

Original Article

Deconstructing Caring and Authentic Measurement

Derek Skea, BSc (Hons); MPhil; PG Cert

Fellow of the Higher Education Academy, UK
Honorary Lecturer, University of Huddersfield, UK

Correspondence: Derek Skea B.Sc Fellow of the Higher Education Academy, UK. Honorary Lecturer, University of Huddersfield, Queens Road HD1 4LE, UK Derek.skea@gmx.co.uk

Abstract

Background: This paper explores a deconstruction of care through looking at hermeneutic methods and their role in a 'stripping back' or deconstruction of the processes and outcomes of care. The societal structures in which care is delivered and the undoubted 'power' operating downwards on both carer's and cared for is often overlooked in current research.

Methodology: It is proposed that Foucauldian discourse analysis could be a useful tool in the deconstruction of care. Further methods based in interpretative phenomenology such as Interpretative Phenomenological Analysis could further deconstruct what it means to care at a more individual level within this wider societal context of caring.

Results: More authentic measures would be obtained and measures based inherently in the wider 'lived experience' of carers and those they care for, moreover phenomenological analysis in itself could produce more authentic measures of care, through its emphasis on individual interpretation and 'meaning' and how this operates in the caring scenario.

Conclusions: This process of deconstruction in order to get a more authentic picture of and measures of the meaning of caring would be useful in the training of management and front line care staff.

Keywords: Discourse/s, Power, Deconstruction, Phenomenology.

Introduction

The term authentic in this work is meant to portray a qualitative version in some sense as that of validity in positivistic empirical research, but more than this, authenticity is believed here to seek the goal of a deeper understanding of care and the caring processes, together with an increase in quality of care provided. Within this paper two methodological couplings are proposed one of which is based in Hermeneutics, specifically to that proposed by Heidegger (1962). Also when talking of Quality of Interaction and care giving, it is in a sense a variety of differing forms of embodied action as forms of 'intentionality' from a phenomenological point of view (Husserl 1983), within the discourse of care. The thinking here is based in interpretative phenomenology (Heidegger, 1962), and specifically as a method to obtain 'thick' 'real life' information, Interpretative Phenomenological Analysis (IPA) (Smith Flowers and Larkin, 2009). Phenomenology is classically concerned

with the first person view (Woodruff 2013), and to deconstruct care it is proposed the experience of the carer from this first person point of view is absolutely necessary in order to understand caring fully. The same applies to the recipient of care, though it is acknowledged from the outset that there can be hurdles to overcome in the cases of Learning Difficulties and Dementia, for instance, these difficulties are not insurmountable. The discourse analytic method as conceived here, regarding caring is still rooted in interpretation and cultural historical knowledge structures in all their permutations (Foucault 1982, Jansen 2008).

It is acknowledged from the outset that rather than the pure description of Husserl (1983), that the act of interpretation should always be tempered with an accompanying danger of mis-interpretation, or put simply, moving away too far from the original embodied meaning within the texts analyzed, or the embodied interaction of caring as observed, in this

sense misinterpretation and hence, misunderstanding. This is an area for future work.

The present work seeks to deconstruct what is meant by 'caring' in the United Kingdom. In terms of the epistemology of caring and caring practices; this essentially means looking at the appropriateness of research methodologies (Crotty 2003) and linking them with the practices and outcomes of caring. This entails tackling head on what can appear to be unfathomable complexities in research methodology and what we accept as 'truth' in the comprehending of the nature of the phenomenon: caring. Only by taking such a stance to the topic can the morphology of caring be more fully investigated; and fully deconstructed.

It is proposed that phenomenological (Moran 2000) and discourse analytic research is of at least equal value as the empirical, quantitative, medical model that the author has previously applied in residential care homes, hospital wards and day-centres. The outcome of this type of research should effectively lead to new practices and an improved quality of life for those being cared for as the social, psychological and 'self' is examined and caring itself deconstructed to its key elements.

The perspective of seeing the individual as a 'case' and the medical-empirical conceptualisation of the individual can lead to inappropriately targeted types of care and sadly, the objectification of the individual together with their specific history, psychology and social needs structures being placed in a vacuum. The political, economic, power structures, knowledge (knowledge in the way that Foucault describes it, see later) as it exists are taken for granted, ignored, and only looked at in terms of often rather scant analyses of the policies within care environments (Skea, 2010). This it is proposed is a mistake and the addressing of this is the aim behind a deconstruction of the caring situation, as well as looking at more novel training techniques aiming at empathic understanding and the social interaction that occurs in the caring situation (Skea, 2014). The stance here is that caring is as at least as much to do with the social-psychological and individual personal needs as physical care per se, this is not new but a perspective that needs continually reinforcing as the World 'advances', grows and its populations live longer.

Here then are the main two points to consider: deconstruction of caring per se and methods not

usually applied or considered to be 'mainstream' when assessing care such methods as discourse analysis, to look at the wider 'context' of caring, together with a more phenomenological framework to assess both the carer's and the cared for, the point being that well trained empathic staff will enjoy their work more, be more effective and stay in their caring profession; a profession with extremely high turnover and staff burn-out and one which is particularly low paid when considered with other areas of work.

The author's previous research in Learning Disabilities and Alzheimer's disease settings will be discussed (Lindesay and Skea 1997, Skea and Lindesay 1996, Skea 2007, Skea 2008, Skea 2010, Skea 2014) as well as other methods involving hermeneutic enquiry and the further deconstructing (Derrida 1972) of what is meant in the term 'caring'. Also methods of enquiry rooted in phenomenology (Husserl, 1983 Heidegger, 1962) such as Interpretative Phenomenological Analysis (Smith, Flowers & Larkin 2009). The intention that is hoped for may be of value in seeing how beliefs, attitudes and knowledge may work into care practices in 'front-line' caring scenarios (Skea 2010, Phelan 2010).

In terms of the role of reflective practice in this type of research, the author has stated previously (Skea 2010:296) 'that after several years of research in care giving contexts such as institutional 'back-wards', community based public and private residential care and day-care centres; there was a scepticism as to whether all was really being comprehended that was actually there in the varying environments and care scenarios assessed and the impact upon the psychology of both the cared for and the carer's'. This research involved fixed time sampling pen and paper observation using the Quality of Interactions Schedule (QUIS) (Dean, Proudfoot and Lindesay 1993) method as an example (Lindesay and Skea, 1997, Skea, 2008), though valuable, it was not participant observation (it was not grounded in ethnomethodology) which the author has come to believe would be of real value in the process of deconstructing caring interactions.

As said, much of the author's experience of research in care contexts has involved a traditional positivistic empirical framework, applying statistical models over time and between care environments and using validated and well tested questionnaires administered to both staff and service users. Through the empirical framework applied in this research (Skea & Lindesay

1996, Skea 2007, 2008) many quantifiable measures were taken; valid, reliable, statistically analysed and constructed measures were applied, and results were found both between and within environments over time on indices of quality of care and quality of life. These results were and still are meaningful, valuable and useful in terms of addressing service provision, Quality of Life (QoL), staff stress and occupational satisfaction. The recognition was indeed there that how the staff may feel and what they get from their occupation, at least, will affect how they interact with their patients, but the recognition is not as yet firmly proven.

Though the previously mentioned results have the above qualities it is not suggested they give the “complete picture” (Skea 2010:248). The author’s contention is we have done little more than achieved a methodological snap-shot, a mere glimpse of how caring is manifested using for example observation and interviewing/checklist research, the reformation has not yet happened.

This work seeks to probe further into what we mean by caring and how as a phenomenon it could be explored further through a more ‘bottom up’ (Crotty 2003) approach, as opposed to the top down hypothetico-deductive approach innate to the empirical method. An approach in which traditional empirical hypothetical assumptions are set aside in order to see what the nature of caring is; from both carer and the cared for individuals perspectives, in this arena of essentially human-social interaction, which of course takes place in a wider politico-social-economic context, where power is manifested, yet the influence of this is so often taken for granted (Gutting 2005).

The stance above means an exploration into not only the hermeneutics of what we understand through the construction of, and interpretation of caring, but an appreciation of post-structuralist methodologies such as Critical Discourse Analysis (Fairclough, Jessop & Sayer, 2004, Fairclough 2009) and Foucauldian (1972) analysis. It is fair to say that this perspective is grounded in social constructionism (Burr 1995) and theorising aligned more with critical psychology (Fox, Prilleltensky & Austin, 2009).

The socio-political and historical context of, and the construction of what constitutes present knowledge regards caring cannot be ignored – for this is the reality of the contexts in which care is delivered in the

multitude of settings and policy environments that act in bringing to life and action the phenomenon of care. Though admittedly (by traditional means of psychological measurement) how societies filter and create notions, beliefs and knowledge of what good care is it is fair to say; given a veritable stream of abuse and neglect cases in the UK, that all is not well, the system is far from healthy, possibly as much for those doing the caring as those being cared for; this is an important point. Previously using measures such as the Goldberg’s General Health Questionnaire (GHQ) (Goldberg and Hillier 1979) and The Minnesota Satisfaction scale (MSS) (Weiss et al 1967) on Nursing and residential care staff, low scores indicating poor mental health and low occupational satisfaction were found (Skea & Lindesay 1996, Lindesay & Skea 1997, Skea 2008).

Though rarely researched, this (put simply), wider context must surely influence the care delivered and indeed what is literally meant by caring. Caring then always manifests itself in a wider socio-political-cultural and historically placed manner as well as in institutional and policy environments. A way to re-view what caring is could mean looking closer at discourse and practice and this too is an obviously good way forward or route to the process of deconstruction.

Regarding nursing environments and discourse within these environments this can be viewed as the use of language “as a form of social practice” Crowe proposes (2005:56) further Crowe (2005:62) maintains discourse analysis has value in helping to understand the “political, cultural and social practice” this then can impact upon the care provided, in terms of method; Crowe (2005:62) logically proposes that “this requires a commitment to reading a wide variety of text to develop an understanding of the context within which health care and nursing practice occur” of course the idea of looking at a wide array of sources is not new in discourse analytic methods (Fairclough 2009).

It is the author’s contention that we need to face ‘head on’ the whole arena of care, particularly the socio-political and knowledge environments of care; only by doing this can we fully understand the phenomenon and how it can be done better. There are a number of wider political-socioeconomic facts to be considered regarding care in the UK. Care workers, in particular front-line are amongst the lowest paid in health and social services in the UK. What does this say, what is the message in this to front line care staff and to those

they care for and the loved ones of those being cared for, indeed to the wider public? It is also the case that front line workers are not only some of the poorest paid in the sector but the least educated in terms of what care is about and most likely due to this, and on the whole, more likely to have little more than a common sense notion of what quality of life is (Hatton 1998). It may be the case given that education, politics and discourse are intrinsically and complexly linked that a lack of education in care may lead to more genuine care not steeped in prescriptive, power leading controlling practices as Foucault (1972:214) has said “shot through with the positivity of a knowledge” that is the positivity in the knowledge may be more about controlling practices and ‘othering’ those who are cared for. The author did get the impression through years of observational research and structured interviewing formats that care given had little to do with level of education but more to do with empathy and responsiveness to clients needs. The author has often wondered if more had not been found out through informal open ended unstructured interviewing as to what front line carers considered caring to be. This then is a case for more explorative research, typical of hermeneutic routes of enquiry (Smith, Harre & Langenhove, 1995).

It is the author’s contention that this lack of a comprehension of the varying perspectives on what it is to be older, handicapped or suffering from psychological problems leaves front line care workers poorly equipped and open to often implicit society wide derogatory conceptions of those they care for, as old as uneconomically viable as demented and decaying in the case of Alzheimer’s disease for instance, as mad and potentially dangerous in the case of the psychologically ‘dis-eased’. There is little to stop these condescending notions manifest in western society having pervasive effects on how we treat those in care, the problem is compounded through the much larger length of time front line care workers spend with clients witnessed in countless empirical observational studies, including the author’s own work looking at quality of interaction (Skea 2008). The problem does not in any way diminish when we look at ‘accepted’ scientific knowledge of ‘illness’.

Discourse, power and caring

All the above leads to the disempowerment of care staff (see below), and those that are ‘looked after’, that is, the recipients of care as manifested in various

forms, through discourse. Jager and Maier (2009; 35) highlight this process saying.

“...discourses exercise power in society because they institutionalize and regulate ways of talking, thinking and acting”.

The ‘talking and acting’ aspects of the phenomenon of care provision and practice are the constituents of any care interaction. Looking at care from the bio-medical perspective implicit in most care staff training, the medical examination turns the individual into a “case”- as Gutting (2011:7) proposes; “in both senses of the terms: a scientific example and an object of care; caring is always also an opportunity for control” Gutting (2005:7).

By way of example of how societal discourse and normalized notions filter down towards older people (as an example) and Nursing behavior and attitudes, Phelan (2010:893) maintains that:

“taken for granted discourses of ageing can implicitly affect how *nurses interact with older people* (Author’s italics). It is important that all nurses are cognizant of the consequences of such discourses in practice”.

To further help clarify the authors thoughts of what discourse is in the caring situation, Link (1983:60) in Jager and Maier, (2009) propose that ‘discourse’ is an “institutionalised way of talking that regulates and reinforces action and thereby exerts power” Jager and Maier (2009:35) liken this to a “flow of knowledge throughout time” (taking a Foucauldian perspective, akin to his principle of Genealogy 1972) the link between discourse and power cannot be downplayed both in the wider caring policy arena and front line care practices indeed discourse and power are intricately related, Foucault (1996:394) does not mean ‘power’ in the common sense notion of automatic inequality and suppression, he maintains power to be:

“ a whole series of particular mechanisms, definable and defined, that seem capable of inducing behaviours or discourses”.

Foucault (2003:8) when talking of discourses mentions and puts emphasis upon “the will that sustains them and the strategic intention that supports them” as Phelan (2010:895) states:

“Foucault proposes that *discourse constitutes reality* by forming the objects of speech” *Archaeology and Genealogy* are Foucault’s two methodological tools as

Phelan puts it (2010:894). “archaeology is non-interpretative and simply allows an alternative, but important, examination of the topics” it involves looking at rhetoric on the surface level which may function to hide political and hierarchically ordered structures enmeshed beneath. Phelan (2010:895) elucidates further:

“instead of asking ‘what’ is the state of knowledge on a particular phenomenon, archaeology asks ‘how’ and ‘why’ did such knowledge emerge and what are the *consequences of such a construction* (authors italics)”.

This is a pivotal point in the present authors notions of deconstructing caring.

Whereas Jansen (2008:109) states:

“Archeological discourse analysis following Foucault can be described as a social linguistic analysis because it is based on a strong constructivist thinking, focuses more on the proximal contexts, and is not so much interested in power relationships”

The ‘proximal context’ within this paper is very much concerned with the caring scenario, within the embodied action of caring, interactions and discursive formations and conceptualizations of care/caring/and being cared for.

Foucault’s second ‘tool’ of method genealogy, is portrayed by Phelan (2010:895) as the “techniques of power, rather than the nature of power” that are concentrated upon. Phelan (2010) maintains from her literature review that ageist discourse is often legitimated through academic research, theories and bio-medicine, healthcare providers and ultimately service provision and the delivery of care by nursing staff.

The application of the above can be examined as Phelan (2010:896) maintains regarding the bio-medical model and bio-medical discourses of old age in the:

“covert production of superior (nurse/doctor) and inferior (client) positions which serve to reinforce existing status quos and devalue both nursing and the older person”.

Regarding theoretical discourses of old age and how nurses ‘understand’ old age. Focusing on ageism Phelan (2010:898) says that this can:

“...be facilitated by healthcare staff in terms of considering health deterioration as part of the ‘normal’

ageing process, resulting in a fatalistic attitude towards what intervention will achieve”.

Jansen (2008) points out that the primary concern of nursing being the physical body has meant only a slow realization that when discourse analysis is properly used in this field then it is indeed applicable and useful in nursing research. Jansen (2008:109) also gives further clarification of Foucault’s conceptualization of what a discursive formation is in terms of four points (and hence an important point of method).

“statements refer to the same object, are enunciated in the same way, share a common system of conceptualizations and have similar subjects or theories”

This pointer above helps in the research process in terms of inclusivity and exclusivity; what to include and what to not include when looking at the discourse of care.

To return to Phelan’s (2010) earlier point regarding fatalistic attitudes to aging in nursing; early on in my research career, I had personal experience of this fatalistic attitude more than once but one example was witnessing a senior ward manager in Dementia and Alzheimer’s tell me that relocation into the community and applying more social care models would be useless in the face of the inevitable decaying and death and that the ‘old school’ methods were better than the ‘new school’ as she called them. Of course this way of thinking of the aged leads to a self-fulfilling prophesy and in a senior member of staff is easily influential on the actual application of care, how the ward is run; in reality, and can filter down insipidly to the younger members of staff, who of course if knowledgeable will have very different ideas of what care is, being newly qualified enthusiastic and new to their profession. Ageism, professional ageism, and political discourses of old age are observed as inherent in knowledge per se and important aspects shaping the genealogy or techniques of power.

Jansen (2008:111) highlights that discourse analysis in the nursing field helps to “introduce a new culture of debate in nursing” and of particular importance as the World gets smaller in many ways is, as Jansen (2008:111) points out:

“Discourse analysis is a way to treat other beliefs with respect and take them seriously and to be able to prove and question one’s own beliefs as well. It allows a

synthesis of different things-it is an open dialogue on different beliefs and opinions”

The above always exists within an institutional policy framework but it is an important point in terms of the value of discourse analytic research and how it may make further sense at micro and macro levels of care and quality of life assessment within the nursing field.

Phelan’s (2010) review points out a paradox in that explicit policies and programs concerning quality of life for older people that re-frame old age via a positive angle in so doing highlight their needs as “somehow different” from other age groups. Further political-economic factors nurture a notion of dependency and virtual financial burden on the state in terms of or often witnessed in terms of, mandatory retirement.

Phelan (2010:899) alludes to how nursing education and practice needs “innovative ways of demonstrating the heterogeneous experiences of old age and the facilitation of *positive interactions* with older people” (authors italics).

Since this above italicized point really does need emphasizing, towards this aim the author has advanced the notion of positive interaction literally towards a training program that aims to focus on interaction *per se* and raise consciousness in a measureable manner within the real life contexts of care (Skea, 2014).

Very importantly in terms of what Phelan’s (2010: 900) paper adds to the subject:

“A Foucauldian approach disturbs canonical normative statements as the certainties of nursing knowledge of older people is transformed, leading to a redefinition of the older person”....regards practice it allows “nurses to be mindful of how dominant discourses can tacitly influence nursing practice”.

This is all valid pertinent and transferable views in the caring phenomenon and its deconstruction. How care is conceived and practiced and of course logically connected to what the likely outcomes of care will be. Of course, the reader would be forgiven for being somewhat dejected by the above portrayal of how care is conceived and practiced, these aspects are framed in terms of that which is notoriously difficult and ‘slippery’ to measure.

There is the other side of this which involves a re-construal a fundamental re-framing of what it means to

be deemed as ‘old’ ‘psychologically disturbed’ to have Alzheimer’s disease or to have learning ‘disabilities’.

From the authors research using pen and paper (transcript) driven observation of quality of interaction (Dean, Proudfoot and Lindsay, 1993, Skea 2007); on reflection a number of points can be made after hundreds of hours of observation in learning disability day centers (Skea 2007) and in Alzheimer’s contexts (Skea & Lindsay 1996). Though what follows are simple statements of reflection they do relate to what is said above regarding notions of power and control, how they are normalized (Foucault 1982) and what they tell us about the ‘caring’ situation:

In Day Centre research non-verbal contact was often involved in both settings observed by Skea (2007), this was almost always initiated by the care staff, it can be noted that the UK culture is not as yet a ‘contact’ culture this contact was always uninitiated in the cared for person. This does not mean that staff was aware of normal conventions of human contact but rather part of what they see as caring involves frequent reassuring touches.

Language was frequently used which can only be described as infantilizing, such comments as ‘my dear’ ‘there you go sweetie’ said in the way one would address a child and so forth was frequently heard and recorded by the author.

Deconstruction and Phenomenological Enquiry

One method that is rooted in Hermeneutic enquiry (Husserl, 1983) and applicable to the deconstruction of caring is a form of thematic analysis called Interpretative Phenomenological Analysis (IPA) (Smith, 2004, Smith, Flowers & Larkin, 2009). This method works on an open ended analysis of semi-structured interview data and aims via increasing levels of abstraction to identify the ‘essence’ or main themes in what is being recounted by the interviewee.

The value of IPA is evident if people who are the carers, family, relatives and service users themselves are interviewed about what care means to them. Perhaps a process of discovery could unfold and new undiscovered aspects of care could be seen.

By this process further in-depth interviews would be generated and designed and actual interventions undertaken with all involved.

Main points of this paper

- Caring per se is not measured in an authentic way
- Since the measurements can lead to inauthentic results through observation and interviewing and care staff not behaving as they would normally then we cannot say we know what caring is
- There is a need for ethnomethodological bottom up phenomenological frameworks to get an authentic picture of what caring is as opposed to the above

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