1990-11-01

The Experience of Female Nurses Being Cared for: A Phenomenological Analysis

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THE EXPERIENCE OF FEMALE NURSES BEING CARED FOR: A PHENOMENOLOGICAL ANALYSIS

by

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A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF NURSING SCIENCE

November 1990

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Publication No. _____

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University of San Diego, 1990

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The focus of this phenomenological inquiry was the question: What is the meaning (essential structure) of the experience of being cared for as lived by female nurses? The purpose of this study was to explore and describe the experience of being cared for.

Phenomenologic methodology was used for this study. Data analysis was patterned after the guidelines set out by Colaizzi, and Miles and Huberman.

Fifteen female nurses described their experiences of being cared for during two interviews with the researcher. Through analysis of the first audio-taped interview metathemes describing the phenomena and a unity of meaning emerged. During the second interview the participants clarified and verified the findings in this study. Five metathemes emerged.

1. Feelings associated with the nurse being cared for are tacit, and understood holistically as being multidimensional and interrelated.

2. The behaviors associated with the nurse being cared for are understood holistically as having instrumental and non-instrumental components and are equated with giving that is multidimensional.

3. The nurse allowing caring to occur uses a dialectic process to validate her feelings concerning her own independence, vulnerability, and the validity of trusting others.

4. Expectations of the nurse being cared for include care giver sensitivity to the tacit perceptions of the care recipient's notion of being cared for.

5. The consequences of being cared for include personal growth and extension of self to others.

The metathemes were merged to provide an exhaustive description of the phenomena, and the unity of meaning, flowing from the exhaustive description, was identified. In the present study, unity of meaning, the essence of being cared for as experienced by nurses, means "persons sharing life with another." The findings in this study serve as a beginning description of the meaning of the experience of being cared for as lived by female nurses.

DEDICATION

This dissertation is dedicated to my caring family, my parents Harold (Jack) and Treva Dyer Skinner, my husband Harry, and my children Robert, Aaron and Shannon for the love and encouragement they have given me over my life time.

ACKNOWLEDGEMENTS

My sincere gratitude goes to my dissertation committee: to Dr. Mary Ann Hautman for her ever-present encouragement, wisdom, and the helpful suggestions offered during my doctoral studies and throughout this dissertation process; to Dr. Kathleen Heinrich whose enthusiasm, insight and support was ever present and well appreciated; and to Dr. Rosemary Goodyear for her confidence and reassurances which were always helpful.

I am especially grateful to the nurses who shared their personal experiences of being cared for with me. This study would not have been possible without their cooperation.

Thanks are also extended to the faculty, students, administrators and board of trustees of Southwestern College for their interest and the support shown me during the doctoral educational process and the writing of this dissertation.

My supportive fellow students and friends at the University of San Diego are sincerely thanked for their caring. I am especially grateful for Betty, my roommate of three summers and my friend for life.

My deepest gratitude is expressed to my husband, Harry, who has made many sacrifices for me and who has supported me throughout my education.

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Chapter One

INTRODUCTION TO THE STUDY

The concept of care is integral to the interpretation of nursing as it is viewed by society and by the nursing profession. The term care carries the connotation of one person being cared for by another. In nursing, the word care is generally thought of as an action or activity done to meet the needs of others. There is another important aspect related to care, that of being cared for. Most often the aspect of being cared for is assigned to another and not to the nurse. Nurses are considered care givers and others are considered recipients of care. However, in an individual's experience in the world of care, both aspects are equally important.

Background of the Study

Personal observation reveals that nurses are uncomfortable with being cared for and may avoid being cared for by others. Nurses often put duty before seeing to their own personal health care needs. They claim to prefer independence over having care provided by others. For example, a nurse acquaintance of this researcher relates that she had been having chest pain for a few days when she decided she needed to see the doctor and made an

appointment for the next day. The day of her scheduled appointment she took her husband to the hospital where he was admitted for treatment of an exacerbation of a chronic condition. Then she went on to work, because there was "so much that needed to be attended to," prior to seeing the physician. All the while she was having chest pain. Finally, she went to her appointment and arrested in the office. The paramedics were called to transport her to the hospital. When she heard the doctor ask for the ambulance "red light and siren," she recalled wondering "who is so sick to need that kind of attention."

Nurses have been observed expressing discomfort when they are the object of another's caring. They proclaim a dislike of being in a position where they are beholden to another. When asked what they do when they feel ill they relate one of two behaviors. They either "get up and get going, and work it off," or they "go to bed and hope no one bothers me."

Nurses complain that they are the only one in the family who can care for people. Married nurse note their husbands are particularly uncooperative and inept personal care givers. Providing for the emotional and physical care of family members is considered a part of the woman's domain, while the male's domain is seeing to the material needs of the family. Although these expectations may be considered cultural traits, they may also be self-imposed.

Nurses, as many other professional women, tend to take on professional responsibility and at the same time are unable to relinquish duties considered traditional women's work.

In the clinical setting nurses complain of "burnout," express doubt concerning their effectiveness and the value of nursing. Still when asked to work on their days off they respond affirmatively, at times in a spirit of martyrdom, at times in the spirit of self-sacrificial altruism. These attitudes of personal self-effacement and self-sacrifice seem to flow naturally since nursing is a women's profession. Ninety-seven percent of the nurses in the United States are women (American Nurse's Association, 1987). Feminist writers note that serving others is the basic principle around which women's lives are organized (Eichenbaum & Orbach, 1987; Gilligan, 1982; Grimshaw, 1986; Lovell, 1981; Miller, 1986).

Miller (1986) posits the notion that women have been led to believe "that they can integrate and use all their attributes if they use them for others, but not for themselves" (p. 61). An example which illustrates this belief comes from a personal observation. While discussing a young woman's romance with her, she explained "there are so many things I would like to do for John," never considering how her own needs would be satisfied should the relationship come to fruition.

In the educational setting it has been observed that

student nurses receive double messages from faculty concerning the importance of meeting their own needs. They are asked to remain at home if they are ill and at the same time they are told "there is no reason to miss clinical save being on your death bed." Such a message instills in nursing students the notion that self-sacrifice is expected.

Furthermore, history indicates nursing is rooted in an attitude of self-sacrificial altruism. Nursing was described as a "calling" by Nightingale (1859/1946), and therefore, service to others was expected. Nursing, in Western civilization, had a long association with Christianity, first with the Catholic Church and later with Protestant denominations (Dolan, Fitzpatrick, & Herrman, 1983; Kalisch & Kalisch, 1986). The ideal of serving God by imitating Christ, the "sacrificial lamb," promotes the notion that to be called to care for others requires self-sacrifice.

Giuffra (1987), and Reverby (1987a, 1987b) acknowledge the altruistic nature of the nursing profession. They note that the concept of altruism has been taken beyond the notion of unselfish regard for or devotion to the welfare of others, to a point of self-sacrifice. Aiken's (1943) early nursing ethics text, lists qualities essential to the nurse. These qualities, which evidence nursing's altruistic roots, include a "keen desire to be of service

to the sick or helpless. . .(and that) desire must be strong enough to lead the nurse to sacrifice her own plans and comfort for the welfare of the sick and those dependent on her" (p. 11). In this decade, the notion that one's being cared for contributes to the ability to care for other's has been posited in feminist literature (Gilligan, 1982; Noddings, 1984). Gilligan (1982) believes that the connectedness inherent in parent-child relationships gives rise to a woman's obligation to be caring. She notes the connectedness is different in boys and girls and leads to different orientations to life. Gilligan (1982) concurs with Chodorow (1978) in the opinion that girls emerge from childhood with "empathy" (Chodorow, 1978, p. 167; Gilligan, 1982, p. 8) as an integral component of their definition of self in a way that is different from boys. However, to get along in a man's world, girls must learn to live by man's rules. Therefore, as adults women accept a self-effacing, self-sacrificial role; caring for others and negating one's own needs.

The concept of care as the essence of nursing is consistently confirmed in nursing literature by Gadow (1988), Leininger (1977, 1981, 1984), and Watson (1979, 1985/1988). Gadow (1988) describes caring as an obligation to alleviate another's vulnerability. She explains that in order to alleviate another's vulnerability one must become vulnerable. This concept is the antithesis of nursing's

historical stance on professionalism. A professional demeanor often means nurses distance themselves from their patients. In an effort to be courteous to all but intimate with none (Densford & Everett, 1946), nurses protect themselves physically, and more importantly, they protect themselves emotionally by not revealing their own sorrows, fears, and vulnerability (Gadow, 1988).

In summary, it has been observed that although nurses are the recipient of care, they practice avoidance behavior when it comes to being cared for, in private as well as professional settings. Professionally, nurses behave according to a standard of self-sacrifice rather than one that is truly altruistic. Furthermore, there is evidence of a long history of such behavior which has been promoted by a well-accepted belief system. It has been noted that there is a dichotomy between what is identified as professional behavior and caring behavior, and that dichotomy is perpetuated when nurses protect themselves from becoming emotionally involved in the lives of their patients. Finally, a theory concerning a relationship between being cared for and the ability to care has been posited.

Problem for the Study

There is not a clear understanding of the meaning which the experience of being cared for holds for nurses. Further, there are no studies addressing the meaning or

essence of nurses being cared for.

Rationale and Significance of the Problem

Rationale

What constitutes a genuine human existence in the world has been an interest of philosophers since earliest times. Although self-knowledge would seem to be most easily understood, it is hardest to acquire. This is evidenced by the fact that in modern times there is still not agreement as to an understanding of what or who the person is. To begin, there must be a differentiation between a person's existence and existence understood as objects which can be seen.

That a person exists means more than a person is: it means there is awareness of existence, of what a person is. Macquarrie (1977), theologian and foremost authority on Heidegger, points out that "objects in nature have their properties given to them, but what is 'given' to man is an existence that stands before different possibilities of being,. . ." (p. 61). The idea of existence differentiates a person's being from being that belongs to objects in nature. Analysis of human existence reveals "polarities," (Macquarrie, 1977) i.e., two parts having opposite properties. Persons live in a world where there is the possibility of existing at one pole or the other, or to exist in the midst, influenced by the properties of both poles. To be in the midst, however, requires that one deal

with the tension or stress of being influenced by the properties of both poles simultaneously. Examples of polarities include opposite concepts such as "possibility" and "facticity," "rationality" and "irrationality," and "responsibility" and "impotence" (Macquarrie, p. 62-66). Also contained in human existence within the world are the "individual and social poles" (p. 66).

Nurses exist in the world of care and in the midst of individual and social polarities. One set of polarities is the kind of caring that is natural caring over and against the kind of caring that is obligatory caring; another set of polarities is the experience of caring for others over and against the experience of being cared for. When one polarity and its properties overrides its opposite the structure becomes disjointed, distorted and destructive (Macquarrie, 1977).

The concept of polarities is not synonymous with dichotomies where one chooses one over the other. Neither can polarities be thought of as a continuum with caring at one end and being cared for at the other. Polarities are more synonymous with the Yin and Yang of life, where each enters into and influences the other. Problems or "pathology" arises only when one's life is out of balance, influenced by only one pole and not the other; completely Yin and void of Yang or completely Yang and void of Yin; consistently caring for others and never being the

recipient of care or consistently receiving care and never caring for others.

Analogous to this notion is the respiratory cycle where life continues as long as one breathes in and then breathes out. With shallow breathing one remains alive. One may experience irregular breathing, with either expiration or inspiration lasting for an extended period of time, or they may simply hold their breath and life continues. However, not breathing in and out ends existence in the world as we know it. Similar are the cycles associated with communication where one hears and then one speaks, and where one reads and then one must write in order to complete the cycle. For nurses to remain in balance they must be able to remain within the boundaries of the world of care; they must experience being cared for in order to be caring with others.

Significance

Although the care giving dimension is important in the development of knowledge related to the concept of care, an understanding of what the experience of being cared for holds for nurse care givers remains unclear. The concept of care has been of interest to philosophers and scholars. The focus has generally been aimed at the attributes of care givers and the benefits care givers receive when they care for others. The benefits of caring reaped by patients have also been postulated. What being cared for means to

the personal and professional lives of nurses has not been explored.

Many theories about care include a component which concerns being the recipient of care. However, nursing research related to being cared for focuses around "caring for the care giver" where the concern is for the lay-person who is caring for a chronically-ill, significant other. Baillie, Norbeck, and Barnes (1988) studied the effect of stress and social support, and their interaction with psychological well-being of family care givers when caring for the impaired elderly. Other authors have addressed the stress associated with being a mid-life care giver, being responsible for the welfare of the children in the family as well the older generation (Baldwin, 1988), and supporting care givers who are confronted with a spouse or parent with Alzheimer's or other chronic debilitating disease processes (Service, 1988).

When nurses are the focus of care giver studies, the study emphasizes the physical danger and stress associated with caring for patients with specific conditions. Examples of recent literature concerning "caring for the care giver" when the care giver is a nurse includes: articles on prevention of cross infection when caring for an AIDS patient (Jenna, 1987); recognizing that nurses are not immune to the stress associated with caring for babies born sick (Simone, 1984); and "burnout" related to the

frustration experienced by home health care givers (Nickles, 1988). That nurses become patients and need care is addressed in anecdotal writings (Brainard, 1989; Mandell, 1988; & Motzko, 1988).

The present study is important for the following reasons. This study can provide a description of being cared for, and clarify the meaning the experience being cared for holds for nurses. Through this beginning description, a better understanding of the care givers willingness and ability to allow others to care for female nurses is attempted. Knowledge of care focusing on the care of the care giver and based on experience can provide explication useful in the practice of nursing and the education of nurses as a better understanding of others is facilitated through personal knowing.

Purpose of the Study

The purpose of this study is to explore the experience of nurses being cared for. The experience of practicing, female nurses who have been the recipient of care from any person will be used. Therefore, this examination will capture the essence of being cared for within the broad context of care. This study will advance the development of a beginning description of the essential themes which being cared for holds for nurses.

A qualitative method will be used to facilitate a shared reality (Heidegger, 1927/1962) of the nurses'

experience as the recipient of care. The research question will be approached from an existential phenomenological perspective. Clarification of the essential structures, i.e., major dimensions, of nurses being cared for will provide for an understanding at the descriptive level concerning the phenomena of care.

Research Question

The question for this study is: what is the meaning (essential structure) of the experience of being cared for as it is lived by female nurses?

Assumptions

Phenomenological analysis dictates that the researcher state assumptions concerning the phenomenon under investigation and then to "bracket" them. In so doing, the experience of the subject is more fully understood and an a priori hypothesis is not imposed on the experience. Therefore, it is assumed:

1. nurses are the recipients of care;
2. nurses are uncomfortable with and avoid being cared for;
3. being invulnerable is considered a professional attribute and therefore influences nurses toward avoidance behavior when it comes to being cared for;
4. there is an essential structure of nurses being cared for;

5. nurses will be able to describe events, situations, feelings and people;

6. the description will reflect the personal experience of being cared for as lived by nurses; and

7. transcriptions will be reflective of the descriptions of the lived world of the participants.

Definition of Terms

The following terms will be defined for the purpose of this study.

1. Nurse - a female registered nurse.

2. Care giver - anyone providing care to another.

3. Being cared for - any interaction with any other person where caring behaviors are being extended to the nurse.

4. Caring behavior - any behavior which the nurse describes as an act of caring.

Summary

In this chapter the background of the research question, the purpose of the inquiry, and statement of the research question were explained. In the background, both social and historical trends which indicate a need for an explication of care, from the perspective of the nurse as the recipient of care, has been explored. Evidence of the self-sacrificial, altruistic nature of nursing was given. A dichotomy between what is thought to be professional behavior and quality caring has been speculated. Further,

a theory concerning the relationship of being cared for and the ability to care for others has been postulated. From the background and the purpose of the study, the research question: What is the meaning of the experience of being cared for as lived by nurses? was derived. The qualitative research method, existential phenomenology, resulted from the research question.

Chapter One concluded with the rationale, significance, assumptions, and a definition of terms associated with the study. The rationale philosophically supported a notion which recognizes the human existence of nurses, and both being cared for and caring for others as integral to the concept of care. The significance of a study which explicates the concept of care, and builds nursing knowledge was cited.

Chapter Two

REVIEW OF THE LITERATURE

In this chapter, selected literature related to the phenomena of being cared for and the philosophical underpinnings of this study will be investigated. A conceptualization of being cared for will be examined through literature aimed, principally, at a better understanding of existential aspects of care. The literature review will include selections from philosophy, psychology, women's studies, and nursing. The philosophical underpinnings of this study will be explored through the writings of phenomenological philosophers, Husserl, Heidegger, and Buber. Finally, the utility of the phenomenological research method for the advancement of nursing knowledge will be reviewed through an inquiry into nursing's literature.

Being Cared For

Philosophical Conceptualizations of Being Cared For

Although the concept of care is alluded to in other philosophical writing, Mayeroff (1971) is one of few who provides a direct discussion. He recognizes care as an integral part of living. Mayeroff describes caring as assisting a person toward growth and self-actualization.

The opposite of caring is using another to meet one's own needs. The measure of true caring, whether it is the television stations that "care about you," parents "caring" for their children or nurses "caring for patients," is determined by his criteria; either one is assisting toward self-actualization and truly caring, or one is meeting personal needs and not truly caring.

There are eight major characteristics of caring according to Mayeroff (1971). The first characteristic is summarized as knowledge which is "explicit and implicit," knowledge "that" something is true as well as "how" to do something, and knowledge that is "direct and indirect" (p. 15). Second, caring is not a habit but requires alternating rhythms, i.e., taking time for reflection and modifying or maintaining behavior accordingly, so that the growth of another person is assisted. The third characteristic concerns patience, the time and space required for the care giver and care receiver to learn. Honesty, the fourth characteristic, has to do with trying to see the care recipient in actuality and not as it is hoped the care recipient would be. Honesty also has to do with the care giver being genuine in the act of caring for another. Characteristic five concerns the trust one must have that the care receiver will indeed learn and grow as a result of making mistakes. Similarly, the care givers must trust in their own ability to learn from mistakes. Sixth is the

characteristic of humility where the care givers truly appreciates their own limitations as well as their own powers. Hope is the courage to stand by the care receiver during difficult circumstances and implies the existence of something which is worthy of commitment. Hope is identified as the seventh characteristic. Finally, the courage to venture into the unknown is the eighth characteristic of caring.

There are certain illuminating aspects of caring. According to Mayeroff (1971) the care givers themselves are also self-actualized in the process of assisting others to self-actualization. Further, he concludes the process of caring, i.e., doing caring, is primary rather than the product, i.e., the outcome of caring, when one is caring for another. Mayeroff believes that to be caring requires the care recipient to remain constant in the relationship. Moving in and out of the relationship prohibits the development of a sense of loyalty. There is guilt on the part of the care giver when they behave with indifference or neglect and the guilt harkens the care giver back to caring. Mayeroff also posits the notion that caring is a "matter of degree within limits" (p. 38). That is, caring is not a "morbid dependency" nor is it a "malevolent manipulation" (p. 38).

Mayeroff (1971) argues that reciprocity is not a requisite of caring. However,

> In a meaningful friendship, caring is mutual, each cares for the other; caring becomes contagious. My caring for the other helps activate his caring for me; and similarly his caring for me helps activate my caring for him, it 'strengthens' me to care for him. But to say that care in this case is reciprocated does not imply that it is a trade - I care for you if you care for me. And this is true even if I cease to care for another simply because my caring is not reciprocated (p. 37).

Further, Mayeroff (1971) avers that just as the care giver must be capable of caring, the care recipient must be capable of being cared for. That is, the one being cared for must give the care giver the opportunity to help. He points out that to comfort someone or to be interested in a person's welfare does not constitute care. To care implies that one is seeing to the growth of another, to the person's self-actualization.

Mayeroff (1971) explains that through caring and being cared for, life is ordered and persons find their place in the world. In an ordered life there is stability rather than uncertainty. The process of life is satisfying. The relevance of life is opened, and autonomy, faith, and gratitude are present.

Other philosophers (Burch, 1979; Frankena, 1983; Pellegrino & Thomasma, 1988) have been concerned with the phenomena of care, however they do not speak specifically to being cared for. There is little written concerning the philosophical aspects of being cared for.

From the discipline of psychology, Gaylin (1976) asserts that humans have a genetic propensity toward caring. In his book, Caring, Gaylin explains that care, i.e., caring and being cared for, allows generations to face changes in philosophies, politics, and scientific development. Caring is seen as a critical interpersonal process which is necessary in the development of human relationships. Gaylin illustrates caring using mother-child relationships. He explains that caring is

> the protective, parental, tender aspects of loving - is a part of relationship among peers, child to parent, friend to friend, lover to lover...As light and visual stimulation are essential for the development of the capacity to see, so to be cared for is essential for the capacity to be caring (p. 63).

Noddings (1984) is an educator and feminist. She believes that "caring involves two parties: the one-caring and the cared-for. It is complete when it is fulfilled in both" (p. 68). No matter what the attitude of the care giver, if care is not recognized by the one to whom caring is aimed, caring can be only partially actualized. Therefore, caring requires a form of reciprocity and some spontaneous response by the cared-for.

Drawing on Buber's (1970) work, Noddings (1984) explains that the one being cared for does not hear the "Thou" in the being cared for experience. When something is experienced, what ever it was that was experienced becomes an object.

> What the cared-for gives to the relation either in direct response to the one-caring or in personal delight or in happy growth before her eyes is genuine reciprocity. It contributes to the maintenance of the relation and serves to prevent the caring from turning back on the one-caring in the form of anguish and concern for self (p. 74).

Noddings (1984) argues that human caring and the memory of being cared for are the foundation of an ethical response. The "natural sympathy humans feel for each other and a longing to maintain, recapture or enhance our most caring moments" (p. 104) gives birth to an ethical ideal. It is difficult to discern caring which is ethical and caring which is merely natural. In summary, Noddings' beliefs about the world of care indicates there are types of caring which include natural caring and ethical caring, and there are ways in which care is experienced that include being cared for and caring for others.

Jourard (1964) describes the qualities nurses must have to make their patients feel understood and cared about. Among those qualities is the ability for nurses to be open to their own experiences, to be self-actualizing individuals. Therefore, self-disclosure is a prerequisite. Jourard contends that the amount of self-disclosure is an indicator of the authenticity of an encounter with another. It measures the degree to which an I-thou relationship exists. He questions the effect of professional educational programs as to their capacity to encourage self-disclosure and their capacity to receive what others disclose to them.

Jourard (1964) contends that persons have a capacity to inspirit or dispirit others. One is inspirited when life is enhanced by an encounter with another. One is dispirited when an encounter demoralizes another. Jourard sees suppression and failure to self-disclose as dispiriting. He claims that when persons withhold the inner self from others it prevents the others from ever getting to know them. Suppression and remaining unknown may at first be seen as a comfortable position. However, it results in estrangement from self and not having one's own needs met. Self-suppression leads to loneliness and feelings of not being understood.

Women's Perspective of Being Cared For

Grimshaw (1986) discusses the emerging thought in feminists literature concerning caring as central to a female ethic. She reviews Noddings' work and then posits three ways in which appealing to caring as a female ethic can be used oppressively. First, it is noted that women are commonly accused of failure to care if they act in a way that is outside of their accuser's definition of care. Second, there is an implied opposition between self-interest and caring. When a person, such as a nurse or other care giver, sets out to protect or promote themselves, they are accused of not caring and being selfish. Third, there are those who, in the pursuit of profit, claim to be caring when in actuality they are reducing those they claim to care for

to a position of dependency.

To counter the oppressiveness, Grimshaw (1986) suggests, among other things, that care be redefined in a way which reflects the importance and legitimacy of caring for oneself. She concurs with Gilligan regarding the difficulty women often have in overcoming the feeling that basing a course of action on one's own needs or desires is somehow selfish or reprehensible.

Miller (1986) acknowledges that women's lives are often organized around serving the needs of others. Miller notes that problems exist when women are taught that serving others is their main goal in life. When the notion of serving others is "carried to its 'perfection,' it produces the martyr syndrome" (p. 62).

Gilligan (1982) devotes a portion of her book In A Different Voice to the concept of self. She notes that women:

> Childlike in the vulnerability of their dependence and consequent fear of abandonment, they claim to wish only to please, but in return for their goodness they expect to be loved and cared for. This, then, is an "altruism" always at risk, for it presupposes an innocence constantly in danger of being compromised by an awareness of the trade-off that has been made (p. 67).

Thus, a dilemma exists when women who wish to please by caring for others, are placed in the position of being cared for.

In their exploration of women's relationships, Eichenbaum and Orbach (1987) recognize that during childhood women learn to be attentive listeners and good givers. They posit as evidence of these abilities their willingness to be supportive of each other, and the understanding, comfort, sympathy and advice they offer each other.

Eichenbaum and Orbach (1987) illustrate "givers", in the personification of a nurse, and how comfortable and safe they feel on the giving end of a relationship. In their illustration they identify behavior which, they claim, indicates an inability of the giver to have her own needs met. They identify the "givers" as those with the "ability to know, to intuit, to read the needs of others" (p. 66) and whose abilities stem from an internal yearning for the same care for themselves. "Givers" are ashamed of their own needs and are unfamiliar with addressing them directly. The "giver" may

> be conscious of them [needs] only when a crisis forces them to surface. The only hint to others and herself is her preoccupation with weight and dieting, a context in which she can talk about how unhappy she is and how out of control she feels around food, But most of the time, as she sits with a friend or a lover, although she feels vaguely unsatisfied, she may be too cut off to even realize how much she yearns for them to reach out to her, to see inside her, to accept and understand her neediness, to give to her. When she is in crisis and people do rally around her, she feels humiliated and hates herself for exposing what feels like unreasonable needs (p. 67).

Lovell (1981) and Reverby (1987a) move away from the conceptualization of caring as a psychological trait and

toward the cultural expectation associated with women and caring. Lovell (1981) notes that the social, political and economic forces that influence women, and therefore nurses, are deeply rooted in history. She states that for women "learning is circumscribed and channeled into areas of male-defined appropriateness that guarantee men dominance" (p. 25). Lovell claims that throughout American history the medical profession has developed and sustained a position of male dominance over women. The women most available for medicine (males) to dominate have been their wives, nurses and women patients. Lovell acknowledges that "throughout the American medical profession's history, physicians ignored the thinking minds and speaking voices of nurses. Physicians made it clear that nurses should 'serve,' but serve silently" (p. 39). Nursing is considered the work place extension of the woman's role of wife and mother.

In her book, Ordered to Care, Reverby (1987a) explores women and nursing from a historical perspective. She argues that care is an identity, but it is work as well. In nursing, however, there is an expectation or duty to care. With the duty to care comes the expression of altruism with little thought to autonomy, i.e., "the right to control their (nursing's) own activities in the name of caring" (Reverby, 1987b, p. 5). Thus, a dilemma exists as altruism and autonomy are separate ways of being. This dilemma's roots extends back in the history of modern nursing and has

implications for nursing and nurses as they presently exist.

Early in the history of nursing, altruism and self-sacrifice merged and resulted in norms which were considered "womanly" and characteristics representative of the "good" nurse. "Womanly" attributes, applauded in the Victorian culture and expected of nurses, included absolute obedience, calmness, self-control, and reconciliation to duty. Acquisition of these characteristics came "through self-discipline exercised by the nurse at all times both on and off the wards" (Reverby, 1987a, p. 53). Education, strong in obedience and skills, was devoid of methods to assist one in independent decision making or autonomy. Seeing to one's own needs often led to disciplinary action which was severe and to additional needs being unattended. Because the nursing work force was made up almost entirely of women, altruism, sacrifice, and submission were expected and encouraged. Nurses as individuals were to conform to the rules, to function according to the duty to care. In the hospital nursing school and within the ideological stance of nursing and Victorian womanhood, radical thoughts about service to humanity without self-sacrifice were occasionally planted but were hardly nurtured. Only recently have the conditions been such that professional and personal autonomy of nurses is considered possible (Reverby, 1987a). Therefore, the notion that nurses have the right to have their own needs met is a relatively new idea. Although

caring and being cared for are learned behaviors (Watson, 1985/1988), being cared for is one aspect of care with which nursing education continues to struggle.

Nursing's Perspective of Being Cared For

Paterson and Zderad's' (1976/1988) concept of humanistic nursing emphasizes the ways in which a person is human. They note that nursing, and therefore care, is a way of relating that includes being and doing. They believe that persons "have a capacity for internal relationships, for knowing themselves and their worlds within themselves, they can relate as subject to object (for example, as knower to thing known) and as subject to subject, that is, as person to person" (p. 26). Both types of relationships are essential for genuine human existence. The notion that nurses need to be able to allow themselves to be vulnerable enough to be the recipients of care is implied in Paterson and Zderad's work. Similarly, the emphasis they place on the need to focus on the participants' modes of being in a caring situation attests to the idea that nurses need self-understanding, and that reciprocity is involved in caring situations.

Leininger (1978, 1984) describes care as "an essential human need for the full development, health maintenance, and survival of human beings in all world cultures" (p. 3). She identified 27 caring constructs which includes both instrumental and non-instrumental behaviors. Care is the

basic nature of nursing (Leininger, 1977, 1981, 1984). It is the most prominent domain and it is central to nursing. The importance of humanistic caring has been negated in today's society, according to Leininger. She speculates that, historically, the act of care has reduced intercultural stresses, assisted in the resolution of conflicts and protected humans since the beginning of time.

Leininger (1977, 1981, 1984) has studied the phenomena of care since the 1960s. She recognizes the many aspects of care and encourages nurses to focus research on caring and to develop it as the scientific basis of nursing. Compilations of research on caring edited by Leininger, reflects many aspects of care. There is, however, a paucity of research regarding the nurse being cared for.

Gult (1983) concluded that the verb caring denotes action, however, the kind of action has not been specified. She notes that actions which count as being caring are dependent on the intentions of the doer, and the context in which the action is done.

In Watson's (1979) philosophy of care, she differentiates "curative" from "carative". The purpose of curative is to cure disease. Carative is associated with the caring process which aims at assisting a person to "attain (or maintain) health or die a peaceful death" (p. 7). Watson identifies humanistic and scientific components, "carative factors," in the "science of caring."

Watson's carative factors include:

1. The formation of a humanistic-altruistic system of values
2. The instillation of faith-hope
3. The cultivation of sensitivity to oneself and to others
4. The development of a helping-trust relationship
5. The promotion and acceptance of the expression of of positive and negative feelings
6. The systematic use of the scientific problem-solving method for decision making
7. The promotion of interpersonal teaching-learning
8. The provision for the supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment
9. Assistance with the gratification of human needs
10. The allowance for existential-phenomenological forces. (Watson, 1979, p. 9)

These factors speak to nursing, and included is the development of a sensitivity to self. Watson[2] (1985/1988) explains further,

> The more human care is actualized as an intersubjective moral ideal, in each moment-to-moment caring occasion, the more potential the caring holds for human health goals to be met through finding meaning in one's own existence, discovering one's own inner power and control, and potentiating instances of transcendence and self-healing (p. 75).

Watson (1985/1988) sees the caring occasion as

"transpersonal" (p. 59) and therefore, the presence of the spirit of both the care giver and the care recipient is allowed. During such a caring occasion the limits of openness are extend leading to expanded human capacities. According to Watson, it is from one another that we learn how to be human. This knowledge is facilitated by identifying ourselves with others or finding their dilemmas in ourselves. What we all learn from caring occasions is self-knowledge. "The self we learn about or discover is every self: it is universal - the human self...[and] the intersubjectivity keeps alive our common humanity and avoids reducing the human being to an object" (p. 60). Consequently, the self-understanding serendipitous to the nurse being cared for is thought to have positive implications for the quality and effectiveness of nursing practice.

Gadow (1985) makes a case for blurring the distinction between nurse as a person and the nurse as a professional. She contends that by separating the professional and personal aspects of the nurse leads to fragmentation of the nurse's individuality, and to self-estrangement. The nurse is unable to act as a 'whole' person and becomes incapable of regarding the client as 'whole.' Gadow's ideas are compatible with Watson's conceptualization of transpersonal caring.

Gadow (1988) defines care as an obligation to alleviate

another's vulnerability. She explains that "care is the moral end, and cure is only a means to that end" (p. 7). Because cure requires power to be exercised over another, vulnerability is increased. Furthermore, disease and the technology used by health care professionals increases vulnerability. To alleviate another's vulnerability, and therefore be caring, Gadow suggests nurses must become vulnerable themselves. With vulnerability comes the self-disclosure of the despair, sorrow, and bewilderment which accompanies human existence.

Benner and Wrubel (1988) submit the Heideggerian notion that caring, as used in nursing,

> means persons, events, projects, and things "matter" to people. Because caring sets up what matters, it also sets up what counts as stressful. The risks and vulnerability inherent in caring can lead to the temptation to create safe places of "controlled caring" where the person dictates what matters and exercises the freedom to stop caring when the person or project is threatened (p. 1073).

Conversely, nurses as the recipients of care, and familiar with the controlling aspects of caring, are thought to control being cared for. They may avoid the risks and the vulnerability inherent in being cared for. The work of Watson (1979, 1985/1988), Gadow (1985, 1988), and Benner and Wrubel (1988) suggests that nurses who deny themselves the opportunity of being cared for may also be denying themselves an opportunity to gain self-understanding.

Benner and Wrubel (1989) address the psychological and social issues surrounding coping with caregiving and examine the reason coping with caregiving presents unique stress and coping issues for nurses. They attend to the issue of nursing being women's work and the implications of duty, subservience, altruism and self-immolation that have historically been associated with tending the sick and caring for the body. She maintains, in these modern times, the "phenomenological view of persons, in which the person is viewed as related to others and defined by those relationships, concern for others is not necessarily oppositional to or competitive with self-interest" (p. 367).

Benner and Wrubel (1989) further contend that today, "caring for others contributes to the world where one can care and expect to be cared for" (p. 367). At the same time, Benner and Wrubel acknowledge caring is devalued. They assert that caring is an embarrassment in a culture that holds a remarkably individualistic view of self and believes that persons ought to engage only in "self-care." "Caring and needing care point up the centrality of interdependence and our essential reliance on others" (p. 368).

To summarize, this section of Chapter Two explored the concept of being cared for by approaching the investigation from the broader concept of care. From this literature review, various definitions of care were posited which are

not in agreement. First, care is defined as more than "mattering," but assisting another toward self-actualization. Others say that "mattering" to another does constitute caring. It is agreed, however, that caring requires a response, some sort of reciprocity, from the one being cared for.

The consequences of care and being cared for includes: an ordered life, finding one's place in the world, stability and satisfaction. When there is care and being cared for autonomy, faith and gratitude are present. There is agreement that being cared for is essential, a prerequisite to caring. Self-disclosure is also considered a prerequisite in the ability to care for others. Suppression, however, leads to not having one's own needs met and results in loneliness and not being understood.

Women's studies literature offers some reasons for the reactions observed when care is offered to nurses. These reasons can be viewed from two perspectives, psychological and cultural.

First, the psychological perspective of caring was explored. In this review it was noted that care is poorly defined and therefore, leaves the care givers (nurses) open to being accused of failure to care if the care givers are protecting their own self-interest. A redefinition is called for, one in which the care giver is allowed to care for self. It is posited that women, and therefore female

nurses, find it difficult to attend to self because they have been taught that their main goal in life is service to others. Women experience a dilemma when they believe they have a duty to others but are in a position of needing care for themselves. Further, it is suggested women are unfamiliar with their own needs and are uncomfortable with expressing them.

The second perspective of caring explored in women's studies literature concerns the cultural/societal obligation to care placed on women. The Victorian roots of our culture lead to the notion that caring is synonymous with the "womanly" attributes of altruism, sacrifice and submission. Only recently has the right for women to have their own needs met been recognized.

In nursing literature, self-knowledge is considered a prerequisite in relating to others and therefore leads to quality care. Nursing recognizes that from a cultural perspective, caring and being cared for has a history of reducing stress, promoting the resolution of conflict, and protecting human life. They recognize the caring occasion provides an opportunity for the care giver and the one being cared for to experience vulnerability, enhance self-knowledge, relate to other persons in a way that objectification of others is diminished. Finally, the controlling aspects inherent in nursing were explored along with the cultural value of individuality and self control.

Rationale was posited as to the effects these concepts have on being the recipient of care.

Phenomenology

Husserl is credited with being the father of phenomenology. It is upon the foundation laid by Husserl that existential phenomenology is based. Therefore, certain themes occurring in Husserl's writing are important to the relevance of existential phenomenology in this study.

Phenomenology "denotes a method and an attitude of mind, specifically 'philosophical attitude' of mind, the specifically 'philosophical method'" (Husserl, 1964, p. 19). It is characterized as the study of existence and essences.

The phenomenology movement is the outgrowth of Husserl's reaction to the claim of the logical positivists that rationalism is the means to absolute knowledge. Husserl counters the logical positivists in his belief that to understand the ways in which people actually think, one must get "back to the thing itself;" to see the essence, the underlying structure. A positivistic perspective leaves doubt when dealing with the complexity of human beings, and therefore does not lead to certain knowledge. Husserl believes when dealing with logical relations among statements and among concepts one is actually dealing with "essences," "universals," "abstract" entities which are not to be identified with perceptual objects (Nakhnikian, 1964).

Husserl (1964) treated all objects as having reality.

He included mental acts such as judgments, beliefs, meanings, values, desires. loves, hatreds, along with things, events and persons. Natanson (1973) explicates this notion stating that things that are "conceived or meant as real" (p. 27), are real, "Their reality is reality-as-intended and their contextual history is a feature of the world as intended" (p.13). As such it would seem that reality would have multiple interpretations and be highly individualistic. However, one characteristic of phenomenology is that the real world exists for everyone. The world is a shared reality (Natanson, 1973). A shared reality is possible because of a second characteristic of phenomenology, unity of meaning. Through phenomenological analysis, the investigator searches for interpretations which will stand as universals and embody meaning which is a part of a shared reality (Natanson, 1973).

Phenomenology calls for the researcher to hold all received knowledge and resulting assumptions, no matter what the source, in abeyance. By so doing, there are no presuppositions about the phenomena under investigation, and nothing is taken for granted. Through a phenomenological approach provision is made for knowledge to be rebuilt in a way that is original (Husserl, 1964).

Husserl's phenomenological philosophy is aimed at epistemology, a search for knowledge, and thus his ideas direct a method by which phenomena are studied. Albeit

Husserl's philosophy influenced the existential phenomenology movement, the aim of the existentialists is quite different from Husserl's. Ontology, an understanding of being, is their focus.

Existentialists

Langer (1989) notes that existential phenomenology umbrellas a host of positions which differ to a large degree. There is not one definition which suits the thought of all those who are considered existential phenomenological philosophers. However, existentialists hold in common a focus on concrete rather than abstract thinking and identify the human situation as the beginning point for a more certain understanding. The notion of absolute knowledge and positivistic objectivity is rejected by existentialists. Human participation in the world is stressed and it is believed that what is known comes from shared existence with others. Existentialist philosophers are concerned that humans have an awareness of their freedom and a responsibility in shaping their situation in life (Langer, 1989). They search for answers to ontological questions about existence through isolating and exploring independent structures and meanings.

Since the purpose of this study is to explore the meaning of being cared for as experienced by nurses, existential philosophy provides a broad theoretical grounding for the study. Themes exposed in the work of two

existential philosophers, Martin Heidegger and Martin Buber, are of particular import to the concept of care and to the meaning of being cared for.

Heidegger's Existentialist Viewpoint

Like Husserl, Heidegger was in search of philosophy void of presuppositions; a philosophy which would delve deeper than any of the natural or social sciences. He believed the meaning of "Being" was the place to begin (Ayer, 1982/1984; Blackham 1952/1961).

Heidegger was not interested in a definition of being, his goal was insight into the essence of "Being." He was not interested in what things are, but what it is to be. Husserl's assumption that being correlates to consciousness was questioned by Heidegger (Ayer, 1982/1984).

Heidegger used phenomenology to understand the nature of being to get at the essence of human existence. "Dasein" is the term Heidegger used to reflect being as existence in the world and not merely as an object, but in the world by virtue of the interests and attitudes of "Dasein" (Ayer, 1982/1984). Blackham (1952/1961) explains that the essence is "Dasein" is in its existence, and because it not something given it cannot be defined. Because there is a mode of existence, i.e., that of being-in-the-world, persons create possibility, and therefore have choices.

"Thrownness" is a term Heidegger used to express his view of a person being-in-the-world. It has to do with

where one is thrown or situated in the world. It is where the entity is in-the-world, when it discovers "Being" (Heidegger, 1927/1962). This "thrownness" demands that the self is not inseparable from the world. Because of "thrownness" one is "not a radically free arbiter of meaning" since one is limited by language, culture, and history (Benner, 1985, p. 5).

Heidegger (1927/1962) posits the concept of "facticity" associated with "Dasein." This implies that "an entity 'within-the-world' has Being-in-the-world in such a way that it can understand itself as bound up in its 'destiny' with the Being of those entities which it encounters within its own world" (p. 82), that is, a person is self-interpreting and has an interest in others. The "facticity" of "Dasein" is split into different ways of being.

The different ways of being have to do with the phenomena of care. Care as concern is thought to be the underlying structure of "Dasein." Heidegger (1927/1962) explains "The Being of Dasein itself is to be made visible as 'care'" (p. 83), therefore, "care," itself, is defined as Being-in. "Concern" is defined as Being-with.

Additionally, there are modes of "concern" according to Heidegger (1927/1962), which can be negative or positive. The negative mode is manifested by deficient or indifferent ways of Being-with one another, or "concern" with one another. "Passing one another by," or "not 'mattering' to

one another" (p. 158) are deficient modes. However, they are characteristic of everyday, average concern.

Heidegger (1927/1962) describes two extreme possibilities associated with the positive modes of concern. One possibility of concern is identified as a "leap in" (p. 158) for another, taking over for another and thereby, taking control of other's "care," i.e., Being-in. An example is an over-protective or domineering parent. A second possibility of concern Heidegger identifies as a "leap ahead" (p. 159). In this instance the action is taken to free other persons of their own bondage in order for them to take over their own "care." Heidegger concludes, "Everyday Being-with-one-another maintains itself between the two extremes of positive solicitude (i.e., concern) - that which leaps in and dominates, and that which leaps forth and liberates. It brings numerous mixed forms of maturity..." (p. 159).

Blackham (1952/1961) summarizes the three elements which constitute Heideggerian care. First, "personal existence is self-projecting...; there is something more to come, and its concern for what it is to be is expressed in the term care." Second, "care also includes my being already found in a world in which this personal existence has to be realized." Last, care "is the structure of the mode of existence of one who exists by anticipating what he will be in a world in which he is found and to which he is

bound" (p. 95). These elements of care assume a concept of time in relation to Dasein's Being.

Being limited by time, i.e., temporality, is another concept which merits explanation if human existence is to be understood from Heidegger's philosophical perspective. A pure "now" is myth, according to Heidegger (1927/1962). He asserts that now is made up of the past, present and future. The past consists of that which cannot be altered. The future is the realm open to possibility. The present is formed in the presence of something about which there is concern. Ayer (1982/1984) clarifies, "...'care' by which the present is supposed to be defined has to be tacitly understood as a temporal presence. It is not only past events that are beyond our power to alter. Not all future events afford us opportunities for choice" (p. 228). However, there is possibility for future choices.

Heidegger's ontological perspective of phenomenology is not complete without an exploration of "Angst." "Angst" is the mood of "Dasein" (Heidegger, 1927/1962). Translated as anxiety or dread, it is that which fixes "Dasein's" existence and has to do with an attitude about death. Being is limited by death and its consciousness of it. The attitude toward death is charged with moral significance because it is intrinsically personal; no one dies the death of another. Therefore, death restricts choices, causes one to take life seriously and to live authentically. Through

authentic living and proper concentration on death, responsible freedom is earned (Ayer, 1982/1984).

Since human existence consists of being in the world and being with the world and persons are self-interpreting, a form of communication is necessary to share that which has been self-interpreted. Language then, is necessary for making sense of the world. It is through language that the world is shared and unity of meaning is acquired. Heidegger endorses the use of hermeneutics, analysis of language, as the method by which unity of meaning is acquired (Heidegger, 1927/1962).

In summary, in this section of Chapter Two Heidegger's phenomenological philosophy is determined ontological, concerned with the meaning of human existence. By exploring "Dasein," Heidegger concludes that there are modes of care which reveal the underlying structure of a person's relationship with the world and the possibility of influencing destiny, and a mood by which persons are compelled to take human existence seriously. It is his belief that by analyzing the relationship of persons in the world, truth reveals itself and therefore, the goal of phenomenology is reached.

Buber's Existentialist Viewpoint

Buber's thought is not unlike Heidegger's. Buber (1970) is also concerned with the problems of "Being" and the connection between individuals and the world. Buber

recognizes the pre[illegible]ce of an estrangement between persons and sees that estrangement manifested in communication. He explicates the difference between the world as experience and the world of relationships through a differentiation between forms of communication.

Buber[3] (1970) identifies two forms of communication. The first form is "I-It." This form of communication occurs when another is experienced as an object, but a relationship does not exist for there is a lack of mutual understanding. The second form of communication is "I-Thou." This form of communication occurs when there is a shared understanding with another. Within such encounters there is a relationship which is mutual and reciprocal. Buber recognizes that both forms are necessary, for it is through "I-It" encounters that objective knowledge, having to do with the things of the world, is acquired. However, to exist in a totally objective, "I-It" world reduces one's humanity.

Buber (1970) also identifies three spheres in which the world of relation arises. First is "life with nature" (p. 56). Although this relationship is without language, it exists because the relationship has been established and the thing in nature is no longer "It." There is a reciprocity but it is not manifested in words. Second is "life with men" (p. 57). A relationship is revealed and there is language. There is a reciprocity which can be manifested in

words. The third sphere is "life with spiritual beings" (p. 57). Buber explains that in this sphere no "Thou" is heard, yet one feels addressed and answers by being, i.e., acting, thinking, or creating in nonverbal ways. In this sphere there is no language, but language is created. For example, after feeling addressed by attending to intuition, one may answer through a poem or prose, a painting or a sculpture. Through such means there is a communication: language is created.

Through this description of forms of communication and the relational spheres, Buber makes the point that "All actual life is encounter" (p. 62). "The basic word I-You can be spoken only with one's whole being. The concentration and fusion into a whole being can never be accomplished by me, can never be accomplished without me. I require a You to become; becoming I, I say you" (p, 62).

Existential Phenomenology and Nursing

In nursing there is a great deal of dialogue concerning the paradigm, positivistic or naturalistic, by which nursing knowledge is best gained. Historically, the empirical concepts researched through logical-positivistic and or quantitative methods have been most valued. Quantitative research methods emphasize facts and causes of human behavior. More recently, the nursing profession has been challenged to bring about a better understanding of nursing as a response to the human situation, and as an experience

lived between human beings (Leininger, 1985; Oiler, 1982, 1986; Omery, 1983; Paterson & Zderad, 1976/1988; Swanson-Kauffman & Schonwald, 1988; Watson, 1979, 1985, 1985/1988). Many nurses recognize the uncertainty of knowledge gained through the logical-positivist's position when dealing with individual human beings. The challenge to bring about a better understanding of nursing beckons the nurse researcher to explore the humanistic concepts of nursing. To do so requires the employment of research methods which will creatively investigate the meanings of human existence, the experience of living, the phenomena of caring and of illness, and will assist in the development of an existential awareness of self and of others. In pursuit of knowledge which facilitates a more complete understanding of individual human beings, the merits of the existential phenomenology movement have been acknowledged in nursing literature.

In nursing literature existential phenomenology, having to do with ontology is referred to simply as phenomenology. In the following review of nursing's advocacy of existential phenomenology, the term phenomenology will be used synonymously.

Paterson and Zderad (1976/1988) advocate phenomenology as a philosophy and method appropriate for the study of nursing, since phenomenology aims at reality, how persons experience the world here and now, and the subjective -

objective state. They pronounce the relevance of phenomenology as ranging from "formulation of nursing constructs to the creation of theoretical propositions" (p. 67), and its applicability to the clinical setting and or to a historical study of literature.

Davis (1978) acknowledges phenomenology as a method for discovering knowledge which is significant to nursing. She believes that the phenomenological movement provides a research approach useful in the study of the social reality implicit in nursing. Davis notes that the humanities give evidence that the multidimensional, holistic person is outside the framework of traditional science. As Merleau-Ponty (1962) notes, an explanation from the level of the cell is not adequate nor does it accurately predict human experience. Phenomenological research gives attention to human experience which results in an increase in the researcher's awareness and a more complete understanding of the whole person.

Oiler (1982) advocates phenomenology as a research method because of nursing's concern with the quality of life and the quality of nurse patient relationships. She holds that the aim of phenomenology is to describe experience as it is lived and therefore phenomenology is a promising research approach for nurses. Like others who advocate phenomenology, Oiler suggests that it is one method among many which can effectively serve nursing.

The constraint of quantitative research methods which reduce persons to an object, and nursing's self-recognition as being a humanistic discipline, provides the rationale for Omery's (1983) advocacy of phenomenology. She believes that phenomenology is a viable and valuable qualitative methodology when exploring human phenomena. Knaack (1984) concurs with Omery's opinion concerning phenomenology. She explores the philosophy, goal, and methods associated with phenomenological research along with its applicability to nursing. She acknowledges the value of phenomenological research in the enhancement of nursing knowledge.

Leininger (1978, 1981, 1984, 1985) exhorts the use of qualitative methods to explore and describe human situations. She explains that nursing knowledge is "closely linked to the cultural lifeways, values and patterns of human groups" (1985, p. 23). She recommends qualitative methods, including phenomenology, as a means of understanding subjective and intuitive states of human beings and thereby discovering "truths" relative to the purpose of nursing, i.e., the care of persons.

Lynch-Sauer (1985) compares phenomenology with other qualitative research methods. She notes that as a young science, nursing is free to search for alternative methods of research and "approaches specifically directed toward increasing nursing's knowledge of the significance and meaning of human experiences" (p. 94). She identifies

phenomenology as a method particularly well suited to the interests of the discipline of nursing. The goal of the phenomenological method is to know human beings, to understand about how they are, and therefore understand how to care for them.

Watson (1985, 1985/1988) declares that the study of caring and the development of nursing as a human science requires a research method based upon reality, relationships, and the truth of statements. Watson advocates phenomenology because the subject matter of this method is human experiences, their structure and their meanings, essences and relationships. She, along with the phenomenological philosophers, contends that measuring or experimenting with human experiences is not possible. Experiences are simply there and they can only be explored in their individual givenness.

In a discussion of the underpinnings of qualitative research, Munhall (1989) recognizes phenomenology as one qualitative method important in facilitating a better understanding of concepts associated with nursing. She also sees that nursing has identified itself as a humanistic profession, and as such, adheres to a philosophy that focuses on individuality. She, therefore, supports the legitimacy of phenomenological research in nursing.

Although nursing is concerned with both the phenomenal and the biophysiological world, both qualitative and

quantitative methods have potential for leading to nursing knowledge according to Benner (1985). She believes the placement of these paradigms in a hierarchy with quantitative proclaimed to be more valuable than qualitative is not appropriate. Benner advocates a Heideggerian phenomenological method as necessary to the development of nursing knowledge because of nursing's concern for the whole person. Exploration and prediction based solely in the biophysiological realm fail to capture the relational quality of the person in the situation. Furthermore, Benner recognizes the importance of building nursing's knowledge from the bottom up. In nursing then, ontological question should precede epistemological questions.

Leonard (1989) also believes that nursing will profit by considering ontological question before considering those of epistemology. Therefore, she supports the use of Heideggerian phenomenology as an important and viable method of doing nursing research.

Summary

In Chapter Two the literature review was three fold. First a review of literature leading to a conceptualization of being cared for was undertaken. Although there is a plethora of theory concerning care, a paucity of research exists concerning the phenomenon of being cared for, itself. The meaning of the experience of the nurse being cared for is not clearly understood.

Second, the writing of phenomenological philosophers was explored in order to develop a clear understanding of the underpinnings of the study. Philosophical themes concerning human existence were exposed which revealed a fit between the research question and a phenomenological research method.

Third, literature concerning the utility of phenomenology as a philosophy and as a research method for nursing was affirmed. There is evidence that a phenomenological approach to nursing research leads to the advancement of nursing's knowledge.

Chapter Three

METHODOLOGY FOR THE STUDY

A qualitative approach, that of phenomenology, was used for this research study. The focus of this was from the perspective of the nurse being cared for. It queried the essential structure of the experience of being cared for. The study endeavored to discover foundational, descriptive knowledge which the meaning of being cared for had for care givers as the recipient of care.

Phenomenological Method

The phenomenological research methodology was inductive and descriptive. The task of this method centered in the investigation and description of phenomena as it appeared. These phenomena included that of human experience (Giorgi, 1985; Parse, Coyne & Smith, 1985; Peterson & Zderad, 1976/1988; Spiegelberg, 1965; Valle & King, 1978; Van Kaam, 1959). Peterson and Zderad (1976/1988) state that a phenomenological method of studying nursing focuses on reality of persons and how the world is experienced by them. It focuses on the subjective-objective state. The intention is to describe nursing situations in the subjective-objective world that occurs between persons. Through description, which focuses

on the complexities of nursing, superficial understandings are exposed.

Since this study searched for the meaning of the experience of being cared for, a method of phenomenology based in existential philosophy was most suitable, and in this study Heideggerian phenomenology was congruous. Leonard (1989) regards Heideggerian phenomenology profound for nursing in that it "offers nurse researchers the opportunity to understand the meaningfully rich and complex lived world of those human beings for whom nurses care" (p 55).

Oiler explains that "People live forward" (1982, p. 179) and it is impossible to understand what one is actually experiencing at the time of occurrence. Looking back is the way in which persons know through what they have lived. Although the tendency is to reflect back on experience, the aim of existential phenomenology is to have the experience speak for itself. Therefore, the process undertaken for this study included the operations of bracketing, intuiting, analyzing, and describing (Colaizzi, 1978; Giorgi, 1985; Spiegelberg, 1965; Van Kaam, 1959).

Bracketing

Bracketing is the setting aside, or reduction, of the researcher's presuppositions both prior to and during the data collection. It is a method used in the attempt to portray accurately the reality of informants, since a

preunderstanding exists through personal experiences, literature reviews and other sources. Through bracketing, an accurate portrayal of the reality of the phenomena as it was lived and described by the research participant is possible (Swanson-Kauffman & Schonwald, 1988). Bracketing is done by stating personal assumptions and holding them in abeyance. Rather than eliminating the participants perspective of reality, it is brought into view (Oiler, 1982). The assumptions concerning this study have been stated in Chapter One.

Intuiting

Intuiting, Spiegelberg (1965) observes, appears elementary, but in practice it is most demanding. It involves looking at the experience as it exists for the participant. All knowledge, facts, or theories concerning the phenomena are held at bay. The researcher concentrates on the experience, becomes absorbed in it, and still must remain separated from it (Oiler, 1982).

Swanson-Kauffman and Schonwald (1988) describe the behavior researchers must exhibit in order for the possibility of intuiting to exist. First, the researcher must be highly attentive to the participant's words and gestures. Second, the researcher must believe that the participant is the expert on the topic, by virtue of the fact that the participant has lived the experience. Third, the researcher must be skilled in assisting the participant

in looking on, reflecting on and discussing the meaning the experience held for them.

Analyzing

Analyzing data is an attempt at apprehending the essential relationships among essences (Spiegelberg, 1965). The phenomenological method of doing research does not dictate one correct way of analyzing data. Instead the researchers are encouraged to develop their own effective ways (Barritt, Beekman, Bleeker & Mulderij, 1984). Swanson-Kauffman and Schonwald (1988) identify analyzing as the empirics of phenomenology and involves the establishment of a plan where by "data may be located, gathered, recorded, sorted, retrieved, condensed, and verified" (p. 100). Oiler (1982) describes analyzing as comparing and contrasting descriptions to a point where reoccurring elements in the descriptions are evident. This allows for the individual units of data or themes (Tesch, 1987) of the phenomena to emerge and the relationship of the themes as well.

Describing

Describing is the final operation identified with the process of phenomenological method. Description is a means of communicating the major dimensions, metathemes (Tesch, 1987), or essential structures concerning the phenomena under investigation. Oiler (1982) explains that effectively describing the essential structures leads

listeners to their own experiences of the phenomena. Therefore, it is through effective description that the possibility of shared reality (Natanson, 1973) of the phenomena exists.

Setting

The experiences of registered nurses being cared for occured both in the practice and outside the practice of nursing. Since these registered nurses formed the context for this study, there was not a specific setting. The participants of this study were interviewed in their office, home or another mutually agreed upon place which provided privacy and comfort for the participant.

Population and Sample

The population for this study was female registered nurses, of any age, who had been active in the practice of nursing during the last year, and who were able to articulate their experiences. This purposive sample of 15 registered nurses, identified by themselves and other registered nurses comprised the sample. This type of sample provided fertile data because of the participants' experiences in the world of care. The sample was limited to 15 participants because of the time and demands inherent in an in-depth phenomenological approach.

Procedure for Sampling

The participants in this study were recruited. The researcher approached four nurse acquaintances, explained

the research study, and asked them to supply the names of four registered nurses whom they believed would be interested in participating in this study. In addition, registered nurses in the community health settings were asked to submit names of potential participants (Appendix A). They were informed that they could submit their own name as well. When thirty names had been collected, the sample was selected from the names submitted.

Protection of Human Subjects

An application for permission to conduct this study was submitted to The Committee on Protection of Human Subjects of the University of San Diego. Following the committee's approval, those selected to participate in the study were contacted by telephone for the purpose of recruiting them to participate in the study. At that time they were informed that an audio-tape recording of the experiences they described during the first interview would be required, and that a second, short interview would be necessary at a later time. If, during the telephone conversation, the potential participant declined participation in the study, the name was discarded and another name was chosen until there were 15 to 20 people expressing interest in participating in the study. During this telephone conversation an appointment was made for an initial, face-to-face, interview at a mutually agreed upon place and time.

During the initial interview, the purpose of the study and the expectations associated with participation in the study, were specifically detailed. Any questions concerning the study were answered, and each participant was asked to give written consent to participate in the study (Appendix B). Participants were told they could terminate the interviews and drop out of the study at any time.

Collection of Data

At the initial interview, each participant was greeted, the research study was explained and an opportunity was given for each participant to have her questions concerning the research answered. Those who agreed to participate were asked to read and sign a consent form agreeing to two interviews. Additionally, written permission to audio-tape the first interview was obtained. Each participant was given a copy of the signed consent form. Demographic data which included age, number of years in nursing, marital status, religion, and information concerning the family of origin and present family situation, was collected. Data related to education and nursing experience was also obtained (Appendix C).

During the first interview the tape recorder was placed near each participant who was informed that she could turn it off any time she wished to terminate the interview. Audio taping of the interview began following

these instructions to each participant:

1. Tell me about an experience when you were being cared for.

2. Talk about it as completely as you can.

3. Give me as much information about it as you can, what you remember, what you felt, what you thought.

4. Do not stop until you feel that you have discussed your thoughts, feelings and perceptions as completely as possible.

During the interview, the researcher allowed each participant to freely express her thoughts and feelings while maintaining an open and attentive attitude. The participant was not interrupted except when clarification was necessary or to encourage further description. The following three questions were developed for that purpose: 1. What comes to mind when you think of being cared for? 2. What about the situation made you think you were being cared for? 3. Is there anything else that made you aware of being cared for?

Treatment of Data

Following the initial interview, the audio-tape recordings were listened to and transcribed verbatim. The transcriptions were then studied following a method corresponding to the guidelines set out by Colaizzi (1978). The transcriptions were further analyzed by pattern coding as explained by Miles and Huberman (1984).

Miles and Huberman (1984) believe it is important to begin analysis of data during the data collection phase of the study. They believe that such practice prevents important portions being omitted from the research. Through the immediate pattern search and coding, the data analysis can begin at the same time as other data is being collected. The researcher becomes better able to focus the research as the study progresses. Additionally, they believe analysis of data is kept manageable and the researcher is not overwhelmed by the task. The following steps of analysis, some of which occured simultaneously, were followed with each description of the nurse's experience of being cared for.

1. The tapes were be listened to and the transcriptions read several times. In this manner a feeling for, or a sense of the meaning of the description was acquired.

2. Subsequent readings occured for the expressed purpose of "extracting significant statements" (Colaizzi, 1978). Key words, sentences and phrases dealing with being cared for were underlined.

3. Concurrently, if an obvious pattern seemed evident at any point in the reading of the transcripts, a note was be made in the margin of the transcript. These notes were intended to help "identify an emergent theme, pattern or

explanation that the site suggests to the analyst" (Miles & Huberman, 1984, p. 67).

4. At this time, significant statements consisting of phrases or sentences directly pertaining to being cared for, were reflected upon. Meanings were formulated which maintained connection to the original description and which were not the product of the application of conceptual theories, i.e., all presuppositions concerning the data continued to be held at bay.

5. During this phase of data analysis, themes representing individual units of meaning were organized into metathemes or essential structures. The essential structures were compared to the original description to assure that they contain nothing which was not in the original description and that nothing had been omitted from the original description.

Colaizzi (1978) stressed the importance of not ignoring what seems like discrepancies or contradictions between themes. In so doing, important findings may be overlooked. By devoting more time and study to the data, the meanings may become clearer and may eventually make sense.

6. Following the verification process the metathemes or essential structures were organized into exhaustive descriptions of nurses being cared for. These descriptions, rather than describing one or two

experiences, were descriptive of all experiences of nurses being cared for. Colaizzi (1978) claimed that through "an exhaustive description of the investigated phenomenon" (p. 61) one comes very close to realizing the essence of a phenomenon.

7. Finally, the descriptions were validated during the second interview. At that time, the participants were given narrative descriptions and asked if the descriptions accurately described their experiences. The participant and the researcher discussed the results of the analysis and reformulated them as necessary.

Validated descriptions serve as universals or exemplars, they symbolize meaning and become a shared reality (Natanson, 1973) when successful description of the experience of being cared for directs other nurses to their own experience of the phenomena of being cared for.

Establishing Trustworthiness

Defending the value and logic, the trustworthiness (Lincoln & Guba, 1985), of qualitative research is equally important as it is in quantitative studies. Marshall and Rossman (1989) note: although it is equally important, the methods used to defend the value and logic of qualitative research differ from those used to defend the value and logic of quantitative research. The issue in either case, however, is one of trustworthiness. Trustworthiness, no matter what the research paradigm, is established in

relation to four terms (Lincoln & Guba, 1985, p. 290):

1. Truth value: How can one establish confidence in the "truth" of the findings of a particular inquiry for the subjects (respondents) with which and the contest in which the inquiry was carried out?
2. Applicability: How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)?
3. Consistency: How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects (respondents) in the same (or similar) context?
4. Neutrality: How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer? (Lincoln & Guba, 1985, p. 290)

Lincoln and Guba (1985) aver that from these terms and the questions they evoke, criteria related to "internal validity," "external validity," "reliability," and "objectivity" indicate trustworthiness in the paradigm of quantitative research. In the qualitative paradigm,

"credibility," "transferability," "dependability," and "confirmability" speak, with equal authority, to the trustworthiness of a study.

Credibility

To demonstrate truth value of a study, it must be shown to be credible (Lincoln & Guba, 1985). Lincoln and Guba point out five techniques by which credibility can be established. First are activities which enhance the possibility of credible findings and interpretations. Second is the technique of peer debriefing, providing an external check on the inquiry process. The third technique is negative case analysis which is aimed at refining as more information becomes available. Fourth, referential adequacy, is the technique where preliminary findings and interpretations are checked against the collected data. The fifth technique concerns member checking, where the findings are validated with the human sources from which they came.

In this phenomenological study credibility was enhanced in that data collection and the Colaizzi method of analysis parallel most of the techniques set out by Lincoln and Guba. Lincoln and Guba (1985) note that the "most crucial technique" for establishing credibility is that of member checking. Member checking is allowed for by the analysis of data and took place during the second interview. Therefore, the definitive test of credibility

in this study was an affirmative answer to the question posed by Oiler (1986, p. 81); "Are the findings recognized to be true by those who live the experience?"

Transferability

Transferability correlates to applicability in Lincoln and Guba's (1985) terms inherent in trustworthiness. In qualitative research studies, the investigator is responsible for reporting a "data base that makes transferability judgments possible on the part of potential appliers" (Lincoln & Guba, 1985, p. 316). In this study purposeful sampling, one technique which enhances transferability, was used. Furthermore, the setting in which the interviews took place and the participants were described. Therefore, a beginning data base for other researchers was established.

Dependability

Dependability or consistency is established in two ways: first by examination of the process of the inquiry, and second by appraisal of the results (Lincoln & Guba, 1985). In this study, the process of inquiry was examined in conjunction with bracketing of prior knowledge. The effectiveness of bracketing was examined by evaluating the questions asked and by evaluating terms used by the researcher during the interviews. The test of bracketing effectiveness occurred as comments and questions posed by the investigator were measured against the questions such

as: Was the term used one of clarification? Did the question asked the participant clarify their description? or Did the question or comment introduce bracketed material?

The appraisal of the results of the study was also be reviewed in an effort to "attest to the dependability of the inquiry" (Lincoln & Guba, 1985, p. 318). Dependability was further attested to when the results of the study were verified by the participants.

Confirmability

To establish confirmability or neutrality, Lincoln and Guba (1985) use an "audit trail" (p. 319) technique. Further, the audit trail provides a secondary check on credibility. Marshall and Rossman (1989) note that in qualitative research, credibility is placed "squarely on the data themselves" (p. 147). The audit trail suggested by the authors requires the researcher to collect certain categories of information which somewhat parallel the research process and method. In this study, parts of the audit trail were used. For example, some pieces of evidence were created. That is, raw data were electronically recorded and transcribed. Themes were indexed and thematic statements were generated from the participants' statements. However, a true audit study was not done.

To summarize, several methods were used to establish

trustworthiness in this inquiry. These methods included: providing for credibility through confirmation of findings with the participants in the study; providing for transferability through purposeful sampling; establishing dependability by examining the process by which data was generated; and confirmability by partially carrying out procedures associated with an audit of the completed research process.

Pilot Study

A methodological pilot study was conducted by interviewing three registered nurses who met the criteria for the population of this study. Using phenomenological methodology, descriptions of nurses' experiences of being cared for was queried as the participants were instructed to tell about an experience when they were being cared for; to talk about it as completely as possible; to give as much information as possible as to what they remembered, what they felt, and what they thought; and not to stop until they felt their discussion was complete. The interviews were recorded and transcribed verbatim.

During the interviews the presuppositions held by the researcher were "bracketed" in order to acquire an accurate portrayal of the reality of nurses being cared for. The act of intuiting was practiced as the participants told their stories about being cared for. It was observed that nurses could talk freely about the experience of caring for

others, but required encouragement when looking on, reflecting on and discussing the meaning of their own experiences of being cared for. To facilitate the expression of the participants' own experiences, the researcher used the technique of restating in addition to the questions developed for the purpose of encouraging further discussion.

Analysis

Analysis of the interviews was conducted using steps adapted from Colaizzi (1978) and Miles and Huberman (1984). As the pilot study was being conducted, the necessity of utilizing three levels to report the results of the analysis became apparent. These levels include metathemes, themes and variations. For the purposes of this study these levels are defined. Metathemes are the major dimension of phenomena studied (Tesch, 1987). Metathemes are reported in this study as conceptual statements which are holistic in nature. Themes are brief statements which depict the substance of the individual segments of data text (Tesch, 1987). Variations are unique segments of data text from the participant's interview which serve to highlight, reinforce, or compliment the themes and metathemes (Barritt, Beekman, Bleeker & Mulderij, 1984). Together the metathemes, themes and variations explain the essential structures, i.e., major dimensions, of nurses being cared for, and serve to describe the phenomena.

The Process of Analysis

The metathemes emerged over successive readings of the transcribed texts, the written analysis, and through reflective discussions with the participants. Originally, the metathemes were reported as themes and stated as phrases which described the participant's experience. The original themes emerging in the pilot study are listed on Table 1.

Table 1

Pilot Study Themes

Personal value
Choosing to trust
Awareness of feelings
Care recipients' expectations
Reciprocity

Themes emerged from the data in two different ways. The first was partly intuitive as themes appeared during the transcriptions of the interviews. Transcribing the interviews word-for-word created an opportunity for total immersion in and reflection on the data. As a result, broad themes were identified. The second way in which themes emerged occurred as data were further clarified and refined through the use of three methods: 1. continued reflection on the data; 2. line-by-line analysis and highlighting (van Manen, 1984); and 3. reflective discussion with the participants (van Manen, 1984).

To facilitate line-by-line analysis each sentence was searched for its contribution to the participant's experience (van Manen, 1984) and coded. Code labels were kept as close to the participant's language as possible (Barritt, Beekman, Bleeker & Mulderij, 1984; Lynch-Sauer, 1985). After transcriptions were coded, each was searched for common themes. In addition, each transcription was searched for statements which appeared to be particularly important for illuminating the participant's experience (van Manen, 1984). Thematic analysis was used to discover and later to refine the metathemes. Finally, reflective discussion was the method applied in order to confirm and modify the metathemes.

An example of the metathemes, themes and variation which emerged during analysis of the original theme labeled

"personal value" appears on Table 2. Following the organization of the findings into metathemes, themes and variations, the three participants of the pilot study were interviewed for a second time. They affirmed findings and organization of the findings were accurate and the meaning of their experiences of being cared for were represented.

Table 2

Pilot Study Metathemes, Themes, And Variations

Metatheme - Personal value is basic to accepting the act of being cared for.

- Theme - Personal value
  - Variation - Valued by others
  - Variation - Self-worth
- Theme - Acceptance
  - Variation - Measure of caring
  - Variation - Embarrassed by need for care
  - Variation - Dehumanization and objectification

This pilot study provided evidence that the methodology needed little modification other than the use of a third category, variation, to highlight, reinforce and complement the themes and metathemes. The interview instructions in conjunction with the supplemental questions did facilitate information appropriate to the study. The phenomenological research process described earlier would allow themes to emerge, and a beginning description of the meaning of being cared for was possible.

Summary

In Chapter Three the phenomenological method and its propriety to this study was discussed. The research process which includes bracketing, intuiting, analyzing and describing were set out. The setting, population sample, procedure for sample selection, and provisions taken to protect human subjects were reported. Data collection and treatment of data were also described. Criteria for establishing trustworthiness were discussed in relation to this study. Finally, the process, methodology and results of the pilot study were discussed.

Chapter Four

ANALYSIS OF THE TEXT

A description of the participants is presented in Chapter Four. The analytic process and the findings of the analysis of the interview text is also reported. The meaning that nurses attributed to being cared for, and the unity of meaning, i.e., the understanding of the concept which is shared by all the participants, is detailed in an exhaustive description of the phenomena.

Description of the Participants

The participants consisted of 15 nurses who had been identified by their peers. They met the criteria in that all were female nurses who had been active in the practice of nursing at least one year, and were able to articulate their experiences. Six participants were the first born in their family of origin, four were middle children, and five were the last child. All but one participant had children of their own. Table 3 illustrates the demographic characteristics of the participants regarding their age, race, marital status, and religion. Table 4 illustrates the demographic characteristics of the participants' educational and experiential background.

Table 3

Demographic Characteristics of the Participants

Characteristic	n	Count
Age	15	
26-35		5
36-45		4
46-55		4
56-66		2
Race	15	
White		14
Black		1
Asian/Oriental		0
Religion	15	
Catholic		4
Protestant		9
Jewish		0
Other		2
Marital Status	15	
Single		0
Married		14
Widowed		0
Divorced		1

Table 4

Professional Background Characteristics of the Participant

Characteristic	n	Count
Years of Experience in Nursing	15	
1-5		1
6-10		4
11-15		3
16-20		2
21-25		3
26-30		1
31-35		0
36-39		1
Highest Degree	15	
Diploma		3
Associate		3
Baccalaureate - Nursing		2
Baccalaureate - Other		2
Masters - Nursing		4
Masters - Other		1

Findings of the Analysis

During this study the following research question was investigated: What is the meaning of the experience of being cared for as lived by female nurses? The analysis of data resulted in five metathemes which describe the phenomena. These metathemes represent the meaning, i.e., feelings and thoughts nurses associate with being cared for and provides a basis for an exhaustive description of the phenomena.

To arrive at the metathemes, the taped interviews of the 15 participants were transcribed and successive readings done. The transcriptions were coded in order to identify significant statements concerning the meaning of being cared for. Themes began to emerge at this point in the phenomenological research process. These preliminary themes were consistent with the themes emerging in the pilot study. The preliminary themes are listed in Table 5. Examples of significant statements are listed in Table 6. An exhaustive list of significant statements from which themes emerged appears in Appendix D.

The significant statements were the raw data used in the analysis. Themes were formulated as raw data clarified and strengthened the preliminary findings and led to further theme development. Finally, fourteen themes emerged and are reported in Table 7.

Table 5

Preliminary Themes

Awareness of feelings
Independence vs. vulnerability
Trusting the care giver
Personal value
Expectations concerning care
Choosing and accepting care
Reciprocity

Table 6

Examples of Significant Statements

1.	I felt secure that she was taking care of me.
2.	You really have to be vulnerable and that's kind of risky and a little scary for me.
3.	I felt cared for, like I say special, secure.
4.	I just didn't feel right about it.
5.	...it depends on if you know the people and you know how trustworthy they are.
6.	I felt rejected, like I was being used as a Guinea Pig.
7.	He valued me and...I was a priority.
8.	I was the total focus of his attention.
9.	I thought "Oh, no dear, she doesn't know what she's talking about.
10.	She did not care for me as a person.
11.	I don't want to have to ask for it.
12.	...almost a fear that I am not going to be what the other person expects out of me.
13.	I was having a lot of feelings that say, "You goofed up." I felt that this other person was disappointed in me.
14.	They can just understand because they have listened to you.
15.	...somebody that you feel cared about, well loves you and does understand who you are and how you generally react to things, and what your values are.
16.	...it's my time with her.
17.	...so we get a lot of one-on-one time.
18.	...spending more time at the bedside.

19. I remember being read to when I was sick and couldn't go to school.

20. They did not spoil me with material things. They did spoil me with affection, during that time.

21. It really makes a difference and it just for some reason helped the pain, the visits, the people coming over, the cards, the calls.

22. He takes care of the financial future.

23. Care is also my husband giving me a paycheck, that's a lot of care.

24. I...(maintain) a fair amount of distance from people until I choose to let them in.

25. I wanted to feel independent.

26. ...he just saw it by looking at me and I didn't have to say anything.

27. It is difficult for me to accept care.

28. Just the sharing of heart, and it took a giving of themselves to do that.

29. It is sort of a mutual support there when we need some support.

30. That was something real special that she got to do for me.

Table 7

Themes Describing the Phenomena of the Nurse Being Cared For

1.	Feelings are tacit concerning being cared for
2.	Positive feelings associated with being cared for
3.	Feelings of personal worth
4.	Being given to
5.	Choices concerning being cared for
6.	Vulnerabiltiy
7.	Independence and self-reliance
8.	Trust based in the care giver's knowledge
9.	Expectation for unsolicited caring to occur
10.	Asking to be cared for
11.	Accepting being cared for
12.	Desirable care giver attributes
13.	Personal and professional growth
14.	The payback

Common themes were clustered and metathemes, i.e., the major dimensions or essence of the phenomena, emerged as the themes and variations resulting from the analysis were integrated. Metathemes, and the clustered themes and variations appear in Tables 8 through 12.

Table 8

The First Metatheme, Themes, and Variations

Metatheme - Feelings associated with the nurse being cared for are tacit, and understood holistically as being multidimensional and interrelated.
Theme - Feelings are tacit concerning being cared for
Theme - Positive feelings associated with being cared for
Variation - Negative feelings
Theme - Feelings of personal worth
Variation - Valued by another
Variation - Self-worth

Table 9

The Second Metatheme, Theme, and Variation

Metatheme - The behaviors associated with the nurse being cared for are understood holistically as having instrumental and non-instrumental components, and are equated with giving that is multidimensional.
Theme - Being given to
Variation - Spiritual sharing

Table 10

The Third Metatheme, and Themes

Metatheme -	The nurse allowing caring to occur uses a dialectic process to validate her feelings concerning her own independence and vulnerability, and the validity of trusting others.
Theme -	Choices concerning being cared for
Theme -	Vulnerability
Theme -	Independence and self-reliance
Theme -	Trust based in the care giver's knowledge

Table 11

The Fourth Metatheme, Themes, and Variations

Metatheme -	Expectations of the nurse being cared for include care giver sensitivity to the tacit perceptions of the care recipient's notion of being cared for.
Theme -	Expectation for unsolicited caring to occur
Theme -	Asking to be cared for
Theme -	Accepting being cared for
Variation -	Caveats
Variation -	Biological
Theme -	Desirable care giver attributes

Table 12

The Fifth Metatheme, Themes, and Variation

Metatheme -	The consequences of being cared for include personal growth and extension of self to others.
Theme -	Personal and professional growth
Variation -	Not caring
Theme -	The payback

The metathemes listed in Table 13 provided a description and led to the unity of meaning which was validated by the participants. However, the majority of the participants stated that the abstractness was problematic and believed that a description using more common language would be more useful.

Therefore, a final validation of the meaning of being was conducted by having participants read the exhaustive description, reported in Table 14, and asking them if it accurately described the experience which they had originally described.

Table 13

Metathemes Describing the Essence of Female Nurses Being Cared For

1. Feelings associated with the nurse being cared for are tacit, and understood holistically as being multidimensional and interrelated.

2. The behaviors associated with the nurse being cared for are understood holistically as having instrumental and non-instrumental components, and are equated with giving that is multidimensional.

3. The nurse allowing caring to occur uses a dialectic process to validate her feelings concerning her own independence, vulnerability, and the validity of trusting others.

4. Expectations of the nurse being cared for include care giver sensitivity to the tacit perceptions of the care recipient's notion of being cared for.

5. The consequences of being cared for include personal growth and extension of self to others.

Unity of Meaning: Persons Sharing Self With Another

Table 14

Exhaustive Description of Female Nurses Being Cared For

Feelings associated with a nurse being cared for are commonly implied and not expressed in words. Feelings expressed about being cared for are understood in a way which exceeds the sum total of their descriptors. They vary in magnitude, and may be experienced as positive or negative. Feelings concerning being cared for are mutually related and connected to ideation of personal value.

Being "given to" is the behavior that nurses associate with their being cared for. Giving may be tangible or intangible, and vary in magnitude.

When a nurse allows herself to be cared for a dialectic process is involved. She logically examines her feelings concerning her independence and vulnerability for their validity, and she judges the knowledge level of her care giver. When possible she chooses to be cared for based on these logical examinations.

The nurse expects her care giver to be able to assess and meet her need for care without direction. She is not comfortable asking for care, and believes the ability to do so is a learned behavior. Accepting care carries with it caveats of unconditionality and sincerity. The nurse being cared for recognizes certain behaviors, corresponding to her value system, as desirable care giver attributes.

The nurse being cared for identifies the consequences of being cared for as personal and professional growth, and the ability to extend caring to others. Nurses expect to return caring in some way to someone. The reciprocation of caring does not require a payback that is in like nor must the payback occur immediately after receiving care.

Unity of Meaning: Persons Sharing Self With Another

The fifteen participants stated that the exhaustive description and the resulting unity of meaning accurately reflected the meaning of their experiences. During the second interview, participants would nod affirmatively as they read the metatheme and exhaustive description, express their agreement with the entire document, and tell how certain metathemes were "especially true" in their life. One questioned the use of dialectic as she was unfamiliar with the term. One asked the meaning of tacit. Another noted the unity of meaning is, "a good summary statement of being cared for."

Summary

In Chapter Four the participants taking part in the investigation were described. A description of the analysis of data and the resulting metathemes, themes and variations were given. In addition, an exhaustive description which provides unity of meaning of the experience of the female nurse being cared is supplied.

Chapter Five

FINDINGS OF THE STUDY

The findings of the investigation are presented in this chapter in the following way. First observations surrounding the interview and analysis will be reported. Second, a discussion of the findings will be offered.

The essential structure, i.e., meaning, of the lived experience of the nurse being cared for are discussed in accordance with the insight provided by the perceptions offered by participating female nurses. The research question for this study was: What is the meaning of the experience of being cared for as lived by female nurses?

Findings

General Description Of Participants And Their Stories

When the participants in this study were instructed to "tell me about an experience when you were being cared for," they first clarified the question and expressed difficulty in thinking about being cared for as they thought of themselves as care givers and not the recipients of care. Generally, a clarification, stating that any experience where they felt they were being cared for would be satisfactory, was necessary. Through such a statement, participants were able to begin their thought processes,

relate stories about being cared for, and bracketing remained in effect.

Many participants began with stories about their experiences of being cared for and soon turned to how they currently practice nursing and caring for others. At such times, participants were allowed to finish expressing their thoughts and led back to telling their own experiences by summarizing their story and asking them to continue telling about the times when they felt they were being cared for. One participant related an experience illustrating this concept.

> In the hospital being cared for, they stuck me 17 times to start an IV. Of course I was dehydrated which didn't help any, and my veins aren't the greatest. But I finally had to ask for the anesthesiologist to come up and start the IV rather than to continue to be a pin cushion... I try twice and if I don't get it I probably won't.
>
> IVs were not exactly my thing in school. I had a real tough time, because if the patient showed any pain at all I wanted to quit. [My instructor] let me start one on her, and it really made a difference. Once you have a success it really makes a difference in your confidence level. I felt that really helped me as far as starting IVs, and now I don't have any problem.
>
> Most of the nurses in public health don't want anything to do with IVs. I think it really helped me to feel like a better nurse, because I've had success. I'm sure that sometime in their life they've had to start an IV because [sic] as a nurse in the public health field you normally don't have to start venipuncture punctures at all. I find that I do a lot more of the blood drawing here than the rest of the nurses do just because of the confidence level.

Interviews lasted from 15 to 60 minutes as some participants felt they had little to tell or told their stories using few words while others told every detail of their experience or had numerous experiences they wanted to share.

Six of the participants were very articulate. Analysis revealed that text of interviews where nurses told of their experiences in a more articulate manner provided more insight than the less articulate nurses. Age and experience also influenced the collection of data. Older nurses and younger nurses who recognized some life experiences as problematic were more able to process and tell their feelings and thoughts more articulately than younger nurses who seemed to believe they were "in control" of their lives. Many of the younger nurses had not experienced situations of forced vulnerability, i.e., situations where they had little or no control over an event in their lives. They had not had a serious health problem, their marriages were intact, and their lives in general had progressed according to their plan. They did recognized that they had been cared for, but had not thought of those caring episodes as vulnerable times in their lives nor had they considered their own feelings during those times of being cared for.

Being cared for, being cared about, and being loved were terms used indiscriminately by the participants when they referred to caring episodes. Thirteen of the fifteen

participants included experiences which were professional, such as being cared for by a health care worker, as well as experiences which were more intimate, such as being cared for in a marital relationship or by a parent during childhood. Most often the ideas of being cared for, being cared about and being loved were included in the experience of one caring episode.

It was observed that caring episodes associated with three conditions in the participants' lives were most likely to be related. Those conditions included childhood and caring from a parent, 9 of 10 times the mother rather than the father; marital relationships and caring associated with their spouse; and caring during an illness and associated with professional care givers. Of the 15 participants, 11 began with an experience when they were ill or giving birth to their children. Three of the 11 began by relating stories of their childhood, while 8 first recalled experiences in their adult years. Additionally, 2 began by telling of the care they received as the result of a family crisis. Another began by recalling the care she received from her husband. Finally, 1 began with an experience when she was cared for as she cared for a family member.

Discussion of Findings

The discussion of findings will be pursued in three ways. First, as Tesch (1987) notes, "Things don't fit into slots that neatly! Some themes overlap, and could be sorted

into more than one category. For others the borders are fuzzy, and they are not clearly distinguishable from another" (p. 233). Tesch explains that when dealing with the data it becomes obvious that something, in this instance the experience of being cared for, which is accomplished as a whole, has been taken apart in order to facilitate better understanding of the whole. During the process of taking the whole apart, metathemes emerge. Metathemes are expressed as abstract entities, therefore concrete illustrations, taken from the data, make the metathemes come alive.

Second, themes are separated out in order to gain a better understanding. "By shedding light on one part after the other and describing each as best we can it is easier to grasp the whole" (Tesch, 1987, p. 236-237). Therefore, explication of the themes and variations using the text of the interview transcriptions will be included. Please note that fictitious names are used to provide interest for the reader and to maintain confidentiality for the research participants.

Third, the findings will be discussed with reference to literature central to the metathemes, themes and variations. During the research process the presuppositions of the researcher were "held at bay" and knowledge concerning the meaning of female nurses being cared for was rebuilt in a way that is original to the research participants. In

keeping with the existential phenomenology philosophy, concrete rather than abstract thinking identified with the human situation was the beginning point as an understanding of being cared for was sought. The findings in this study provide a description of the phenomena which supports many of the ideas about caring and being cared for as set forth in the literature review in Chapter Two.

Metatheme I: Feelings Associated With The Nurse Being Cared For Are Tacit, And Understood Holistically As Being Multidimensional And Interrelated

Feelings associated with a nurse being cared for are commonly implied and not expressed in words. Feelings expressed about being cared for are understood in a way which exceeds the sum total of their descriptors. They vary in magnitude, and may be experienced as positive or negative. Feelings concerning being cared for are mutually related and connected to ideation of personal value.

Watson (1985/1988) describes the art of caring as the activity begun by the human interaction in a caring situation. The human interaction calls forth a feeling within the care giver. "Having experienced that feeling and having evoked it in oneself, then by means of movements, touch, sounds, words, colors, and forms, the [care giver]...transmits the feeling so that another person experiences the same feeling - that is the activity of the

art of caring" (p. 68). Watson notes the feelings which are impressed on the mind of the care recipient may be varied and multidimensional.

Theme: Feelings Are Tacit Concerning Being Cared For

All of the participants in this study commonly thought of themselves as care givers. To address their feelings during a caring episode required thought and retrospective reflection. Each nurse was able to recall experiences wherein she felt cared for. However, finding words to express their feelings while being cared for was difficult. At one time during each interview, each participant searched for words to express what she felt during a caring episode. The interview with Connie further illustrates the tacitness of being cared for.

> Connie: When you reverse your role as a patient instead of a giver, you're a taker. That's always a different role for a nurse.
>
> Researcher: When did it happen to you?
>
> Connie: The latest, well the only hospitalization I've had as an adult, other than obstetrical, was when I had gallbladder surgery which was like eight years ago or so. And I would say it was a nice experience.
>
> Researcher: A nice experience?
>
> Connie: It really was. You know it had been a long time before they finally diagnosed that it really was gallstones and that's what I needed to have done, and time for us to work it into the schedule so I could be off work, you know, at a time when my work load would allow for it. And I really looked forward to that stay in the hospital and being cared for and getting that problem taken care of. And it was a good experience. I have a mom, you know, and when she has had surgery I've been there for her, and she came for me that night after surgery. And that was something

> really special that she got to do for me. Kind of a reversal of mom-daughter, you know, daughter being nurse for mom in that instance. And I guess it was comfortable being in the hospital where I had trained, where I know most of the aids, most of the nurses, most of the doctors. I was not uncomfortable in my environment in any way it was just real (pause). You know, I know them professionally, I knew the kind of work they did. I respected their job and what they did...

Nurses often expressed their feeling as "I felt cared for," "It was good," "a nice experience," or paused, grasping for a word which would adequately describe their feeling. For example, at one point in Gloria's interview she paused, thought for awhile and said "maybe that's what I felt, special."

Theme: Positive Feeling Associated With Being Cared For

Each participant chose to described positive feelings associated with their being cared for experiences at the beginning of their interview. The interview with Ellie, who is both verbose and articulate, illustrates a search for words to express the feelings experienced by many participants.

> Ellie: [My brother] swung the bat back and hit me in the forehead, right above my left eye and knocked me unconscious for about ten minutes. And I don't remember anything except for waking up crying and my mother had me in her arms and had taken me across the street to a doctor who was our neighbor, who was mowing his lawn. I remember him lifting up the eye lid and telling my mother the eye looked okay. I remember her being hysterical and crying, and suddenly my brother and his friend weren't around any more. And uh, I remember getting a lot of attention and enjoying the attention of being cared for during those three weeks. I was out of school for three weeks...(describes the role of each family member and their relationships with each other).

> Researcher: I see, and do you remember what you felt like during the time you were being cared for?
>
> Ellie: Special, I guess. Okay, my father is a physician, He's retired now. I felt very lucky that my father was a physician, that he would take care of me. I felt very secure. I felt I was going to be okay even though they were all still worried about me. I did not know how worried they all were about me until I did this paper this last year, that they were really that concerned about me. To me it was just kind of "Haw Haw" funny, my brother hit me with a bat and I had a black eye for three weeks, and I got out of school, and all my friends came over and I got a lot of attention. I never felt that I wasn't going to be okay. I felt cared for, like I say special, secure, because I had so much caring I guess. They did not spoil me with material things. They did spoil me with affection during that time.

Words such as "special," "secure," "comfortable," "lucky," "thankful," "appreciated," "peaceful," "protected," "understood," and "warm" were included as descriptors of feelings associated with being cared for. These feelings also attest to the positiveness of being cared for.

Two participants described negative feelings associated with being cared for along with their positive feelings. On occasions when negative feelings were present, the care recipient perceived the care giver as taking away "power and autonomy" and described the experience as times when they felt a "not nice" feeling, "smothered," possessed," "frustrated," or "humiliated." In all instances the care recipients recognized the care giver's acts as caring episodes, even though the feelings associated with them were perceived as negative.

Wilma noted:

> Caring from my husband has been, for me, a frustrating experience because the things that make me feel cared for are not the things that he, in his value system, labels as caring or conveys caring. So things that he labels and that he does for me, to care for me, are not the things that make me feel cared for. As a matter of fact some of the things make me feel smothered and possessed.

Heidegger's thought gives credence to the notion that legitimate caring, i.e., caring done because the care giver was concerned about the care recipient, that she mattered to the care giver, may evoke negative feelings in the care recipient. In Heidegger's (1927/1962) philosophical thought about "Dasein," i.e., being-in-the-world, there is an underlying structure related to care. Two possibilities are associated with the underlying structure. One is the possibility of "leaping ahead," liberating the cared for in a way that enables them to assume caring for themselves. The second possibility is to "leap in" for another, to take charge and to take control of another person's life. Both of these possibilities are identified as caring from Heidegger's philosophical stance. However, to "leap in " for another person, particularly a person who sees himself as self-sufficient, can lead to negative feelings even though the "leaping in" kind of care may have been done with appropriate motivation.

Mayeroff (1971), on the other hand, believes one criteria for an act to be considered an act of caring, is

that it must promote the self-actualization of the care recipient. His thoughts differ from Heidegger's in that to have concern or to have something/someone matter to another does not mean that one is caring for another. Mayeroff notes that caring must be recognized as such by both parties. He would question the validity of caring that produced negative feelings in the care recipient.

Theme: Feelings Of Personal Worth

Nurses believed the feelings associated with being cared for are directly related to their feelings of worth as a person. Positive feelings were likened to being understood and valued as a person by another person and by oneself.

Carla explained that her husband helped her through labor and she felt, "That he cared and that he loved me and that he didn't want me to have pain. That's worth a lot. He valued me and that I was a priority. I was the total focus of his attention." Beverly felt valued when the EMT who helped her during her time of crisis came to see her in the intensive care unit after the crisis had ended. Connie described how "little caring things," having someone let you know "they care about you as a person and not just a Cholecystectomy in room 206," made her feel valued by another.

Wilma's experience illustrates one way in which being cared for can cause one to question her own self-worth.

> ...his protectiveness became threatening to me because, to me, it was taking away my autonomy and the fact that I had good enough judgment to take care of myself.
>
> If I was late getting home, very late getting home, he would start out to look for me. And most of the time I was late because report had drug overtime or I was at a meeting that lasted too long. And it was humiliating to me to think that if we went 15 or 20 minutes over that I had to go out and get a phone and call him, but if I didn't I could pretty well count on meeting him somewhere on the road looking for me. And I resented that bitterly, but that was his way of conveying caring. But again, it threatened my power and autonomy to continue to be independent and meet my own needs.

Just as being cared for is subjective, described as a feeling, caring for another has subjective aspects too, according to Mayeroff (1971). When a care giver genuinely cares they assist in the care recipient's growth and do not attempt to satisfy their own needs.

Jourard (1964) believes that through caring the care recipient is either "inspirited" or "dispirited." The result of being cared for, on any one occasion, is that the care recipients see themselves as inspirited, worthy persons, able to grow, or they see themselves dispirited, unworthy persons, discouraged and discontented.

To summarize, life enhancing aspects of being cared for were demonstrated as positive feelings were verbalized. The negative feelings verbalized exemplify the dispiriting quality of being cared for. Personal worth is a feeling, a direct result of the art of caring. Personal worth is enhanced as one feels valued by another and valued by self.

All caring is subject to the interpretation of the care recipient. Therefore, the same caring acts may evoke life enhancement in one person and be dispiriting to another.

Metatheme II: The Behaviors Associated With The Nurse Being Cared For Are Understood Holistically As Having Instrumental And Non-Instrumental Components And Are Equated With Giving That Is Multidimensional

Being "given to" is the behavior that nurses associate with their being cared for. Giving may be tangible or intangible, and vary in magnitude. Gult (1983), like Mayeroff (1971) sees caring as an action verb, i.e., giving. However, the specificity of what is given is not a list of agreed upon articles or acts. For an action/gift to be caring the one caring must intend it to be. Accepting the gift of caring is dependent on the receptiveness of the caring action by the care recipient and the feelings the care recipient bestows on it.

Theme: Being Given To

Nurses associate giving with being cared for. They recognize giving time, giving attention, and giving material things as equal in importance. Selma explained that she did not

> look at all of the things that I should for care. I look at feeling, touching type things as care, but if he didn't care for me he wouldn't give me his pay check and the right to do with it as I feel.

Jean recalled that with the death of her father she experienced "one of the hardest pains," she hurt like never before. She explained that caring came from many people,

> in particular Laura. She just really has a way with words that make a difference. One of the things she said, and you know, I don't know why it helped, but she said, 'that's the risk of being loved and loving, pain like that.'

Jean explained that feelings of being cared for flowed from the acknowledgement that people respected her father and

> that they were really thinking of [her]. The visits, the people coming over, the cards, the calls, ... with Laura it is that philosophical, just giving direction to things that helped.

These examples demonstrate the holistic nature of the giving related by all of the nurse participants in this study. Included in this experience is caring that is instrumental, i.e., cards, visits, calls, and caring that is non-instrumental, i.e., words that give "direction to things." These notions about caring support the caring constructs included in Leininger's (1977, 1984) work.

Tracy told about the multidimensional gifts of caring as she related her experience.

> I always remember hands being involved. One time... [when] I was not feeling good...I remember one of my daughters coming up [to me]. [She was] probably a two or three year old, and I was lying on the couch ill and really having a hard time dealing with the fact, at that time I had been diagnosed as having Lupus and really having to struggle with accepting having a chronic disease, and she just patted. I remember being comforted, just on a very deep level, feeling so much comfort from that.
>
> I was extremely poor at the time and really struggling and I knew my current husband. At that

> time I was not married to him and we were close friends, really had not gotten to a romantic level. There were several times that I remember out of the blue that he would bring me groceries. He would go to the store and then bring them by. "Well, I thought you could use this," and it is very significant in my mind seeing him come up to my house carrying these sacks of groceries.
>
> ...I remember the night that my house burned down. It was 3 o'clock in the morning, thank goodness my daughters had stayed at their father's and I had worked the 3-11 shift. I ran outside and I was almost encompassed by the smoke and smoke inhalation. Woke up when the firemen were breaking all of the windows, ran outside like they told me to and ended up being taken to a little motel close by because I had nothing. I was wearing, like, a little pink nightgown.
>
> Because my situation is what it is I could not call my parents and say my house is burning down, could you come and help me, but instead I chose to call one of the other nursing students that I was going to school with and she came. And again I just remember her bringing her little clothes and every thing so that I would have something to wear and just walking over and just holding me for a long time. And that was, I guess, that's again, I remember someone reaching out and caring for me.

Two nurse participants placed caveats on their definitions of giving in order for there to be no misunderstanding of giving which is "truly caring." Hazel and Connie believed that care must be given with the right attitude, not grudgingly. Hazel noted that she would rather not be cared for if the caring is not freely given. In addition, nurses believe they can judge the care giver's attitude during a caring occasion and feel justified in deeming the action a "task," and therefore, not an act of caring as it is not given freely.

In the present study the term "giving" used in labeleling this theme denotes the attitude with which caring is rendered and the multiplicity of caring actions which are accepted by nurses as caring acts. Both attitude and action are deemed important aspects in the experience of being cared for.

"Givers" are noted in the work of Eichenbaum and Orbach (1987) as those with the "ability to know, to intuit, to read the needs of others" (p. 66). When nurses are cared for they are said to yearn for the same kind of treatment from others. Thus, their ideas of being cared for include a giver bearing the gifts of time, attention or material.

Jean described another dimension of being cared for when she related her feelings about being cared for on the occasion of the death of her father. She recalled the care she received from others included

> kind of a sharing of energy, you know,the holding of hands in an energy way. Not necessarily physical but just spiritual support, I guess is one way that you could put it. As far as feeling that (pause). Just a sharing of heart, and it took a giving of themselves [the care givers] to do that. I think that's real significant.
>
> You know, it's not...the knowledge that you spread out but the sharing of your own self that makes a difference. And I can see that with faculty. You know, the faculty that don't share themselves are the ones that have problems with students, I think. And some people just can't do that. They have a real hard time and it causes problems. It's just that they can't open the door to themselves.
>
> I don't know it, it's the openness of thought or even feeling, you know, the ability to admit that they are wrong or that maybe there is another way to do it

> or a better way. The students are real people. And faculty seem to keep it defensive. I think that related to the caring part is that you have to be vulnerable to really provide the caring.

Jean's experience of being cared for in a way that extends into the spiritual realm supports the thought of Watson (1985/1988) concerning care. In her study of cross-cultural nursing Watson identified an aspect of nursing which she labeled "transpersonal nursing," (i.e., an intersubjective human to human relationship [p. 59]). In transpersonal nursing the care giver's presence is included as a caring action along with "giving time and taking time" (p. 34). She describes transpersonal human care and caring transactions as "those scientific, professional, ethical, yet esthetic, creative and personalized giving-receiving behaviors and responses between two people...that allow for contact between the subjective world of the experiencing persons (through physical, mental, or spiritual routes or some combination thereof)" (p. 58).

Watson (1985/1988) theorizes human care transactions as those which include the use of self in a way that a person's condition is reflected back upon herself, i.e., they are able to see in the care giver their own condition. In so doing, feelings, thoughts and suppressed energy are released, harmony restored within both the care recipient and care giver, and both find meaning in the experience. Through transpersonal caring experiences there is contact

with the subjective world, one is able to "reach out and touch the higher, spiritual sense of self, or the soul" (p.58). Watson believes that in so doing an "I-Thou" (Buber, 1970) relationship exists.

Metatheme III: The Nurse Allowing Caring To Occur Uses A Dialecic Process To Validate Her Feelings Concerning Her Own Indepencence And Vulnerability, And The Validity Of Trusting Others

When a nurse allows herself to be cared for, a dialectic process is involved. She logically examines her feelings concerning her independence and vulnerability for their validity, and she judges the knowledge level of her care giver. When possible, she chooses to be cared for based on these logical examinations.

Being cared for calls for those being cared for to logically examine the validity of relinquishing their independence and placing themselves in a vulnerable position, and whether or not to trust their care giver. This dialectic process is explained by Stevens (1984). Although she describes the dialectic method in relation to theory development, her description can be applied to the process female nurses use when submitting to being cared for. Stevens explains:

> [The dialectic process] works by taking as its perspective a whole that it organizes. Whatever whole is so organized governs the relationships and provides coherence to the parts of that whole...All components are seen as parts of a larger whole, a whole that is different from and greater than a mere summation of

> its parts. The parts, taken together, do not exhaust the whole: the whole organizes the parts (p.37).

Theme: Choices Concerning Being Cared For

Some nurses shared times when they were able to make choices concerning being cared for. Gloria described a time when she made a choice about being cared for.

> Another time that I felt taken care of, it wasn't because of illness but it was needing emotional support when I went through the divorce. I have always been a pretty independent person, not, well sort of kept my own counsel, I guess. Right up until the time that I decided that I certainly didn't have any choice, that we could not work it out and that I must go through the divorce. I had not said much to anyone, including my parents, because I kept thinking that if we worked it out I didn't want them to have animosity towards my husband at that time. When I finally decided that there was no choice and I did spend sometime at home, probably a couple of weeks, they were very, very helpful.

Connie choose to go back to the hospital where she "trained" and to the people that she knew and trusted to have her baby. Velma choose to go to friends and family in the time of crisis when she needed care extended to her. In each of these cases there was a decision about being cared for that was made which was based on logically examinating the validity of feeling independent and invulnerable.

Others told of experiences where there was "not a choice." Selma's husband was in the military and "there wasn't much choice" when her doctor was not on duty and a stranger delivered her baby. These experiences call to question Heidegger's (1927/1962) concept of "thrownness," and the freedom and responsibility which existentialists

believe humans have and use to shape their life situations.

Heidegger (1927/1962) refers to "thrownness," a person's situation in the world when that person discovers "Being", i.e., their place when, as persons, they realize their being-in-the-world. In this instance, the realization of being-in-the-world is coming to the awareness of the need to be cared for.

Benner (1985) and Miller (1986) agree with existential thought, the notion of "thrownness" and a connection with the world. Furthermore, Miller (1986) argues that the development of autonomy and/or independence, and the issues of basic feelings of weakness and vulnerability, are intimately related to, and associated with, the position, i.e., the "thrownness," assigned to women in our social and psychological structuring of life. Accordingly, though persons have freedom to make choices in their lives, the situations in which they find themselves when the need for care arises may limit their choices. Selma's choice was a strange doctor or no doctor at the birth of her baby because of her situation in the world when labor began.

All of the participants experienced times when being cared for called for examining the validity of preserving independence, being vulnerable and trusting a care giver. Participants felt the fear and risk associated with being vulnerable and examined the validity of those feelings. Similarly, the validity of trusting the care giver was

examined by the nurse. Excerpts from Beverly's story of a recent medical crisis demonstrates the dialectic process and the themes grouped with the third metatheme.

Theme: Vulnerability

Beverly relates:

> I knew something dreadful was happening to me, but I didn't know just what. I found out that there wasn't a nurse in the clinic that day and I was very frightened and I didn't want the doctor to leave me and he didn't.
>
> ...The thing that went through my mind was, "I wonder if I'm going to die." Somehow or other I didn't think I was going to. But I was probably a little angry and frightened because there wasn't a nurse there that would know what to do for me next. And then I heard the doctor say, "send the ambulance, red light and siren" and I thought, "someone in here is really sick."

Theme: Independence And Self-Reliance

Beverly continues:

> ... Then I was being cared for by the EMTs who came. They were putting needles into my veins and hooking up machines and doing all that kind of technical kind of things and suddenly I realized, "I'm going to be carried out of here, I'm not going to be able to walk. Good Lord, I'm not sure I want to be carried anywhere...But I realized I didn't have an alternative, and I [began]...to think that I don't have any options left. 'Cause I've got to have some options, I've got to make some decisions for myself. That's just part of me and until I can see some options, and at that point I had none. It was lie down, shut up and do what they're telling me to do, if you want to live, and that occurred to me, and this is the only option I have if I want to live... To have to suddenly have to be totally submissive to everyone else's best thought for my health, and that is a little, that's a disturbing thing to me.

To relinquish decision making when decision making for self and others is a way of life, and the risks are known,

requires a blurring of the distinction between nurse as a person and nurse as a professional.

Miller (1986) conjectures that women have struggled to become strong and independent individuals, and have reached a place where they are able to determine the nature of their connections. They can decide for themselves with whom they will make relationships. They can begin to elect relationships that encourage mutual growth. This is, however, an unfamiliar and uncomfortable position. The findings in this study support Miller's (1986) position concerning the unpleasantness of being placed in a vulnerable position. Women, she believes, are able to admit their feelings of vulnerability and tolerate those feelings, which are common to all people. In fact, vulnerability is seen as a strength by Miller. She contends that, instead of being weak, women in vulnerable positions have the opportunity of developing a unique understanding of vulnerability and appropriate ways out of it.

Theme: Trust Based In The Care Giver's Knowledge

Beverly recalls:

> They were just doing things to me and not telling me what they were doing. I did not like that, because suddenly I wondered, "what is it they're putting in these needles and putting into my venous system. I wonder what they are going to put in there and I wonder if these EMTs really know what they're putting through there." And the only thing I could do was to trust these people that they were not going to do anything to hurt me any worse. So that was what was going through my mind, I have to trust these people. I certainly hope that they have the knowledge that

they need to do this.

The epistemological aspect of being cared for comes into focus and the conjecture of Watson (1985/1988) and Mayeroff (1971) is supported as care recipients reported choosing to trust knowledgeable care givers. Watson's theory of human caring involves, among other things, knowledge. Mayeroff believes that caring persons have knowledge that is more than can be verbalized. Therefore, caring is communicated to the care recipients in overt ways as well as ways which are implicit and indirect. Trusting one to care appropriately is judged as nurses evaluate the care giver's knowledge level and the application of that knowledge.

Nurse participants in this study alluded to these notions repeatedly when they talked about being understood, deciding by virtue of the care giver's education that they knew what actions were in the best interest of the care recipient. Often the participants in the study compared the care they received with the care they would give under the same circumstances and made judgments as to the ability of their care giver. Additionally, care givers must know the recipient of their caring well enough to provide some clue telling the care recipient that their best interest is being attended to. A clue may be that the care giver takes time to understand the care recipient as fully as possible. Knowing the care givers educational or practical experience

may also provide an indication that time has been spent learning about people and therefore they are trustworthy care givers.

Metatheme IV: Expectations Of The Nurse Being Cared For Include Care Giver Sensitivity To The Tacit Perceptions Of The Care Recipient's Notion Of Being Cared For

The nurse expects her care giver to be able to assess and meet her need for care without direction. She expects her care giver should be able to "read her mind," and then provide caring which is acceptable. She is not comfortable asking for care, and believes the ability to do so is a learned behavior. Accepting care carries with it caveats of unconditionality and sincerity. The nurse being cared for recognizes certain behaviors, corresponding to her value system, as desirable care giver attributes.

Theme: Expectation For Unsolicited Caring To Occur

Nurses believe that they assess the needs of others and go about extending care to assist others in meeting their needs. Nurses expect the same to be done for them. They value caring acts that are spontaneous, given freely and ungrudgingly, and those that meet their unspoken ideas of what they believe they need.

The nurse participants told of experiences when unsolicited caring occurred, and they shared their thoughts and feelings about instances when they felt they needed care and their need was either ignored or unrecognized by the

person from whom they expected to receive caring. Gloria's story illustrates these notions.

> We had planned a vacation, just a short vacation. Some friends of ours had a cabin, he was an osteopathic doctor, the doctor and his wife had a cabin at the lake and we had planned on going to the cabin and I just really didn't feel well but I think that Joe thought it was kind of an inconvenience. But anyway, we proceeded and we had our two girls with us, they were young at the time. When we stopped by the doctor's house to get the key for the cabin, he just looked at me and knew that I was sick and so he said, "Let me get you some medicine." He went and got me some medicine for me. I remember crying and it still makes me cry. I can't explain it. I think it was because I felt like I wasn't being cared for and here was someone who recognized it, offered it. That was kind of significant. And he just saw it by looking at me and I didn't have to say anything.

Benner and Wrubel (1988), Eichenbaum and Orbach (1987), Lovell (1981). Miller (1986), and Reverby (1987a, 1987b) all agree that women's role in society has historically been one of altruistic self-sacrifice, and as such, it has contributed to the inability nurses have to express their needs overtly. Eichenbaum and Orbach contribute to the understanding of the nurse participants' expectation for unsolicited caring from others when they suggest that nurses are ashamed of their own needs and not accustomed to addressing them directly. The nurses in this study seemed to agree, as they "sent out signals" when they needed care, but found it difficult to ask for caring directly.

Theme: Asking To Be Cared For

Nurses claim that they are not comfortable overtly asking to be cared for. Two participants explained that

they "send out signals" that caring people would recognize as a need to be cared for, and if they want to provide that care, it would be accepted. The participants expressed their reluctance about asking to be cared for in relation to a variety of situations. Gloria relates:

> I do remember when I moved back here to Iowa after my divorce, I was living in Oklahoma at the time. One of my emotions was that I don't want people to feel sorry for me. I can remember that was a very strong feeling. I just didn't want everybody to know my business and certainly didn't want anybody to feel sorry for me. I didn't tend to talk about it a lot with anybody other than my family because I wanted to feel independent. It is hard for me to ask for help, I suppose, at times. I really want to do it myself if I can.

Overtly asking to be cared for is to admit to vulnerability in a man's world where vulnerability is shunned. Although women have the ability to admit their feelings of weakness and vulnerability, they have not recognized the importance of that ability (Miller, 1986). According to Miller, women are strong in many ways, but they have difficulty admitting their strength. She claims that "Only someone who understands women can understand how this psychic element operates, how widespread and influential the fear of not being weak can become, and how persistently it can hang on without being recognized for what it is" (p. 32).

Theme: Accepting Being Cared For

Carla states that she believes that she is beginning to learn to ask for care and she is beginning to learn "to

reach out to other people." "Learning to receive that [caring] is challenging for someone that's not used to it." Sheila is learning to accept being cared for. She recalls that being cared for is easier to accept from some people than it is from others. She related that, "from him I have a hard time accepting it...[because I had] to make sure I maintained this role." Care from her grandmother is experienced differently. "I can take it if it's from someone like Grandma, you know, if it's from somebody that really believes that I deserve caring in the sense of I'm an okay person and I deserve it."

Watson's (1985/1988) theory that during a caring episode both action and choice are accomplished by both the care giver and the care recipient is supported by these data. It is during a time of caring that two persons have an "opportunity to decide how to be in the relationship - what to do with the moment...If the caring occasion is indeed transpersonal, (i.e., an intersubjective human to human relationship), and allows for the presence of the geist or spirit of both, then the event expands the limits of openness and has the ability to expand the human capacities" (p. 59). Such a relationship can be equated with the "I-Thou" relationship, where growth is experienced by both the care recipient and the care giver, and an "I-It" relationship, where being cared for is considered an object (Buber, 1970).

In Mayeroff's (1971) work On Caring, he posits the idea that being cared for results from and promotes relationships, which are growth producing. Mayeroff contends that a constant relationship, one in which the care recipient remains in relationship to the care giver, is primary to being cared for. This notion is supported by the fact that the nurse participants described caring occasions in which the care giver was a parent, spouse, friend or co-worker all but two times. Even when caring occasions were experienced during an illness, all but two participants described their feelings and thoughts when a person with whom they had a well-established relationship was the care giver.

The nurse participants attached additional caveat to being cared for. Along with accepting care if they deserve it they accept care if it is "sincere," done "with the right attitude," that is "given." To be accepted the caring act must be deemed appropriate to the care giver. Anna explained her thoughts about being cared for by her parents.

> I feel it's easier to accept care from nurses and Jeff than to accept care from my parents. It's a little different to think, "Well, I'm older." If I'm young and healthy and they're supposed to be getting older, then the care role reversed a little bit. And that it's a little harder to accept care from them. I think, "you're supposed to be independent, and into your own...If we were in a financial pinch, I don't know that I could accept that kind of caring because that would be kind of admitting failure.

In addition to these caveats attached to the acceptance of being cared for, one nurse explained that, in her experience, accepting care was often related to her menstrual cycle. Selma recalled:

> At the beginning of the month, I feel good and on top of the world and could accept care a lot better if I were sick. At the end of the month, right before a period, I would tend to be a lot more grumpy, may take things wrong, say things more hurting and not mean to. Not accept care as easily, sort of push off.

Selma's thoughts describe symptoms which may be associated with premenstrual syndrome. Brown and Zimmer (1986) report that over 74 different symptoms many of which may be umbrelled under the term "tension" are associated with what is commonly referred to as premenstrual syndrome. Although 70 to 90 percent of women in the United States report premenstrual syndrome symptoms, and many of those report cyclic times when they feel more frustration, anxiety, irritability and argumentativeness, only one of the participants in this study connected their feelings about accepting care with their biological make-up.

Theme: Desirable Care Giver Attributes

The nurse participants in this investigation included desirable care giver attributes as they described their experience. Their expectation was to feel respected by their care givers, they expected them to be perceptive to their emotional or physical pain, and to be understanding. They believe that care givers are open to themselves as well

as others. Nurses see their care giver as having the ability to know when to take on decision making for the care recipient and how to relinquish decision making when the care recipient is able to take over again. Tracy's thoughts explain this eloquently.

> I guess it is almost a variety of ways having someone share the burden, and the burden may be to share the pain, to share the emotional pain, the physical pain. Not to take it away for me because I don't really feel that we can do that, but to somehow, on some level share that. Share that with me. Therefore, like take a little piece away so that, it's almost like you can handle so much but it gets to the point about the straw that breaks the camel's back, and it is the straw that the care giver takes and holds and says, "you know, I know there is this extra little piece that you can't handle and I am going to hold this piece for you so that you can handle whatever.

Tracy's thought parallels Heidegger's (1927/1962) notions about the positive mode of concern that include one possibility of care as "leaping ahead" for another. Tracy explained that her care giver "held," in some way, the "extra little piece," i.e., the care giver's action liberated Tracy in such a way that she was able to resolve enough of her multitude of problems to eventually be able to reassume responsibility for those being held for her. Tracy's description of "leaping ahead" represents the counterpart of the possibility of "leaping in" identified as a mode of concern by Heidegger. "Leaping ahead" is a behavior that fits into their value system and agrees with nursing's accepted definition of caring.

Metatheme V: The Consequences Of Being Cared For Include Personal Growth And Extension Of Self To Others

The nurse being cared for identifies the consequences of being cared for as personal and professional growth, and the ability to extend caring to others. Nurses expect to return caring in some way to someone. The reciprocation of caring does not require a payback that is in kind, nor must the payback occur immediately after receiving care.

Velma, most straight-forwardly, said,

> I think if I had not felt, during that time, emotionally fed and strengthened by others' love and reaching out, I would feel like I would never had the courage to go on and attain some goals that I have done since then, some personal goals and professional goals that I have done...

Theme: Personal And Professional Growth

In this study the participants' experiences and their thoughts demonstrate that the meaning of being cared for includes the existence of consequences. The first consequence concerns the care recipient herself. Nurses report that their self-esteem and feelings of personal worth were enhanced. They had courage and strength to go on and work through difficult situations.

Second, there is a consequence that occurs in caring relationships. Velma reported that the relationship with the care giver deepens, "Those people whom we allowed to reach out to us and touch us both physically and emotionally, our relationship was never the same, it was

deeper, naturally." Other examples include the belief that a "closeness" with the care giver resulted, or when a "complete trust" developed with the care giver.

Third, the nurse participants consistently claimed their experiences of being cared for made them better care givers. For example, Gloria was able to write a letter to someone who was going through a similar experience. Lacey decided not to become a "hard or hardened" nurse. Anna knew better how to work with women laboring in childbirth. The nurse participants not only learned technical aspects of caring, they developed attitudes about giving and receiving care that reflected their own experiences. Gloria noted that the care she received as a child, when her mother knew how she felt and allowed her to play with the cat inside the house, helped her be able to accept care later on when she experienced an emctional crisis.

Contrary to caring experiences which foster the nurse participants' growth as care givers is the experience of Wilma. Wilma claimed to be frustrated with the care she received in her marital relationship. Although she labeled the experiences as times when she was receiving care, it was not the care she hoped to receive. She concluded that because she did not have her care expectations met, her "caring pools dried up."

Mayeroff (1971) explains that in "meaningful friendships, caring is mutual" (p. 37) that one person's

caring for another "activates" (p. 37) care being returned. However, when caring behaviors are not recognized as such, caring can not be mutual.

Noddings (1984) would contend that Wilma's experience was not true caring because it was not accepted as such by the care recipient and the care giver alike. Wilma's experience is one where the "Thou of the "I-Thou" (Buber, 1970) relationship was not heard by the intended care recipient.

Theme: The Payback

The nurse participants expect to pay back the care they received even though, when care is freely given, a payback is not expected. Ellie stated, "He's not the kind that would feel like I owed him anything. But there are times that I've given to him, emotionally, like when he has had a crisis at work or whatever." Recalling a different experience, Ellie remarked, "In fact, sometimes they give more to me than I an able to give back to them." Gloria described a caring relationship as "a mutual support there when we need some support, whether it has to do with our school nursing [or not]. That is good, too, to have somebody that you can talk a situation over with." Connie recalled that "when she has had surgery I've been there for her, and she came for me the night after surgery. And that was something real special that she got to do for me." Velma summed the theme of reciprocity as she reflected on

her experiences of being cared for, and stated, "I think an experience like this changes you and you're never the same. Just some of the changes that I've seen, or some of the results coming from this, is that we were able to turn around and help, then, some of the same people as they went through stress situations in their lives, nothing exactly like what we had, but some deaths in the family or different things."

The literature is replete with ideas concerning the reciprocal nature of caring. Mayeroff (1971) devotes space in his work to develop the notion that care is not always returned to the care giver, although there are times when caring is mutual. Noddings (1984) also vouches for reciprocation on the part of the care recipient, as integral to being cared for. She agrees that caring may not always be mutual, and questions the how of a caring relationship, if "relation is reciprocity" as Buber (1970, p. 58) declares. Buber explains further that relationships can continue in a less than "I-Thou" relationship because the ones being cared for know more, do more and have more impinging upon them than they realize. Buber suggests that the care recipient tacitly responds, and seeing the growth within the care recipient is reciprocation enough for the care giver.

Summary

In Chapter Five the findings of the study were

reported. First, observations surrounding the interview and analysis were discussed in order to better understand the participants and their interaction with the researcher. Second, there was discussion of the essential structure of female nurses being cared for surrounding each metatheme, theme and variation. Through the discussion, a better understanding of the data and how the data was separated out was facilitated. Finally, the findings in the present study were discussed with reference to literature which was central to the metathemes, themes and variations. Through the discussion of the findings in this study a better understanding of a beginning description of the phenomena of being cared for was set forth.

Chapter Six

CONCLUSIONS FROM THE STUDY

In Chapter Six, conclusions drawn from this present study will be reported from a general perspective and in relation to nursing theory. In addition, implications of this study in relation to nursing education, nursing practice, and nursing research will be discussed. Finally, recommendations for further study will be presented.

Watson (1985/1988) includes a "sensitivity to self and others" (p. 75) as a "carative" factor in her theory of nursing. This study, which sets out to describe the meaning of the experience of being cared for in the lives of female nurses, is also an attempt to become more sensitive to self as a person and as a nurse.

In the beginning of this study it was noted that nurses commonly believe that as a group, they are uncomfortable with being cared for and avoid being cared for by others. The rationale for this study centered around the philosophical thought which suggests being cared for enables one to care for others. This study revealed female nurses are cared for. They were each able to recall caring episodes which were in their distant past as well as ones which were more recent. It also revealed nurses recognize

their being cared for leads to their understanding of self and others, and to their ability to provide caring. Still, female nurses claim to resist and to not feel as comfortable being cared for as they do caring for others.

The findings in this present study support the philosophical and theoretical thought on human caring from the perspective of the care recipient. The experience of being cared for, as lived by female nurses, is an interaction between care recipient and care giver, and is dependent on the ability of each to encounter one another as human beings. An encounter seems to be facilitated by either chance or choice on the care recipient's and the care giver's part. Positive caring offered on the part of the care giver may be rejected by the intended care recipient. Decisions concerning the acceptance and/or rejection of being cared for are value laden.

It should be noted that nurses did not describe caring episodes as "transpersonal" (Watson, 1985/1988) when their care giver was a stranger. Descriptions of transpersonal caring occurred only when there was an established relationship prior to the caring occasion and during a crisis which was emotional rather than physical. Caring episodes occurring in the acute care setting were acknowledged as true caring, however they did not describe "the transpersonal nature and presence of the union of two persons' soul(s), that allow for some unknowns to emerge

from the caring itself" (p. 71). This may cause one to ponder the validity of considering that "style," i.e., "transpersonal nursing" as the norm, and the possibility of "transpersonal nursing" becoming the goal of nursing. It implants a notion of the existence of degrees of nursing care which may include "transpersonal nursing."

Encounter also involves a dialectic process on the part of the care recipient as she logically evaluates the validity of her feelings of independence, vulnerability and trust in relation to the greater good of being cared for. Non-instrumental caring/psychological support on the part of the care giver is recognized as integral to being cared for by female nurses and overall seems to be more meaningful than does instrumental caring/support through material means.

Being cared for is life enhancing for the most part. Care recipients recognize personal and professional growth as the result of being cared for. The fact that behavior deemed caring by the care recipient, but which leaves her dejected and with negative feelings of self-worth, is labeled as caring, is an area where philosophers, theorists, and nurses being cared for disagree among themselves and with each other. It would seem that actions which cause the care recipient to have feelings of reduced self-worth, and leave them dispirited, are done with a self-serving interest on the part of the care giver, and not in the interest of

the care recipient's self-actualization.

This study has enhanced the understanding and provided a beginning definition of being cared for. It has shown some positive influences being cared for has for nurses both personally and professionally. It has identified problems confronting nurses in relation to their own nurturing experience. Clearly the results of this study demonstrates caring is more than can be observed by an outsider. For the nurses in this study the experience of being cared for means persons sharing self with another.

Nursing Theory

The purpose of phenomenological inquiry is to advance the understanding of a phenomena; it is not intended to develop theory. However, the congruence of the results of this study with the concepts of existential phenomenology concerning caring relationships and being cared for, and certain concepts in Watson's (1985/1988) theory of nursing, became obvious. The present study adds support to the thought of Heidegger (1927/1962) with regard to his concept of care as concern and the possibilities inherent in that notion. Buber's (1970) ideas concerning "I-Thou" versus "I-It" relationships are also supported by the results of this study.

Watson's (1985/1988) theory of nursing is championed by the results of the present study. Her theoretical description of transpersonal caring displays a time during

the caring process where the care recipient and the care giver are involved in the relationship in ways that are subjective beyond the obvious. Similarly, a mutual sharing of soul, which produced an inner harmony, was described by some of the participants in this study.

Implications

Nursing Education

In the present study, implications can be thought of as "what ifs." What if, in nursing education, undergraduate students were exposed to existential philosophy, transpersonal psychology, and literature dealing with the history and myths of the past as they formulate dreams for the future and develop their world view? Would such exposure enhance the possibility of greater understanding of self, of others, and of the world in which we live? Perhaps, as nurses, they would be able to bring more of themselves to caring situations.

What if faculty were able to strip off some of their objectiveness and enter into students subjective world during interactions with students? What if faculty would allow themselves to be vulnerable in the teaching/learning setting? Would not faculty and students alike experience growth?

Watson's (1985/1988) Nursing: Human Science and Human Care and Patterson and Zderad's (1976/1988) Humanistic Nursing, each reflect existential thought. Perhaps these

works could be used to assist faculty as well as students to integrate philosophical thought into their personal and professional lives. Perhaps incorporating educational experiences where the phenomna of care and being cared for are explored in ways which do not negate the cognitive and psychomotor skills associated with care but enhances the affective realm of caring is called for.

This study validates the importance of truly understanding the phenomena of care and the importance of integrating the phenomena into the curriculum and lives of nursing students and faculty. The methods for doing so are as varied as the people involved in nursing education who value the idea of care being more than an "I-It" experience.

Nursing Practice

What if the nurses in practice were truly aware of the consequences of being cared for? What if they could clearly distinguish between being cared for and being controlled by others? What if they were able to enter into encounters in which the subjective worlds of both the care giver and the care recipient are shared? Perhaps it would increase the quality of nursing, the power of nursing and the personal satisfaction of being a nurse.

How can nurses who have thought of themselves as strong and independent persons learn to maintain their strength in a society which socializes women to accept being controlled by others, particularly men, in the name of being cared for?

What will facilitate nurses in practice recognizing their being cared for as affecting their self-actualization, both personally and professionally? What will help nurses avail themselves to being cared for when occasions for being cared for arise?

The answer to these questions lie in the insight nurses might acquire through continuing education workshops and journal articles aimed at helping individuals develop a better understanding of the phenomena of care and the experience of being cared for. Nursing leaders who recognize the value of care and conceptualize the phenomena of care as more than a doing for others, have the responsibility of assisting other nurses toward a higher sense of self as both care recipient and care giver.

Nursing Research

What if the findings of this research can be applied to nurses who are men as well as women nurses? What if other cultures and other disciplines experience being cared for in a way that is different from the way nurses experience it? What if the relationship of being cared for and the ability to care for others is related in ways we have yet to discover? What if there are degrees of caring and the highest degree of caring and being cared for requires the existence of an established relationship in these times of high acuity and short stays? What if maturity, i.e., age and experience, is related to the ability to accept being

cared for and to being caring toward others?

These questions and the implications posed as questions concerning nursing education and nursing practice lead to recommendations for further study. Peterson and Zderad (1976/1988) note, since phenomenology never exhausts the meaning of a phenomenon, by compiling and synthesizing phenomenological descriptions over time, the science of nursing will be made distinct.

Recommendations For Further Study

Recommendations for further study include the following research questions.

1. What is the meaning of the experience of being cared for as lived by male nurse?

2. What is the meaning of the experience of being cared for as lived by men and women in other disciplines?

3. What is the meaning of the experience of being cared for as lived by men and women in other cultures?

4. What is the relationship of nurses being cared for and their ability to provide caring for others?

5. What is the description of the dialectic process which allows nurses to voluntarily become vulnerable?

6. What are the ways that maturity of the care giver and the care recipient affect caring and being cared for?

7. What is the meaning of the experience of transpersonal caring by faculty for students in the educational setting?

8. What is the effectiveness of nursing education which promotes a phenomenological approach to nursing education?

9. What is the importance of a long term relationship to the experience of being cared for?

10. Do patients and nurses experience "transpersonal nursing" in the short stay setting?

The studies proposed here would further develop an understanding of the nature of caring.

APPENDICES

APPENDIX A

Sample Selection Form

"Experience of Nurses Being Cared For Study"

Dear Colleague:

In order to provide a sample for the "Experience of Nurses Being Cared For Study," you are being asked to submit the names of four registered nurses who are currently engaged in the practice of nursing, and who you believe would be interested in participating in the study. One of the names may be your own, if you wish. The names you provide will be used in the process of selecting participants for the above named study. Due to the small sample size all nurses named may not be in the sample. Your participation, and the participation of those who you name, is voluntary. If you choose to participate, please do not indicate so on this paper. Your name will be placed in a pool from which the sample will be selected.

Thank you,

Sharon Shetlar

Registered Nurse #1:_____
(Please Print)

Registered Nurse #2:_____
(Please Print)

Registered Nurse #3:_____
(Please Print)

Registered Nurse #4:_____
(Please Print)

APPENDIX B

University of San Diego

CONSENT TO ACT AS A RESEARCH SUBJECT

"Experience of Nurses Being Cared For Study"

You are invited to participate in a study of nurses and their experience of being cared for. I hope to learn what the meaning being cared for holds for nurses. This study will be conducted with approximately 20 registered nurses, practicing in various settings located in the Mid West.

If you decide to participate, I will ask you to talk to me about the thoughts and feelings you experience when you are the recipient of care. The initial interview will take approximately one hour and one half hour will be required for the second interview. The interview will be audio-taped, transcribed and analyzed.

There are no known foreseeable risks or discomfort associated with this study. However, it is possible that some participants may feel uncomfortable or nervous when ask to discuss their thoughts and feelings. Others may find that participating in this study an enjoyable, insightful experience that leads to increased self-awareness.

Confidentiality will be maintained by the following measures. One list of names and identification numbers will be made. The list along with your signed consent form will be kept in a locked safe. Your name will not be associated with the information you provide. Tapes and transcripts of your interview will be identified by a code number which is necessary for me to identify you for the second interview. Demographic information sheets, coded tapes and transcripts will be retained by me under lock and key in a place separate from the code key and consent forms. The demographic sheets, tapes and transcripts will be kept until the completion of the study and then destroyed. Any information obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your written permission. Information in this study will be used to complete a doctoral dissertation in nursing.

This study will not provide you with any direct benefit except the satisfaction from knowing that you have contributed to the development of knowledge concerning the concept of care and to the profession of nursing. Your decision whether or not to participate will not affect your future relations with the University of San Diego nor the agency in which you are employed.

If you have any questions, please ask me. If you have additional questions later, please feel free to contact me at the address or telephone number listed below.

Sharon Shetlar, M.S., R.N.
1608 John
Winfield, Kansas 67156
Telephone: (316) 221-3503

You can contact my dissertation chairperson who will be happy to answer questions as well. The name and address of my dissertation chairperson is listed below.

Dr. Mary Ann Hautman
University of San Diego
Philip Y. Hahn School of Nursing
Alcala Park
San Diego, California 92110
Telephone: (619) 260-4548

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate in this research study. You may withdraw at any time without prejudice after signing this form should you choose to discontinue participation in this study. Furthermore, there is no agreement, written or verbal, beyond that expressed on this consent form.

- - - - - - - - - - - - -

I, the undersigned, understand the above explanations and, on that basis, I give consent to my voluntary participation in this research.

_____ _____
Signature of Subject Date

_____
Location

_____ _____
Signature of Witness Date

_____ _____
Signature of Researcher Date

APPENDIX C

Demographic Data Collection Sheet

"Experience of Nurses Being Cared For Study"

1. Age: _____ Gender:_____

2. Marital Status: Married _____ Single _____

Divorced _____ Widowed _____

Living with significant other ____

3. Religion: Catholic _____ Protestant _____

Jewish _____ Other _____

4. Family of Origin: No. of members _____

Birth order placement _____

5. Present Family: No. of members _____

No. of adults _____ No. of Children _____

6. Basic Nursing Degree:

Bacc. _____ A.D. _____ Dip. _____

Highest Nursing Degree: _____

Degree Other Than Nursing: _____

7. Years of Experience in Nursing: _____

8. Current Employment: _____

9. Nursing Specialty or Area of Expertise: _____

- - - - - - - - - - - - - - - -

Note: The information supplied on this sheet is confidential and will not be used where the individual participant will be identified.

APPENDIX D

Significant Statements From Caring Experiences

1. I didn't feel comfortable saying this to any one else, but I said to her...
2. she was going to see that what I wanted done was going to get done.
3. I felt secure that she was taking care of me.
4. that really made it special.
5. Maybe that's what I felt, special.
6. that he cared and that he loved me and that he didn't want me to have pain.
7. It just makes you feel warm inside, like a warm fuzzy.
8. I just think of the support that I feel...
9. I remember being comforted, just on a very deep level, feeling so much comfort from that.
10. I felt comfortable that they know what they were doing.
11. I never felt that I wasn't going to be okay.
12. kind of a sharing of energy, the holding of hands in an energy way.
13. I felt comfortable with him.
14. We do a lot of fun crazy things, but there was that closeness, that trust that came with caring.
15. Not necessarily physical but just spiritual support.
16. nobody can touch us as long as we are in our little living room and doing our weird things that we do.
17. She was planning ahead and that made me feel very secure.
18. I would say it was a nice experience.
19. It's nice, comfortable, makes me feel good about myself.
20. Makes me feel warm.

21. I felt very secure.

22. I felt I was going to be okay even though they were all still worried about me.

23. I felt cared for, like I say special, secure.

24. It was a good experience.

25. "I just feel a lot more secure with your arm around me."

26. So we've grown together.

27. I feel very comfortable around her, and that word "secure" again and I feel like we'll remain friends no matter where I live.

28. It is a peaceful, comfortable feeling that someone knows what makes me feel cared about.

29. that they take the time and effort to do something that conveys caring.

30. It was comfortable being in the hospital where I had trained, where I know most of the aides, most of the nurses, most of the doctors.

31. I was glad to see my first nurse at the hospital, because they hadn't had a nurse at the clinic that day.

32. being a nurse I was looking for one, and would have felt more comfortable with one.

33. he was able to understand me and what made me feel cared for enough to meet those needs.

34. there is an element, when I look at the health care aspect, that I have care givers that take the time to sit down and make sure that I understand and to share the knowledge with me.

35. Sometimes you don't even have to explain yourself very much.

36. They can just understand because they have listened to you.

37. I remember that being kind of special, feeling, you know, that she understood what would make me feel better.

38. They made a very difficult time better with the things that they did.

39. caring about somebody is really listening to them and trying to understand their situation and how they feel about things.

40. even though he was supportive in my going back to school and finishing off my education, verbally and financially, he was unable to understand and made no attempt to meet my need for time to do that and succeed.

41. They could see the reasons and that I felt understood.

42. Understood is another word that is very important.

43. A lot of times, even people that we love don't feel like we understand their viewpoint exactly and it is a frustrating feeling.

44. and the fact that we enjoyed each other as people, as individuals, and became very, very sensitive to each other and feelings.

45. Everybody needs it, I think it is basic and when you are going through a relationship that is failed, you need some positive relationships to help balance the failure that you feel.

46. It was reassuring to some extent to know that they understood why I had to do this, that it wasn't that I failed and that there were reasons that the relationship didn't work.

47. Then I'm sick at my stomach, and I was terribly upset because I vomited all over the carpet.

48. That concerned me terribly at that moment and I kept worrying about that.

49. But why is it so hard for me to ask to be cared for?

50. Does it mean that I question my worthiness?

51. In my heart I know I'm worthy.

52. If it doesn't come spontaneous then I'm not going to ask.

53. I'll just take what come spontaneous and do without the rest.

54. It is something that I feel a lot when I need to be cared for and I guess, almost a fear that I am not going to be what the other person expects out of me.

55. I know that he would do anything for me but I tend to not let him do it.

56. It is hard for me to be sick for a very long time.

57. I don't know that I could accept that kind of caring because that would be kind of admitting failure.

58. I feel guilty if I am sick longer than a day.

59. I really felt kind of down and I went to another person about it.

60. I'm probably not a very good patient because I can't tolerate the pain very well.

61. I would have asked someone else to try rather than continue to waste all the supplies, and to put me through the trauma of trying to poke you 17 times.

62. I felt that this other person was disappointed in me and I needed to share this feeling.

63. I needed someone who just took the time and listened to my feelings.

64. I was having a lot of feelings that say, "you goofed up."

65. I can take it if it's from someone like grandma, . . . it it's from somebody that I really believe that I deserve that caring (from) in the sense of I'm an okay person and I deserve it.

66. that would make me feel better, was very sensitive to my need to have my head elevated so I could breath easier.

67. Very, very understanding and very caring.

68. I was really ashamed of myself for having done this and feeling all kinds of guilt.

69. He valued me and that I was a priority.

70. I was the total focus of his attention.

71. My mother was always giving, positive and caring.

72. It felt good, I felt that she cared about me and that she loved me, that I was valuable.

73. She way always the one that gave you, "hey, you are okay."

74. You know that they will love you through thick and thin, through the things that you do wrong and the things that you do right.

75. If you just totally mess up, you like, whether they agree with you (or not) but you know that they will still love you.

76. "Quit worrying about this, you're the most important thing in the world." And I believed it, that he cared more about me than I cared about myself.

77. I think it is just important to feel like there is somebody that really cares about what is happening to you, really is interested, that you are important to.

78. It is just something that is basic.

79. I think that is, I want to say "cared," there is that word again, interested in a loving, you know, relationship.

80. I thought, he managed to make me laugh. I'm probably going to get well if I can manage to laugh through all that.

81. It's just the showing, and I think the main thing was the showing that people, it's either the respect for, like dad, or the just acknowledgement that they were really thinking of you.

82. I wanted to scream and yell and not be a nurse and just be a crazy 'ol person who was having a baby, and I did that and received the caring I needed.

83. But I felt like people need to be a little more compassionate, and maybe not make. . . To me that was a nursing judgment and not a receptionist's judgment.

84. They treated me like a human being.

85. The caring I heard at that point was she cared about me as a person.

86. The little things let you know that they care about you as a person, not just as a cholecystectomy in room...

87. It's the little things that they do that they don't have to do, it's the extras.

88. I felt like the communication just wasn't there.

89. There's nurses that are real professional about the things they do like making sure you're covered when you're having a procedure that's kind of personal or whatever.

90. She did not care for me as a person.

91. I feel it's more balanced, we can enjoy the times we have and we don't have to be doing the laundry, doing the dishes, doing the food, whatever.

92. I thought, "Gee, nursing has come a long way." Things like that, about how technically dependent we are, but yet the same old kind of things, like the person who touches, the person who talks to me, they can't put that in a machine, and that's an important caring aspect even though the other things are extremely important, to monitor and to do things like that.

93. So that was a time that said to me this person does not care for me...

94. I became so frustrated with the deficit that, according to my value system, that I saw in caring.

95. When he doesn't see my need, I feel hurt because they don't care.

96. ...it was humiliating to me.

97. That was his way of conveying caring, but again it threatened my power and my autonomy to continue to be independent to meet my own needs.

98. I felt rejected, like I was being used as a Guinea Pig.

99. I didn't feel like I was cared for at all.

100. As a matter of fact some of the things make me feel smothered and possessed.

101. Maybe sometimes I perceive their caring as an intrusion.

102. Caring from my husband has been for me a frustrating experience because the things that make me feel cared for are not the things that he, in his value system, labels as caring or conveys caring.

103. ...when somebody really doesn't want to do it, then it's not special.

104. I just didn't feel right about it, even though I wanted the clothes real bad.

105. I felt exploited and used by her.

106. things that he labels as caring and that he does for me, to care for me, are not the things that make me feel cared for.

107. It is a really nice quality, and I of course enjoy.

108. He'll do something that night to make me feel better.

109. I just remember her bringing her little clothes and everything so that I would have something to wear.

110. just walking over and just holding me for a long time.

111. I remember someone reaching out and caring for me.

112. (They are saying), "I know that's too much for you right now and let me help and let me comfort."

113. He takes care of the financial future, the financial stuff because that is the thing that he likes to do.

114. Care is also my husband giving me his paycheck, that's a lot of care.

115. he says I should know that (he loves me) because he provides me with a good home, three children and he takes care of my financial needs.

116. I don't feel that I look at all of the things that I should for care.

117. I look at feeling, touching type things as care but if he didn't care for me he wouldn't give me his paycheck or the right to do with it as I feel.

118. I always felt, growing up, that she was even more giving than I.

119. She enjoyed giving and she is still that way.

120. I said, "Don't tell me that you love me and you care for me. Your actions speak louder than words, and you simply have never acted like you cared. You took but you didn't give."

121. He started sharing the ways he had cared for me.

122. it is very significant in my mind, seeing him come up to my house carrying these sacks of groceries.

123. It really makes a difference and it just, for some reason, helped the pain, the visits, the people coming over, the cards, the calls...

124. they let me know they were missing me at school and I enjoyed that. I felt cared about in that way.

125. They did not spoil me with material things. They did spoil me with affection during that time.

126. I just think about somebody really paying attention, really being interested in how you are feeling and what they can do to make you feel better.

127. I remember being read to when I was sick and couldn't go to school.

128. ...he would always take charge at that time and would bring me medicine that would help.

129. ...having a struggle with accepting having a chronic disease...

130. ...and she just laid down beside me and just patted .

131. ...with Patricia it is that philosophical, just giving direction to things that helped.

132. ...if they have time just to poke their head in.

133. It's the coming when you're not called for, you know, that really shows how much they care.

134. They'll do something and they don't even realize it, they'll do something real caring.

135. ...a nice word here or there, or the way he says something.

136. The special things that they say, the hugs or the other things that they like do for you.

137. I really like it when someone tells me that I'm really pretty or that I look nice.

138. That is just a very special feeling inside.

139. I know she cares about me because never a week goes by that she doesn't call me at least once.

140. People that didn't have to call called, and that was, I really liked it.

141. ...suddenly I realized that Rick loves me very much, and I love him.

142. I really eat up their attention.

143. ...he was right there, and wouldn't leave.

144. ...when I got back, he had roses in my room and he wouldn't leave the bed(side)...I loved it.

145. ...he just looked at me and knew that I was sick and so he said" let me get you some medicine."

146. I think really caring for somebody is going beyond doing the basics that have to be done.

147. The rest of them were busy working machinery, but he was busy telling me it was going to be okay.

148. I remember getting a lot of attention and enjoying the attention of being cared for during those three weeks.

149. ...you're doing things, you're listening, you're trying to see what sorts of needs this person has that you may be able to meet one of those needs during your time...

150. He went and got me some medicine...

151. I could tell when they did little extra things... knowing I wasn't being treated like just the run-of-the-mill patient. I was getting special treatment.

152. I got out of school, and all my friends came over and I got a lot of attention.

153. I remember, the thing that came to my mind first was the warm milk and bread that mother would make for us when we were sick. . . I do remember feeling cared for, particularly by mama.

154. she was always there to help with what ever needs I had or the children had.

155. If I needed just a sounding board, she was always there.

156. She was never not there when I needed her.

157. ...he came to see me a couple of times in the ICU and so evidently he felt concern for my welfare.

158. ...he came over to face me and he put his hands on mine. (He said) this is what I am going to do and you are just fine and I will talk you through this so that you will know what I am doing every step of the way, and that, I guess that, that comforting I really need from my health care givers and probably expect that, maybe more so than, maybe, someone that is not in the health profession.

159. If there was anything I needed she would get it.

160. I remember mother being really concerned and just taking good care of me.

161. ...he invested a lot of caring and effort to help me get back on my feet, back doing the things I wanted to do.

162. ...whether I had Blue Cross Blue Shield or not, she was more concerned with whether I was going to survive or not, so I felt a lot more comfortable on the ride up the elevator to the ICU.

163. That was really nice, basically it was just somebody listening to my feelings and they took the time to just listen how I was feeling.

164. She didn't just come and do her thing, she always had time to visit with me.

165. She spent a lot of time keeping me distracted away from those chicken pox because I really had them hard.

166. I didn't feel as close or didn't feel as cared for by the nurses as I did by the nurse aides.

167. Taking time to visit with a patient although you have 20 other patients.

168. ...the time they are willing to spend with someone.

169. ...it really bothers me to be rushed. Being rushed tells people that I really don't have time for you, and I think that gives a bad feeling,

170. ...it's my time with her. I don't have to compete.

171. ...we get a lot of one-on-one time.

172. I recall them as being my best friends, so they must have been compassionate.

173. I remember the nurse stopping and explaining to me that my head was sewn back to my body.

174. I felt that the nurse was the one who really helped me through with that.

175. ...they were the ones who were spending more time at the bedside, in my room doing things that you were needing, or just checking on you because they were more available.

176. I don't remember any specific stories or feelings.

177. ...the family was there and cared about what I was going through.

178. I think that being cared for, and cared about, is that just being listened to is one of the most important ways that we do that and that it is done for us.

179. I guess being cared for has to do with love.

180. ...the support, that caring for me, or caring about me was very important at that moment.

181. I think of my husband and how much he loves me.

182. That even though they couldn't do anything for me physically, they were going to be there to support me emotionally.

183. ...somebody that you feel cares about, well loves you and does understand who you are and how you generally react to things and what your values are.

184. You have to be really open with people and really let them know what is going on.

185. ...it is just my personality that I sort of keep things to myself or within my immediate family.

186. It's kind of risky.

187. I think that as a nurse I get cared for more and I am trying to learn how to care for myself and to ask if there are needs that you need met, reaching out to other people.

188. I have these feelings and I need to talk.

189. "Do you have the time, I need to talk? I am starting to do that a lot more as an adult than I did growing up.

190. I thought, "Oh, no dear, you know she doesn't know what she's talking about."

191. I certainly hope that they have the knowledge that they need to do this.

192. I was probably a little angry and frightened because there wasn't a nurse there that would know what to do for me next.

193. I felt like, "she understands all this machinery, so what ever she tells me I'll feel comfortable with, because she knows what she's doing."

194. I felt very lucky that my father was a physician, that he would take care of me.

195. (I was thinking) "I wonder what they are going to put in there and I wonder what these EMTs really know what they're putting through there.

196. I said, "I don't think you understand. I need to see a doctor today." So she refused to give me an appointment.

197. I thought...I don't want someone like that caring for me because I want them to know what they are doing.

198. So along with that, caring has to be to have the knowledge.

199. I knew them professionally, I knew the kind of work they did.

200. I respected their job and what they did.

201. I know an aide that...supposedly one caring for you, and she came in and took my pulse over here (indicating wrong side of wrist).

202. I felt like everything was fine.

203. I guess it depends on if you know the people and you know how trustworthy they are.

204. I called back out to that particular clinic, asked to talk to a nurse and she immediately told me to come in and they admitted me to the hospital.

205. When I'm the care receiver I trust their capabilities as they care for me.

206. ...if I know them professionally, I can respect, and I have a lot more trust in what they do on me.

207. I felt real comfortable because I know the staff so well, that I trusted what they were doing.

208. It's a complete, trusting feeling.

209. ...it's nice to just cuddle up and let her take care of things for awhile and be the kid and not worry about anything.

210. ...from Grandma I can take it.

211. I felt free to ask her questions.

212. I developed a great trust relationship with her and only felt comfortable with her caring for me.

213. The only thing I could do is to trust these people, that they were not going to do anything to hurt me any worse.

214. So I trusted him.

215. I don't know why I trusted him more than I did the rest of them.

216. I think that makes nurses a little more uneasy when we are in a situation where we are being totally cared for by other people.

217. ...maybe they wouldn't have my confidence, I had that completely with Syb.

218. ...a very close friend made me feel cared for in the fact that there was ultimate trust there.

219. (I thought), "I have to trust these people."

220. It takes a lot of reaching out to other people, trusting...

221. We never ever had to worry about each other betraying that confidence.

222. I feel cared for in that I feel that there is trust between myself and my husband, and between my mother and myself, and between my daughters and I.

223. I think that it needs to be somebody that you trust.

224. So there was a sharing of not just fun things, come to think about it, but of problems.

225. We were actually able to talk about anything.

226. I just didn't think I could do it, and I couldn't have. None of it made sense.

227. ...it was probably during the most difficult part of my life.

228. It's like I can take so much of it and then it's like "Stop, Stop," but it's getting better.

229. Back rubs and those kinds of things help.

230. ...maybe that discomfort is a vulnerability.

231. I was going to be there by myself and I was really scared.

232. It was scary and, just really scary.

233. I hadn't felt bad and I didn't realize anything was going wrong but being put in shock position. . .

234. You really have to be vulnerable and that's kind of risky and a little scary for me.

235. It depends on how much I'm willing to let down my guard, to accept it.

236. When we are receiving care we are on the needy, more vulnerable end, allowing someone else to have more power or equal power.

237. ...they were careful that I didn't ever feel completely uncovered and whatever you know, vulnerable I guess.

238. ...'cause I don't ever want to be helpless.

239. I don't have any image to maintain.

240. I was very frightened and I didn't want the doctor to leave me and he didn't.

241. To have to suddenly have to be totally submissive to everyone elses' best thought for my health, and that was a little, that's a disturbing thing to me.

242. I am not going to be strong enough that I can do anything and everything on my own, and letting the other people know that, I guess, that I need things too, is vulnerability for me.

243. Scared and untrusting at that point.

244. I didn't know the people from Adam, except for the one doctor that I know that, I liked better than the others.

245. ...allowing yourself to be vulnerable, I think, to be cared for by other people.

246. I associate it again in a variety of, you know, in times that I have felt physically ill, at times that I have felt emotionally distraught.

247. ...my first response was, there are other people you should be caring for, and I can care for myself. I will be okay.

248. ...everyone needs to be cared for and to be able to care for.

249. I have a hard time letting those who really love and care for me fulfill that need to care for someone in my independence.

250. I was being my tough self.

251. It's a little harder to accept care from them.

252. I think, "you're supposed to be independent and into your own."

253. I want to be in control of myself in just about any situation.

254. Another time that I felt taken care of, it wasn't because of illness, but it was needing emotional support when I went through the divorce.

255. I have always been a pretty independent person, not, well sort of kept my own counsel.

256. I want to make my own decisions.

257. I think sometimes caring people, and its true with me, have some of the Savior Syndrome in them, and that as long as we're giving caring we're on the savior and power end.

258. I was very self-sufficient and took care of my own babies.

259. I have always had this image of being real strong since way back.

260. I'm so independent that I have to be very, very careful...

261. I really want to do it myself if I can.

262. I wanted to feel independent.

263. It is hard for me to ask for help, I suppose, at times.

264. I don't want other people making my decisions.

265. ...'cause I've got to have some options.

266. It was lie down, shut up and do what they're telling me to do, and if you want to live, and that occurred to me, and this is the only option if I want to live.

267. I don't like being put on those litters and being carried anywhere.

268. I realized I didn't have an alternative.

269. I think that I tend to choose people that, I almost want to say are knowledgeable, that I feel very comfortable in their knowledge, that are willing to share that knowledge with me.

270. I am learning, but it is a process allowing people to know what you are feeling, what you are really feeling and being real honest.

271. (It took) time for us to work it into the schedule so I could be off work,you know, at a time when my work load would allow for it.

272. I really looked forward to that stay in the hospital and being cared for and getting that problem taken care of.

273. I almost see myself as being someone that really maintains a fair amount of distance from people until I choose to let them in.

274. ...it depends on who it's coming from and it depends on the situation.

275. I don't think that I would let myself open for that, with an irresponsible, immature student, and I don't know if they would be capable of giving it either.

276. ...instead I chose to call one of the other nursing students that I was going to school with and she came.

277. At least I take it as I care for you and that's why I'm doing these things for you.

278. I have a tendency to hold people at arm's length until I decide, "Okay, now I will let you in and I can care for you and you can care for me."

279. Just the sharing of heart, and it took a giving of themselves to do that. I think that's real significant.

280. The people that I am real attached to or attracted to are those that do their part and in a way that's taking care of me because I over do...

281. The ones that are more selfish, or more "I" oriented take energy.

282. It's just that they can't open the door to themselves.

283. I think that related to the caring part, is that you have to be vulnerable to really provide the caring.

284. ...he's not a person who is real demonstrative affectionate-wise.

285. Care is given, otherwise it would just be a task.

286. They were all very, very relaxed people.

287. They communicated a feeling that they all know what they were doing to me.

288. What ever they did, even though it was not according to Hoyle as I learned Hoyle, it was certainly comfortable for me.

289. ...it's the openness of thought or even feeling, you know, the ability to admit that they are wrong or that maybe there is another way to do it or a better way.

290. When you're around someone, you can tell if they were just told to do it, or if they're really caringly, just coming in and sitting down.

291. ...for me, being cared for is, understanding and knowing me, becoming sensitive to my needs for growth, happiness and fulfillment, and supporting me in meeting those needs.

292. I knew my nurses were my advocates and that's what I wanted and I wanted a support person to make my needs known.

293. It's not something they're forced into. That probably has something to do with caring.

294. ...willingness to take the time and to go beyond the usual day-to-day.

295. I felt much better that she told me, and you know, was honest, and so it was very sincere.

296. ...there was nobody up there that acted like they were just doing their job, that they weren't caring.

297. ...having someone share the burden, and the burden may be to share the pain, to share the emotional pain, the physical pain, not to take it away for me because I don't really feel that we can do that, but to somehow, on some level share that.

298. I try to graciously accept it.

299. ...not accept care as easily, sort of push off. I really think a lot has to do with the (menstrual) cycle.

300. It is difficult for me to accept care.

301. I was able to accept that caring.

302. Learning to receive that, is challenging for someone that's not use to it.

303. I am enjoying that, just realizing that he wants to give that because he wants to give it.

304. Nice to me means that it is okay. When it's not nice, it may be something nice happening, but I can't accept it. I don't want it, it's not nice.

305. If you're really caring and you want to bring me something to make me feel better, then I'll accept it,that's fine.

306. ...but you really aren't doing it with a giving heart or whatever.

307. ...it is almost fun to be sick because I appreciate the care, the special care, and I don't let him do that very often.

308. It probably taught me something about accepting help.

309. I enjoy being cared for, if it's sincere.

310. It is just more difficult when someone cares for you.

311. ...not so much from other people, but from him I have a hard time accepting it.

312. I think it was because I felt like I wasn't being cared for and here was someone who recognized it, offered it, that was kind of significant and he just saw it by looking at me and I didn't have to say anything.

313. I felt that if he cared he would have taken on some of the responsibilities.

314. I have a lot of people just doing things without my having to go and say. . . can you take on this for me.

315. I want him to know me well enough that he is sensitive to unspoken needs and nonverbal communication.

316. I felt a severe deficit in caring there, because the expectations that were not to be questioned of me did not apply to him.

317. I have this feeling it's okay to go the extra 100 miles, but I think that both mates must be willing to do that, but he had said, "No," that was just for me.

318. Sometimes David will do something without being asked.

319. At first I had a really tough time with that because I always thought that a husband should see your needs without being asked to.

320. He was totally insensitive to that and actually unwilling to fulfill that role.

321. ...there are lots and lots of little things that people seem to just do.

322. ...he volunteers to do things to meet my needs without my having to out right-ask him.

323. ...because I would have driven a bomb and never minded. I would have lived in a tent to have you share my life and to have helped me to have a Christian home and to raise our children with a stable set of values that we shared.

324. That (caring) is a byproduct of love, like, and so to ask for caring is to ask for love and like, a favor, and that is something that I want to be voluntary and spontaneous.

325. I just flat don't ask.

326. I was verbal with them and told them what my needs were.

327. I don't want to have to ask for it.

328. I finally had to ask for the anesthesiologist to come up and start the IV rather than to continue to be a pin cushion.

329. Just not comfortable, never comfortable asking for it and I am probably the type that sends out signals but I don't, but it's real hard for me to ask.

330. ...I would not leave that hospital unless she was waiting on my door step when I got home.

331. Sometimes I'll just ask him for hugs and sometimes he gets kind of frustrated with me.

332. ...it is real hard to ask for things.

333. I said, "Will you do some discharge planning on circumcision for me, 'cause I don't know how to take care of a circumcision?"

334. I thought, "well why am I not getting that." They said, "Well, Oh, if you want one, we'll do it."

335. ...now I've gotten to the point where if I feel I have a need he's not taking care of, I just ask him.

336. I don't know when you have to ask for something if that is really, and someone does something for you, if that's really caring. It's a response to a request.

337. It is very easy for me to give caring, especially in nursing, the cup never runs dry.

338. So when you see those little differences made, it gives you the energy or fills up your caring pools so that you can keep going.

339. I thought, "Holy Smoke, I need to be taking care of him and here I am needing to be totally cared for. What a mess."

340. When I think about caring, most of the time I think about how I have cared for other people.

341. It comes so natural to care for others whether it be at home, situations in the hospital or when somebody is in trouble.

342. I feel like I should be taking care of him or the kids. That's always seemed to be my role in life.

343. I prefer to be a caregiver rather than a care receiver.

344. I guess being cared for is real difficult for me. . .

345. It is real hard for me to think about being cared for.

346. I felt that I cared, and I cared, and I cared until the well ran dry, because what I labeled reciprocal caring simply was not there. And I literally did, my caring just ran out, and I found there was no caring left.

347. I am realizing now that you get cared for a lot more than just then.

348. I say that Terry had gotten better about, I think that it wouldn't come natural. I think that he has had to learn to do some stuff.

349. I've got him well trained.

350. ...it's the way we say something to him.

351. I am working on learning to appreciate it and say, "this is great," which is neat.

352. I am learning to give too, to him just whenever.

353. I have learned, I think, to be a care receiver when I need it.

354. ...you know that you can go to a friend's house and you are known and appreciated, and you are free to do what you need to do...

355. ...you begin to care for somebody that normally you wouldn't have.

356. I felt there was not much compassion from the nurse.

357. I made that a goal of being a nurse not to become hard and hardened, and to try to remember that although the patient is very sick they do have feelings whether they are able to show you or not.

358. I think it created a closeness...that probably couldn't have happened any other way.

359. It is sort of a mutual support there when we need some support...

360. ...when she has had surgery I've been there for her, and she came for me the night after surgery, and that was something real special that she got to do for me.

361. ...her not (to) expect anything from me in return for that care.

362. ...it's still not 50/50, never will be, but that's life.

363. In fact, sometimes they give more to me than I am able to give back to them.

364. ...he's not the kind that would feel like I owed him anything.

365. ...there are times that I've given to him, emotionally, like when he has had a crisis at work...

366. If you are giving all the time and with children, being a mother you do that a lot, it is nice to have somebody that takes the time to listen.

367. I'm beginning to enjoy it without feeling like I have to do something for him, you know, unconditional.

368. The most important thing that she did was of course, was to just hold me while I sobbed in her arms.

369. I felt a little strange being comforted by someone my own daughter's age.

370. That really felt good to me, that we got that kind of support from the counselor, principal and teachers.

371. There were several hugs which felt good of course.

372. ...they called frequently and dropped notes in the mail to let us know that they were thinking of us.

373. ...people that we were, well, aquainted (with), through the church, showed their support and concern in various ways.

374. ...sometimes people would stop over with a plate of cookies or sometimes they would even come to my door and say, "lets go out for a Pepsi."

375. After it was over, we got support from them but we did feel just a little bit hurt and just a little neglected from that age group.

376. Those people whom we allowed to reach out to us and touch us both physically and emotionally, our relationship was never the same, it was deeper naturally.

377. He was wonderful, he was a great support and he would do both verbal hugs, if you wish, and real hugs and then just real emotional support.

378. ...some of the results coming from this is that we were able to turn around and help them, some of the same people as they went through stress situations in their lives, nothing exactly like what we had but some deaths in the family or different things.

379. I feel like my self-esteem, which certainly had been battered at that point, was able to be raised to a much higher level.

380. The most important thing that people did was to listen and to be there, and I feel now that I can do the same for others at a deeper level than what I had done previously.

381. Certainly, if that experience had never happened to us I wouldn't be who I am, you know.

382. ...so I just was not afraid to face the day.

383. I think if I had not felt, during that time, emotionally fed and strenghtened by others' love and reaching out I would feel like I would never had the courage to go on and attain some goals that I have done since then, some personal goals and professional goals.

384. Our daughter, of course, had continued to give us problems, and I feel like I've been able to face those much more easily because of the caring during that particular three to four month period of time.

385. Then they would come in and ask me how I was and that made me feel really cared for, not as a nurse but as her mother.

386. (It made me feel) super. It just lets me know that there are people that do what they'er supposed to do because it's part of what they feel.

387. I just went and sat on his porch and started to talk and the understanding for me as a parent was just unbelievable.

388. Nobody has ever listened like that and he can almost read me, and that's not cool.

389. I don't like to be read, and he does. . .

390. I think that they are really genuine, they really care.

391. I try and return that...

392. I'm used to giving, and when I receive the caring it takes a while to accept it, because I think, "hey, what is this."

393. As far as the giving and receiving, I'm getting better, but I did have this thing here, that I could touch but I had problems being touched, I felt "what's your angle?"

394. It felt good to have her around.

395. ...you understand more of what they are going through once you've gone through it yourself.

396. Mom always gives good back rubs and that's more emotionally being cared for, I think, than physically being cared for.

Footnotes

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