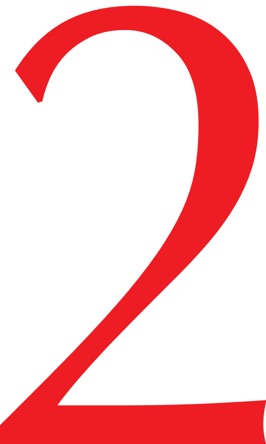

Abstract
The aim of this study was to describe the biopolitics of involvement discourses articulated by nursing staff concerning relatives in nursing home institutions, using a Foucault-inspired discourse analytical approach. Previous research has described how relatives have not been involved in nursing homes on their own terms. This is partly due to a lack of communication and knowledge, but it is also a consequence of an unclear organizational structure. Results from a discourse analysis of six focus group interviews with nursing staff show that the "involvement discourse" in nursing homes can be described as a "new" vs "old" family rhetoric. This rhetoric can be said to uphold, legitimize and provide different subject positions for both nursing staff and relatives concerning the conditions for involvement in nursing homes. As part of a "project of possibility" in elderly care, it may be possible to adopt a critical pedagogical approach among nursing staff in order to educate, strengthen and support them in reflecting on their professional norming and how it conditions the involvement of relatives.

Key Words discourse analysis, focus group interviews, involvement, nursing home, nursing staff

Replicating the Family: The Biopolitics of Involvement Discourses Concerning Relatives in Nursing Home Institutions

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According to Swedish law, all health care should be provided with respect for and considering the dignity of the individual, and contribute to health and well-being among the care recipients.[1,2] Accordingly, the involvement of relatives in nursing homes is an important element in holistic and individualized care,[3,4] for the residents' psychosocial well-being[5,6] as well as for the development of high quality nursing home care.[7,8]

In Sweden, approximately 90 000 persons over the age of 65 live in nursing homes.[9] Today it's basically just the most acutely ill persons who end their lives in nursing homes. As a supplement to municipal efforts, relatives play a crucial supporting role as informal caregivers while the older person lives at home.[10]

Previous research on the involvement of relatives in nursing homes shows that relatives want to continue being involved in the care of their older family members even after they move to an institution.[11,12] Studies have described how the move sometimes involves a transition for both the residents and their relatives as new relationships are formed with the nursing staff.[13,14] Due to the move and the form of care in nursing homes, relatives who have previously played a significant role are expected to transfer care responsibilities to the nursing home staff. This implies that the earlier care by family members, which complemented the municipal care, is demoted in importance in the context of the nursing home.[15] Many relatives find it a relief to have their older family members cared for professionally, and they accept the need for a transition in roles.[16,17]

However, some relatives find it difficult to understand

what is expected of them in the nursing home and do not understand how they can best continue being involved. This leads to conflict between family members, the nursing staff and heads of units responsible for the nursing homes.[3] Previous studies argue that this conflict may be due to a lack of a philosophy of care and unclear guidelines on how family members can be involved[18] within the framework of what is legally possible.[1,2] The nursing staff sometimes feel that relatives make unreasonable care demands, which leads to the description of relatives as "challenging" or "difficult".[12] The relatives, in turn, do not feel that their views are valued[19] and feel they are mainly regarded as "visitors" whose role includes only limited involvement.[20] Researchers have pointed to the need for new approaches that will improve and facilitate the involvement of relatives in practice.[14,21]

Research on the involvement of relatives has been going on for several decades.[3,22-24] However, such research still appears to lack certain perspectives. To our knowledge, up to date studies with a more explicit critical stance that address the involvement of relatives in nursing homes are almost totally absent.[cf. 18] More critical research is needed in order to enhance the quality of nursing home care by focusing on the involvement of relatives.

In line with a critical research approach, Michel Foucault[25] offers some perspectives that may be valuable as a theoretical framework. Such a framework has been utilized in this study. In general, Foucault's theory of power is a useful tool when studying the biopolitics of public welfare-state institutions such as nursing homes, and specifically when studying upholding discursive practices governing such institutions.[26,27] To facilitate the understanding of this framework, we will briefly describe the most important and relevant concepts underpinning Foucault's theory of power,[25] such as discourse, power/knowledge, and biopolitics. We do not claim that this presentation is in any way exhaustive.

Theoretical framework

In examining the discourse on involvement in this paper, we start from Foucault's[25] views about power as being relationships in societies expressed through language and practices. In other words, a set of statements or practices that systematically constructs the objects of which it speaks. The power in the form of discourses controls the ways in which we can express ourselves, act and think, and each discourse has its own limitations. The discourses produce both truths and subjects in this way. Different discourses enable different subject positions and it is not possible to be outside a discourse. In this way, subjects (nursing staff and relatives) reproduce the discourse on involvement at the same time they are constructed by them.

To Foucault,[27] the concepts of power/knowledge are inseparable. It takes power to produce knowledge, and knowledge itself produces power relations. Foucault claims that power is pervasive and involves all aspects of social interaction. Power is thus relational, without an absolute center, and it is irrelevant who holds the discourse on involvement. This means that power is not directed against the subjects themselves (nursing staff and relatives) but toward subjects' possible actions. Accordingly, this study does not seek to make the nursing staff accountable when they as well as relatives are governed by the "involvement discourse". Instead of studying power top down, Foucault[27] focuses on how knowledge in the form of discourses operates and produces "truth" and subjects. Foucault argues that power is productive and not always negative in an oppressive and sovereign manner. Power is not an institution, but may be exercised within institutions such as nursing homes, as shown in this paper. As soon as there is a purpose and a goal, power is exercised in relations. While the discourse on involvement is influenced by power, it also reproduces power through linguistic representations. Foucault stresses that we only have access to reality through language. It is through representations that we produce discourses that are never reflections of a preexisting reality. Power in the form of biopolitics[26] is thus exercised through language, which is expressed among the nursing staff.

Biopolitics, according to Foucault,[26,27] is the modern state's control of citizens' lives and health. The biopolitical strategy is communicated and maintained through language and is imposed through various social institutions. Historically, knowledge has been established in the form of public health programs, with a view to controlling people's behavior.[26,28] Biopolitics thus involves the entire lifespan and constitutes the link between the subject, social institutions, expertise and practice. Foucault[27] further describes how biopolitics intends to construct a modern, self-regulating and responsible subject. In line with this, he has also linked biopolitics to the medical discourse and described how the lives of people are governed and affected by the status in society of the medical sciences as guide and "bearer of truth".

In this paper, we will address the "involvement discourse" as part of a biopolitical strategy in the care of the elderly that relates to a governmentality. We also assume that biopolitics

and issues related to what happens in later life are closely linked, where biopolitics is one way to control the discourse on involvement. There are for example discourses on what to eat, and that one should exercise and what is considered old age and how later life should be lived.[29] These discourses are launched and sustained through language by using scientific knowledge, which in itself becomes a force with various biopolitical meanings. Part of these aging discourses can also occur when one is a relative of someone who moves to a nursing home and there is a meeting with the nursing home, creating a discourse on how the family can be involved.

Language, knowledge and power may play a central role for relatives in the meeting with a nursing home, because the discourse that is created conditions their involvement. The aim of this paper is thus to describe the biopolitics of involvement discourses articulated by nursing staff concerning relatives in nursing home institutions, using a Foucault-inspired discourse analytical approach.

A Foucauldian-inspired discourse analysis

In this paper, we have used Allen and Hardin's[30] step-by-step analysis about how to conduct a foucauldian data analysis within the field of nursing science[a]. A foucauldian analysis focuses on power relationships in societies as expressed through the intimate connection between language and practices.[25] This approach focuses on analyzing *how* power is exercised and how it can be understood, rather than studying *who* is in power. Before we describe the data analysis, a short overview of participating informants is provided and a description of how the focus group interviews on which the analysis is based were conducted.

As part of a larger ethnographic project, 27 nursing staff members from three nursing homes in central Sweden were recruited for focus group interviews. The intent of conducting focus group interviews was to study how the nursing staffs collectively constructed meaning of the involvement of relatives, rather than their individual perceptions.[cf.31] Each head of unit in the nursing homes was informed that we wanted to interview approximately 30 nursing staff in groups of four to five people. The informants were to be Swedish speaking, permanent employees of the nursing homes, and actively engaged in nursing care practice. We also wanted the focus groups to be as heterogeneous as possible in terms of gender, professional affiliation, ethnicity, age and work experience. This was to capture a diversity of opinions and perspectives about involvement.[cf.31] The result was six groups, two from each of the three nursing homes. There were a total of 27 nursing staff members, 26 women and one man, originating from Europe and Asia and aged 36-63 years. Their work experience varied from two to eighteen years and their workload varied from 37%-100%. All informants received both oral and written information about the purpose of the study before giving informed consent. They were told that their participation was voluntary and that they could withdraw their participation at any time without any restriction.

The focus group interviews were conducted as six sessions during one month in early 2011. The interviews took place in connection with the nursing staffs' regular shifts. The first (JH) and last (HE) authors conducted the interviews together. The interviews took place in reserved staff rooms and coffee rooms in the nursing homes, where the interviews could be carried out privately and undisturbed. The interviews lasted between 59 minutes and one-and-a-half hours, with an average of 75 minutes. Each interview began by asking the nursing staff member to describe what her or his work in the nursing home consisted of during an ordinary day. Their stories always included relatives in one way or another. Based on this, we asked questions related to relatives' involvement in care activities. In an attempt to avoid taking for granted things the nursing staff discussed, we felt it was important to let them speak uninterrupted while we asked naive clarifying follow-up questions. The interviews alluded to the complex situations where the perceptions of relatives and the nursing staffs diverged. For instance, we asked what would happen if relatives presented a suggestion and what responsibility nursing staff and relatives had for the residents feeling well. Each interview ended with an open-ended question asking if the interviewee wanted to add to, modify or withdraw any of what was said during the interview. No one wanted to take back anything that had been said. However, the interviews often ended with informants beginning to expand their reasoning and sometimes they also started to talk about other things. The interviews were conducted in Swedish, as authors and informants spoke Swedish. All interviews were digitally recorded and transcribed verbatim by the first author.

Data analysis

Based on the foucauldian theoretical framework, presented in the background section, we analyzed the focus group interviews, focusing on three starting points as outlined by Allen and Hardin.[30] The starting points focus on linking language with practice, asking social and historical questions and creating public models of subjectivity. Based on these methodological implications, the following questions led us

through the analysis:

•What differences do the nursing staff mark and construct through their language linked to the practice of involvement for relatives in the nursing homes? What "involvement discourse" is identifiable?

•What other groups or institutions in the society have historically marked and constructed differences in a similar way and what are the consequences?

•What possible subject positions are available for relatives, based on the "involvement discourse"?

The analysis started with naïve readings of all the transcripts by the first author. After intuitive understanding of the overall content, the first author together with the last author started by asking the first question of the data. Passages that were explicit about involvement were used as points of departure for identifying key statements that were repeatedly used and shared in the transcripts. These key statements were marked and discussed in relation to this question. An excerpt from the interview data may serve as an example of this process:

> Lucy: What I might think is difficult, is when the expectations and wishes of the relatives don't correspond with the residents' [wishes] because it's not at all unusual. The resident wants it in one way, and then comes the relatives here and tells that, that is not the way it's going to be, my mother or father are going to be cared for in this way.

In the quote above, we identified the key statements that upheld the shared language about involvement. The key statements constituted the naturalistic generating structure that accompanied the "involvement discourse" that we wanted to identify. In this example, we noted key statements such as "difficult", "expectations", "don't correspond" and "comes the relatives here and tells".

After this identification of key statements, we condensed transcripts in relation to the process in the first stage of analysis. The first and last author addressed the second question using the gathered material. In this analysis, the first author read the condensed transcript again, constantly discussing with the last author how the key statements could be understood as techniques used in a broader "involvement discourse". Based on how it was guided, we made a genealogical attempt to understand the "involvement discourse" in a historical and social context. The key statements were put in a broader context. For example, we noted that the specifics of the "involvement discourse" could be related to several other institutions and to an overall assumption of a "caring state", such as psychiatric health care facilities, foster home institutions and boarding schools. This analysis was then discussed among all the co-authors.

After consensus in relation to the second question, the first author went back to transcripts, condensed transcripts, memos and notes from the discussions concerning question one and two and focused on the third question. This step in the analysis process was driven by an interest in interpreting the key statements we previously structured as "difficult", "expectations", "don't correspond" and "comes the relatives here and tells", as concepts that were defining the available social positions for relatives. In this we applied an alternative reading of the meaning of the concepts where we distanced the wordings as they had been used by the informants to create an alternative understanding of the techniques used in the discourse on involvement and how it was guided. For example, the constant use of family as a concept has a specific meaning for the nursing staff, but we distanced the concept from their use and related it to various public models of "a family" in plural, defining the specifics of the concept and interpreted in relation to our previous analysis. The analysis was again discussed among all the co-authors. Three assumptions were identified that uphold the biopolitics in "involvement discourses" concerning relatives in nursing home institutions. These are presented in the results.

Research ethics board approval

The study was granted approval by the Regional Ethical Review Board [No 2010/658-31/5] and ethical considerations are in accordance with the Declaration of Helsinki.[32] In order to protect the informants' integrity, their names, ages, nationalities, professions and places mentioned in the interviews were encoded.

Results

Three assumptions upholding the "involvement discourse" were interpreted as "*we are family", "for the residents' best interests",* and *"with the mandate to care*". The specifics of the "involvement discourse" had a point of departure from within the resident's family. Through the language, the nursing staff were placing themselves *in* the relations of the resident's family structure. The motive for this was presented as this being the position that best served the interests of the residents. Underpinning this was a dualistic reasoning about formal and informal care.

We are a family

The central and influential discourse in all focus group interviews was the construct of the residents being a part of an

already existing family formation in the nursing home culture. As the "old" family, relatives were sometimes constructed as "has beens" in favor of the nursing staff. The nursing staff ascribed to themselves a significant role in the provision of care for the residents from the moment the resident arrived at the nursing home. This was clearly expressed in the third focus group interview:

> JH: So in general…what responsibility do the nursing staff have to support the residents to have a good life?
>
> Judy: A lot of responsibility.
>
> JH: Yes.
>
> Judy: You have a 100% responsibility because, what should I say… you are a mother, a caregiver, psychologist, a friend, relatives, you are everything. I think that this job is the most complex job among all caregiver jobs, to work as a professional caregiver or as a nurse you know…Nurses are kind of more distant [in relation to the residents] but enrolled nurses and nursing assistants are so close, so close. No money could pay for this responsibility.
>
> Karen: And we who work in a nursing home, they [the residents] become as part of a family.
>
> Judy: Yes they are.

The family as referred to in the interview seemed to constitute a fundamental position from which the nursing staff defined their responsibility, based on what it meant to be "part of a family". The coalition between them and the residents was also upheld and legitimized by them being professional caregivers with "100%" responsibility".

This practice was inevitably linked to the conditions of relatives' involvement, since it operated continuously and functioned as conditional for the relatives as "new" family members. The following excerpt from the fifth focus group interview illustrates the reasoning of some nursing staff about the significance of past relationships between relatives and residents. Laura told the following:

> Laura: We kind of end up in these family tragedies so…, they…have a collectively need of…
>
> Zoe: Punish [the nursing staff].
>
> Laura: Yes and a collectively need for therapy [laughs] yes… I think that they would need to go in some kind of therapy. There are many in that generation that is… daughters and sons that were fostered during a tough period and they would need therapy. It's the way you feel, see someone and blurt it out, it is precarious. There is a frustration that must seep out somewhere.
>
> JH: How important are the relationships between the residents and their relatives?
>
> Zoe: Oh well…
>
> Laura: The relational aspect is always important.
>
> Zoe: Even when it works.
>
> JH: Yes.
>
> Laura: Then it's fantastic. Everything runs smoothly. Then the relation between us [nursing staff and relatives] turns out good… if people have had good relations to their mothers or fathers they are satisfied.
>
> JH: Mm…
>
> Laura: Then they [relatives] possess the social skills, they have brought with them from home [laughs] how to behave properly.

As shown in the conversation above, when Laura says "We kind of end up in these family tragedies" it was stated that the nursing staff took a step into the families and engaged in relationships in the "old" families of the residents. In this way the nursing staff had a central subject position on different levels, where they knew just as much about the residents as their "old" families. "To care for" meant not only taking care of the residents, but also collectively engaging in all areas of their "old" family's responsibilities, fully and wholeheartedly. The nursing staff further spoke partly based on their own experience and partly based on something that they marked as common sense.

For the residents' best interests

During the focus group interviews we were also told that the nursing staff mostly listened to what the residents wanted and desired, or more specifically what the nursing staff thought was the best for the residents. They told us about several situations where relatives had views on the residents' care that the staff marked as different from the residents' perceptions and desires. It might apply to what the resident would wear, how often s/he would take a shower, or when the resident should nap or what s/he should have for dinner. The fifth focus group illustrates how the nursing staff reason about who to listen to when relatives have comments about care activities:

> JH: So what do you do if a resident has not showered in five weeks but relatives want them to do it?
>
> Laura: Then we talk to family members about why.
>
> Annie: We're not supposed to listen to relatives.
>
> Jamie: It is not the relatives who should decide, it is the residents who will decide.
>
> Laura: No, maybe then they go in to the resident themselves, and try to persuade them [to take a shower] [laughs] ... I believe that family members can join in with familiar strong persuasion. But it does not concern ourselves with what they do in the family so to speak, unless it gets ....yes, unless that we can see that the residents almost cries afterward and you notice that it almost becomes a mental abuse. So we have not had much [situations like that] right now, but earlier in room X, then we needed to intervene and control a bit.

When Annie in the quote above says, "We're not supposed to

listen to relatives" it marked where the nursing staff positioned themselves in the resident's family. It seemed as though the staff were taking on a position of being the interpreter of what was the best for the residents, placing themselves as a Hermes in the family structure. This demarcation seemed to be important when talking about the relatives' involvement. As Jamie states, "it is the residents who will decide" and within that rhetoric it seemed to place involvement from a top down family configuration (staff-residents-relatives) where involvement was dependent on the staff's presence and their interpretation of situations of involvement in the nursing home.

Another example of how the nursing staff marked involvement in relation to relatives was identified in the first focus group interview:

> Mary: Well, it's a gamble all the time because you're supposed to be able to cope with our job…we're not here to discuss and argue with relatives and then it's easy to succumb to make the business work, otherwise we would argue and quarrel and go to supervision sessions with relatives all the time.

Again, the top down family configuration was addressed when talking about how to manage involvement. Inviting to discuss the job with relatives could have unexpected consequences, so "keeping them short" was referred to as being a more important approach to involvement than negotiation. On several occasions the informants addressed this as being crucially important in their ability to function in relation to the residents.

With the formal mandate to care

The nursing staff also marked involvement based on themselves as professional caregivers and the relatives as informal caregivers, as illustrated below. The starting point seemed to be based on a quite traditional division of responsibilities in the fifth focus group:

> JH: If I would be a relative here in the nursing home, how can I be involved? How can I help and get involved?
>
> Samantha: Take a walk with your mother. Come and visit, have coffee with her.
>
> JH: Yes.
>
> Samantha: Perhaps talk a bit with us.
>
> Jennifer: Just be here.
>
> Samantha: Yes, exactly, just be.
>
> Jennifer: Not engage in endless squabbling.
>
> Samantha: [Laughs] If you manage your business, we'll take care of ours.

A recurrent and frequent statement, when discussing relatives' involvement in the discussions was the division of chores and labor. As stated by Samantha, "If you (relatives) manage your business, we'll take care of ours". A key statement such as this, upholding the "involvement discourse," seems to focus on relatives as social visitors, just being there and socializing but within defined boundaries. For example, walks and having coffee were relatives' domains, while intimate care was a staff function. It was when this division was not honored that the risk of "endless squabbling" came to the fore.

The nursing staff often returned to the fact that it almost always took some time for relatives to adjust to the routines and hand over the care. Pauline gave us an example of this process during the sixth focus group interview:

> Pauline: Oh yes, you notice when you talk to them [relatives] that they find it hard and heavy [to engage in the care work], yes.
>
> JH: Do you have any good examples or an actual experience that you can share with us?
>
> Pauline: Yes, there is an old man, that is older than the resident, he can stay here…oh yes, but now he leaves at 9 pm in the evenings…then he thinks it's hard [to leave] but I tell him that it's optional, you don't need to fix with everything, but he, he wants to because he wants to be a bit of a martyr [laughs] I think. I mean… there is no one who force him but he really wants [to care for the resident], or else perhaps he doesn't really trust us [laughs] no, I don't know, he is special.
>
> Sara: No he wants…I think that he wants to check on us, that everything is properly done.
>
> Pauline: Many times, they [relatives] have a bad conscience because they have put their older family members in the nursing home.
>
> Sara: Mm…
>
> Pauline: That's why they come her every day, and are so worn out.
>
> Sara: Yes, usually older people.
>
> Pauline: Yes, older men.
>
> Sara: It is also a question of trust as well.
>
> Pauline: Yes exactly, because later on they let go, gradually.

In the text above, the given, normal pattern and expectation marked among the nursing staff seemed to be that the relatives were supposed to trust them and automatically hand over the care. The "new" family expected the relatives to let go, although this handover could be protracted and lengthy according to the nursing staff. The relative in this case, who was seen as having difficulties handing over care to the staff, was constructed as a playing a martyr role and the nursing staff's competence was consequently questioned. One could also interpret this as an expression of the fact that even the most enthusiastic relative eventually had to hand over care

responsibility to the nursing staff in order to fit into the "new" family order.

Discussion

How can the biopolitics of involvement discourses concerning relatives in nursing home institutions be understood? Before answering this question, we would like to briefly comment on two main points of departure: in this paper biopolitics should be seen as a way to govern and legitimize the "involvement discourse"; and based on how the "involvement discourse" is expressed discursively through language among nursing staff, what is said also becomes a "truth" and knowledge about involvement, giving the subjects (nursing staff and relatives) different influence and opportunities.

The biopolitics in the identified "involvement discourse" in this paper could be linked to a discourse resting on a "new" vs "old" family rhetoric. It is thus a family rhetoric that upholds and legitimizes the "involvement discourse" in nursing homes and provides different subjects positions for both nursing staff and relatives. The first interpreted assumption of the results, *we are a family*, shows how the representatives of the "new" stepfamily (nursing staff) steps into the "old" family (the original family of the resident) and place themselves in the center of it and attribute to themselves a pivotal position. This corresponds with previous research that showing that the relatives often are given a peripheral role in relation to the nursing staff when handing over the care responsibility.[15]

The second assumption *for the residents' best interests* upholds the biopolitical aspect of nursing staff prioritizing first and foremost the voices of the residents even though their relatives try to contribute with valuable information to optimize the care provided to the resident. This is in line with previous research indicating that relatives are playing an important role as part of holistic and individualized care, in helping the residents achieve well being.[3-6]

The last assumption, *with the formal mandate to care*, upholds the "involvement discourse" with the rhetoric of a reasoning of formal and informal caregiving based on a traditional division of labor in nursing homes. This specific discourse conditions what caring activities relatives and nursing staff should engage in. Holmgren et al.,[20] have described the consequences of this particular part of biopolitics, providing relatives with the subject position as "visitors", preferably focusing on social and practical activities in relation to the residents and nursing staff.

Biopolitical meaning presents itself through language in the "involvement discourse," with the help of "natural" assumptions. These assumptions can result in the relatives' experiences of finding themselves being on the "outside looking in" on the "new" family coalition between the nursing staff and the residents, as Baumbusch and Phinney[18] have described it. The assumptions seem to be so obvious and "natural" that they are rarely questioned or challenged. The question that can be asked is whether the nursing staff are too oblivious about their privilege of interpreting the residents' needs and desires. And if that's the case, then in whose benefit?

Similar involvement discourses in a broader societal context

Based on the first and third starting points of the analysis, it can be noted on a macro level that the use of family oriented rhetoric has a specific meaning for the nursing staff. In relation to the second starting point, in distancing ourselves from their use of the concept, we have related it to various public models but in a broader societal context.

In this study, we have described the prevailing social processes in terms of an "involvement discourse" that comprises the complexities and social interaction in the form of a family formation conditioning the involvement of relatives. The discursive practice becomes the social interaction of the nursing staff, which is in constant renegotiation, dynamic and revision. The fact that the nursing staff positioned themselves in the families of residents, positioning relatives "outside" of the "new" relation with the residents, is not specific for nursing homes. It is rather just one example of many institutions that are characterized by the construction, reproduction and implementation of a sometimes traditional "involvement discourse" and its practice.[26,27] Similar power structures and biopolitical incentives that are constructed and reflected in the nursing home culture have been and are still dominant in society's many institutions.[27] This kind of macro power process can easily mount in conservative and collective milieus where individuality, creativity and a critical stance are not always encouraged. Other examples of such institutions in the society, nationally and internationally, may be psychiatric health care facilities, foster home institutions and boarding schools.[cf. 26,27] A unifying concept for these institutions, as well as for nursing homes, is that they represent something that one could call the "caring state" - a state that takes care of and protects citizens and that is designed to strengthen the relationship between families and the state in the pursuit of equality, community and solidarity.[33] The idea of the

Swedish welfare state[34] can be seen as an example of this approach, where biopolitics has been about welfare, resting on social sciences and enactment of public institutions.

In conclusion, this study's results are largely consistent with previous research on family involvement. This study has also reviewed the relatives' involvement from a new angle by using a biopolitical framework to analyze involvement discourses articulated by nursing staff. "Replicating the family" is ultimately about how the nursing staff in relation to the "involvement discourse" takes on the subject positions as "new" family members. Their role becomes that of representing what is moral and biopoliticallly "right" and "wrong" regarding the care that is best for the residents. Studies that have calling for better cooperation based on holistic care and a partnership between nursing staff and relatives,[16,35,36] seem to have been overlooked, based on this study's conclusions.

Displacing the "involvement discourse" in nursing homes – a "project of possibility"

Based on the discourse analytical approach presented in this paper, there is great potential for understanding discourses on involvement in alternative ways, since this is only one of several possible interpretations. Cheek and Porter[37] reason about how a foucauldian approach could change the social situations that are not always constructive, and in some sense oppressive to a "project of possibility".[38] They argue that it is not always about making large disruptive changes to achieve positive outcomes. It should rather be small modifications that could lead to positive social changes. Although there are probably no quick and easy solutions to change the power structures that circulate and condition the involvement of relatives in nursing home, it might be worth exploring the best practices in similar venues where professional norming and practices have been changed and improved successfully. In order to attend to a "project of possibility",[38] we believe it is necessary to reconsider the elderly care contents and biopolitics. This could possibly initiate a transformation of the existing "involvement discourse" partly providing nursing staff with new knowledge and insights as well as encouraging a more reflexive critical approach to the notion of family involvement in institutional care.

Foucault[26] points out that there is always a possibility of resistance where there is power. The "project of possibility" could in particular help to support nursing staff in making relatives more involved through an open and unbiased way of understanding their role and contributions to the care of residents.

However, knowledge itself probably won't lead to good professional practice if it is not applicable to practice, and if it does not enable a reflective and critical approach.[cf. 39] We believe that if we are to achieve a "project of possibility" in elderly care, it also requires other components. The Swedish school system is an arena where successful work has been done, in questioning norms and common assumptions.[40] Based on a critical pedagogy presented among others by Paulo Freire,[41] it is possible to create social change. The critical pedagogy is ultimately about promoting social justice and democracy by paying attention to how norms and notions sometimes marginalize people. In elderly care, a more pronounced organizational holistic care culture may be a theoretical base from which to start.

Previous research has shown that such framework both protects health care workers in elderly care from burnout and promotes workplace engagement.[42] This ensures a caring work culture where one is treated with respect and fairly, social support at work to experience connectedness and the experience of having an important mission. We believe this holistic approach could also benefit the residents and their relatives, in the transformation of the current "involvement discourse". As it stands today, in a biopolitical sense it appears that the "involvement discourse" is challenging and unreflected. Acquiring the skills and support to work with issues of involvement, in more conscious ways could be valuable for both nursing staff, residents and relatives.

As previous stated, a critical pedagogical approach[41] can be beneficial to change institutional practices such as involvement of relatives in nursing homes. This could be done through long-term critical pedagogical work that should aim to educate, strengthen and support the nursing staff in reflecting on their professional norming and how it conditions perspectives about the involvement of relatives. For example, by using recurrent forum plays and various valuation exercises in a holistic caring environment,[40] it might be possible to improve cooperation between relatives and nursing staff in a future postmodern elderly care.

Clinical and research considerations

In order to achieve a holistic practice and a critical and reflexive approach in nursing home institutions, we suggest not only a framework of critical pedagogy but also implementation of a systematic assessment and benchmarking of a holistic practice. This would provide a quality improvement indicator, which may show the effectiveness and outcomes of a holistic and critical intervention approach. There is a need for more research about how power relations operate in the nursing

home arena and how we can find ways for to change the current structure for the better.

Methodological considerations

The methodological shortcomings present in this study are associated with the theoretical perspective that guides the discourse analytical reconstruction of the focus group interviews. This means that the foucauldian power perspective influence what to focus on in relation to the aim of the study, and also provide the framework for how things can be interpreted. The consequence may be that deselected interesting and valuable aspects can be omitted, since they do not correspond with the perspective. This does not mean that other interpretations would not have been possible, since the ontological basis of the study assumes that knowledge is constructed rather than that it exists objectively and independently outside of human influence.[31] Even if it was the aim of the study that guided us through the interviews, it cannot be overlooked that we as researchers were co-creators during the interview process. This meant that we expressed ourselves and presented relatives' involvement in elderly care based on our own situated individual positions in the interaction with the nursing staff. This made us conscious and reflexive in that we helped produce and were produced by prevailing discourses concerning the elderly care context during the interviews. From this perspective, the focus group interviews should be considered not as innocent transcripts, but as power producing where we as researchers are not innocent and neutral but highly operating. There is a criticism that interviews as data are not preferable because researchers are as co-creators of data to a great extent. This is something of which we are aware and that may affect the outcome, but we believe that there are no neutral stories or genuine truths behind the prevailing discourses in any form of data. However, we have presented both the interview questions and the nursing staff's answers from the transcripts in order to give a wider perspective on the interview contexts. To minimize the risk of over-interpretation of the results, the first author has enjoyed continuous reconciliation and dialogue with the other co-authors regarding the reasonableness of the interpretations. In cases where we have had different views of the material, we have discussed this and reformulated the interpretations. Finally, the results and the paper as a whole has been reviewed, during an academic seminar by other researchers who had not participated in the research process. This was to assure that what was presented in the paper would seem reasonable and convincing.[31] As these researchers had not participated in the work of the paper, they had the opportunity to look at our work in a more objective manner. Where they had comments, we took these into account and revised the paper accordingly.

Notes

[a] There is an ongoing development of literature concerning discourse analysis and how to conduct such a method. However, within nursing science, the literature on discourse analysis is relatively scanty. Allen and Hardin provide a method for conducting this kind of analysis, developed within the nursing science field.

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Acknowledgements
We want to thank the informants who participated in this study. Without them it would not have been possible to conduct this study. We also want to recognize and express our gratitude to the AMF Pension and the Division of Nursing, NVS, at the Karolinska Institutet, which has funded the project. Thanks also to the School of Nursing at University of Washington and the School of Health, Care and Social Welfare at Mälardalen University, which in various ways have provided support in conducting this study.

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