The Meaning of Being Supportive for Family Caregivers as Narrated by Registered Nurses Working in Palliative Homecare

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The aim of this study was to illuminate the meaning of being supportive to family caregivers who care for a relative at home as narrated by registered nurses. The context used to allow for the meaning of being supportive to be illuminated was palliative home care. The study uses a phenomenological-hermeneutical method inspired by the philosophy of Ricoeur. Data consisted of narrative interviews, which were analyzed in three recurring phases: naïve reading, structural analyses and interpreted whole. Twenty nurses from the hospitals in Sweden participated in the study. Two core themes were found: forming a relationship and keeping caregiving at home.

In perpetually moving toward in-home care for older persons in need of care, it seems reasonable to assume that nurses will continue to play a crucial role in the interaction between informal caregivers and formal healthcare providers. Our interest in support for family caregivers originates from the current trend in Sweden, where focus seems to be shifting away from an institutional and professional care toward informal family care at home, specifically for persons needing long-term or terminal care. The extent of in-home caring enabled by family caregivers is reflected by Sundström, Johansson, and Hassing's (2002) research where family caregivers were estimated to have provided 70% of all care to elders in the Swedish community. Studying issues surrounding family caring from a nursing point of view therefore seems warranted. This study is about the meaning of being supportive as told by nurses experienced (more than 1 year of practice) in working with family caregivers who care for a terminally-ill relative at home.

The concept of support is an issue surrounding family caring, which from a nursing point of view is important but

seems unclear. Support is recurrently used in relation to family caregivers and recurrently portrayed as something that is desirable for family caregivers to experience (Stoltz, Udén, & Willman, 2004). However, a comprehensive understanding of the experience of being, or not being, supported seems relatively unexplored so far. Consequently, support is forwarded as an experience, while the meaning of that experience remains unexplored and not comprehensively described. In addition, the meaning of being supportive seems likewise uninvestigated, but should be particularly interesting from a nursing science point of view, considering nurses' crucial role in the interaction between informal caregivers and formal healthcare service providers in homecare.

This study to some extent stands in contrast to previous research on support for family caregivers who care for a relative at home. In such research, support often appear as something that is delivered, provided, or given as a service. Singular examples of this are the studies of Mant, Carter, Wade, and Winner (2000) and Magnusson and colleagues (2002). However, this study strives to forward the value and importance of studying support as something potentially occurring between

human beings. The authors argue that research specifically exploring comprehensive ways of understanding the meaning of being supportive is lacking but warranted. Such research has potential to diversify and advance the contemporary way of thinking of support for family caregivers in practice as well as in research. The literature searches were inclusive and no studies were successfully identified where the meanings of being supportive were studied or conceptualized in the same way as in this study. The studies identified as resembling the aim and scope of this current study all had the family caregivers' experiences as the point of departure, whereas this study departed from nurses' experiences.

The Aim of the Study

The aim was to illuminate the meaning of being supportive to family caregivers of relatives at home as narrated by registered nurses working in palliative home care.

Method

This study followed a phenomenological-hermeneutical method inspired by the philosophy of Ricoeur (Lindseth & Norberg, 2004; Ricoeur, 1976). The method draws upon the tradition of Western philosophy, combining phenomenology with hermeneutics and is essentially about illuminating the meaning of lived experiences of phenomena in humans' lifeworld. The assumption underlying this method is that phenomenology presupposes hermeneutics and vice versa, the transcribed texts from the interviews need interpretation in order for the meaning of the lived experience to be illuminated (Lindseth & Norberg, 2004; Ricoeur, 1981). Therefore, while the experience of the phenomenon such as lived always will remain private, its meaning can become public by way of the hermeneutic interpretation (Ricoeur, 1976).

Data consisted of narrative interviews (Mishler, 1986) with voluntary participants. The narratives were gained through unstructured interviews, which were then transcribed verbatim into text. The transcribed interview texts were analysed in three recurring phases: naive reading, structural analyses, and comprehensive understanding. The analysis encompassed a continuous dialectical movement between the whole and the parts of the text, between understanding and explanation. First, a thorough reading of each interview was carried out, to naively capture a first surface conjecture of the text as a whole (Lindseth & Norberg, 2004; Ricoeur, 1976, 1991). The naive reading was followed by structural analyses, which allows for a deepened understanding of the initial naive reading. The structural analyses were thematic. They involved an identification, condensation, and organization of meaning units, which are sequences of text that convey meaning.

This research method distinguishes between understanding and explanation. The structural analyses were the *expla-*

nation of the text and they involved a validation and rectifying of the initial *understanding* of the text as a whole (the naive reading). The structural analyses phase also prepares the way for a widened and deepened understanding of the text as a whole (named the comprehensive understanding or interpreted whole). The final phase was the interpreted whole which takes into account the naive reading, the structural analyses, and the pre-understanding of the authors. In the interpreted whole, the center of gravity in the interpretation, understandings from the analysis process, was mirrored in the literature, opening up for a widened and deepened understanding of the text (Lindseth & Norberg, 2004). The choice of literature was conscious of a search to illuminate the meaning of being supportive as a human experience and therefore it was directed at philosophical and theoretical literature that can widen and deepen the understanding of such lived experiences. The literature's perspective was not forced upon the text, instead the intention was to let the literature illuminate the text and let the text illuminate the literature (Lindseth & Norberg, 2004, p. 151).

Participants and the Interviews

A total of 20 registered nurses were interviewed, of which three were men. All participants chose to be interviewed in their workplace. Ages ranged from 32 years to 52 years ($M = 43.8$). The participants had been working as registered nurses ranging from 2 years to 32 years ($M = 14.4$). They had been working within advanced home care from 1 year to 8 years ($M = 3.9$). The interviews lasted 38 to 72 minutes ($M = 53$). Transcripts amounted to a total of 628 double-spaced pages. All interviews were performed between October 2003 and December 2003 by the first author (PS). Participants were asked to narrate about their experiences of being supportive, using the initial question: *Please tell me about your experiences of being supportive toward family caregivers*. Open-ended follow-up questions were used to encourage further narration such as: *Please give another example. What happened next? How did you feel? Please tell me about a time when things didn't turn out so well?*

At the initiation of this study in spring of 2003, Advanced Home Care (AHC) was well established at three hospitals in the southern region of Sweden covering 12 of the 33 existing municipalities. All interviewees were registered nurses working in AHC at these three hospitals. The registered nurses were approached in the following way: at one AHC, five registered nurses volunteered to be interviewed. At the two remaining AHCs a list of employed registered nurses was obtained from which every third name was chosen. These nurses were sent a letter which explained the aim and procedure of the study and asked them to contact the first author to say whether or not they agreed to participate. Aside from the five volunteers, a total of 23 nurses received the letter asking for their participation, of which 15 of them agreed to participate. A total of 20 nurses participated in the study.

Subthemes	Themes	Core Theme
Striving for a connection Keeping a distance Experiencing a distance Surrendering the relationship when feeling unable to care	Striving to build a trustful relationship	<p>FORMING A RELATIONSHIP</p> <p>Confidence & Trust</p> <p>Attentiveness</p>
Moving within the confidence of the family caregiver Failing to become a person who can be trusted with caregiving Sharing the family caregiver's emotions through their storytelling Hearing the family caregiver out without acting or passing judgment	Being a confidant	
Picking up on signs of needs Being courageous Giving precedence to family caregivers' decisions Harmonizing with family caregivers' needs Harmonizing with the ways of the family Giving family caregivers undivided attention in time and space	Being attentive (to family caregivers' needs)	

Figure 1. Subthemes and Themes of Forming a Relationship

Ethical Approval

All interviews were performed with consent. The authors are in no way affiliated with the AHCs. The study was approved by the research ethics committee at Lund University, Sweden.

Interpretation and Result

Naive Reading

Reading the interview texts gave the impression that being supportive is about creating good conditions for the family caregivers to care for their relatives until the end, preferably at home. The impression was that being supportive is about investing in the relationship with the family caregivers so that they can feel safe and confident in caring. The nurses' narratives portrayed support as something that is accomplished over time as the nurse and family caregiver come to know each other. But it is also about timing, that is, looking out for the right moment in showing the way through difficult situations and also trying to keep an even pace with the families' journey in caregiving. Being supportive means talking with family caregivers, being there, and encouraging and commending them for the work that they do. The nurses were really mindful about how they came across and what happened when they were together with the families in their homes. Nurses talked about having a respectful attitude to the predominant atmosphere in the home and adapting themselves accordingly. The nurses spoke of having to quickly change priorities at the slightest hint and show that they had willingness and plenty of time to sit and listen to what needed to be said even though they were really busy.

Thematic Structural Analyses

Using the naive reading as the point of departure the texts were thoroughly read again in order to identify meaning

units. These could be one or more sentences that conveyed meaning according to the aim of this study. The meaning units were lifted out from the initial text into tables and gradually condensed according to the following sequential order. Meaning units were transformed into one or two sentences, condensed as closely to the initial text as possible. Meaning units and transformations were then taken into account when subthemes, themes, and core themes were formulated. The gradual condensation of subthemes and themes into core themes are displayed in Figures 1 and 2.

The structural analyses of the interview texts gave rise to two core themes regarding illuminating the meaning of being supportive. These core themes were formulated as *forming a relationship* and *keeping caregiving at home*. The structural analyses are reported below. Core themes are displayed as headings, themes as subheadings and subthemes are reported in the running text (see also figures 1 and 2). In some cases quotes from the initial text are used to display singular examples of meaning units.

Forming a Relationship

The structural analyses revealed time as a recurring aspect perpetually underlying the meaning of being supportive formulated as *forming a relationship*. This was perhaps most clearly illuminated in narratives where nurses perceived themselves as being out of time, for example due to an unexpectedly rapid illness trajectory of the person being cared for. Having time seemed essential for forming a relationship. But when there was no time, the nurses' narratives expressed that their support to the family caregivers was not as optimal as it could have been. In addition to the prerequisite of time, the effort of building the relationship revealed dimensions of confidence and trust which were recurring dimensions throughout the interview texts. Moreover, once the forming of the relationship was in motion, possibilities were opened within the relationship, here formulated as *becoming attentive*. For a vi-

sual presentation of the theme *forming a relationship* see Figure 1.

Striving to Build a Trustful Relationship

The nurses' narratives elucidated an effort to build a trustful relationship involving the contrasting cases of on the one hand *striving for a connection* and on the other hand *experiencing a distance*. Narratives on *striving for a connection* expressed the importance of establishing a relationship and getting to know each other, as the relationship seemed the key for being able to care for the family in the first place. One participant shared,

I was their nurse so I really wanted to get to know them well. I was there a lot. I was probably there twice as much as anyone else, so it was probably this that I dared to do more or that I knew them. Maybe I listened more to what they didn't say because I felt that we had a relationship. That I felt safe with them and they felt safe with me.

Although the nurses' willingness to know the family was genuine and strong, their efforts were sometimes in vain, but their experienced unsuccessfulness in connecting with the family seemed to reinforce the notion of the relationship as essential. The nurses spoke about *experiencing a distance* in the relationship. This was an impediment which prevented the nurses from excelling in their care. Again, time was important for the successfulness or unsuccessfulness of getting to know the family. Failing to connect with the family caregivers was also exemplified in some narratives where the family caregivers were portrayed as not wanting the help of the nurses. Caregivers were distrustful of the nurses or considered that the nurses were not prepared to connect with the family. Negative emotions between the family caregiver and the person being cared for were also an impediment to the nurse excelling in caring and this wedged a distance in the nurses' relation with the families.

Although the nurses were striving for building a relationship, they spoke of *keeping a distance* in that they balanced being close with coming too close. These nurses were mindful of entering into the families' private affairs or taking upon themselves the grief and sorrow that the families were experiencing. Moreover, the nurses narrated what they had surrendered in their relationships with the families to a colleague who supposedly was better suited to care for the family. In such examples the nurses spoke of being honest to themselves and of *surrendering the relationship when feeling unable to care*.

Being a Confidant

As the forming of the relationship began, the nurses experienced gradually winning the family caregiver's trust. Gaining the family caregivers' trust and becoming a person who can be trusted, illuminated aspects of confiding and confidence. With time, the nurses were *moving within the confidence of the family caregivers* and becoming more able to ex-

cel in their support. Getting to know the family caregivers was fundamental before the nurses could experience the family caregivers as reachable, prepared to open themselves, feeling confident to ask questions, relating personal matters, or trusting the nurses. However some of the nurses' narratives concerned situations where the nurses experienced themselves as *failing to become a person who could be trusted with caregiving*. They felt suspected of being sloppy, careless, or forgetful. In such narratives, the dimension of confidence seemed to be illuminated through its absence in the relationship between nurses and family caregivers.

Being a confidant appeared as most of all concerning *sharing the family caregivers' emotions through their storytelling*, which was exemplified in situations where the nurse gave family members an opportunity to really express their feelings. One said, "It was really good that he kind of felt that you came and that it had helped him very much. And really you feel that you haven't done anything else than just be there and listen to him."

Family caregivers' feelings ranged from anxiety and despair to distress, worry, and aggression. Allowing the family caregivers to express their feelings could entail an initiative by the nurses to dialogue. What the nurses did was to be there, to witness and share in the family caregivers' expressed emotions, sometimes allowing them to narrate over and over again to ventilate and deal with the situation. The nurses' job was to listen, refrain from passing judgement, and share in the moment. According to the nurses, the family caregivers could feel confident enough to relate emotions that might otherwise remain hidden, for example saying that they wished that the person being cared for would die soon. Such statements should be devoid of the nurses' value judgements. Consequently being a confidant appeared to entail *hearing the family caregiver out without acting or passing judgement*. Sometimes the nurses perceived the family caregiver as being in greater need of expressing their feelings and struggles than the person being cared for.

Being Attentive

The developing nurse-family attentiveness was illuminated through several aspects which are represented by the subthemes as reported below. The attentiveness was facilitated by the fact that the arena of care was the families' homes. Nurses were excelling with the power shift that the home entailed, becoming even more keen in their attentiveness to understand family needs.

Picking up on signs of needs was an important aspect of the work with family caregivers. The nurses were perpetually attentive to how the family caregivers were feeling. They were also attentive to the families' need to talk or to have more assistance. This was exemplified in situations where the nurses spoke of being sensitive to the atmosphere in the family, or picking up on signals in conversations that needed to be followed. There was, for example, the possibility that a problem like sleeplessness could signify an even greater problem.

Therefore, picking up on signs of needs did not simply mean to register the need. It also meant to follow up on it. The response on the nurses' part was about taking time to hear what the problem consisted of, to consider if something could be done, or to take time to stay and talk if that was what the family caregiver needed. One nurse said,

I saw in her face, when we were about to leave that she was all red in her eyes, she really struggled, and we were standing in the door, and were dressed and I just looked at her and then I said "How are you really?" and then it just burst for her, so I looked at X (the physician's name) and then I said, "If you don't have time to stay you may go, I'll stay." He said "No, we have time."

The nurses' narratives also illuminated courage as a dimension of attentiveness. Being close and attentive to the needs of the family caregiver involved *being courageous*, not dodging or giving way to difficulties. For example, if the nurses suspected some mischief in the atmosphere while visiting the family, the nurses spoke about it, daring to open the conversation, daring to engage in discussions about death and dying or other topics that may be difficult to touch upon. The nurses spoke about daring to be close and daring to stay in spite of difficulties, although there really was nothing the nurse could do, other than be part of the conversation without searching for the *right* words to say.

In being sensitive to family caregivers' needs the nurses spoke of *giving precedence to family caregivers' decisions*. Despite conflicting opinions, the nurses felt they had no right to pass judgement on the family caregivers' decisions. Instead nurses honored the family caregivers' decisions, conscious that their own point of view does not necessarily equal the family caregivers' point of view, and of not letting their feelings show if views were different.

Regarding being attentive, the nurses' narratives also illuminated that being supportive entails an attentiveness to what the situation requires, to *harmonize with the family caregiver's needs*. The nurses spoke of increasing intensity and diversity of their measures for helping the family caregivers. The only thing the nurses knew for sure was that their aid to the family caregivers was individual as opposed to general, and no two situations were the same. The support needed to be tailored to the caregiving or illness trajectory, increasing in intensity and diversity as the person being cared for became more severely ill.

In the forming of the relationship, the nurses spoke of learning how to behave and conduct themselves while visiting the families, *harmonizing with the ways of the family*. Becoming attentive to the families' customs and manners meant learning about how to harmonize with, in the words of the nurses, the families' *culture* and *language*. Rather than ethnicity, the nurses were referring to the uniqueness of each family's way of being together, of being with each other. Harmonizing with the ways of the families meant the nurses must understand and learn about their own role in interacting with

the family, and alter their ways of being with different families. Harmonizing with the ways of the families also meant considering the families' routines and, if possible, finding times of the day that were suitable to the families' routines in caring for the ill person. Moreover, the nurses described their consideration of the integrity of the home as it could be compromised with hospital equipment or many professionals visiting.

Giving family caregivers undivided attention in time and space was an aspect of being attentive to family caregivers' needs which was exemplified when nurses prioritized to take time and make time to listen to the family caregivers regardless of how much work they had to do later in the day. The nurses spoke of staying with the family caregiver if they perceived that the family caregiver needed to talk. The nurses did not think about where they had been or where they were going after the visit. Instead, they were striving to be unhurried and present while visiting. Conscious of what they signalled with their body language, they wanted to come across as unhurried. One nurse labelled this as "being 100% present." Narratives on *giving family caregivers undivided attention in time and space* were illuminated by examples where the nurses were part of creating an undisturbed space where they could be with and listen to the family caregiver. For example, the nurses could deliberately bring a colleague to visit with the family, making it possible to share a moment alone with the family caregiver. If the nurses' attentiveness toward the family caregivers' needs was undivided in time and space, they could talk about issues which the family caregiver did not feel at ease discussing in front of the person being cared for.

Keeping Caregiving at Home

The core theme *forming a relationship* coexisted with another core theme *keeping caregiving at home*. Both were elucidated by the nurses' narratives as regarding understanding the meaning of being supportive. *Keeping caregiving at home* was underpinned by the themes and subthemes as reported below (see also Figure 2).

Striving for a Preparedness Through a Shared Understanding of What Is and What Will Be

The nurses' striving for a shared understanding of what is and what will be entailed several aspects pointing toward attaining a preparedness regarding the family caregivers' ability to deal with the situation of caring for a dying person at home, contrasted by a feeling of unpreparedness which was desirable to avoid. Narratives, where the nurses spoke of striving for the family caregivers to understand what caring for a dying person entails, were formulated as *striving for the family caregiver to realize the significance of caring for a dying person at home*. In the eyes of the nurses, the family caregivers should be tuned in to the significance of the situation, and they tried to find out about the family caregivers' preparedness by asking about their beliefs about the future, expectations, feelings, wishes, and views on caring. Thus, the

Subthemes	Themes	Core theme
Striving for the family caregiver to realize the significance of caring for a dying person at home Striving for the family caregiver to realize the gravity of the situation Striving for open communication Discussing physical signs of end of life approaching Illuminating new boundaries for what may pass as "normal"	Striving for a preparedness through a shared understanding of what is and what will be	<p>KEEPING CAREGIVING AT HOME</p>
Giving affirmation Receiving affirmation Feeling unacknowledged	Sharing reciprocal affirmation	
Having to choose between meeting family caregivers' or patients' wishes	Experiencing opposing demands	
Helping family caregivers to surrender caregiving Promoting family caregiver involvement while remaining responsible Trading places with the family caregiver to secure a moment of respite	Balancing caregiving responsibility	
Liaising between resources and the family caregiver Convincing the family caregivers of the advantage of a source of help Working together toward fulfilling last requests	Facilitating caregiving	
Teaching ways to handle caregiving Striving to get the family caregiver to trust in their own ability to care Proving one's worth through the performance of promises Reassuring the family caregivers of a responsiveness to their needs	Reassuring the family caregiver of the feasibility of caring at home	
Encouraging the family caregiver to continue with their own lives	Encouraging the family caregiver to establish an equilibrium in caring	

Figure 2. Subthemes and Themes of Keeping Caregiving at Home

family caregivers were made to deal with difficult but important questions. The nurses spoke of a need for the *true* or *real* situation to become illuminated. One nurse shared,

You kind of have to talk to him and ask, "How do you see it?" "What is it like for you when your wife is this ill?" "What do you think is going to happen?" "What are your expectations?" And if they say, "well this is going to be fine," then you know you'll have to put more effort into it.

Positive situations within this dimension were when the family caregivers were so prepared, and tuned in to what was going to happen, that the family caregiver expressed an acceptance toward the fact that death will occur. Moreover, the family caregivers were prepared to almost take care of the death themselves, making the nurse superfluous. Corresponding negative situations were exemplified when family caregivers got scared or panicked as end of life was approaching, resulting in the person being cared for being sent to hospice or the hospital. The nurses spoke of family caregivers as having to become aware of what they were getting themselves into and to consider whether caregiving at home was suitable for them. Practical arrangements needed to be sorted out, and there were differences in attitude and possibilities of the care provided by the hospital in contrast to being cared for at home.

As the family caregivers found themselves having to deal with the unfamiliar situations brought about by the cared for

persons' diseases, the nurses spoke of *illuminating new boundaries for what may pass as normal*. What could be experienced as remarkable and strange by the family caregiver really could be quite normal considering the given situation. For instance, explaining to the family caregiver that experiencing problems with eating, being aggressive, or not taking an interest in the outside world, really are part of the cared for persons' diseases. Through the nurses' normalizing of the situation, the family caregivers could rest assured in knowing that others were experiencing similar emotions, instead of feeling alone.

Striving for the family caregiver to realize the gravity of the situation, the nurses spoke of being honest as regarding what problems can occur and what can be done to solve them, as opposed to clinging on to treatments that are not in question. The nurses did not want to let the family caregivers be lulled into false expectations. This was expressed by one nurse as refraining from saying that *everything will be all right*. The nurses wanted to be open about the severity of the cared for persons' illnesses without being blunt. The nurses wanted to know if the family caregivers understood how ill the cared for persons really were, so that the family caregivers were, as the nurses said, *in synch with the disease*. Thus the nurses were working for a preparedness in family caregivers in coming to terms with impending death as well as understanding the difference between curative and palliative care. Nurses wanted to avoid death coming as a surprise or shock to

the family caregiver, but sometimes they failed to prepare the family caregiver for what was about to happen. Then the family caregivers did not keep up with the end of life illness trajectory, not realizing that the cared for persons were in the process of dying.

The nurses were struggling and striving for an open communication between the family caregiver and the cared for person as it was portrayed as desirable. If the family members could talk openly and honestly with each other they could deal with the situation together and be sad together. A situation where the family caregiver was hoping for the cared for person to get better was described by the nurses as terrible and catastrophic. The nurses spoke of a preparedness in the family caregivers through *discussing physical signs of end of life approaching* so that the family caregivers could predict what was going to happen with the cared for persons, for example changes in breathing or skin tone. The nurses perceived that knowing and recognizing these signs of a dying person calmed the family caregivers. The nurses wanted family caregivers to feel assured and calm in staying close to the dying person.

Sharing Reciprocal Affirmation

From the interview texts it was clear that the nurses were both *giving affirmation* and *receiving affirmation*. The nurses spoke of encouraging the family caregivers, telling them how good and capable they were in caring for their relatives. They were mindful of commending the family caregivers and acknowledging them for their worth and value in caring and caregiving. By some nurses it was elucidated that all the confirmation and affirmation expressed by the nurses to some extent was purposeful, keeping the family caregivers caring and managing to go on a little longer. In the eyes of the nurses it was thanks to the family caregivers that the persons being cared for could stay at home. In return, the nurses spoke of the confirmation they received from patients and family caregivers for keeping them going and sustaining them in their continued work. The nurses felt invigorated by the expressed gratitude and in doing something meaningful for someone else. However, when the confirmation and affirmation from the families was absent or withheld, nurses spoke of *feeling unacknowledged*. The nurses could experience feelings of frustration when they, in their own eyes, put their heart and soul into caring for the family and nothing was returned to them. The nurses seemed to be in need of feedback to feel satisfaction.

Experiencing Opposing Demands

When the family caregivers and the cared for persons' needs and wishes were in opposition, the nurses found themselves in the dilemma of *having to choose between meeting family caregivers' or patients' wishes*. This was illuminated by the extreme situations when on the one hand, the family caregivers felt they could no longer go on caring for their relatives at home. On the other hand, the cared for person refused

or expressly did not want to be admitted to the hospice. Sometimes it was not until after the death of the cared for persons that the nurses found out about the family caregivers' wishes. These situations were delicate, as there was no way of taking everyone's needs into consideration. Moreover, there really was no way of admitting the cared for persons to the hospice against their expressed will. Even if there were cases when the nurses could bring about a reconciliation, the solutions were never optimal for all.

Balancing Caregiving Responsibility

Although the nurses' narratives elucidated a striving for a continued caregiving at home, they also narrated about contrasting situations where they were *helping the family caregivers to surrender caregiving*. If the situation was too demanding for the family caregivers, or if they were feeling too pressured to care, the nurses could help the family caregivers by talking with the cared for persons and endorsing a move to the hospice. This could awaken feelings of guilt in the family caregivers but nevertheless, to no longer bear the 24-hour caregiving responsibility was favorable.

Even though some family caregivers wanted to be involved in, for instance, managing pharmaceutical pain-relief, the nurses were mindful of remaining responsible and accountable for the overall caregiving. The nurses themselves were *promoting family caregiver involvement while remaining responsible*. The nurses balanced the family caregivers' caregiving responsibility by *trading places with the family caregivers to secure a moment's respite*. If nurses assumed the caregiving responsibility during a visit, family caregivers were able to leave the house or to take their mind off things for awhile. Furthermore, if the family caregivers felt burdened or overwhelmed by caregiving, the nurses offered to stay or to find other short-term solutions to temporarily balance the family caregivers' caregiving responsibility.

Facilitating Caregiving

The nurses were *liaising between resources and the family caregivers*. Nurses used their resourceful knowledge of what the Swedish society in general is able to assist with practically, financially, or emotionally to help family caregivers. For example, they explained to family caregivers about financial compensation for loss of wages. All who care for a severely ill relative at home are eligible. Moreover, in cases where the nurses felt at a loss or insufficient in helping the family caregiver, they acted as an intermediary between the family caregiver and other professionals who potentially were better suited to meet the family caregiver's needs. Professionals, for example priests or almoners, were often mentioned by the nurses. The nurses searched for ways that the family caregivers could access more assistance when in need. For example, nurses suggested home-help services, support-groups, respite care, or hospice as viable options. Sometimes the nurses found themselves *convincing family caregivers of*

the advantage of a source of help. Not all family caregivers were thrilled with the idea of having an alarm system installed and some were skeptical about attending support groups or meetings with priests.

Although directed toward the family in general instead of the family caregiver in particular, the nurses and family caregivers were *working together toward fulfilling last requests*. If the family wished to travel somewhere it was rarely impossible to arrange, with the assistance of the nurses.

Reassuring Family Caregivers of the Feasibility of Caring at Home

Reassuring family caregivers of the feasibility of caring at home was portrayed in the nurses' narratives as being about promoting self-confidence in the family caregivers. Promoting family caregivers' confidence in the nurses was important. The nurses also spoke of *teaching ways to handle caregiving* to caregivers. This included issues arising in caregiving ranging from handling and administering pain killers, to helping the cared for persons with their hygiene. In knowing how to deal with situations that otherwise could feel unfamiliar, there was no need for the family caregivers to feel powerless to act or worried. The nurses were working to have the family caregivers feel in control and for the family caregivers to feel assured by knowing what to do and how to get in touch with the nurses. Seeking a sense of security and safety in the family caregivers through knowledge and ability to act in different situations.

Instead of feeling insecure about doing caregiving tasks, nurses were *striving to get the family caregiver to trust in their own ability to care*. The nurses spoke about the importance of the family caregivers feeling that they were capable of doing caregiving tasks. The nurses encouraged and commended the family caregivers' involvement in caregiving and boosted their self-esteem in managing caregiving. It was more important in the eyes of the nurses that the family caregivers dared to do caregiving tasks instead of achieving absolute perfection.

Integral to reassuring family caregivers of the feasibility of caring at home was *proving one's worth through the performance of promises*. The nurses did not just uncover the family caregivers' needs, they also translated words into deeds. The nurses did what they said they would do. They kept their appointments and came when the family caregivers called. Moreover, honoring promises also entailed not setting expectations or promises that could not be met. One said,

It is an important support to be able to show the family caregivers that this we can do, and then give concrete proof of that, so that it's not just a lot of talk about what one could do, but also to give a concrete example.

In their ambition to get the family caregivers to feel safe and secure with the AHC team, the nurses spoke of *reassuring the family caregivers of responsiveness to their needs*. The nurses reminded the family caregivers that they were always wel-

come to call them at any time. There was always someone there to take their calls, and the nurses wanted the family caregivers to be assured that their needs would be met. The nurses felt family caregivers should not have to worry about accessing the help they needed. Nurses spoke of a willingness to meet with family caregivers. They really wanted to help them and sometimes went to extra lengths to do so. They sometimes called the family caregiver just to hear how they were doing, so that family caregivers did not always have to *ask* for help.

Encouraging Family Caregivers to Establish an Equilibrium in Caring

From the nurses' narratives, being supportive also seemed to be about *encouraging family caregivers to continue with their own lives*, stimulating them to do other activities that are not about caring. Nurses spurred the family caregivers on to attending sporting events and going swimming or dancing. The nurses helped in planning respite care. This way the family caregivers could attend to their own needs also.

The Interpreted Whole and Reflections

This column points out one possible interpretation of understanding the meaning of being supportive as a contribution to the ongoing debate voiced by practitioners and researchers interested in understanding support for family caregivers. Before going into detail about the dimensions to being supportive that were illuminated through the structural analyses, the overall impression following the structural analyses was that the meaning of being supportive entailed aspects of both acting and experiencing—of both doing and being (Edvardsson, Sandman, & Rasmussen, 2003). Consequently, there are two parallel aspects to the meaning of being supportive. One aspect has to do with actions and reactions flowing through the nurses as responses to situations they are encountering in their supportiveness toward family caregivers. The other aspect is an experience that is lived and touches upon the nurses' way of being and prerequisites surrounding their way of being. The importance of actions, or more specifically reactions to family caregivers' needs has also been illuminated by an ongoing study (Stoltz et al., 2005).

Being supportive comes across as a phenomenon which interlaces doing and being, and furthermore seems to involve a direction from one person to another. Even though being supportive is a phenomenon that arises in an encounter between human beings, it flows from a potential supporter to a supportee. In briefly returning to Figures 1 and 2, one can discern that for example the theme *facilitating caregiving* alludes to nurses' doing/actions, while, for example, the theme *being attentive* has more to do with the nurses' way of being. The interlacing aspects of being and doing seem recurrent within the field of nursing, and have been described by Paterson and Zderad (1988).

As reflected by the structural analyses, the aspects of being supportive are rich in diversity in this material. Consequently, reported below are some of the most salient dimensions brought forth by the structural analyses as opposed to a complete and exhaustive description of all dimensions which would be too voluminous.

The core theme of *forming a relationship*, illuminates the importance of understanding the meaning of being supportive, namely the nurse-family caregiver relationship. Even though there is a temporal aspect to relationship building, it does not have to be a lengthy process (Tarlier, 2004). When established, the nurse-family caregiver relationship opens possibilities for mutual confidence, trust, and attentiveness, according to the nurses' narratives. Seen through the lens of Tarlier's (2004) work, the case in point here may be called a *responsive relationship* underlining the significance of a response on the nurses' behalf to attend to family caregivers' needs. The nurses spoke of an immediacy in meeting the family caregivers' needs, and of taking time to listen to the family caregivers here and now. This resembles the idea that a genuine dialogue cannot be planned in advance (Buber, 1953/1990).

Indeed, as previously stated in the structural analyses, the attentiveness to family caregivers' needs does not merely involve a perceptiveness of the need. It also involves action. Recognizing the call of the other and responding to it reveals the crucial moral dimension to being supportive as an intersubjective phenomenon. To be with the other in this fuller sense requires turning one's attention to the other, being open to the here and now situation, and communicating availability (Paterson & Zderad, 1988, p. 14). Responsiveness in the present and concrete situation is also called by Buber (1947/2002), an opening of oneself to others and responding to their needs even when the others are not aware that they are being addressed. The ethical and moral dimension to being supportive through an established relationship is further illuminated by Milton (2002) and Sumner (2001). They illuminate that the immediate act of taking time and listening to the other in the here and now may be to act faithfully in the nurse-person relationship, although such an action may go against the flow and stream of healthcare as we know it (Milton, 2002). High moral development of nurses is required to disregard some rules and responsibilities that should be completed within their shift (Sumner, 2001), to instead act faithfully and choose to affirm the mutual process with the other, who is viewed as a priority (Milton, 2002).

In the structural analyses the expression to *harmonize* with family caregivers' needs is used with a similar meaning to what Tarlier (2004) chose to call responsiveness. There is no one single way to be supportive for family caregivers. Instead the nurse should *tailor* the responsive relationship to dynamically meet the needs and expectations of particular persons, in this case family caregivers.

The responsive relationship can be a framework to view caring behaviors (Tarlier, 2004). One such caring act identi-

fied through the nurses' narratives is to listen to family caregivers and share their emotions through their storytelling. Here the quality of trust is particularly elucidated since trust is the foundation of expressing experiences and being listened to (Skott, 2001). Trust creates an atmosphere of confidence that is the breath of life of the authentic conversation (Buber, 1953/1990). Furthermore, it can be discerned from the nurses' narratives that all intersubjectivity or *being with* need not be verbal. Dialogue is not the mere interchange of words; genuine dialogue can also take place in silence, whereas much conversation really is monologue (Buber, 1947/2002). It is the open situation that gives the storyteller (the family caregiver) narrative power. However, telling does not come easy and nor does listening (Frank, 1995). The nurses spoke of having to be courageous, of not shying away from difficulties, and also of giving precedence to family caregivers' decisions. Buber (1953/1990) wrote of accepting the person who stands in front of you without shying away. In a genuine conversation nurses must be open and contribute with themselves (Buber 1947/2002). Nurses must be courageous as they can potentially be hurt through their openness and as a result they may refuse to hear and deny the voice of the other (Sumner, 2001).

Returning to the qualities of trust and confidence in the nurse-person relationship as described by Tarlier (2004), it is clear that trust is not only related to morals, but also to professional qualifications, skills, and competence. From the nurses' narratives, the family caregivers' trust and confidence in the nurse seemed gradually established, enabling the nurse to be supportive for the family caregiver who can confide in the nurse as well as trust the nurse with caregiving abilities. The development of trust is a multidimensional process which may depend on a person's ability to predict the individual nurse's likely moral responses (Tarlier, 2004). This is similar to what the nurses expressed through the subtheme of *proving one's worth through the performance of promises*.

However, for the relationship to be established in the first place the nurses spoke of a need for a genuine, perhaps reciprocal, connection with the family caregiver, otherwise some passed the relation on to a better suited colleague. This aspect of being supportive seemed to reflect the notion of authenticity in relationships as emphasized by Buber (1953/1990). The nurses spoke of this as the most honest thing to do. Again the moral and ethical dimension of being supportive illuminated honesty, generosity, and selflessness as basic moral values relevant to any relation between one person and another (Tarlier, 2004).

From what has been argued so far regarding the meaning of being supportive, a purposeful attunement to family caregivers' needs is interlaced with intentional actions by the nurses. Based on Habermas' theory of moral consciousness and communicative action, Sumner (2001) used the concept of discourse to illuminate the dialogical interaction in the nurse-person relationship. In the discourse, both persons are interactors and the accepted goal of the discourse is health for

the ill person and all that pertains to achieving it. Here, in the case of the meaning of being supportive, the goal of the discourse is voiced by the core theme of *keeping caregiving at home*.

In the nurses' narratives there were two contrasting situations outlining *keeping caregiving at home*. These cases were defined by whether or not the family caregivers could be reconciled to the idea of caring for their relative at home. If the family caregiver in the discourse between themselves and the nurses felt willing and confident in caring for their relative at home, interaction and actions taken by the nurses to actually keep caregiving at home were favorable. In such cases the discourse between the nurses and the family caregiver was positive for both. The turn of events can then be a sense of fulfillment which gives meaning to the person as well as the nurse (Sumner, 2001). This may be seen as reflected by the subtheme of *receiving affirmation*. The nurses expressed their experience of fulfillment in caring. However, if the family caregivers did not feel at ease with caring at home, or did not believe themselves capable to manage, interaction and actions taken by the nurses to keep caregiving at home were potentially coercive (Sumner, 2001). The turn of events can then end up with the ill person being cared for at home against the family caregivers' will.

To keep caregiving at home, the nurses seemed to invest in family caregivers' self-confidence in managing caring at home. Preparedness through understanding, reassuring, and affirming the family caregivers were some of the salient features. Seen through the lens of Halldórsdóttir's (1996) work, aspects of facilitating knowledge development and empowering people can be seen as evidence of professional caring in a nurse-person encounter. Halldórsdóttir (1996), Tarlier (2004), and Sumner (2001) related to the concept of caring. Moreover, in resemblance to what initially has been discussed on the importance of the nurse-family caregiver relationship, Halldórsdóttir (1996) pointed out the personal relationship as the fundamental difference between caring and uncaring. Again, attention is directed toward the concept of caring in understanding the meaning of being supportive. The results of this study closely related to the way ideas on the substance of caring are discussed in the literature. One possible explanation for this is that being supportive is a larger, more intricate and important dimension of nurses' work as it is interwoven with the concept of caring and with moral and ethical aspects. Future studies that further contrast and compare the phenomenon of being supportive and the concept of caring may be warranted.

Methodological Considerations

Reviewing the results of this study may give the impression that it was the concept of caring, rather than the meaning of being supportive, that was discussed. Although the phenomenon of being supportive may be difficult to isolate and separate from the concept of caring, all interviews were directed to the phenomenon of being supportive and the follow-

up questions were continuously aimed at elucidating the meaning of being supportive. Therefore, in spite of the fact that the meaning of being supportive may appear the same as the concept of caring, the authors are confident in successfully having described the meaning of being supportive as a pattern that is outlined against the background of caring.

The final *interpreted whole* is the product of the researchers' reflexivity anchored in the initial texts. All authors worked closely together, strengthening the interpretations by contesting and supplementing each other's readings as a part of reflexivity (Malterud, 2001). The research method used in this study successfully combined interpretation with analysis, or in other words understanding with explanation. This combination vouches for arriving at not the only interpretation but the most possible interpretation (Ricoeur, 1976). Similar studies in other settings are suggested, as such studies may potentially contribute to a deeper and richer description of the phenomenon of being supportive.

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