Gerotranscendence from a Nursing Perspective – from Theory to Implementation

BY

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Abstract


The overall aim of the present thesis was to gain further knowledge about the nursing theoretical basis of care of older people, to translate the theory of gerotranscendence into practical guidelines, and to implement the theory and guidelines in practical settings.

Study I comprised a literature search and a review with qualitative analysis of nursing theories. The conclusion drawn was that nursing theories do not provide guidance on how to care for older people or on how to support them in the developmental process of ageing. Thus, there is a need to develop a nursing care model that, more than contemporary theories, takes human ageing into consideration.

Study II was a qualitative interview study involving staff working in care of older people. The interviews were qualitatively analysed. The conclusion was that staff members need an interpretative framework that allows them to understand the signs they sometimes observe in older people. Such a framework would enable staff to develop a broader approach to their care for older people. Parts of this framework can be found in the theory of gerotranscendence.

In Study III, guidelines for practical care of older people were derived from the theory of gerotranscendence. Focus group interviews were used and other sources supporting the guidelines were given. A qualitative analysis of the interviews was carried out, and the theory of gerotranscendence was used as the theoretical framework. The guidelines could be used to promote a development toward gerotranscendence and could also be of value for people who have already attained a state of gerotranscendence. The guidelines focus on the individual, activities and the organisation.

In Study IV, the theory of gerotranscendence and practical guidelines were introduced in a nursing home. Data were collected via qualitative interviews with staff and residents, and observations were made. Qualitative analysis and triangulation were performed. As theoretical frameworks, both the theory of gerotranscendence and innovation theory were used. The result showed that the most used guidelines were those focusing on the individual; these concern what each staff member could do in his/her relation to the resident and care. The findings showed further that those staff members who interpreted signs in line with the theory of gerotranscendence also used the guidelines. The staff who were early to adopt and promote the guidelines were those individuals who described a feeling of harmony with essential parts of the gerotranscendence theory.

The most important finding of this thesis was that it was possible to translate a theory such that it could generate practical guidelines that could be used by the staff. There are probably many theories that could be translated in order to be implemented in practical care, e.g. to build a bridge between theory and practice, thereby helping staff. Innovation theory could be of general interest in all contexts in which work towards change is being conducted.

Keywords: Gerontology nursing, Gerontological care, Gerotranscendence, Nursing theory, Nursing models, Gerontological theory, Ageing, Care of older people, Nursing, Guidelines, Innovation

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Sammanfattning

Det övergripande syftet med denna avhandling var att få kunskap om den omvårdnads teoretiska basen för vård av äldre, och att översätta teorin om gerotranscendentens till praktiska guidelines, och att införa teorin om gerotranscendentens och guidelines i praktiken.


Studie II, var en kvalitativ intervjustudie med personal i äldrevård. Intervjuerna analyserades kvalitativt. Studien påvisade att personal behöver mer kunskaper om åldrandeprocessen så att de kan förstå tecken och beteenden de ibland observerar hos de äldre. Detta skulle göra det möjligt för personal att utveckla ett vidare perspektiv för hur de kan stödja äldre personer.


Det viktigaste resultatet in denna avhandling är att det var möjligt att översätta en teori till praktiskt användbara guidelines. Förmodligen finns det
fler teorier som skulle kunna översättas och implementeras i praktisk verksamhet, vilket skulle vara att bygga en bro mellan teori och praktik, och hjälpa personal att kunna omsätta teorier praktiskt. Innovationsteori kan vara av generellt intresse i alla sammanhang när förändringsarbete bedrivs.
This thesis is based on the following papers:


IV Wadensten B. & Carlsson M. (2003). Nursing home staff’s adoption of a ‘software innovation’ based on the theory of gerotranscendence. (Submitted)
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Preface

When I went through my nursing education and became a registered nurse in the middle of 1970s, I did not read or learn anything about nursing theories. In the 1970’s, nursing theories were relatively new and not widely known in Sweden, and they were definitely not included in nursing education. At that time, nursing education was very much focused on memorising lists of the signs and symptoms of common diseases, and performance of technical skills was given great importance. Nursing was based on medical models and seen as subordinate to medicine. This has changed with the passage of time.

During my work as a nurse, I always tried to obtain current valuable knowledge for my nursing practice and to keep myself up-to-date in all aspects of nursing. I worked towards these goals by attending different university courses. The courses I have taken and teachers I have met have, of course, given me knowledge and influenced me in various ways. Two areas of influence have been my views on the nurse’s role and on how nursing should be carried out in different care situations.

When I read a course in psychology of health care, the teacher talked a great deal about the instructional value of textbooks and descriptions of how you as a member of the nursing staff should perform care. He compared this to maps based on different scales, pointing out that maps with larger scales hardly provide any details at all. Instruction for nurses concerning, e.g., treatment is often quite general – concrete examples and details are lacking. This deficiency is something to which I have given considerable thought, and these thoughts have influenced my views.

As time passed, I learned about nursing theories. During one course I read about nursing theories for the first time. One course assignment was to analyse a nursing theory. I found them interesting, but I did not understand how they could be used, especially not in nursing practices. I was fully occupied trying to understand the concept of the theory; my conclusion was that the theory was nothing more than a general description of a nurse’s function, i.e., to give good care and take into consideration that different patients have different needs. My teacher on that course thought I was too critical, and told me that it would be better for me to create my own theory.
However, I retained my interest in theories and in how human understanding guides human actions and behaviour patterns.

During my Master’s level education in nursing sciences, I was most interested in a course on theories in nursing: There were not many of us with this interest.

The teacher of this course wisely understood my interest and encouraged me to devote my Master’s thesis to the topic of nursing theories, which I did. Actually, I am not sure whether I chose my thesis topic or it chose me.
Problem formulation and aims

The outcome of care of the elderly depends on theoretical perspective

Care and treatment of older people are affected by the knowledge and views that staff and society have about the implications of ageing. Staff members’ views on ageing affect how they address and treat older people, as well as which needs in the caring situation they feel must be satisfied. What one considers as important in the care of older people actually depends largely on one’s theoretical perspective. Care of old people is explicitly or implicitly steered by theoretical assumptions about what old age entails. Depending on which theoretical perspective one has on ageing and what this perspective implies, the needs one sees in older people and the interpretation of their behaviour will differ. The theoretical perspective on ageing and how to accomplish care has been learned by staff through societal norms and values, both in education and at work. Therefore, it is of great value for staff working with older people to be acquainted with different theories of ageing, so that they can develop a nuanced understanding of older people and adjust treatment to their needs.

Psychosocial theories of ageing offer different perspectives in their descriptions of the ageing process and what ageing signifies. These theories have variously influenced society and staff as regards their views on the ageing process and how care of the elderly should be carried out. These theories describe the ageing process, but do not provide guidance on how to care for older people or support them in the process of ageing.

I consider that in care of older people in Sweden, staff, care activities, and organisation of care are all influenced by activity theory. It is not clearly pronounced that we have this perspective, but in the law on social care of the elderly (SFS 2001:453) and in other official documents (SoS 2001, SoS 2002), it is expressed that older people should be offered an active life together with other people. Further, statements implying that rehabilitation is one of the most important aspects of care of older people are common. Thus,
the theoretical perspective is seldom clearly stated; instead it is something we carry with us that is implicit in the society in which we live.

**Aims**

The overall aim of the present thesis was to gain further knowledge about the nursing theoretical basis of care of older people, to translate the theory of gerotranscendence into practical guidelines and to implement the theory and guidelines in practical settings.

**Specific aims:**

- To investigate nursing theories in order to delineate the views on ageing presented and to investigate whether there are descriptions of how nursing care of older people could be organised (Study I).

- To investigate whether nursing staff working with old people could recognise signs of gerotranscendence and, if so, how they interpreted such signs. Furthermore, to describe how the staff addressed and cared for older people with signs of gerotranscendence (Study II).

- To derive guidelines from the theory of gerotranscendence that could be used in practical care of older people (Study III).

- To describe and analyse an intervention in a nursing home, where the intervention constituted an introduction for nursing staff regarding the theory of gerotranscendence and guidelines derived from the theory (Study IV).
Introduction

Gerontological nursing

Gerontological nursing involves the care of ageing people and emphasises the promotion of the highest possible quality of life and wellness (Eliopoulos 2001). Gerontological nursing is different from geriatric nursing, which focuses on care of sick older people. In short, geriatrics deals with the knowledge and treatment of illness in older people. Gerontology concerns knowledge about the normal process of ageing, and includes biological, psychological and social perspectives (Eliopoulos 2001). In practice, these knowledge fields often overlap, because many nurses need knowledge from both in order to carry out their practical care of older people.

Eliopoulos (2001) described the landmarks in the growth of gerontological nursing. The unofficial beginning of gerontology as a speciality within nursing could be considered to have occurred in 1950, when Eleanor Pingrey published the first master’s thesis on care of the aged in the US. In gerontological nursing, the perspective has focused upon the supporting function, not upon treating disease (Whall 1999).

Roach (2001) defined some attributes of importance for the gerontological nurse:

- ability to form a therapeutic relationship with older people,
- appreciation of the uniqueness of older people,
- clinical competence in basic nursing skills,
- good communication skills,
- knowledge of physical psychosocial changes that occur with age and
- ability to work with and supervise others
These attributes are vague and imprecise, and could actually be applied within all areas of nursing, including gerontological nursing. Further, Roach (2001) stated that nurses must be willing to take the time to develop a therapeutic and trusting relationship to the older people for whom they care. There is no description, however, of how such a relationship can be developed or of what the content of the relationship should be.

Work in gerontological nursing includes a variety of roles, such as being healer, caregiver, educator, advocate and innovator (Eliopoulos 2001). Eliopoulos defined the role of healer as helping individuals to stay well, overcome or cope with disease, restore function, find meaning and purpose in life, and mobilise internal and external resources. An important part of this could be to support older people in the process of ageing. Eliopoulos (2001) also stated that one point of holistic gerontological care is to facilitate growth toward wholeness by guiding the elderly in understanding and finding meaning and purpose in life, and supporting them in the ageing process.

Roach (2001) also discussed the importance of nurses supporting older people in their ageing process. A relevant question here is, of course, what one should do when helping an older person to find meaning and purpose in life, and what the ageing process is or could be. There is, however, only scanty information on how this support should be given. Therefore, it would seem to be important to develop our understanding of how the ageing process can be supported.

Wykle (1999) argued that myths and stereotypes about ageing are promulgated by a lack of scientific knowledge of the developmental tasks and mental needs of the older adult, and by influences of culture. Further, Wykle argued that we do not know enough about ageing and that, therefore, developmental paradigms must be created for the second half of life so that ageing can be better understood. I have found such a paradigm in the theory of gerotranscendence. The theory describes the ageing process and what it can lead to at best. Gamliel (2001) stated that the theory of gerotranscendence offers a new paradigm both for the developmental shift into old age and for the situational shift in the daily life of older people.

**Staff in gerontological care in Sweden**

In Sweden, the traditional types of accommodation for older people in need of different care are service flats, group accommodations and nursing homes. Nursing homes represent the accommodation option where older people most in need of care can be found. The staff working in care of older people in Sweden, such as in nursing homes, and home-based nursing, have a wide
range of education and experience. Most of the staff in nursing homes are nurse’s aid and assistant nurses and some are nurses. Some have no formal education in gerontology or geriatrics. Some staff have training in social care, especially some of the directors of the nursing homes or home help service.

The majority of municipalities in Sweden report continuing problems with recruitment, primarily regarding college-educated staff such as nurses, physiotherapists and occupational therapists. Likewise, a shortage of staff is being reported at a variety of locations in Sweden (SoS 2001). The National Board of Health and Welfare is of the opinion that the ability to offer good nursing and care depends greatly on how well municipalities are able to cope with the supply of skilled staff. It also stated that development in this area is very disquieting and that the actions implemented by the trustees, trade union organisations and national players are insufficient (SoS 2001).

In a study of work conditions for assistant nurses, nurse’s aids and home-helpers, Fahlström (1999) found that staff working at institutions suffered more often from high strain than did staff in home-care settings. Working with care of older people has a low status in society (Dahl 1979) (Tellis-Nayak & Tellis-Nayak 1989) (Robertsson & Cummings 1991), and many nurse’s aids regard their work as temporary (Szebehely 1995).

There are, of course, a number of possible explanations for the problems found in Swedish elderly care today. I would like to suggest, however, that perhaps some of these problems are related to the fact that staff working with the elderly lack the knowledge and tools necessary to meet the needs of older people.
Theoretical background

Theory
The term *theory* is defined in many different ways. Some state that a theory is something very formalised and describe it in terms of logically linked, mathematical propositions. At a more basic level, a theory has been described as a systematic explanation of an event in which constructs and concepts are identified and relationships are proposed and predictions made (Streubert Speziale & Rinaldi Carpenter 2003). A theory comprises concepts, propositions, laws and set of propositions that can be verbalised and communicated (Dickoff & James 1968). A common definition is that a theory is a statement that purports to account for or characterise some phenomenon, but a theory is always shorthand for understanding or characterising a phenomenon (Stevens Barnum 1990). In this way, a theory is like a map, it picks out those parts that are important for its given purpose. But no map (or theory) reflects all that is contained within the phenomenon.

The use of theory offers structure and organisation of knowledge and provides systematic means of collecting data to describe, explain and predict practice. Use of theory also promotes rational and systematic practice by challenging and validating intuition (McEwen & Wills 2002). A theoretical framework helps the scientist to accumulate and integrate data into a body of knowledge, as well as to provide directions for new research (Schroots 1996). One useful classification simply divides theories into those that describe and those that explain phenomena (Stevens Barnum 1990).

Thus, the term theory is defined in various ways, from a very formalised to a very broad sense; here I choose the broader definition.

Nursing theories
A nursing theory attempts to describe or explain the phenomenon called nursing. Theories of nursing, just as theories in other disciplines, are
classified in many different ways. In her anthology and analysis of nursing theorists’ works, Marriner (1986) described how the focus of theories has shifted over the decades. She also discussed how theorists have changed their views over time as their historical perspectives changed.

Fawcett (1995) described the structural hierarchy of contemporary nursing knowledge; here, the distinction is in terms of the level of abstraction. The first level is the metaparadigm, the second the conceptual models and thereafter the theories. Fawcett (1995) suggested a metaparadigm for nursing care consisting of the primary concepts of person, health, environment and nursing. The developmental perspective is treated within the concept of person and is further reflected in the concept of nursing care in practice.

Nursing theories also differ in scope. The grand theories are the broadest, whereas the middle-range theories are narrower in scope and often the most useful, because they can be empirically tested and applied in practice. Meleis (1997) took a more liberal view of the term theory, extended it to embrace conceptual frameworks and rejected the narrower view of theory as a term reserved for propositions verified by research.

Nursing theories are developed to challenge existing practice, create new approaches to practice and remodel the structure of rules and principles. Furthermore, theories ought to ultimately improve nursing practice. This goal is usually achieved by using theory or portions of theory to guide practice (Chinn & Cramer 1995).

Thus, nursing theories vary in scope, but they tend to be less formal and less rule-governed than conceptual models. In my view, conceptual models and theories of different scope are all of interest when discussing application of theories in nursing, because irrespective of level of abstraction, they should serve to inspire and improve nursing. Therefore, in this thesis, the concept of theory is used both for theories in the narrow, formalised sense and for conceptual models.

One aim of the thesis was to investigate nursing theories in order to delineate the views on ageing presented and to discover whether there are descriptions of how nursing care of older people could be organised.

**Psychosocial theories of ageing**

Psychosocial theories of ageing attempt to explain human development and ageing in terms of individual changes in cognitive functions, behaviour, roles, relationships, coping ability and social changes. These theories cover different aspects of the ageing process, but only indirectly address crucial
issues regarding attitudes and the manner in which nursing care should be structured.

The three theories presented first are part of the same idea tradition and are discussed in chronological order. Thereafter, I will present Erikson’s psychodynamic theory and, finally, Tornstam’s theory of gerotranscendence.

Activity theory
In many theories of ageing, there is a hidden assumption that activity is vital to well-being. Stress is placed on the importance of older people being dynamic and active participants in the world around them. Activity theory is a comprehensive name for a perspective on ageing. Havighurst (1953) published a book on the concept of development tasks in a life span perspective, which included six development stages or age periods. According to this concept, the successful achievement of each task leads to happiness and better chances of success with later tasks. Havighurst argued that maintaining the activity patterns and values typical of middle age is necessary to have a rich and satisfying life. Later on, the central organisation concept of the development tasks was named activity theory (Schroots 1996). It is assumed that the degree of subjective satisfaction achieved depends on how active the individual is (Hooyman 1988). This theory implies that there are no differences between middle-aged and old people, with the exception of biological and health-related factors, and it is assumed that all older people have the same psychological and social needs and preferences. Activity and social interactions are highly valued. This theory emphasises that well-being and life satisfaction, defined as ‘successful ageing’, are reflected in old age in the extent to which the individual is able to remain involved in the social context, e.g., to maintain social roles and relationships. As losses occur that are associated with ageing, they should be replaced with new and different roles, interests, or people. Ageing should be denied as long as possible and this should be accomplished by not changing the individual personality. According to activity theory, ageing means relative changes in the structure of interaction with other people. Simply put, the more active the individual, the greater degree of satisfaction with life. The activity theory proclaims that an older person should continue a middle-aged lifestyle, denying the existence of old age as long as possible. It also proclaims that society should apply the same norms to old age as it does to middle age and not advocate diminishing activity, interest and involvement as its members grow old. Thus, activity theory could be regarded as the opposite pole to disengagement theory.
The disengagement theory
In the 1960s, Cumming (1960, 1961, 1963) and Cumming and Henry (1961) published the disengagement theory of ageing. This theory assumed that ageing is a determined, inevitable, gradual tendency to disengage and withdraw from social roles and activities when growing old. The process is irreversible once it has started. As a preparation for death, the individual and society gradually separate from one another. The ageing person has an increased preoccupation with self and a decreased involvement with others. The society’s tendency, at the same time, is to reject ageing individuals. This results in decreased interaction between the ageing person and others in the social system. The theory does not indicate whether society or the individual initiates the disengagement process. The process is satisfying both for the individual and for society. Disengagement does not lead to dissatisfaction or problems for the individual; instead it is associated with satisfaction and harmony. Thus, according to the disengagement theory perspective, successful ageing is best achieved through abandoning social roles and relationships and by the individual reducing both activities and involvement. According to this theory, disengagement is a culture-independent concept, but its expression varies across cultures. Variation in timing and style depends on the individual’s health, personality, earlier type of engagement in social life and the life situation.

Continuity theory
Havens (1968) has presented the continuity theory, a psychosocial theory of ageing. The basic premise of the theory is that, as middle-aged and elderly adults adapt to changes associated with the normal ageing process, they will attempt to rely on existing resources and comfortable coping strategies. In other word, as individuals strive to achieve their goals and cope with ageing, their past experiences, decisions, and behaviours will form the foundation for their present and future decisions and behaviours. The theory states that an individual develops habits and preferences and other dispositions during the process of becoming adult, these become connected with the personality, and behaviour remains the same when ageing; one does not change a great deal. The personality and basic patterns of behaviour are said to remain unchanged as the individual ages. The continuity theory of ageing is also referred to as a developmental theory, because it relates personality and predisposition toward certain actions in old age to similar factors during other phases of the life cycle. Atchley (1989) transferred the concepts of the continuity perspective on ageing to a more structured theoretical framework. This theory states that it is of importance for the identity of the person to
preserve roles and capacity when growing older. Thus, in this theoretical view, successful ageing depends on the individual’s ability to maintain and continue previous behaviour patterns or to find new roles. Continuity theorists relate behaviour and coping patterns of ageing to similar patterns during other phases of the life cycle.

**Erikson’s psychodynamic theory**

E. Erikson’s psychodynamic theory (1950, 1982) is well known. It is a theory of human growth and maturation from birth to old age, which includes the process of ageing. According to this theory, human development passes through seven stages, each associated with different identity crises and solutions. Having arrived at the end, the eighth stage, it is hoped that an individual has attained a higher state of maturity. Successful passage through the stages leads to a synthesis that may be the basis for development towards the last stage, old age. Thus, the ego integration of the eighth stage refers to an integration of the elements of the earlier stages. During this eighth stage, the old individual looks back upon the lived life and sums it up. If the individual is able to accept with satisfaction the way life has turned out, he/she will achieve ‘ego integrity’. If the individual does not reach the eighth stage of ego integrity, he/she will experience despair and fear of death. Erikson called this negative component, in contrast to wisdom, disgust and contempt (Erikson 1982, Erikson et al. 1986). If the individual achieves ego integrity, he/she will have a fundamental acceptance of the lived life, regardless of how good or bad it has been, and this could be regarded as satisfaction with life. The individual looks back and feels satisfied with the past. This synthesis at the eighth stage is called wisdom, but does not describe what wisdom actually implies (Erikson 1982, Erikson et al. 1986). In an extended version of *The life cycle completed*, published by Joan M Erikson, both wife and colleague of Erik H Erikson, a ninth stage of old age and a chapter on the theory of gerotranscendence are included (Erikson & Erikson 1997).

**Theory of gerotranscendence**

In his theory of gerotranscendence, Tornstam (1989, 1992, 1994, 1996a, 1996b, 1997a, 1997b, 1997c, 1999a, 1999b) has presented a new understanding of the developmental process of ageing. Tornstam has based his theory on his own studies as well as on the theories and observations of others. Tornstam (1994) has referred to Jung, Erikson, Gutman, Peck,
Tornstam has suggested that human ageing, the very process of living into old age, is characterised by a general potential towards gerotranscendence. According to Tornstam, gerotranscendence is regarded as the final stage in a natural progression towards maturation and wisdom, and achieving gerotranscendence implies achieving wisdom. As in Jung’s theory of the individuation process (1930), the theory of gerotranscendence assumes a predisposition for a progression towards maturation and wisdom.

The theory of gerotranscendence states that human development is a process continuing into old age, and that this process, when optimised, ends in a new perspective, which is qualitatively different from those occurring earlier in life. It offers an idea of what positive old age may entail, and attempts to describe a positive and natural form of life for the elderly.

Gerotranscendence is a shift in metaperspective from a materialistic and rational view of the world to a more cosmic and transcendent one, normally followed by an increase in life satisfaction. It defines a reality somewhat different from the middle-age reality and lifestyle. According to the theory, the individual develops towards gerotranscendence and may experience and show a series of changes. In the process of gerotranscendence, the individual experiences a redefinition of Self and of relationships with others and a new understanding of fundamental existential issues. Thus, the theory of gerotranscendence adopts a perspective that emphasises change and development. It proposes that the individual becomes, for example, less self-occupied and at the same time more selective in his/her choice of social and other activities. Older people who withdraw from physical and social activities should not be regarded as disengaged or apathetic because they have a greater need for reflection.

The signs of gerotranscendence can be described as ontological changes on three levels: the cosmic level, the level of Self and the level of social and personal relations. These levels and their components, as observed in and described by healthy older people, are summarised in Table 1.
Table 1 Signs of gerotranscendence

<table>
<thead>
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<th>Level</th>
<th>Signs</th>
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| **The cosmic level** | **Time and space.** Changes in the definition of time and space develop. For example, a transcendence of the borders between past and present occurs.  
**Connection to earlier generations.** Increasing attachment. A change from a link to a chain perspective ensues. **Life and death.** A disappearing fear of death and a new comprehension of life and death.  
**Mystery in life.** The mystery dimension of life is accepted. **Subject of rejoicing.** From grand events to subtle experiences; the joy of experiencing macro-cosmos in micro-cosmos materializes. |
| **The Self**         | **Self-confrontation.** The discovery of hidden aspects of the self – both good and bad – occurs. **Decrease of self-centredness.** The removal of self from the centre of one’s universe occurs. **Development of body transcendence.** Care of the body continues, but the individual is not obsessed by it. **Self-transcendence.** A shift occurs from egoism to altruism. **Rediscovery of the child within.** Return to and transfiguration of childhood. **Ego-integrity.** The individual realising that the pieces of life’s jigsaw puzzle form a wholeness. |
| **Social and Individual Relations** | **Changed meaning and importance of relations.** One becomes more selective and less interested in superficial relations, exhibiting an increasing need for solitude. **Role-play.** An understanding of the difference between self and role takes place, sometimes with an urge to abandon roles. A new comforting understanding of the necessity of roles in life often results. **Emancipated innocence.** The addition of innocence to maturity. **Modern asceticism.** An understanding of the petrifying gravity of wealth and the freedom of ‘asceticism’ develops. **Everyday wisdom.** Reluctance to make simple duality categories of right from wrong is discerned and a preference for withholding judgements and advice is developed. Transcendence of the right-wrong duality ensues. |

(Tornstam, 1996b)
These changes imply several types of transcendence, e.g., surpassing of definitions, restrictions and borders that were natural in an earlier stage of life. Ageing, or living, also implies a continuous increase in experience, which should not be confused with wisdom. Experience may be necessary, but it is not a sufficient prerequisite for wisdom. The developmental process towards gerotranscendence is a lifelong and continuous one, however the process can be obstructed or accelerated by life crises and grief. For example, the process might be accelerated by a life crisis, after which the individual totally restructures his/her meta-world instead of resigning to the former one (Tornstam 1989). The process is in principle universal. But elements in the culture can facilitate or impede the process. Furthermore, the caring climate can obstruct or accelerate the process towards gerotranscendence (Tornstam 1996a). Given that the process towards gerotranscendence can be either obstructed or accelerated, many different degrees of gerotranscendence in old people will become evident. Not everyone will automatically reach a high degree of gerotranscendence. Rather, it is a process, which at very best culminates in a new cosmic perspective (Tornstam 1989).

Tornstam’s theory of gerotranscendence is different from other theories of ageing, because it offers new concepts, different from other well-known theoretical concepts in gerontology.

Tornstam (1989, 1994) described how the theory of gerotranscendence was born of the feeling that something was lost when the theory of disengagement was refuted. Tornstam (1994) stated that although the disengagement theory and its counter-theories seem to be very different, they flourish in the same meta-theoretical framework. He indicated that this framework is the common positivist one, in which the individual is regarded as an object directed by internal and external forces and the researcher is mainly interested in the behaviour of the individual. It is of interest to point out some differences between the theory of gerotranscendence and the other theories of ageing presented in the introduction.

Tornstam stated that gerotranscendence is something new and different from the old concept of disengagement and the basis for the theory of gerotranscendence differs from the disengagement concept in several ways. ‘Disengagement’ implies only a turning inward; ‘gerotranscendence’ implies a new definition of reality. Disengagement connects with social withdrawal; gerotranscendence correlates positively with social activity, but also a greater need for ‘philosophising’ is experienced. The social activities that are positively correlated with gerotranscendence are those in which more of the initiative for activity rests with the individual. The coping patterns of an individual with a high degree of gerotranscendence are composite; the individual takes an interest in self-chosen occupations and is not passive.
From the disengagement view an individual instead has a passive or defensive coping strategy. A high degree of gerotranscendence also relates to a higher degree of both life satisfaction and satisfaction with social activity, at the same time as the degree of social activity becomes less essential for life satisfaction (Tornstam 1996).

The theory of gerotranscendence is based on the notion of a dynamic development process, just as is E. Erikson’s psychodynamic theory of human development (1950, 1982), but it goes even further. Tornstam (1994, 1996) described an important difference between Erikson’s eight stage model and gerotranscendence. In Erikson’s theory, the individual is looking back at the life lived, but from within the same old paradigm. Gerotranscendence implies a looking forward and outward, with a new view of the Self and the world.

Tornstam described what it means to attain wisdom. He offers an idea of what positive old age may entail, and attempts to describe a positive and natural form of life for the elderly.

In the Encyclopaedia of Gerontology (Schroots 1996), the theory of gerotranscendence is described as interesting because it adds a new key concept of understanding to the developmental process of ageing and the transition into old age. Schroots also made a comparison between the theory of gerotranscendence, the disengagement theory and Erikson’s theory. This comparison points out some important differences, e.g., that gerotranscendence implies a redefinition of reality. Schroots also indicated that gerotranscendence is connected both with social activity and with a need for solitude, whereas disengagement is only tied to social withdrawal. Compared to Erikson’s concept of integrity, which refers to the integration of life elements that have passed, gerotranscendence implies new elements in the future, which includes a redefinition of reality.

In an analysis and critique of the theory of gerotranscendence, Hauge (1998) pointed out that the theory is interesting and relevant for nursing because it offers a new understanding of living into old age. It can therefore offer new practical ideas regarding which methods in nursing care are appropriate for older people.

The theory of gerotranscendence could accordingly provide new key concepts for understanding the developmental process of ageing and the transition into old age. With a theory that specifically describes the development and the meaning of development into old age, it is possible to begin to discuss how care of older people could be structured, and also how staff in care of older people could promote the process of ageing. Therefore, I have chosen this theory for the part of the research project that is the basis of my thesis.
Process of innovation

Because part of this research concerns practical implementation of the theory of gerotranscendence, a framework was required to which the results could be related and discussed. Rogers’ innovation theory (Rogers 1995) is well known and was chosen as a framework for the study of innovation with theory and guidelines (Study IV).

Rogers, a social scientist, developed his first ‘diffusion of innovation model’ in 1962. The model was revised in 1971, 1983 and 1995. By using this theory as a framework, it is possible to examine the process of change and innovation diffusion through a social system or a group over time. The theory addresses the adopters, the nature of the innovation, the social system and the communication patterns. Innovation is defined as an idea, practice or object that is perceived as new by an individual. All diffusion occurs within a social system. The social structure of the system could facilitate or impede the diffusion of innovations (Rogers 1995).

According to Rogers, innovation is a process of actions and choices that are in progress more or less at once, but an individual always passes through a chronological sequence of five stages as he/she adopts new ideas, practices or objects (Rogers 1995).

The five stages:

- The knowledge stage involves learning about the innovation.
- The persuasion stage involves the individual forming positive or negative attitudes to the innovation.
- The decision stage, the individual then tests the acceptability of the innovation, a decision that may be characterised by some degree of instability. This is done in the individual’s thoughts.
- The implementation stage, occurs when an individual decides whether or not to put an innovation into practice, e.g., the individual uses the practice on a more regular basis. This stage involves a behavioural change.
- The final stage, confirmation, involves confirmation or discontinuance of the innovation, where the individual seeks validation to support his/her decision.

Progression through these latter three stages does not signify a clear-cut decision of acceptance. Individuals may choose to retract their decisions based on introspection, experiences with the change and many other external influences.
Rogers specified three types of relevant knowledge adopters require concerning an innovation:

- **Awareness knowledge**: This is essentially an information-seeking and information-processing activity whereby an individual learns about the innovation. In this process the individual is motivated to learn about the advantages and disadvantages of the innovation. Awareness knowledge motivates an individual to seek ‘how-to’ and principles knowledge.

- **How-to knowledge**: This is the information required to use an innovation properly. The more complex an innovation is, the more how-to knowledge is needed.

- **Principles knowledge**: consists of information on the functioning principles underlying how the innovation works. It is possible to adopt an innovation without principles knowledge, but the danger of misusing the new idea is greater, and discontinuance may occur.

Rogers also described five innovation attributes significant for adoption of an innovation. The probability of adopting an innovation increases with increased:

1. Observability (visibility)
2. Relative advantage associated with using it
3. Lack of Complexity (understandability)
4. Compatibility with extant values
5. Trialability (potential to be acquired ‘piece by piece’)

These are not the only qualities of innovations affecting adoption rates, but they are the most important characteristics of innovations in explaining the rate of adoption.

Not all individuals in a social system adopt an innovation at the same time. Rather, adoption occurs over time. Individuals may be classified into ‘adopter categories’ on the basis of when they first began using a new idea. Rogers described five categories based on how quickly individuals adopt an innovation. According to Rogers, the adopter categorisation can be illustrated in a normal distribution. The five categories of adopters are ideal types that serve as a framework for synthesis of research findings. Rogers described the characteristics of these five types:

- **Innovators**: Venturesome, they are eager to try new ideas, they are risk-taking and able to cope with a high degree of uncertainty.
• **Early adopters:** Respectable, they are a more integrated part of the local social system than are innovators. This adopter category, more than others, has the greatest degree of opinion leadership in most social systems.

• **Early majority:** Deliberate, they tend to demonstrate a conscious willingness to adopt change. Their innovation-decision time is relatively longer than that of the innovators and early adopters.

• **Late majority:** Sceptical, they may follow in due time, adopting new ideas just after the average member of a social system. They often require intense encouragement.

• **Laggards:** Conservative, they are the last to adopt an innovation. They possess almost no opinion leadership. The point of reference for the laggards is the past. The resistance of the laggards may be attributed to a variety of organisational factors.
Flow chart of studies

This thesis is based on four qualitative studies. Throughout the work, the result of each study has given rise to new questions and inspired new studies. The figure below provides a brief overview of what will be described more thoroughly in the method section.

Figure 1. Flow chart of studies

The theory of gerotranscendence has been used as the theoretical framework for Study II, III and IV. In Study IV, Rogers’ innovation theory has also been used as a theoretical framework. How this is accomplished in each study is described in the method section. Qualitative studies often involve looking at informants’ descriptions of a phenomenon, free from a priori theoretical perspectives. I have instead chosen to make my analyses and interpretations related to a theoretical background, and I argue that this approach is more interesting. The use of the theory of gerotranscendence in Studies II – IV is unavoidable, as these studies deal with the theory
specifically; use of the theory, however, facilitates presentation of the results. The use of innovation theory in Study IV has allowed me to uncover more interesting findings, because it permits a much deeper and more detailed interpretation and discussion of the findings. These ideas will be developed in the method section. In the following section, called summary of studies, each study is presented. Thereafter follows a section with the methods and critical discussion of methods and results.
Summary of studies

Study I: Nursing theory views on how to support the process of ageing

The aim of Study I was to investigate whether it is possible to make use of nursing theories in care of older people, when the aim is to support them in the development process of ageing. Therefore a review of nursing theories/models was carried out in order to delineate the views on ageing presented and to discover whether there are descriptions of how nursing care of older people could be organised.


For the review, the research questions below were formulated and addressed with respect to each theory:

- How is the development of the individual described and explained?
- How is the ageing process described and explained?
Do the nursing theories describe how care of older people could be structured?

If the theory does not describe how older people should be cared for when the aim is to support older people in the process of ageing, is it possible, based on the theory’s underlying assumptions, to identify how care could be structured?

The result showed that most nursing theorists see human ageing from a developmental perspective, but none of these seventeen theorists has actually discussed what the result of human development is expected to be. None of the theorists has described the developmental aspects of the ageing process. Benner & Wrubel, K. Eriksson, King, Leininger, Martinsen, Newman, Orem, Parse, Peplau, Rogers, Roy, Travelbee and Watson have discussed individual development. King and Roy have directly referred to E. Erikson’s psychodynamic theory of human development (Erikson 1950, 1982), but none of them has described or discussed what they mean by development into old age. Henderson (1964, 1982, 1991), Nightingale (1946), Orlando (1961, 1987) and Wiedenbach (1964) have not discussed human ageing at all.

All nursing theorists have advocated an individually structured nursing care program. The descriptions in the nursing theories studied are general in character and do not specifically deal with gerontological care. Some of the theorists, however, have dealt with aspects of human development that indirectly affect attitudes towards care of older people, namely Benner & Wrubel, King, Roy, Travelbee and Watson. Only in these few theories were some important aspects of nursing care of older people discussed, but no concrete instructions on how to apply these aspects to nursing care were given.

It is apparent that most of the nursing theorists have taken a more or less clear developmental perspective, since they believe that, as a function of individual experience, people develop and change during the life course. However, none of them has shown what this development is leading to, or what the needs of older people are.

Some theorists (Benner & Wrubel, Eriksson, King, Martinsen, Newman, Orem, Parse, Peplau, Roy, Travelbee, Watson and Wiedenbach) have made reference to philosophical foundations or to other theories that have influenced them and in some cases provided the bases for their own standpoints. Many of them have given general indications as to what has influenced them, whereas others have clearly indicated that they adhere to a particular line of thought or philosophical tenet. King and Roy have
indicated that E. Erikson’s psychodynamic theory of human development has inspired them.

This absence of practical guidance on how nurses could act and what actions can be taken to support old people in the process of ageing highlights the need to further develop and discuss how gerontological care should be provided. It also gives inspiration for the development of a nursing theory based on an ageing theory in which development into old age is included. I argue that important features in care of older people should focus on supporting old people in their development and personal growth, which in my opinion is a part of the ageing process.

The conclusion drawn in Study I was that nursing theories do not provide any guidance on how to care for older people and how to support them in the development process of ageing. Thus, there is a need to develop a nursing care model that, more than other contemporary theories, takes human ageing into consideration.

**Study II: A qualitative study of nursing staff members’ interpretations of signs of gerotranscendence**

The aim of Study II was to investigate whether nursing staff working with older people had recognised signs of gerotranscendence and, if so, how they interpreted and cared for older people showing such signs. In addition, we aimed to describe how staff cared for older people showing signs of gerotranscendence.

The informant group included 34 staff, both from a nursing home and a group working with home-care services. They had different experience, educational background and belonged to different age groups, and they were not familiar with the theory of gerotranscendence before the interview took place. Their age varied from 20 to 59 years, and the sample included nursing assistants, registered nurses and occupational therapists.

An interview guide was designed based on Tornstam’s theory of gerotranscendence. The indicators of gerotranscendence in the theory were used as descriptions of signs of gerotranscendence, and informants were asked whether they had recognised such signs. Informants were also asked to provide an interpretation of the meaning of each sign and to explain how
they cared for older people showing these signs. They were requested to consider individuals without diagnosed dementia.

Data were analysed by qualitative method. The results were organised in three qualitatively different sections: signs of ageing interpreted as ‘pathological’, ‘invisible’ and ‘normal’.

The results showed that all staff members had noticed signs corresponding to the theory of gerotranscendence. However, there was a great deal of variation as to the number of signs and which signs they had noticed. There was also variation in interpretations and in how these older people were treated.

*The following signs of gerotranscendence were interpreted by the staff as ‘pathological’ behaviour of older people:*

- Changed perception of time-space, for example that they lived in the present and past simultaneously (time and space);
- Great capacity to take pleasure in the small things in life (rejoicing);
- New perspective on social contacts. That is, that it did not seem as important for the residents to have many contacts as to have deeper relations with a few people, and an increased need for solitude (changed meaning and importance of relations);
- Withdrawal from some social activities and preference for and satisfaction with sitting alone and thinking (changed meaning and importance of relations);
- Display of innocent behaviour by asking questions or doing things not common to adults (emancipated innocence).

The above signs – interpreted by staff as ‘pathological’ signs of ageing – constitute undesirable behaviour within an activity-theory-based framework. Role theories explain the old person's withdrawal as loss of a role in society, and from this perspective it is undesirable for old people to withdraw from some social activities and to prefer to sit alone and think.

The most common approach toward residents showing a changed perception of time and space was to correct them and try to bring them back into the present; but some staff let them remain in the past. The primary manner of dealing with residents who withdrawal from activities was to activate them.
The following aspects are called ‘invisible’ signs as they were scarcely noticed by the staff:

- Looking back on life and understanding various events and episodes in a different light in old age (ego-integrity);
- Becoming less self-centred and less egotistical (decrease of self-centredness);
- Discovery of new aspects of themselves with age – both positive and negative qualities (self-confrontation);
- Reluctant to make simple duality categories of right vs. wrong and a withholding from judgements and giving advice (everyday wisdom).

Among those who noticed residents who were less self-centred, the interpretation was that they had always been that way. Staff also had the opinion that it was more common that older people were very sure of their opinion than reluctant to make simple duality categories of right vs. wrong. If they recognised some of the above signs, staff behaviour was to be passive.

Some signs were noticed and considered to be a part of the normal ageing process, although interpretations of ‘normality’ varied.

What staff to varying degrees noticed and interpreted as ‘normal’ was that the older people:

- thought a lot about their childhood (rediscovery of the child within);
- seemed to gain another/closer connection to earlier generations;
- did not care much about the bodily changes resulting from ageing (body-transcendence);
- allowed occurrence of supernatural explanations for things, i.e., it is not possible to explain or understand everything (mystery in life);
- showed a decreased fear of death (life and death);
- showed a decreased interest in material things (modern asceticism).

These signs interpreted as part of a ‘normal’ ageing process are also considered normal within the framework of activity theory or in a developmental perspective. Therefore it is understandable that staff members would interpret these signs as normal aspects of ageing.

The most common manner from staff toward residents showing those signs was a passive approach. Sometimes staff members made comments or asked questions. They did this because they felt that older people need
someone to listen. When a resident talked about death, various ways of dealing with the situation were reported. Even if staff had the opinion that the resident was not afraid of dying, some reported trying to change the topic. Another approach was to talk the issue away and try to cheer the person up. Others reported not knowing how to act, and still others said that they listen and talked about it. Some had not noticed older people talking about death at all.

Thus, the most common manner among the staff was a passive approach. Staff had difficulty in identifying needs of older people other than those of a strictly practical nature.

Conclusions of this study were that staff members need an interpretative framework that allows them to understand the signs they sometimes observe in older people. Having an interpretative framework in which all these signs are seen as normal aspects of ageing would enable staff to develop a different attitude towards older people and another approach to caring for them. Parts of this framework can be found in the theory of gerotranscendence.

Study III: Theory-driven guidelines for practical care of older people, based on the theory of gerotranscendence

The aim of this study was to derive guidelines from the theory of gerotranscendence for practical use in care of older people. The guidelines could be used to promote a development toward gerotranscendence and could also be of value for people who have already attained a state of gerotranscendence.

The method for deriving guidelines from the theory was focus groups interview. The involved groups varied in composition, the aim being to achieve variation and to produce as many proposals as possible. In these groups, the theory of gerotranscendence was used as a foundation for stimulating discussion. It was also used as a foundation for the analyses, when organising the emerged proposals. From these proposals, concrete guidelines at three levels – with focus on the individual, activity and organisation – were derived.
The individual level concerns what staff members could do in their individual care of the residents; activity concerns what kinds of activities staff could arrange; and organisation concerns what the staff as a whole could consider in the organisation of daily care. The concrete guidelines are introduced in themes, organised into the three levels. Below each guideline, the rationale from the theory of gerotranscendence is given.

Focus on the individual

Theme 1: Accept the possibility that behaviours resembling the signs of gerotranscendence are normal signs of ageing

Do:

- Do accept signs of gerotranscendence as possibly normal signs in the ageing process.

Do not:

- Do not automatically regard signs of gerotranscendence as undesirable and incorrect.
- Do not always try to correct older people with signs of gerotranscendence or change aspects of their behaviour.

Accepting the possibility that behaviours resembling signs of gerotranscendence are normal signs of ageing is, of course, fundamental. Accepting these signs as normal also entails respect for residents’ own desires as to how they spend their time.

Link to theory:

The guidelines above link to all signs of gerotranscendence described in the theory.
**Theme 2: Reduce preoccupation with the body**

**Do:**
- Do choose a topic of conversation not focusing on health and physical limitations.

**Do not:**
- Do not always routinely ask the residents how they feel.

It is unnecessary that staff constantly and routinely comment on and make conversation about the residents' state of health. It is common that discussions on health status focus on physical limitations. By reducing the number of conversations about the residents' health, the focus will then automatically shift to other subject matters, away from the common topic of health and physical limitations.

**Link to theory:**
This is in accordance with the development of body transcendence proposed in the theory.

**Theme 3: Allow alternative definitions of time**

**Do:**
- Do respect that older people can have a different perception of time, such that the boundaries between past, present and future are transcended.
- Do ask the person to talk about their ‘adventures’ in the past.

**Do not:**
- Do not routinely correct older people about the time, when for example they seem to be in the past.
- Do not always try to bring them back to the present.
It is not necessarily so that an alternative definition of time is a symptom of the beginning of dementia (though it may be). The theory of gerotranscendence allows another interpretation and another attitude towards older people with this sign. Perfectly healthy older individuals have been shown to transcend the borders of time.

*Link to theory:*

This is related to the cosmic level: changes in the definition of time and space.

**Theme 4: Allow thoughts and conversations about death**

*Do:*

- Do listen when someone talks about death, let them speak, listen and ask questions, stimulate further thoughts.
- Do inform residents if someone among them has died, and allow talking about it.

*Do not:*

- Do not lead the conversation away from death to other topics.

If an older person begins talking about death, this is presumably something essential for him/her. As a staff member, it is important to listen to this person and to talk about death, death struggle and the question of life after death.

*Link to theory:*

This is related to the cosmic level: the fear of death disappears and a new comprehension of life and death results. Fear of death generally decreases with age, and thus it becomes more natural to talk about death.
Theme 5: Choose topics of conversation that facilitate and further older people’s personal growth

**Do:**

- Do ask in the morning what the older people have dreamt about, instead of asking how they feel. If they did dream, ask questions about the dream and what it might mean.
- Do encourage the older person to recall and talk about childhood and old times, and how he/she has developed during life.

In care of older people, it is not common to choose topics of conversation intended to further people’s personal growth. Looking back and reflecting allows for reconfiguration. If this reflection takes a great deal of older people’s time and is important in the process of reconfiguration, it must be of value to promote the process. If staff speak and ask questions about the older person's life and their development during life, the process of personal growth could be promoted.

**Link to theory:**

Tornstam has, referring back to Jung, in informal conversations, discussed the possible importance of dreams for the individual’s growth. Recalling and talking about dreams could start dream work for old people and provide an opportunity for self-confrontation and personal growth. Looking back and reflecting is in accordance with various parts of the theory. It could be a way to rediscover the child within; it could also strengthen the connection to earlier generations or be part of the ego-integrity process.
Focus on activities

Theme 6: Accept, create and introduce new types of ‘activities’
Create and introduce new types of ‘activities’ that encourage and support older people in their process toward gerotranscendence. A number of methods, introduced below, could be suitable and feasible.

Do:
- Do let older people decide for themselves whether they want to be alone or participate in ‘activities’.
- Do discuss in a group or in individual conversations the topic of growing old, and introduce older people to the theory of gerotranscendence as a possible and positive process of ageing.
- Do start reminiscence therapy as a way of ‘working’ with one's own life history. This can be done in different ways, such as writing down the life history, talking about life-history and discussing with staff or talking about life-history in a group of other older people.
- Do arrange a meditation course. Meditation may be a way to get in touch with the inherited mental structures, which Jung refer to as archetypes in the collective unconsciousness.

Do not:
- Do not assume that participating in arranged activities is always the best alternative.
- Do not, without reason, nag a person to participate in arranged activities.
- Do not, without reason, question the person or see the fact that some want to spend a great deal of time alone as a problem.

Of course it is important that residents should make their own decisions about participation in activities, no matter what the activity is. Talking about growing older and introducing the theory of gerotranscendence as a possible process could give older people a broader perspective on what is ‘normal’ in ageing, and also promote the process towards gerotranscendence. When the common assumption in society is that ‘good ageing’ is synonymous with continuing and preserving midlife ideals, activities, roles, and definitions of
reality, older people can feel guilty if their own development is different from the expected. This could impede the process towards gerotranscendence.

Talking about our life history could be a way of understanding our life and giving coherence in life. The guidelines above concern using reminiscence in different ways, and promoting the process of gerotranscendence instead of only maintaining present identity, which is the most common use of reminiscence therapy. From the perspective of gerotranscendence, the goal is the development of identity through reminiscence therapy. This is a larger reorganisation and reconstruction process than that in Erikson’s theory, because it also includes changes in the ontological definitions of existence. Tornstam discussed, therefore, that reminiscence work could focus on development of identity rather than mere maintenance.

One component of the theory of gerotranscendence is the need for time for solitude and ‘meditation’. In Sweden, meditation has been introduced in recent decades as a method for relaxing and understanding oneself, which is part of a developmental process. Meditation is not commonly used, and so its introduction could involve teaching a concrete method.

**Link to theory:**

Not everyone will automatically reach a high degree of gerotranscendence. Rather it is a process that, at best, culminates in a new perspective. It is a process generated by normal living, but the process can be facilitated or impeded. Reminiscence can be important in older people’s developmental process; it may contribute to the change and reconstruction not only of identity, but also of the way people understand reality. The theory of gerotranscendence states that human development is a process continuing into old age and that, when optimised, this development ends in a new perspective. This process involves development in which individuals gradually change their basic conceptions; it is a shift in individuals' approach to defining reality.
Focus on organisation

Theme 7: Encourage and facilitate quiet and peaceful places and times

Do:
- Do remember to plan and organise for quiet moments of rest and also to respect a person’s wish to be alone in his/her room.
- Do organise so that an older person can have meals in his/her own room if desired.

Do not:
- Do not organise a large number of activities in the main rooms or have the television or radio on in the day-room the whole day.

This involves both respecting older people's desires and deliberately providing opportunities for quiet time, which could be for solitude and 'meditation'.

Link to theory:
This is related to various parts of the theory of gerotranscendence. It refers to the changed meaning of social and individual relations. One becomes more selective and less interested in superficial relations, exhibiting an increasing need for solitude. This is also an approach that promotes the possibility of reminiscing.

For some of the signs of gerotranscendence it was difficult or impossible to develop concrete guidelines. This may be because these signs seem to be too abstract. Another cause may be that the theory introduces quite a different view on ageing.

In the article, references are given to other sources that support each of the guidelines. This shows that other theorists and researchers have had thoughts in line with different parts of the ideas presented both in the theory of gerotranscendence and in the guidelines.
Study IV: Nursing home staff’s adoption of a ‘software innovation’ based on the theory of gerotranscendence

The aim of Study IV was twofold:
   a) to describe and analyse the process of an intervention in a nursing home, where the intervention constituted an introduction for nursing staff regarding the theory of gerotranscendence and guidelines derived from the theory, and
   b) to discuss the result with reference to innovation theory.

The following specific research questions were formulated:
   • How do staff change their recognition and interpretations of signs of gerotranscendence in older people?
   • If they changed, what signs did they change their description of?
   • How do staff change their behaviour and which guidelines did they use?
   • Who are the early adopters and the laggards in response to the intervention with this 'software innovation’?

The intervention, including the theory and practical guidelines derived from the theory, was introduced in a nursing home. An intervention with new guidelines for practical care could be conceived as a ‘software innovation’. The theory was introduced to the staff through lectures and discussion groups; thereafter the guidelines were introduced in discussion groups, where instructions and discussion dealt with how to use the guidelines in relation to the residents. Further discussions with staff were carried out with the aim to provide an opportunity for reflection for staff and to create a forum in which staff members could influence one another. Conversation topics included staff’s feelings and opinions about use of guidelines. The staff also received guidance concerning how to behave in relation to the residents.

Qualitative method was used, and triangulation of methods was used both in data collection and analysis. Data collection began with interviews with staff, followed by observations and interviews with residents. During the intervention period, which was fifteen months in duration, data were collected at different times and in different situations, as well as in daily care in the nursing home and in conversations and discussions with staff and residents. The intervention period ended with an observation period focused
on staff compliance with guidelines and thereafter interviews with staff and residents.

Both the theory of gerotranscendence and the theory of innovation were used in the analysis. Results from each method of data collection were combined in the triangulation, and in this phase data from each data collection were compared at the individual staff level, when this was possible.

The interviews with staff showed that staff members changed, to varying extents, how they recognised and interpreted signs of gerotranscendence. The signs that, in the first interviews, were interpreted by the staff as ‘pathological’ showed most changes. After the intervention, many interpreted these signs as normal signs of ageing. Regarding behaviour, the aspect the staff described as most changed concerned their caring for older people who were more selective in their choice of social activities and preferred to sit and think alone. Staff described that they, after the introduction of the guidelines, met this behaviour with more acceptance and respect than earlier. Most staff reported that, after the intervention, they generally let the residents decide more about their participation in activities. Staff also stated that they less frequently tried to activate the old people or nag them about participating in activities. Some staff described that they now dared to listen when the residents started talking about death, whereas before the intervention some said that they thought it was harmful for the residents to talk about death, as such talk could make them depressed.

The residents’ descriptions of staff behaviour indicate that it did change to some extent. The most explicit change reported by residents was that some staff had changed their behaviour regarding choice of conversation topics. Some residents reported that staff members paid attention to them in a different way, and also that some staff really talked to and showed an interest in them, not simply talking about ‘anything’. Another report from the residents concerned the atmosphere in the ward, which was described as having become more peaceful. Some residents described that some staff members no longer nagged them about joining other residents on the ward. After the intervention, the staff let them have more choice about how they spend their time.

The observations showed that the guidelines most commonly put into practice were those focusing on the individual; these concern what each staff member was able do in his/her relation to the resident and care. All these guidelines were complied with, but to varying extents. The guidelines focused on activities were hardly put into practice. The only such guideline used concerned not assuming that activity is always best, letting residents decide for themselves, and not nagging them to participate in arranged activities. Only one new activity was initiated by some of the staff, namely
reading and discussing books about the past. The guidelines focused on organisation concerned facilitating quiet and peaceful places and times. These were put into practice by most of the staff in their treatment of individual residents; the residents who wished to be alone and even wanted to eat in their rooms were encouraged and respected.

In the triangulation of results, when results from interviews with staff and residents and observations were combined, staff members were grouped into qualitatively different adopter categories in accordance with Rogers’ theory. This was done both with respect to their assimilation of knowledge of the theory and with respect to their readiness to use the guidelines. This showed that those staff members who interpreted signs in line with the theory, also put the guidelines into practice. The following describes the characteristics of these categories and the staff who belonged to them.

**Innovators:**
According to Rogers, this group includes individuals that are eager to try new ideas. No member of the staff belonged to this group; I had taken on the role of innovator.

**Early adopters:**
This category includes, according to Rogers, individuals that seem to be respected by both staff and residents and that are an integrated part of the local social system. In the present study, two staff members who caught on and promoted use of the guidelines belong to this group. These staff used more of the guidelines in comparison with the others. They described many of the signs of gerotranscendence as ‘normal’ from the beginning, and had not changed a great deal in their interpretations, but started to use the guidelines. They had many thoughts and ideas about how to address and treat the residents and took an active part in care; they also took responsibility for many duties on the ward. Characteristic was that they described being in harmony with essential parts of the gerotranscendence theory. They felt they had developed and changed considerably in connection with difficult personal experiences, and that they had started a personal developmental process in line with the theory. These two individuals were quite different: one was young without any education in care, but had three years experience of working with older people; the other was a middle-age woman with education in care and long experience of elderly care.
Early majority:
These staff members tended to demonstrate a deliberate willingness to adopt change. These individuals adopted the guidelines without furthering their use; they changed their interpretations and also started to use some of the guidelines, but were not promoters. Characteristic of staff in this group was that they were younger than individuals in the group ‘late majority’ and ‘laggards’, and had worked a shorter time in care. Among this group were both staff members with and without education in care.

Late majority:
Characteristic of individuals in this group is that they were sceptical. In the present study, this group included staff members who wait and see, changed somewhat in their recognition and interpretation of signs, but not in their behaviour. This group showed the most variation in terms of staff education and age, and it is difficult to identify common characteristics, other than a sceptical attitude.

Laggards:
Laggards are, according to Rogers, the latest to adopt an innovation. In the present study, these were the staff members who, through their negativity, impeded the progress; they did not comply with the guidelines or change their recognition and interpretation. They were sceptical to the theory and avoided participating in the lectures and group discussions. Characteristic of the two individuals in this group was that they expressed a negative attitude towards their work.

Rogers described the following attributes as significant for adoption of an innovation: 1. observability (visibility), 2. relative advantage associated with using it, 3. lack of complexity (understandability), 4. compatibility with extant values and 5. trialability (potential to be acquired ‘piece by piece’).

For the present innovation, trialability is the only one of the attributes described by Rogers as significant for adoption that applies. Thus, the innovation can be acquired ‘piece by piece’, where understanding is the first phase and compliance with the guidelines at the organisational level the final phase. The other attributes do not apply to this innovation. The innovation cannot be described as observable, instead it is quite abstract, because it
deals with changing interpretations and values with regard to ageing and eldercare in a way not common in care today. The relative advantage is not immediate; instead it might be more trying to become involved with the residents. The innovation is quite complex, takes time to understand, adopt and put into practice. It is not compatible with extant values, but quite different in that it is based on a rather radical and new theory with a different base than prevailing theories.

Yet, the present innovation does have one positive attribute for adoption not found in Rogers’ model, namely, the ‘aha-experience’ attribute – the feeling that something has fallen into place and that a missing key to a locked door has been found. When describing the characteristics of staff who were early adopters, the common denominator was that they felt in harmony with essential parts of the theory. They both had an ‘aha-experience’ while learning about the theory. The theory matched something they had experienced themselves, which made it theoretically understandable. Therefore, a sixth attribute was added to Rogers’ five: the ‘Aha-experience’: if the innovation results in an ‘aha-experience’ it is more likely that it will be adopted. If the innovation gave a staff member an ‘aha-experience’, the probability was greater that this person would adopt the innovation.
Methods and critical discussion of methods and results

This section includes descriptions of the research process, the methods used and their application in the present studies, a critical discussion of methods, the choice of methods and results. The intention in the method section is to provide detailed information on how data collection was performed and how interpretation has been accomplished.

An overview of the sample, data collection, data analysis and theoretical frameworks used in the studies is presented in Table 2.

Table 2 Sample, data collection and data analysis in the studies

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However, this section begins with some general points. The research process involves both describing the problem area and attempting to answer specific questions. In this thesis, the results of the first study have influenced the design of the second study, the results of which have in turn influenced the next study, and so on. Thus, one could say that elaboration of the study designs has followed a developmental path.

My analyses have been based on the work of Grinnell (1997). I have subsequently found that Ryan and Bernard’s (2000) descriptions of ‘text’ analysis are quite similar to Grinnell’s description. Ryan and Bernard described the process of ‘text’ analysis as one of identifying themes, describing these, and comparing across cases and groups, and finally combining themes into conceptual models and theories to explain and predict social phenomena. Thus, given the above description, all analyses in this thesis could be regarded as a form of ‘text’ analysis – the theory analyses in Study I, as well as the more traditional qualitative analyses in Studies II – IV.

The first task in a qualitative analysis is description, which constitutes the foundation for later interpretations. The description phase in these studies included transcribing and organising the data collected in the nursing theories text and in interviews and observations. Patton (1990) argued that description must be carefully distinguished from interpretation, because interpretation involves explaining the findings, answering the ‘why’ questions, and putting patterns into an analytical framework. While gathering and organising the data, ideas about possible ways to analyse and explain the data do, of course, occur. These ideas constitute the beginning of analysis. In this thesis, all analysis of material collected from interviews and observations began with careful reading of verbatim texts with the aim to discover and link themes to the theoretical frameworks.

Coding is the heart and soul of text analysis, and forces the researcher to make judgements about the meanings of contiguous blocks of text (Ryan & Bernard 2000). The fundamental tasks associated with coding are sampling, identifying themes, building codebooks, marking text, constructing models or relationships among codes, and relating them to and testing them against the empirical data. How these tasks are performed varies across research traditions. Ryan and Bernard (2000) provided good general descriptions of the content of these tasks, and their ideas serve well as a general description of the qualitative analyses performed in this thesis. The following is a summary of their description: Sampling involves identifying a corpus of text and selecting the units of analysis, and thereafter identifying the basic units of analysis; this can be applied to books, interviews, grammatical segments and so on. The basic units of analysis are abstracts constructions that can be identified before, during and after data collection. Ryan and Bernard
described marking texts as the act of coding that involves assigning codes to contiguous units of text. The coding serves two purposes in qualitative analysis. First, codes act as tags to mark off text for later retrieval or indexing. Second, codes act as values, assigned to fixed units. Constructing models or relationships among codes, and relating them to and testing them against the empirical data can be accomplished in different ways, and it is perhaps this aspect that differs most across various research traditions and study aims.

Interpretation involves going beyond the descriptive data. It means attaching significance to what was found, offering explanations, drawing conclusions, making inferences, building linkages, and comparing meanings with rival explanations. The interpretation may take different forms in different kinds of studies (Patton 1990).

This was a general description of qualitative ‘text’ analysis. In the following, an explanation of the settings and how data collection and analysis in the studies in this thesis were carried out will be provided. The section begins by describing how each study was performed, and this includes some reflections. Thereafter the research process is discussed.

The nursing theory study (Study I)

The aim of this study was to discover whether it is possible to make use of nursing theories in care of older people. For the review of nursing theories and in order to obtain an overview of well-known theories in Scandinavia, appropriate books describing and analysing nursing theories were scrutinised (Kirkewold 1994, Marriner 1986, Rooke 1991). Then the original works of these theorists were used. The search was accomplished using reference lists from these books and by searching the database CINAHL. Seventeen nursing theories/models were chosen because they were deemed to represent a 30-year period from the early 1960s to the early 1990s.

The ability to read the nursing theories in a new way was facilitated by use of specific questions in Study I. These questions covered the following areas: how the theories describe individual development; how they describe ageing; how they describe how care of the elderly could be structured; and whether they have underlying assumptions that elucidate this. Addressing the research questions was not a simple task. It was a question of whether I
could find descriptions in the theories that dealt with these areas and provided answers to the questions.

The study included seventeen nursing theories/models. More theories could have been included, but this would probably not have added a great deal to the analysis. Instead, the impression that saturation was reached with the selection made would seem to be reasonable. Thus, including more theories would probably not have given a more complete picture of the various nursing theories’ views on ageing.

Another approach could have been to study whether any of the theories have been implemented in gerontological care and the outcome of those attempts; but this could not replace Study I. My aim was to investigate the theorists’ descriptions and views. If I had instead studied how some theories have been put into practice, I would have had access to another person’s interpretation or application of the theory. This could be the basis of a further study investigating which nursing theories have been implemented in care of older people, and what results this has had in terms of nursing behaviour.

The interview study with staff (Study II)

The aim was to investigate whether staff working with older people had recognised signs of gerotranscendence and, if so, how they interpret the signs and cared for people showing such signs. The informant group included 34 persons. They were at a randomly selected ward at a nursing-home, or were members of a group working with home-care services. The recipients of care were in varying states of health, many had physical disabilities or diseases, and a few were suffering from senile dementia. The informants were chosen to include staff with different experience, educational backgrounds and belonging to different age groups. Staff members were not familiar with the theory of gerotranscendence before the interview took place. The age of the staff varied from 20 to 59 years. The sample included nurse’s assistants, registered nurses and occupational therapists.

As regards accomplishment of the qualitative interviews, this complies with the general rules; this was described by, among others, Kvale (1997).

An interview guide was used both in this study (Study II) and in the study on innovation with the theory and guidelines (Study IV). It was based on Tornstam’s theory of gerotranscendence, and questions were constructed concerning whether the signs of gerotranscendence were judged as
The indicators of gerotranscendence in the theory were used as descriptions of signs of gerotranscendence. The purpose of these interviews was to discover whether the interviewees had noticed signs of gerotranscendence and to obtain their descriptions of how they interpret such signs in the elderly. The informants were therefore asked whether they had recognised such signs, and they were requested to give examples with descriptions of the signs they had observed. They were also asked to provide an interpretation of the meaning of each sign and to explain how they cared for older people showing these signs and why they act or react in these manners. They were requested to consider individuals without diagnosed dementia.

Asking for staff descriptions was a way to discover how they explain the various signs and to understand the perspectives from which they view ageing. All interviews were performed at the informants’ place of work. The interviews, lasting from 40 to 100 minutes, were tape-recorded and transcribed verbatim.

Data analysis of staff interviews was performed using a method described by Grinnell (1997). The analytical phase began by reading all interviews; they were then reread and the coding began. While reading the interviews, similarities and differences were noticed in the text. This phase of coding was concrete and involved identifying properties clearly evident in the text. All descriptions from different interviews were studied and those with similar meaning were grouped into categories. Each answer was classified as either similar to or different from the others. This coding procedure constituted a kind of constant comparison, and proceeded in stages, the first step of coding being concrete and involving identifying concrete properties clearly evident in the text. In this phase, answers to each question from all interviews were analysed separately. Interpretations of gerotranscendence signs were assigned to three qualitatively different category groups called: a) ‘pathological’ signs, b) unnoticed or ‘invisible’ signs, and c) signs interpreted as ‘normal’. The term ‘pathological’ was chosen to illustrate a behaviour that staff signified as undesirable, ‘normal’ designated signs staff described as normal signs of ageing, and the ‘invisible’ signs were those staff had not noticed. For example, some staff used the word ‘pathological’ when relating that they had observed that some older people had a changed perception of time-space, which was often described as the beginning of dementia. Further they used the term ‘normal’ when describing signs they consider to be included in what they believe constitutes normal ageing. Thus, the choice of these terms was a consequence of staff use of words and descriptions of the signs. Staff descriptions of their care of older people were similarly assigned to category groups.
The next step of the analysis was more abstract and involved interpreting the meanings underlying the more obvious ideas contained within the data. Underlying meanings were identified for staff members' interpretations of the signs and for their descriptions of care for older people. Thus, the specific purpose was to identify underlying assumptions that might have influenced staff, i.e., a comparison to ageing theories was made. This step of the analysis made it clear that staff were influenced by different theoretical perspectives on ageing. The signs interpreted as part of a ‘normal’ ageing process are also considered normal within the framework of activity theory or in a developmental perspective. The signs interpreted as ‘pathological’ are undesirable behaviour within an activity-theory-based framework. And the ‘invisible’ signs are those not considered as part of ‘normal’ ageing in an activity or developmental perspective, thus staff had no theoretical framework to relate to.

This investigation constituted the basis for further studies. In the following section, I will discuss the interview study with staff (Study II). In many cases, staff interpreted signs of gerotranscendence as a ‘pathological’ behaviour. This is probably because staff members had no access to theoretical tools enabling other interpretations. Those signs that were viewed as undesirable or ‘pathological’ are also interpretable as such from the perspective of activity theory, thus they are not desirable when seen from this perspective and must be dealt with and changed. Some signs were scarcely noticed. The reason could be that staff members had no theoretical framework to relate to, because these signs are not considered as part of ‘normal’ ageing in an activity theory or developmental perspective.

Some signs of gerotranscendence were noticed and implicitly interpreted as common, and in several cases as ‘normal’, based on either an activity theory or developmental perspective. Staff members with training in the caring professions have most likely encountered the activity approach, and it is therefore natural that they have adopted it.

In some situations, some staff perceived a conflict in that some common signs of gerotranscendence are not considered acceptable. Their training and work tradition have taught them that these behaviours are undesirable, and that part of their duty is to counteract them. Old people who do not wish to participate in the various arranged activities exemplify this. In these situations, some staff felt that they must activate these people, despite their observations that they obviously do not wish to participate. Thus, in some situations some staff felt frustration, because they did not know how they should act.

The most common manner of approaching the signs was to be passive. Sometimes staff members said that they made comments or asked questions. This, however, was not considered as an important aspect of their work,
merely something that arose while attending to practical duties. Creating inter-personal relationships was not something most of the staff considered an important part of their duties, which were of a more practical nature. They had difficulty identifying needs of the old persons other than those of a strictly practical nature and related to practical duties. Duties directed towards practical things, such as assisting with hygiene and cleaning, were reported to consume most of their time and perceived as their main tasks. Older people’s psychosocial needs were not described by staff to any great extent and, therefore, the staff’s role in addressing these needs was not considered either.

After this study, I made two important conclusions: First, that staff require more knowledge about the ageing process and about different theoretical views on ageing. Second, that staff members feel their main responsibility is to perform the duties related to practical care, such as assisting with cleaning and hygiene.

These observations cause one to stop and think about what the content of care of older people should be and about who is responsible for the current content. I will return to this later on.

There is a risk that older people developing along the lines of gerotranscendence may try to hide some signs not generally accepted as signalling desirable ageing, or that they may try to adapt to staff expectations – expectations that arise when staff members do not recognise and understand these signs. The result could be obstruction of these individuals’ development. Promoting development during ageing requires an understanding that the aged can develop and that this developmental process is, according to the theory of gerotranscendence, not the same in content as that of younger or middle-aged people. Caregivers, therefore, need an interpretative framework that allows them to understand the signs they sometimes observe in older people. Furthermore, the discussion must concern the content of eldercare.

This study was based on staff’s self-reported behaviour with regard to their manner towards older people. An observational study of staff behaviour might have provided another view, in cases where some of their descriptions do not correspond with their behaviour. With reference to the study on the innovation with the theory and guidelines (Study IV), where interviews were compared with observations of staff behaviour, it can be shown that such discrepancies did exist, but not to any great extent.
The study about deriving guidelines (Study III)

The aim of this study was to derive guidelines from the theory of gerotranscendence for practical use in care of older people. Developing the guidelines was a way to elucidate what is important in such care, if the theory of gerotranscendence is used as an interpretative framework.

Three focus groups with different compositions were used. The groups consisted of four to nine persons, with a total of 18 persons. Group 1 consisted of individuals without experience in caring, group 2 were staff with caring experience, but not from gerontological care, group 3 consisted of staff working in a nursing home. The use of groups with different compositions was a deliberate choice. The aim was to achieve variation and to produce as many viewpoints and proposals as possible. The choice of including people without caring experience was made to try to obtain ideas not biased by previous work in the area. Staff members from other kinds of wards were chosen to provide alternative views of care. Staff members working with older people in a nursing home were chosen to obtain ideas from staff with these experiences. All groups included both men and women. The participants were recruited through information to the workplaces and all interested parties were allowed to participate.

A focus group interview is a group interview about a defined topic (Krueger 1994, Morgan 1998). The topic chosen is developed through interaction among group participants, and it is possible for participants to bring up and discuss their own experiences with and thoughts on the topic (Stewart & Shamdasani 1990, Morgan 1998).

The focus groups were first given a brief lecture on the theory of gerotranscendence. The signs of gerotranscendence were described and a short description of the distinction between the theory and other theories of ageing was given. Thereafter the participants were asked to suggest what actions and components of care could promote development towards gerotranscendence or what might constitute good care for people already approaching gerotranscendence. They were encouraged to speak as frankly as possible and were told that all proposals emerging from the discussions would be of interest. This initial discussion led to some proposals. To further stimulate and deepen the discussion, each sign of gerotranscendence was discussed to obtain suggestions on how to promote development towards this particular sign. Each focus group interview lasted 1.5 – 2 hours and was audio tape-recorded.

The purpose of the analysis was to identify many proposals as well as to present them easily and comprehensibly.

The first step was to arrange all proposals from all focus groups in a list, so that proposals from all focus groups were combined and analysed.
together. The theory of gerotranscendence was used as the basis for organising the proposals that emerged. All proposals were compared with the theory of gerotranscendence to discover each one's relevance in supporting development towards gerotranscendence, or in helping people already approaching gerotranscendence. Thus in this step the proposals were arranged according to the individual signs of gerotranscendence. If the same proposals were suggested for several of the signs, they were placed under several signs. Some signs had no proposals and some proposals were removed, as they did not refer to any of the concepts of the theory.

In the second step all proposals were compared with one another to detect those with the same content and to discover relations among them. Comparison showed that some proposal content was the same or concerned a similar domain. These proposals were then combined. From this arrangement of proposals, seven themes emerged. The themes are not mutually exclusive, and some themes are so closely connected that they overlap. For example, the theme ‘create and introduce other types of activities’ also includes conversations that further older people’s personal growth. At this stage, a nursing colleague assisting as co-examiner made a judgement concerning the arrangement of proposals into themes. The co-examination showed a few differences, and these were discussed until consensus was reached.

In the third step the seven themes were then grouped into three levels: the individual level, the activity level and the organisation level. The individual level concerned how each staff member could act as an individual in the daily work, and the activity level concerned what sorts of activities could be arranged and how staff ought to behave toward residents regarding their participation in activities. The organisational level concerned organisation of care on the ward. The seven themes were arranged into these three levels, and concrete guidelines for each level were developed. These guidelines are presented in statements under the headings ‘Do’ and ‘Do not’ in Study III. This was an obvious way to report the result, because the questions concerned suggesting what actions and components of care could promote a development towards gerotranscendence or what might constitute good care for people already approaching gerotranscendence; these were put under ‘Do’. In these discussions, statements also emerged about components of care that could be negative and that could obstruct the process; these were put under ‘do not’.

The best composition of the focus groups could be discussed. It might have been possible to include a group of older people who had attained gerotranscendence; this could perhaps have led to additional guidelines. But it is not certain that this would have helped. The theory introduces quite a different outlook on ageing, and the task of conceptualising ways to promote
such a developmental process would seem to be quite abstract, even for elderly persons who have attained gerotranscendence.

The innovation with theory and guidelines in a nursing home (Study IV)

The nursing home at which the intervention took place was located in a rather large city in Sweden. The nursing home had eight wards. Two wards located next to each other were randomly selected. Eighteen staff worked and twenty-six residents lived on these two wards. The organisation of care was that typical of Swedish nursing homes, and there was no explicit ideology or common value system used as the basis for how to care. Care, however, was influenced by activity theory. During the study period, some of the staff members both began and ended their employment, and some of the residents died. Informants in this study were 12 staff members who had worked at least six months on the wards. Their education and care experience differed. Their age varied from 20 to 63 years, and the sample included nursing assistants and registered nurses. Some staff had also participated in a focus group, where the guidelines were derived. The resident informant group included six residents 68 to 96 years old, who had lived in the nursing home during the intervention period, at least sixteen months. They were in varying states of health, suffering from different physical disabilities or diseases, but showed no signs of dementia.

The innovation involved introduction of the theory of gerotranscendence as well as the guidelines derived from the theory. An intervention with new guidelines for practical care could be thought of as a ‘software innovation’. The theory was introduced to the staff through lectures and discussion groups. These lectures and discussions took place in the nursing home. The aim of the first lectures was to describe the theory of gerotranscendence and discuss how it differs from other perspectives on ageing. These lectures were arranged at eight occasions. There were two different lectures, both of which were offered 4 times, so that everyone would have a chance to participate.

Thereafter the guidelines were introduced in discussion groups; here the focus was on the guidelines and how to use them. These discussions groups started with instructions about the guidelines. Thereafter, the participants discussed together how they could be used in practical work with their residents. These discussion groups were arranged eight times, and all staff participated at least twice. The introduction of guidelines was the same, but
the discussions differed in content, because different staff members were interested in discussing different topics. Further discussions were carried out with staff during daily care and in connection with various staff meetings. These discussions were carried out for two reasons: to provide an opportunity for reflection on the part of the staff and to create a forum in which staff members could influence one another. Conversation topics included staff’s feelings and opinions about the use of the guidelines. Also these discussions took place on several occasions and in the nursing home. The staff also received guidance during the daily care concerning how to behave in relation to the residents. The aim of this guidance was to encourage staff members to think more about how they behave towards the residents. The first author carried out all these parts of the intervention. The intervention period was fifteen months, from February 2000 to May 2001.

Data in this study were collected through interviews with staff, interviews with residents and observations. These will be described in the following.

The interviews performed with staff in the nursing home, in Study II, were used as pre-intervention interviews, and were supplemented with interviews with new staff. The interview with staff was performed with the same interview guide as in the interview study with staff (Study II). Also here, the aim was to obtain staff members’ descriptions of how they explain the signs. An additional aim was to compare these responses with those from the previous interview to see which signs they now described differently and to explore how their descriptions had changed. Therefore, the pre- and post-intervention interviews were compared. This comparison showed how each staff member had changed his/her interpretation of signs. The staff descriptions of how they addressed and cared for older people were also compared between the first and second interview. These comparisons were used in the triangulation. However, the main aim, in Study IV, was to describe and analyse the introduction of the intervention, and one part of this was to obtain staff descriptions of which guidelines they had put into practice. Therefore, the post-intervention interviews were supplemented with questions about staff members’ opinions about using the guidelines. During the intervention period data were collected at different times and situations in informal talks performed in connection with observations. These were included in the field notes.

Interviews were performed with the residents both before and after the intervention period. An informal interview technique, in the form of a conversation focusing on the informant (Spradley 1979), was used. The resident was encouraged to narrate around specific topics, which were specified in the themes related to some questions. The residents were encouraged to speak about activities, health, social contacts, life satisfaction and opinions about the nursing home and staff. The interviews, lasting from
30 to 70 minutes, were tape-recorded and transcribed verbatim. During the intervention period, informal interviews were also performed in connection with the observations, and these were included in the field notes.

The analyses of the interviews with residents were aimed at discovering whether the residents’ descriptions of care differed prior to and after the intervention period, as well as at revealing any differences between residents. Thus, these interviews were not analysed in the same way as the interviews with staff. Rather, in the resident interviews, focus was put on differences in the descriptions made before and after intervention, as well as on how the residents described individual staff members. In these interviews, the first level of analysis was made when descriptions of the residents’ views had been extracted. The comparisons were summarised in notes in which residents’ descriptions of changes were arranged into themes. Comments and opinions about some staff were added and used in the triangulation.

The observation method used in this thesis is fairly similar to the method Leininger (1985a) called ‘sequenced phases of observation-participation field method’. It is described as a method for ethnonursing, but the structure of the observation sessions is applicable even to other observation studies. The method allows the researcher both to become aware of his/her role and to collect data in a systematic manner. According to Leininger, an observer’s role evolves through phases. It starts with primarily observations, followed by primarily observations with some participation, which continue with more participation during the observation sessions. Finally, there is a reflective observation period at the end of the study. In this study, the observations started after the first interview, and were made to find out how care was accomplished at that time. The observer’s role was to participate passively in daily care, but sometimes to assist some staff and lend a helping hand. The observation units comprised staff and residents in their daily contact with one another. This phase gave a broad view of how the staff worked and of daily living in the nursing home. Thereafter observations were made during the intervention period. In connection with the observations, conversations, sometimes with questions, were carried out both with staff and residents. Here, the observer role was a more active role as staff supervisor, but still involved passive participation in the daily care and sometimes lending a helping hand. Thus, in this regard the observation method differs from Leininger’s method and becomes more similar to methods used in action research. Yet I do not wish to characterise the present work as an action research project, because it has the specific aim to test the developed guidelines, whereas action research is, according to Streubert Speziale (2003), aimed at finding solutions to practical operational problems.

Field notes (example of field notes is given in Appendix I) were written during observations according to a procedure described by Grinnell (2001).
The first level of field notes was written during the observation sessions, and thereafter expanded with more details during transcription. The field notes constitute a mixture of observations of what took place together with quotations of what was said; they also include the observer’s notions about emotional expressions. Observations were also made during discussion group sessions with staff; some of these were tape-recorded. These discussions dealt both with how to act in accordance with the guidelines and with how staff experienced the use of the guidelines. The focus during the final observations was on how staff addressed and treated the residents and on whether they complied with the guidelines. Here the observer role was again that of a more passive observer.

The observations were analysed to reveal which staff members used the guidelines and which guidelines they used. The observations were classified according to whether staff used the guidelines or not. During the second level, interpretative notes were written; these notes included interpretations of the words and actions observed. Each observation note was read and staff behaviour in different situations was classified as being in accordance with the theory and guidelines or as not being so. At least two observed occasions of conformation to guidelines were required if a given staff member was to be classified as having changed his/her behaviour. The third level of field notes, the thematic notes, was used to record emerging ideas and hypotheses. These notes expanded during the analysis.

Triangulation is the use of multiple methods or perspectives to collect and interpret data in order to converge on an accurate representation of reality (Polit & Hungler 1999). In this study triangulation of methods was used in data collection, data was collected in interviews both with staff and residents and in observations. In the analysis both the theory of gerotranscendence and Rogers’ innovation theory were used. The aim of this stage of analysis was to use several data sources simultaneously to obtain a clearer and more reliable description. Results from each method of data collection were combined, and in this phase, data from each data collection were compared at the individual staff level, when this was possible. The residents generally described the staff as a group, but in some cases, the interviews with residents contained statements about various individual staff members’ behaviours and treatment, and these data were also added to the analysis at the individual level. This was performed in a systematic way; the result from each staff interview was compared with the observation result. This was carried out with a focus on each sign and each guideline. In Study IV, the tables show which guideline each staff used and the classification of each staff member’s description of each sign before and after the intervention, the number of each type of interpretation for each sign. The number of equal or changed types of interpretations, before and after the intervention, is also
given for each staff member. This method of sorting and describing might seem to reflect quantitative thinking, but the aim has been to elucidate the process of analysis and interpretation used. Most qualitative studies include some form of categorisation as a way to facilitate description. These descriptions were presented as a way of clearly describing how the data were sorted. These descriptions also provide a basis for understanding how staff members were later sorted into different adopter categories.

An informant check was carried out with two of the staff after the categorisation into adopter categories. This method was described by Lincoln and Cuba (1985) and refers to the provision of feedback to the study participants regarding the data and the researcher’s findings and interpretations. This is a technique used for establishing data credibility. The check showed that the informants agreed with the description, and in this way they confirmed the categorisation.

In a previous study, the theory of gerotranscendence was introduced in a nursing home through seminars and group discussions (Tornstam 1996a). This study showed that a large portion of staff felt that the theory corresponded to their experiences as caregivers, and some of the staff changed their behaviour towards the care recipients by increasing listening and permissiveness. However, this study did not use an innovation process approach in evaluating its result. Therefore it was important to carry out a study to identify which of the staff members accepted/adopted the theory and guidelines, and the reasons for their adoption. Furthermore the previous study did not include instructions to staff that were as concrete as the derived guidelines in this study.

Several signs of a development in accordance with gerotranscendence that were interpreted by many of the staff as ‘pathological’ before the intervention were described as ‘normal’ after the intervention. That the signs came into view and that staff received another interpretative framework might indicate increased understanding of older people showing these signs. According to innovation theory, this might mean that the staff acquired ‘awareness knowledge’, allowing them to make new interpretations.

Some signs of gerotranscendence seemed to be more unnoticed than other signs. One explanation could be that close and long-term acquaintanceship with an old person is required to recognise some of the signs, or to perceive a change that is in accordance with gerotranscendental development. Another explanation could be that some signs occur more rarely than others. Gerotranscendence should be seen as a process; a person’s progress will determine which signs are observable.

After the intervention, most of the staff recognised more signs and were more accepting of them. Other staff members described a changed behaviour in the interviews, but the observation showed relatively less changed
behaviour. One explanation might be that some situations were not observed closely enough, but another clear explanation is that some staff did not change their behaviour. Some of them perhaps intended to do so, or were on their way from recognition, to understanding and application. This is in accordance with Rogers’ description of the five stages that all individuals pass through as they adopt new ideas. Because this process takes more time for some, these individuals have not changed as much. Of course we cannot expect that everyone will adopt the innovation. Reaching everyone requires continued intervention in the form of, e.g., continued guidance and discussions.

Staff members who had recognised signs of gerotranscendence prior to intervention and described them as ‘normal’ signs were also those who put more of the guidelines into practice. The innovation attributes, described in the theoretical framework, can explain some of the problems with adopting the guidelines and why adoption was easier for those who already recognised and interpreted many signs as ‘normal’. For these ‘early adopters’, the guidelines were not so abstract; instead they met a need, helping staff in their treatment of the residents. Other staff required more time because they, using the terms of innovation theory, had to acquire both ‘awareness knowledge’ and ‘how-to knowledge’. For example, they needed to learn about the theory and incorporate this view of ageing before they could make use of the guidelines.

The innovation theory holds that prior conditions are of importance in the adoption process. It is also argued that individuals tend to expose themselves to ideas that are in accordance with their own interests and extant values. In this connection, the ‘early adopters’, as mentioned before, were those who felt acquainted with the essential ideas of the theory of gerotranscendence and acknowledged this as part of their own individual growth. The theory of gerotranscendence became a confirmation of signs they recognised in older people, and the guidelines therefore became a ‘solution’ for them, because they needed instructions on how to act. This study showed no differences in adoption of the guidelines between those who had and those who had no nursing training. The younger staff members tended to be the early adopters (early majority). The question, then, is whether new ideas are more easily introduced among staff with less experience. Perhaps they have not had time to establish a set of norms concerning how to perform care.

Rogers (1995) pointed out that the structure of a social system can facilitate or impede the diffusion of innovations in the system. The established behaviour patterns become the norms of the members of a social system. They define a range of tolerable behaviour and serve as a standard for the members of the social system. Such conformity norms might also explain why staff members were more likely to use guidelines applicable at
the individual level than those demanding co-operation among staff. Some of the guidelines affect some norms in the social system, and some norms are difficult to change. Organisational research in Swedish care has shown that among groups of nurse’s aides and assistant nurses conformity is important (Lindgren 1992), for example, the notion that all staff should engage in the same duties. Therefore, problems arise if some staff adopt new habits and start to give more time and attention to conversation with residents than to cleaning up. Szebehely (1995) described organisation of work in service houses as divided into sections as in a production line, such that staff are ‘sequentially dependent’ on one another. This supports the notion that it is difficult to introduce ideas that disturb the system. This can perhaps also explain why it is easier to use the individual guidelines while performing other duties.

Rogers (1995) also claimed that it is problematic for an individual to adopt an idea before the organisation has adopted it. One could, of course, discuss whether it is the staff or the organisation that decides whether an idea will be adopted. An organisation can decide that many things should be done and introduce new ideas. Here the organisation can facilitate an introduction and here the leader has an important role in facilitating and supporting new ideas, unless the leader shows clearly that he/she rejects these ideas. But in the end, the individual staff members have the last word; they can decide whether the new ideas will be used in practice. Getting new ideas to work in an organisation requires that several adopt them at roughly the same time. The leader also has an important role in managing the content of the work. In the present case, we can simplify the question as follows: what is most important, cleaning rooms or talking to the residents? What an individual staff member does in isolated situations does not provide the same impact on adoption of new ideas in the organisation, as when a decision is taken in the organisation about application of the guidelines. In Study IV, use of the guidelines began at the individual level, i.e., at the level of what each staff member could do in his/her performance of care. This may depend on the fact that individual staff members can decide what can be done and how, without co-operation with other staff, e.g. they can use the guidelines they like. As concerns activities, three factors are involved: co-operation with other staff, lack of correspondence with work norms, and perhaps a lack of specificity in the guidelines themselves. These work tasks are, of course, completely new to the staff. Initiating new activities is quite unfamiliar and abstract for staff, because they have not thought along this line before. Therefore this part of the guidelines must be made more specific. I think that in their present form, these guidelines do not have enough instructional value for the staff.
In Study IV, I was an observer on the ward and I spent some of my time as a facilitator, giving staff and care recipients support in whatever way was needed. By acting as a staff member in some situations, I showed that I had an understanding and knowledge of their area of work, which gave me credibility as a practitioner as well as a researcher. It was never my intention to fully participate, as this would have limited my ability to study the use of the guidelines. One practical dilemma was the staff turnover during the study period. This resulted in considerable time being spent on introducing new staff members to the guidelines. In the concluding remarks, I will address what it could have entailed if innovation theory had been used when planning this study.

The research process

The analysis of the nursing theories inspired me to try to do something of great instructional value that could be applied to the care of older people. I found that the theory of gerotranscendence was the most interesting theory of ageing to try to apply, because it offered a description of what the developmental process leads to, i.e., it describes what ageing positively can imply. Therefore it is also possible to discuss how the developmental process can be promoted. Yet I first needed to investigate whether staff working with older people recognised signs of gerotranscendence, and I also needed to understand how they addressed their care recipients.

Performing the interview study with staff (Study II) was a first step in this direction. Data collected in this study provided considerable knowledge of how staff members talk about the content of their work; more knowledge was gained in this study than was targeted by the specific questions in the study. For example, when staff described something about their behaviour toward the residents, many of them reported doing nothing in particular; they said that their behaviour mostly involved listening passively. Some described that they sometimes made comments to the residents or asked them questions. An impression was that many of the staff had not considered that speaking with residents might be an important aspect of their work. In general, they downplayed their own role in the contact with residents. The use of qualitative interviews gave a great deal of knowledge and an opportunity to follow up with questions related to the informants’ answers. In addition, I gained an understanding of the staff members’ work and of their thinking about their work. This was of great value and was used as a basis both for preparing for and for carrying out subsequent studies. It was important to conduct individual interviews, because they reveal so many different aspects. If focus group interviews had been used in this study
instead, this variation would probably not have appeared; instead the informants would likely have influenced one another and answered along the same lines. The interviews were conducted both with nursing home staff and with home care staff. What become clear to me was that it would be much more difficult to make observations in a home care setting, because I could only observe one staff person at a time and because home-care staff care for many more older people than do staff working on a nursing home ward. This influenced my decision to use a nursing home setting for the study on the innovation with the theory and guidelines (Study IV), as it appeared that it would be easier to carry out the study and observations there than in home care settings.

At the beginning, my aim was to use a quasi-experimental design in Study IV, with intervention for an experimental unit and no intervention for a control unit. This would, of course, have had methodological value for evaluation of the effects of intervention. But in practice it proved very difficult to find two identical or compatible units, and also to have control over these units regarding things that could influence the result. I gave great consideration to what could be measured and what possible differences might be found between an experimental unit and a control unit. I considered, for example, measuring work satisfaction, which guidelines staff put into practice, residents’ quality of life and so on. But what then would be the dependent variable? It could be changes in staff care, staff work satisfaction, the residents’ opinion of quality of care or whether the residents showed signs of developing towards gerotranscendence. When considering this, I realised that the most interesting approach would be to follow the process, and try to explain and discuss it, e.g. what happen, how and why?

While planning this study, I realised that it would be difficult to make quantitative measurements, so I decided, together with my supervisors, to use qualitative methods here as well. Furthermore, when studying different instruments for quality of life measurement and other such measures, it appeared that these are influenced by the activity theory and the continuity theory and also include many items dealing with medical symptoms.

During analysis of the data collected, I found Rogers’ innovation theory (Rogers 1995) useful, because it was interesting to study the process from an innovation theory perspective and to look at this at the individual staff level, as opposed to the group level. Thus, using the innovation theory, one does not only study the ‘before and after’, but the more interesting processual aspects. These aspects include how an innovation can be implemented and the factors influencing implementation. The use of this theory provided me with much more knowledge about the innovation process, and of course had I had this knowledge earlier, part of the introduction of the theory and the guidelines could have been conducted in a more stringent way.
Quality and trustworthiness

In all research, it is important to obtain results of high quality and trustworthiness. In quantitative research, the concepts validity, reliability and generalisability are used to describe the quality of studies. These positivist concepts are sometimes also used in qualitative research, but should preferably not be used, because they bring with them a quantitative logic not relevant in qualitative studies. Still other concepts are used to describe what characteristics ensure the quality and trustworthiness of qualitative studies. Grinnell (1997), for example, discussed three steps that are important to take during a qualitative analysis: establish your own credibility as a researcher, document what you have done to ensure consistency, and document what you have done to control biases and preconceptions. Lincoln and Guba (1985) mentioned the same characteristics in their four concepts, called criteria, when they described what is important for establishing the quality and trustworthiness of qualitative data and analysis. These criteria are: credibility, dependability, confirmability and transferability. These criteria are often used by qualitative nursing researchers (Polit & Hungler 1999), and are therefore well known in the field. Therefore, these criteria will be used here to discuss the quality and trustworthiness of the studies.

Credibility refers to people’s confidence in the truth of the data. This concerns carrying out the studies such that believability of findings is enhanced, but also in order to demonstrate credibility. Lincoln and Guba described several actions that can be taken to improve credibility: prolonged involvement, persistent observation, triangulation, peer debriefing and member checks. In this thesis, describing and illustrating the research process used and accounting for the data collection procedure and the steps in the analysis together constitute a way of establishing the credibility of the present work. In the studies, several steps were taken. In the interview study with staff (Study II), the second author performed parts of the analysis. In the study deriving the guidelines (Study III), a nursing colleague assisted as co-examiner and made a judgement concerning the arrangement of proposals into themes. In this study, even the references to other sources supporting the guidelines could be considered as a step that strengthens the credibility. In the study on the innovation with the theory and guidelines (Study IV), the observation period was relatively long, triangulation was used, both in data
collection and analysis, and informant checks with two of the staff were performed. Furthermore, the results of the studies have been discussed with supervisors and presented at seminars. This is in line with Sandelowski’s (1986) opinion that a qualitative study is credible when other people, for example, other researchers, recognise the experience described in the study, when they are confronted with the result.

Dependability is a criterion used to measure trustworthiness. This criterion is met when a researcher has demonstrated the credibility of the findings, in other words, there can be no dependability without credibility (Lincoln & Guba 1985). This relation is similar to that between validity and reliability in quantitative research, where there can be no validity without reliability. Polit and Hungler (1999) pointed out that a technique related to dependability is the inquiry audit. Here I argue that the detailed descriptions of the procedures constitute the most important method for establishing dependability in my studies.

Confirmability concerns the characteristics of the data and process criteria (Lincoln and Guba 1985). Lincoln and Guba pointed out that confirmability is achieved when data are linked to their sources such that the reader can understand how the interpretations and conclusions arise from the data. The steps taken to establish credibility involved describing, as clearly as possible, the data and phases of data analysis that led to the interpretations presented in the studies. I think sufficient credibility has been established for the present studies through detailed presentation of ‘raw data’, descriptions of analyses and explanations of how the theoretical framework has been used. But it is not certain that other researchers will agree with all my conclusions. Sandelowski (1998) took a more extreme stance when she argued that only the researcher who collected the data and has been immersed in them is able to confirm the findings.

Lincoln and Guba (1985) described transferability as the extent to which the findings can be transferred to other settings and groups. Both in the interview study with staff (Study II), and in the study on the innovation with the theory and guidelines (Study IV), the descriptions of the settings where the studies took place are of importance in evaluating whether the findings are transferable to other nursing homes, or to other settings for care of old people. For example, if the staff turnover had been low and all staff well educated, this would not correspond with the real situation in nursing homes in large cities in Sweden today. The use of innovation theory when describing the process in Study IV is a way to allow transfer of the present findings to other settings. This is because when we use a theoretical framework, the findings can be more comparable with other innovation studies in which concepts and findings are described in similar ways.
Use of theoretical framework

It is important to be aware of the importance of the choice of theoretical perspective in studies; a point of departure other than the theory of gerotranscendence would, of course, have influenced the interpretations and given another result. Yet I have clearly indicated all along that this is the theoretical framework I have used in Study II – IV. In this thesis, the theoretical perspective is clearly declared, which allows the reader to follow how the theory has influenced the studies, and also to understand that another theoretical perspective would have influenced the outcome.

Polit and Hungler (1999) claimed that a framework constitutes the conceptual underpinnings of a study. Further they stated that although not every study is based on a theory, every study has a framework, and yet this is not always made explicit and explicated. It is my opinion that clear declarations of the theoretical context in which researchers work, of the paradigm they start from and their preconceptions are often lacking in research reports and in the literature. And sometimes a theoretical perspective is used in research, but not clearly discussed in terms of what it implies for the study. Could it perhaps be the case that we often ‘forget’ to put the research into a theoretical framework or at least to declare our theoretical perspective? Or is it perhaps that many researchers are unconscious of what theoretical context they are working in and how this context may influence their interpretations?

In the interview study (Study II) and the study with the theory and guidelines (Study IV), the staff descriptions of signs and their behaviour could have been expressed and reported in their own words. This would have resulted in descriptions that are more ethnographic in character. Instead, in the present studies, a theoretical framework was used. This has several advantages. The theory helps to bring organisation to the findings such that they can be placed in, or linked to, a larger body of knowledge. Thus, the present results have been moved to a higher level. In these studies, what has been elucidated above all is how the theoretical context influenced staff. Moreover, using a theoretical framework, important factors in an innovation process appear more distinctly; this was especially true at the individual staff level in Study IV. Therefore I agree with Patton (1990), who stated that an analysis is greatly sharpened by the theoretical framework within which the study is conducted.
Ethical considerations and reflections

The ethical rules for humanistic-social science research (HSFR) in Sweden have been used as a point of departure for the studies (II - IV).

Before the studies began, the director of elderly care in the municipality was asked about the possibility of conducting the studies and a preliminary research plan was presented. After approval was obtained from the municipal director, the directors of the nursing home and home care, respectively, were contacted and informed about the interview study with staff (Study II).

In the interview study with staff (Study II), all staff members received information about the study before the interviews were carried out. The subjects were informed that their participation was voluntarily and that, if they wished, they could end the interview at any time without explanation. The first information was given at several staff meetings at each workplace. Thereafter, each staff member was asked about participation and an appointment for the interview was made.

In the study deriving guidelines (Study III), the focus group members were recruited on a voluntary basis from the different workplaces where an inquiry was made. One of these was the ward in the nursing home. Informed consent was obtained from all participants.

Before Study III took place, the first observations in Study IV were performed.

The innovation with theory and guidelines in a nursing home (Study IV) included observations prior to introduction of the guidelines. The municipal director of elderly care and two managers in the nursing home were informed about Study III and IV and how they would be carried out. After obtaining the approval of all three directors, all staff on the two wards included in the study were informed about my wish to participate in the care and to observe their daily work activities. This was accomplished at several staff meetings where they had the opportunity to ask questions. Thereafter, the staff were given one week to discuss the studies among themselves before the director asked if they approved of my participation in care.

After the agreement from staff, the residents were contacted. Before these contacts were made, the staff had informed me about which residents were suffering from dementia or aphasia and would therefore be impossible to interview. The staff introduced me to the residents, and each resident was informed individually about my wish to interview them and participate in the
care. The information was given both orally and in written form. Some days after they received the information, they were asked whether they were willing to be interviewed and whether they accepted my presence on the ward; all residents accepted. The following week, relatives of the residents were informed at an ordinary meeting held for them in the nursing home.

At this point, all were informed about the interview and observations aimed at examining the present care situation. Only the directors were introduced to the idea of introducing the theory and the coming guidelines, which had not yet been derived.

When the interviews and initial observations were finished, staff were asked about possible participation in a coming study, and they were introduced to the idea of deriving guidelines from the theory and trying to introduce them in practical care. After general information was presented to staff at staff meetings and in informal discussions, they had the opportunity to consider the matter. Thereafter the directors asked them whether they were willing to participate, and they were.

At this point, the staff were introduced to the theory of gerotranscendence and those who wished participated in a focus group to derive guidelines.

When the guidelines were derived, they were discussed and introduced to the staff. The residents were informed that the staff were involved in a research project that may entail some changes in staff behaviour; staff may start talking about new topics or offer them different activities. They were encouraged to tell whether there was anything they did not like and they were also informed that participation in all activities was voluntarily.

This project includes some very special ethical considerations, shortly addressed in the following. Doing research in a nursing home entails working in old people’s own home. Older people living in nursing homes have suffered physical disabilities and have diseases, and are therefore dependent on staff and care. It was important to make clear that my presence on the ward and especially in their own rooms was something they not should feel forced to consent to, instead it was something with regard to which they could have opinions and make decisions. Therefore, in the beginning of the project, I always asked each individual whether they would permit me to be in their room, and I avoided being present during more intimate situations, such as toilet visits. The more time I spent in the nursing home, the more acquainted with the residents I became, and many residents showed their interest in and appreciation of my presence. Becoming acquainted with them was also an ethical dilemma, because I would only be on the ward a limited time, and thereafter not be there regularly. For those residents who appreciated talking with me, my sudden disappearance may have been perceived as deceitful. I have, therefore, on several occasions,
visited the ward, and had informal talks with some residents after the study was finished.

Informed consent was problematic, as the participants could not be fully informed at the very beginning of the project. This was because at the beginning of the project all details had not been outlined and also because it was necessary that the initial interview and observations be conducted prior to introduction to the theory. But the ethics of this procedure could be called into question, as this step-by-step design made my presence in the nursing home increasingly natural, and this may have made it difficult both for staff and for residents to decline participation in the study. Yet during the course of the project more information was provided, as described above. Also with regard to the final stage of observation, there was a question concerning how much the observed staff should know about the observations and the purpose of conducting them. Providing information during a study is called process informed consent (Streubert Speziale & Rinaldi Carpenter, 2003) and is appropriate in this sort of qualitative study.

Another ethical dilemma concerns the practice of grouping staff into the adopter categories, which was done in Study IV, this could signify a possibility to identify individual staff members, which could be experienced as negative by the staff. This grouping was not planned at the time when data were collected, but during the analysis phase grouping the staff appeared as the most relevant way to show the result. The descriptions of individuals have been made so that it would be difficult to identify individual staff members.

Sometimes I was forced, for ethical reasons, to relinquish my role as observer and act as a professional nurse. For example, staff sometimes asked me about how they ought to act in particular care situations, and in some care situations I acted as a nurse. When I, on a few occasions, observed new medical symptoms or needs, I reported these to the ordinary nurse in charge. However, I did not find this to be problematic.
Concluding remarks

The review of nursing theories in the nursing theory study (Study I) highlights some areas of interest for further discussion: theoretical descriptions of human ageing and their general implications, their specific implications for care of older people and their instructional value for nursing practice.

Most of the nursing theorists presented in Study I have explicitly or implicitly adopted a developmental perspective. However, the implications of this development and the outcome of development are not described. Nor have the theorists provided any insight into how they perceive ageing. However, some of the nursing theorists have presented several descriptions of human development in their theories. Benner and Wrubel, as well as King, Leininger, Newman, Peplau, Rogers, Roy, Travelbee and Watson have all expressed the opinion that early experiences and events influence the way in which the individual experiences and reacts to events later in life. That is, the past influences the manner in which the individual develops, and this in turn influences how the individual reacts to different life events and also to the stress experienced during illness and crises. Their descriptions of human development only contain a very general description of what human development towards old age entails and what it is influenced by. Some theorists, such as Benner and Wrubel, and King and Travelbee, have also mentioned that crises can present an opportunity for personal development. These theories also describe human development in terms of a life-cycle perspective. They seem to indicate that people develop throughout the life span, even during old age, but do not describe how. They lack an underlying foundation in which the significance and meaning of ageing is described. One can interpret these theories as claiming that even older people have possible paths of development. But they do not discuss the possible outcomes of the development, or how such outcomes might be attained, and they only indirectly discuss what aspects should be taken into consideration in nursing care.

Two of the studied nursing theorists, King and Roy, have indicated that their theories were inspired by E. Erikson’s psychodynamic theory of human development (Erikson 1950, 1982). Thus, these theories had an underlying foundation, wherein human development is described. One might expect,
therefore, that King’s and Roy’s theories would have contained more practical applications to care for the elderly, but this is not the case. Yet parts of these theories could, in principle, be developed further and made more specific with regard to care of older people, as they discuss human development towards old age. Erikson described a development during the entire lifetime and pointed out that this development could result in attainment of a state of wisdom. However, Erikson did not actually describe what he meant by wisdom. Because a definition of wisdom is lacking, it is difficult to know how older people can attain it, and what staff could do to promote it. But Erikson did describe different crises and the need for individuals to resolve such crises if they are to achieve ego integrity. This points to the important role gerontological care could have in helping older people understand their lives and develop.

Yet it has been of no practical help that these theories have an underlying foundation when they have failed to describe anything that might be of specific importance in the care of older people. This is, however, something one might have expected in theories such as these. Thus, regardless of whether the theories have an underlying foundation, they have not, yet, helped us gain practical knowledge about what is important in the care of older people.

We can conclude from the nursing theory study (Study I) that none of the studied theories contain suggestions regarding how care for older people should be structured. Neither do they mention what course of actions should be taken into consideration or how to promote the developmental process. Thus even theories that should perhaps have addressed these practical aspects – theories with underlying foundations or that view human development in a life-cycle perspective – have failed to do so. It is left to the nurse to build the bridge between theory and practice.

Nursing theorists have taken individuality in care into account and mentioned the importance of structuring nursing on the basis of each individual’s needs. Since individually structured care is strongly emphasised, it is stressed that the needs of the patient should constitute the basis for nursing. They leave it to each nurse, however, to decide what needs are important. The nursing theorists have provided no practical guidance concerning care of older people, but only raised general issues, e.g., that the nurse should help the individual put earlier experiences to use or assist the patient in his/her development. It is perhaps not surprising that the issue of care of older people is absent from the discussion, as the theorists have not addressed the aged specifically, instead they seem to be age blind. On the whole, if we consider the number of older people in need of nursing care, it is surprising how little the ageing process is discussed in nursing theories.
One might expect that nursing theories would more specifically address how to care for patients with different needs. I have studied care of the elderly, but perhaps this criticism applies to all areas of care: nursing theories are too general and do not provide any precise instructions. The reason the theories are so general is probably because they are intended to cover as broad an area as possible. Thus, they are supposed to cover different patient groups, both young and old patients, patients with different diseases as well as with handicaps. Furthermore, they have also been used to define the area of nursing care.

In summary, no specific guidance can be found in the studied theories regarding how the nurse can help older people in their individual growth or how to address older individuals. We can, on the other hand, read these theories as meaning that old people have needs other than the physical, and that nursing care should take this fact into consideration. But the assumption that individuals develop and have different needs is not accompanied by information on what these needs are and how they can be met. Thus, the nursing theories have very low instructional value; their relevance to the care of older people resides in their descriptions of all-embracing aspects.

This absence of practical guidance, regarding how nurses could behave and what actions can be taken to support old people in the developmental process of ageing, highlights the need to address further the issue of how gerontological care should be provided. It also provides inspiration for the development of a nursing theory based on an ageing theory in which development into old age is included. It could be of great value to discuss and develop nursing knowledge and more concrete nursing theories or practical models. Here, we can also discuss what gerontological care should include. As regards care of the elderly, I argue that it is important to not only focus on medical care but also on supporting old people in their development and personal growth. There is no opposition here, instead both components are necessary and important. But I cannot help wondering why there are so few concrete instructions on how to perform nursing care of elderly.

Nursing care must include an understanding of the needs brought about by a changed life perspective. Thus, practical care must take into consideration and show respect for older people’s changed perspective and the particular needs this change implies. What has been lacking here, quite simply, is a new nursing care model based on specific theories of human ageing, which could provide instruction for staff on what is important in care of older people.

Tierney (1998) critically discussed whether extant nursing theories and models have relevance today, and stated that without theory there is no sense of place for new knowledge and no clarity of overall direction for development of the nursing discipline. This is clearly a discussion worth
continuing. I would like to add to this discussion an important point: nursing care needs theories of a different scope. It needs conceptual models that describe more generally the nursing care area and theories that could be used in practice. These are not mutually exclusive; there is a need to develop more theories that can be used in practice.

The nursing theories contain an overall description of the content of care and nursing. One could say that they define the area of nursing. The theories should be seen in a historical perspective, which helps us to understand that part of their purpose was to define nursing, and in this sense they are important. Yet it is also important to continue developing extant nursing theories as well as new ones.

My observations suggest that many nurses simply claim that theories are unnecessary and toss them aside. I am of the opinion that this is because much of the discussion on nursing theories has put too much emphasis on content analysis of theoretical statements and concepts and too little on evaluating their applicability. It would seem that the next step in nursing should be to develop new nursing theories or to further develop extant theories so they can be used in practice.

If we return to the ageing theories introduced in the theoretical framework, we can establish that other measures have been deemed important in care for the elderly. According to the activity perspective, interventions should involve activating the old person and encouraging greater social interaction. According to a disengagement perspective, the aged individual should reduce activities and social roles, thus staff should be passive. According to a continuity perspective, nursing interventions should help the individual to cope and to continue earlier life patterns, or to find new roles. And according to Erikson’s psychodynamic perspective, one role for staff could be to help old people reflect upon and sum up their lives. The above is, of course, just a brief comparison, but it does show that the measures considered important in care of the elderly are largely dependent on one’s perspective, or theoretical view, on the meaning of ageing.

Thus, the derived guidelines do propose something quite different from what is regarded as important in the care of older people based on other theoretical perspectives. It should be possible to take the other ageing theories and translate these into guidelines as well. However, it is important to keep in mind that different theories will result in different guidelines, and therefore different toolboxes. And my opinion is that we need to develop guidelines for many more theories within different care areas. By developing guidelines it will be apparent for staff what different theories imply in practice. If different toolboxes are offered to staff, they have the opportunity to choose what is best suited to the work they do. A question of interest, then, concerns the consequences of giving staff toolboxes with concrete
guidelines from different ageing theories. Because the different theories are in opposition, their respective toolboxes will offer quite different guidelines that contradict each other on many points. One option is to allow staff to choose which guidelines they want to use, perhaps by deciding to use one perspective and proclaiming this clearly. For example, a nursing home could decide to announce that it works in accordance with one theory. Another possible outcome is that individual staff could use different guidelines in the care of different residents. That is, theories would be used to design individual care. In the latter case, we could say that the toolboxes with guidelines from different theories supplement each other, and also promote care that is tailored to the individual. But this requires that staff have the knowledge and capacity to choose, otherwise such a mixing of theories might instead lead to confusion and frustration.

The theoretical perspectives on ageing and how to accomplish care are perhaps ideas of which staff members are unaware, the result in the interview study with staff (Study II) partially supports this notion. Staff members are not aware of the theoretical perspectives influencing them to various degrees. Staff can perform care without thinking about why they behave in a certain manner. This applies particularly to how they address older people and to the topics of conversation they choose. A Swedish report called attention to the fact that staff felt they had too little education in how to provide good treatment in the care of older people (SoS 1997). Thus staff in gerontological care are in need of more knowledge about ageing theories and what these theories imply in practice; they are, of course, also in need of different practical toolboxes/sets of guidelines.

In the introduction of the theory and guidelines to staff in a nursing home, which was carried out in the study on innovation with theory and guidelines (Study IV), the basic requirement was to give staff knowledge about the theory of gerotranscendence. This involved letting them become familiar with the view of ageing introduced by the theory of gerotranscendence, e.g., giving them a theoretical base and instructions on how to behave in practice. This constituted one method of training staff about one way of providing treatment of older people from the perspective of gerotranscendence. Therefore, staff members were introduced to the theory and the guidelines, the goal being that they should incorporate this perspective into their own views on what normal ageing can be and how ageing can be expressed and how they could promote the process of gerotranscendence. In the nursing home in which the study took place, care was influenced by an activity perspective. The guidelines were introduced with the aim that they would be used as a supplement to enrich the care of older people, but not as a replacement for the present care.
Earlier I posed the question of who is responsible for the content of care of older people. I still have no answer. Of course many things play a part, such as norms in society and norms in care. The individual staff member is very important, because how staff treat the resident and perform the care matters for the individual resident. Here, I wish to return to what I argued earlier, that staff need more knowledge about ageing theories and what they imply, and that they need toolboxes showing how to use these theories in practice. Staff members are perhaps also in need of more knowledge about many other things if they are to have the opportunity to perform good care. This points to other important aspects, namely staff education and staff turnover. If elderly care is to include more than cleaning and very basic care, we need to improve the care and we cannot regard each staff member as interchangeable with just anyone.

When introducing an innovation, it would seem to be important to take both individual and organisational aspects into consideration. This study has focused primarily on individual staff and not examined the leadership role. With regard to the present study, it is interesting to note that the managers did not appear to be engaged in the care or to promote the process, and that, during the intervention period, there was a change in leadership at the managerial level.

When introducing an innovation similar to the present one, it would seem wise to identify potential early adopters at an early phase of the project and to try to make use of them. Early adopters, if they are able to influence other staff members, could help in promoting and facilitating the innovation process. Identifying the laggards might also be of importance, as providing them with more ‘awareness knowledge’ could promote their adoption.

It might also be of value to think in innovation theory terms in all contexts in which new ideas and routines are introduced. If you understand how innovations will be met and have knowledge about the process of adoption, you can plan the intervention process better and have realistic expectations about the result and the time required for an innovation to be adopted. Thus the innovation theory could be of general interest in all contexts in which work towards change is being conducted.

For example, in the study on the innovation with the theory and guidelines (Study IV), the introduction could have been planned more in accordance with Rogers’ descriptions of the five stages through which an individual passes when adopting new practices. If I had determined each staff member’s starting point, I could have tried to provide more individualised instructions, tailored to each person’s progress with the guidelines. Another possible way to increase the speed of adoption could have been to identify the early adopters and use them to influence the others.
Involvement on the part of the manager could be an important organisational factor, because it could promote and facilitate the innovation.

In these studies, I have shown the process of introduction as well as the particular difficulties of introducing an abstract innovation and of introducing change in a care organisation. Thus, these studies have revealed how many factors are involved in work towards change. It is not merely a question of providing staff with knowledge about a particular thing, as in this case about the theory of gerotranscendence and the guidelines. It is, instead, quite complex and several factors influence whether an innovation will have an impact.

The most important finding of this thesis is that it was possible to translate a theory such that it could generate practical guidelines, a toolbox, that could be used by the staff. I argue that this could be done with many other theories, not only ageing theories. This, I argue, could be done with regard to many more aspects of care, and within different areas of care. There are, naturally, many areas of care in which translation of theories to practical guidelines could help staff. There are probably many theories that could be translated in order to be implemented in practical care, e.g., to build a bridge between theory and practice, thereby helping staff. I am of the opinion that translating theories and offering them to staff for use in practical situations constitutes one important way to improve and develop care. Individual staff members should not themselves need to build the bridge between theory and practice; this is a passage they should be offered.

With this thesis I hope I have begun a discussion on the potential of deriving guidelines from theories as well as on the advantages of thinking in terms of innovation theory when introducing new ideas.
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References


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Appendix

Direct observation note

*Tuesday 07.10*

(Staff indicated by capital letters, residents by numbers)

'B' and 'H' are in the kitchen looking at the staff schedule (hanging on the wall). They discuss and count out loud to each other regarding which people are working today and what time they start work.

'B' writes a list of staff working the morning shift.

'B' and 'H' discuss what each resident needs help with in the morning. In connection to each staff name, 'B' writes names of residents and assigns, in this way, who will take care of each resident.

'H': - '4' is so tiresome and such a whiner, I can’t deal with caring for her today

'D' knocks at ‘5’’s’ door, and walks immediately into the room without waiting for an answer. It is dark inside the room; the Venetian blinds are closed. ‘5’ is in bed

‘D’: - Good morning, did you dream about anything last night?

Interpretative notes

There is a tense feeling between ‘B’ and ‘H’ when they are discussing how to share the work this morning
‘5’: - Yes, strangely enough, I did, I don’t dream frequently, but I don’t want to tell you about what I dream. I would like to know what the weather is like today. Will you please open the Venetian blinds.

‘D’: - It’s a sunny day, but a little cold in the morning, she says and starts to open the Venetian blinds.

She continues by describing for ‘5’ that she had frozen when waiting for the bus in the morning.

‘5’: - Oh I like that I don’t have to go out every day in the mornings nowadays and instead can enjoy staying in bed and sleeping longer in the mornings.

‘D’ tries to use one guideline and does not talk about health.

The fact is that he can’t get out of bed by himself. He seems to like the story about the cold morning.
Thursday 8.00

‘E’ knocks on ‘3’s’ door.

‘3’; - Come in
‘E’; - How are you today?

‘3’; - I’ve already got up. My knees hurt

‘3’ is sitting in her armchair with an electric pad on her knees.

‘E’; - I’m sorry to hear that you always have pain

‘3’; - I want to die. Why can’t I be allowed to pass away, all my relatives are dead and I’m so old, why must I sit here, when I want to pass away?

‘E’; - Oh you’re not so ill. You can do a lot of things by yourself. You are one of the healthiest residents here. It’s not so bad; you can do a lot of things and manage yourself. Think of that.

‘E’; - I’ll make your bed

‘E’ makes the bed

‘E’; - Will you go out and eat your breakfast now?

E offers to help ‘3’ get up

‘E’ leads the conversation away from death to a discussion about health and activity
Direct observation notes

Thursday 13.30

In the dayroom
It is quiet and calm in the dayroom

‘C’ and ‘2’ are sitting in the dayroom on the couch. They look together in a book with old photos from the town and talk about them.

‘C’: - Please, tell me something about what you remember about this house and block from your childhood. I love to hear you talk about the past.

‘2’ – Of course, then I was a little girl and I grew up near this house. I have many memories…. When I look at this photo I start to think of all the happy times we had there. You know we were eight children in our family and there were many children in all families, so I always had someone to play with.

‘2’ continues to talk about her childhood

Interpretative notes

I am in the kitchen next to the dayroom and hear most of the conversation

‘C’ encouraged ‘2’ to talk about her childhood and old times.
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