilbert Jr, D. R., & Freeman, R. E. 1994. A feminist reinterpretation of the stakeholder concept. ***Business Ethics Quarterly***, 4(4): 475–497.

Wilkinson, M. J. 1995. Love is not a marketable commodity: new public management in the British National Health Service. ***Journal of Advanced Nursing***, 21(5): 980–987.

Wilson, P. 2012. Václav Havel (1936-2011). ***The New York Review of Books***. http://www.nybooks.com/articles/archives/2012/feb/09/vaclav-havel-1936-2011/. Accessed October 1, 2012.

Winnicott, D. W. 1965. ***The maturational processes and the facilitating environment***. New York: International University Press.

Wodak, R. 2004. Critical discourse analysis. In C. Seale, J. F. Gubrium, & D. Silverman (Eds.), ***Qualitative research practice***. London: Sage.

Wright, T. A. 2010. More than meets the eye: The role of employee well-being in organizational research. In P. A. Linley, S. Harrington, & N. Garcea (Eds.), ***Oxford handbook of positive psychology and***

work: 143–154. New York: Oxford University Press.

Wright, T. A., & Cropanzano, R. 2000. Psychological well-being and job satisfaction as predictors of job performance. ***Journal of Occupational Health Psychology***, 5(1): 84–94.

Wright, T. A., & Cropanzano, R. 2004. The role of psychological well-being in job performance: A fresh look at an age-old quest. ***Organizational Dynamics***, 33(4): 338–351.

Wright, T. A., & Cropanzano, R. 2007. The happy/productive worker thesis revisited. ***Research in personnel and human resources management***, 26: 269–307.

Wrzesniewski, A. 2003. Finding positive meaning in work. In J. E. Dutton (Ed.), ***Positive organizational scholarship: Foundations of a new discipline***: 296–308. San Francisco, CA: Berrett-Koehler.

Wrzesniewski, A., Dutton, J. E., & Debebe, G. 2003. Interpersonal sensemaking and the meaning of work. ***Research in organizational behavior***, 25: 93–135.

Wrzesniewski, A., McCauley, C., Rozin, P., & Schwartz, B. 1997. Jobs, careers, and callings: People's relations to their work. ***Journal of Research in Personality***, 31(1): 21–33.

Wuthnow, R. 1991. ***Acts of compassion: Caring for others and helping ourselves***. Princeton, NJ.: Princeton University Press.

Yin, R. K. 2009. ***Case Study Research: Design and Methods*** (4th ed.). Thousand Oaks, CA.: Sage Publications.

Zeeman, E. C. 1976. Catastrophe theory. ***Scientific American***, 234(April): 65–83.

Özbilgin, M. F. 2006. Relational methods in organization studies: a review of the field. In O. Kyriakidou & M. F. Özbilgin (Eds.), ***Relational perspectives in organizational studies: A research companion***: 244–264. Cheltenham, UK.: Edward Elgar Publishing.

One day in the nursing home, I observed a nurse feeding a resident whose hands were already too weak for such activity. The atmosphere of the whole scene resembled a mother feeding her baby. Such was the tenderness in the eyes of the nurse as she looked upon the resident and such warmth was in her voice when she asked the resident, "Is it too hot for you?" And such was the satisfaction in the eyes of the resident who received such tender care. Both participants were attuned to each other and fully absorbed in the shared situation. It was not just a professional fulfilling a basic need of her client. It was also two human beings in an engaged relationship who cared for each other at that moment. It was a moment of caring connection.

Aalto-DD 144/2012

ISBN 978-952-60-4847-5
ISBN 978-952-60-4848-2 (pdf)
ISSN-L 1799-4934
ISSN 1799-4934
ISSN 1799-4942 (pdf)

Aalto University
School of Science
Department of Industrial Engineering and Management
www.aalto.fi

BUSINESS + ECONOMY

ART + DESIGN + ARCHITECTURE

SCIENCE + TECHNOLOGY

CROSSOVER

DOCTORAL DISSERTATIONS