Received: 23 January 2023 | Accepted: 26 June 2023

DOI: 10.1111/scs.13194

Scandinavian Journal of Caring Sciences

THEORETICAL ARTICLE

Encircling discourses—A guide to critical discourse analysis in caring science

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Abstract

Aim: The aim of this article was to introduce Fairclough's critical discourse analysis (CDA) in caring and nursing science, to provide a guide on how to perform such an analysis, and to describe the wider context of discourse epistemology.

Design: The article is designed as a methodological paper, including (a) epistemological roots of discourse analysis, (b) an overview of discourse analytical research within caring and nursing science which points out an increased trend, and (c) a guide to conducting a CDA.

Analysis: It is important that discourse analysis is available and accessible to nursing and caring researchers. Through the process of encircling discourses, valuable insight is given into fields that otherwise would be lost or would not be available.

Conclusion: Our summary stance is that discourse analysis as it is presented in this article is strongly advisable for use in nursing and caring sciences.

KEYWORDS

caring science, critical discourse analysis nursing, discourse analysis, research methods, social construction

INTRODUCTION

The use of discourse analysis has increased in caring and nursing science, even though it still is rarely used compared to other qualitative methodologies. In this article, we introduce Fairclough's critical discourse analysis (CDA) and offer a step-by-step guide on how to perform such an analysis. The development of the theoretical and methodological starting points in CDA took place in the 1980s. In his book Discourse and Social Change, Fairclough [1] discussed the marketisation of universities from a discourse perspective. As healthcare has been exposed to marketisation in the same way, with a top–down imposition of market models, his ideas are relevant for caring science and nursing too. Healthcare discourse has changed along with marketisation; today, we talk about patients as 'consumers' and healthcare services as 'producers' of care. These discourses are slowly transformed into changes in the structure, management and practices of healthcare and can be seen as an example of the relation between power and ideology.

THE PURPOSE OF A DISCOURSE ANALYSIS

Discourse analysis is a term that summarises a variety of methods used to analyse language use, its function and

its relationship with power. By discourse, we refer to the way we talk, 'a definite way of talking about and understanding the world' [2, p. 15]. To use discourse analysis is to analyse how language is used in different contexts, and its relationship with power. According to Bacchi [3], language is structured in patterns that our opinions follow when we act in social domains; a discourse analysis is the analysis of these patterns. One purpose of using discourse analysis is to identify what discourses in a text are supported by societal institutions and, therefore, are given the opportunity to make a cultural impact. Put differently, discourse analysis is "to examine the role of discourse in the constitution of the world" [3, p. 199].

EPISTEMOLOGICAL ROOTS

The emergence of various discourse analyses has broadened the perspective of linguistics. A very summary description of the importance of "the linguistic turn" in academic research is that it made it possible to classify phenomena and their relations with use of the language, and language became a non-neutral medium for the transfer of knowledge. From focussing on descriptions of grammar and pronunciation in the 1970s, research developed towards focussing more on the structure of conversations and texts to grasp implied meanings and contextual interpretation, and how language interacts with non-verbal communication.

Discourse analysis is not only a method, but a methodology; it follows ontological assumptions about the world and the role of language in the categorisation and construction of this world. The starting point in discourse analytical research is that objectivity can never be achieved, as the very reality we study is socially constructed and founded on sets of assumptions which may be invisible to us. Epistemologically, this means that all knowledge is constructed in relationships and open to change and that there is no distinct line that can be drawn between the observed phenomena and the observer [4]. Language can, therefore, never only be an objective carrier of the truth or an objective tool for representing reality. This insight was central in the development of the linguistic turn mentioned above. In constructionist ontology, language use plays an integral part in constituting reality. For example, when a certain health condition is given a name, it is at the same time created as a disease, because people will relate to it and understand it as such. This illustrates that the way we speak about things constitutes the way we see them. For caring science, this is an insight that can help researchers become aware of the power of language. Analysing discourse can help us understand why and how phenomena develop—such as disease classification—and the effects this can have on healthcare professionals' attitudes and actions.

Michel Foucault's (1926–1984) work has been a decisive starting point for the emergence of different types of discourse analyses. Foucault [5] saw discourses as objects that provide the basis for conscious knowledge. But not all discourses are afforded equal authority and presence, some are marginalised while others are dominant. These foucauldian perspectives are not included in the caring science canon, but they can help to widen the epistemological perspectives in the field. Nursing and caring discourses, for example, have for long been marginalised compared to the medical discourse. When Foucault analysed the birth of the modern clinic, he identified how physicians objectified and claimed the truth about patients [6]. This became the dominant discourse for a long time, even to this day. Discourse analysis can be a way for caring science to break free of dominant narratives like this.

THE USE OF DISCOURSE ANALYSIS IN CARING AND NURSING SCIENCE OVER DECADES

Discourse analysis has been used to develop and broaden the research in caring science. A simple search (Figure 1) shows a sharp increase in the use of discourse analysis as a method in various areas of health and care sciences during the last four decades. This trend is also confirmed in a breakdown per database.

The beginning of the 21st century brought an increased interest in the use of discourse analysis in nursing and caring science. A rapid technological development with an explosive use of social media, mobile phones and internet access to over 5 billion users worldwide brought a shift in the interest of 'language' in nursing research during these decades [7]. The growth of patients' interactions in digital health forums meant increased clinical online presence with exploratory medical and nursing interventions just a click away [8] These interactions suddenly became important activities to monitor for nursing researchers. Using discourse analysis was one way of understanding these emerging patterns of interconnected relations that online caring enabled through cyberspace [9]. Consequently, the subversive challenges for nursing to grasp the new dimensions of power that information technology made possible led the discipline to an increased interest in using discourse analysis in a wide range of areas, even in clinical settings [10]. Since 2010, the method has had a stable presence in nursing and caring science, utilising various models for conducting discourse analysis in a broad range of research within nursing and care practices. In the section below, the most common models are presented briefly.

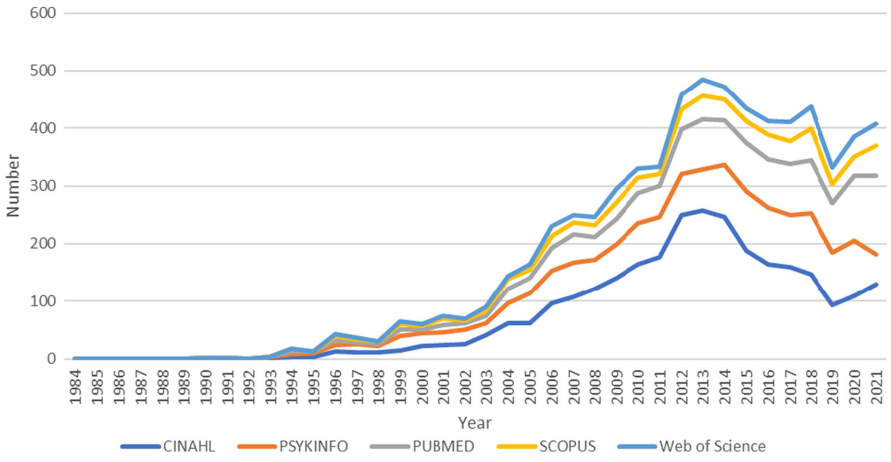

FIGURE 1 Publications using discourse analysis as a method in various areas of health and care sciences during the last four decades.

DIFFERENT DISCURSIVE METHODOLOGICAL APPROACHES

The major approaches of discourse analysis are discourse theory, discourse psychology and CDA. First, discourse theory is the scholarly approach that considers all practices to be discursively constructed. Representatives of this orientation are Laclau and Mouffe [11]. Second, there is discourse psychology, in which the focus is on rhetoric strategies used in writing or speech, with an interest in how these strategies serve to construct social status and power relationships. This approach is used to look at subject positioning in relation to how persons construct themselves and their identity in relation to others [12]. The last approach is CDA, a method that seeks to combine linguistic analysis with overall societal discourses. CDA is critical in the sense that it aims to reveal that our language use is linked to causes and consequences in our social reality that we are not aware of in our everyday world [13]. Language plays a role in creating and recreating inequity and injustice. The aim of CDA is, therefore, to identify and analyse the relations between everyday language use and the societal exercise of power. CDA is the approach that is the focus of the rest of the article.

CDA AS AN AVAILABLE METHOD

Discourses are ideological in so far as they include representations of a "common sense" which characterises the power of dominant social groups, and thereby regulate and dominate society [14]. Ideologies are assumptions of what is taken for granted as "common sense" in society and are shown as ideas, conceptions or knowledge that work to maintain existing social relations and power relations, embedded in institutions [15]. Through micro-level language use, we are exposed to the "common sense", without being aware of it, but through CDA, hidden ideologies in the language of discourses can be revealed.

Ideological assumptions are associated with relationships of power and when an ideology makes its way into a variety of discourses and becomes part of everyday life, hegemony is established [14]. As for healthcare, there are several ideologies that rule its practice, and if there is an established consensus that one of these ideologies are superior and rules, this has achieved a hegemonic position. If for example increased administrative work in healthcare becomes a matter of common sense and something that is taken for granted, then a step towards an ideological hegemony of bureaucracy has been taken. A critical discourse analysis can then reveal that the discourse of administration is the discourse that has the greatest impact, both in language and in practice.

A CDA is not just a way to analyse and criticise discourse; the aim is also to change existing reality in which discourse can be related to other social elements, such as power relations, and economic and political strategies [14]. It is important that CDA has wider objectives than just text analysis if it is to contribute to and become a part of critical caring science.

A GUIDE TO THE THREE DIMENSIONS OF CDA

Critical discourse analysis is used to identify the reproduction of discourses, how new meanings are based on established meanings, and how they can change. A tool for achieving this is Fairclough's three-dimensional model (Figure 2), used to explore the links between text, discourse practice and society [1, 16]. The CDA is carried out in three steps, corresponding with the discourse dimensions shown in the model: (1) description (text analysis), (2) interpretation (processing analysis) and (3) explanation (social analysis).

Figure 2 illustrates the methodological steps and dimensions one undertakes in a CDA. An analysis always begins in data (the text) and is thus empirical in its claims. The underlying epistemological assumption is that the text produces a discursive practice that represents a wider social and institutional order, which often feels 'natural' to all involved, but which always contains power relations.

This dominant discourse can be revealed and contrasted with other inherent discourses in the same context (those discourses are collectively called the discourse order). As the right side of the figure shows, when carrying out a CDA, a systematic reflexivity is used back and forth between text (i.e., the text analysis) and two dimensions of interpretation (i.e., the processing and social analysis) of the text in wider dimensions until the discourse is circled and described. These are the dimensions of the discourse analysis.

Step 1. First dimension: Description (text analysis)

The first dimension is a linguistic analysis of the text. The focus is the language that constructs the discourse—how the text is linguistically and grammatically built [16]. The text should be read thoroughly multiple times to get an impression of its content and a sense of the entirety of the text. Thereafter paragraphs and sentences in line with the aim of the study are selected for the text analysis. This can be done in different ways, e.g., by highlighting text directly in the document(s) or by transferring the relevant parts to a separate document. This selected text is the focus of the remaining description of dimensions steps 1–3.

How to implement the different parts of the dimensions in the analysis process in the selected text can be illustrated using an example from a study about "the reasonable patient" [17]. In the study, we analysed web-based information intended for cancer patients from healthcare providers. The analysis revealed healthcare's ideas and construction of the receiver: the patient. Below is one example of such a text:

> There is nothing right or wrong about how you chose to talk about the fact that you have cancer. Some feel the need to tell others as soon as possible, perhaps even before they have much information about the disease, but they feel the need to share their feelings of shock and worry with someone.
>
> Excerpt from 'Receiving a cancer diagnosis' (16)

The following questions can be asked of this text: Which words and personal pronouns are used? Are the words value-laden and do they signal frustration, difficulty, usefulness or resourcefulness? What words are used that involve an element of assessment, such as 'often', 'much', 'never', 'everybody' or 'nobody'? To what extent are modal auxiliary verbs used, such as 'should', 'can', 'may' or 'will'? Such verbs indicate relationships of power in the text, e.g., who it is that states that someone must, or should, act in a certain way.

As we analysed the excerpt above in this first dimension, we concluded that the voices of the authorities, the healthcare experts, appeared to be toned down and non-authoritarian. This became apparent when analysing phrasing such as 'feel the need'. The phrasing indicates the wording of an expert who has the power to invite the patient to 'feel the need' for something. An equally reasonable agency is consequently expected from the patient.

When carrying out the analysis of the first dimension, it is important to look at all the words, concordance, phrases and metaphors in the text, and not to select what seems to fit a certain idea best. This is the first step of reflexivity, which will follow throughout the analytical work. According to Fairclough [1], metaphors structure

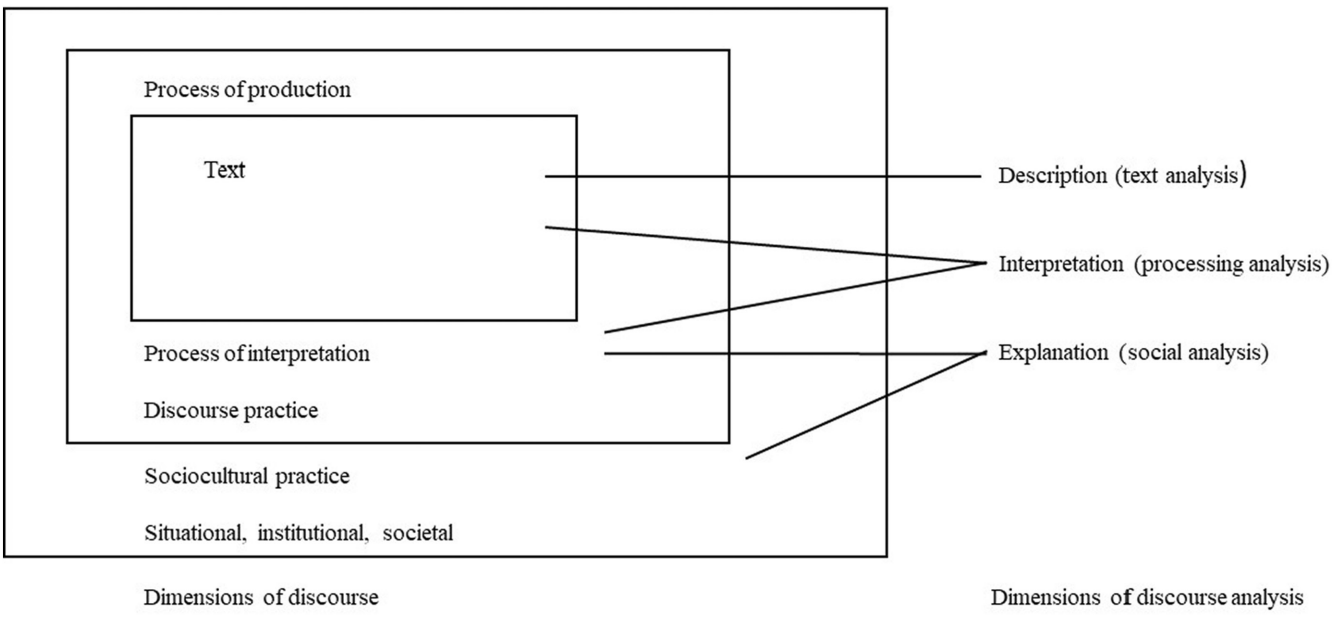

FIGURE 2 A three-dimensional conception of discourse and discourse analysis. Reproduced from original resource by permission [1, p. 133].

our systems of knowledge and belief, as well as the way we think and act, and to look for metaphors can provide much knowledge about the beliefs underlying the text. To understand changes in discourse at the text level, it is important to examine word choice and metaphors, and the possible reasons for using certain words rather than others, before moving to the second dimension of analysis: interpretations of the discourse practice.

***Step 1. Description*:**

- How is the text is linguistically and grammatically built?
- Which words and personal pronouns are used?
- How can wording, phrases and metaphors be understood?

Summarise your analysis of the text in reserach notes answering the questions above. This can be done in the margin of the document being studied and/or in summaries in a reserach logg book.

Step 2. Second dimension: Interpretation (processing analysis)

In this second dimension of the analysis, the focus is the discourse practice of the text. This includes analysis of the production and consumption of the text and the process in which it was created, which is combined with the linguistic description from the first dimension of analysis. To analyse the production and consumption the following questions can be asked: For what purpose has the text has been produced? Who has produced it and under what conditions? Who is the text addressed to? What are the consequences of the text? Using what processes has the text been created?

The second dimension also includes analysis of intertextuality and interdiscursivity, which refers to the text's relation to other texts and discourses. Through analysis of these relations, it is possible to identify the reproduction of discourses. Intertextuality includes analysing in what way a text is based on elements and discourses from other texts, and to highlight signs of change in the discourse through questions such as: Which words have followed over the years? Which are new? and Which are not used anymore? Interdiscursivity means clarifying the existence of different discourses in a text and identifying the practice of expressing and combining them in the text. This analysis is performed by identifying words and phrases in the texts that originate from other discourses, as well as in what way these are used. Identifying the discursive practice is exhaustive work; it requires that the analysist is familiar with the context and history of the study object, not just the text.

Again, returning to the analysis of the excerpt from 'the reasonable patient' as an example, we can see the following patterns in discursive practice. When it comes to interdiscursivity, the information texts speak to the reader in a way that is recognisable from popular psychology and self-help discourse. This is a tone many readers are familiar with, which focuses on what one can do to help oneself. This fits well into a societal discourse where the individual is held responsible for almost every life choice and consequence and will create a sense of recognition in the reader. If the producer of the text wants to create a bond with the consumer of the text, this is a smart move. As for intertextuality, the information texts are constructed using a non-authoritarian healthcare voice, a move away from a traditional image of health care recommendations. Before the 1990s, healthcare providers used much more uncompromising, demanding and objectifying language in their communication, where patients were not expected to respond or participate in the conversation. Intertextuality shows that the discursive practice of healthcare has changed into being an agent who uses reasonableness in its persuasion and, therefore, also expects reasonableness from the patients it is addressing. The consumption of text concerns cancer patients and their close ones who are the receivers of these texts. How do they interpret the texts and how do they act on them? They might change their lifestyle in the direction suggested by the non-authoritarian experts in the text, but they might also feel lost, and that they have been left without clear advice. The processes in which the texts are created also add to the discursive practice. Information campaigning, for instance, is a process with its own rules and logic, borrowed from commercial marketing. How could that have influenced the texts?

Step 2. Interpretation

- For what purpose has the text has been produced?
- Who has produced it and under what conditions?
- What are the consequences of the text?

Summarise your ideas and arguments in reserach notes answering the questions above. This can be done in paragraphs in a research diary or logg book. Do not shy away from using diagrams, charts or drawings to simplify and visualise your findings about the intertextuality.

Step 3. Third dimension: Explanation (social analysis)

In the third dimension of CDA, critique of discourse is combined with explanation of how the discourse works within and contributes to social practice. This is the dimension where the uncovering of power relations and ideology is central. The social practice is the way in which we use the discourses, for example, how healthcare services can use specific discourses to change their work to meet societal demands and expectations. Simultaneously, the reverse relationship can prevail: social practice has a potential to influence discourses.

Again, using 'the reasonable patient' as an example, in the third dimension of analysis, a discourse of informed consent was identified. Reasonableness was our explanation of healthcare's ideas and construction of patients in the texts. This Swedish notion of agreeing, usually referred to as 'the Swedish model' by state authorities, is based on being able to make decisions on the basis of information and creating consent in a meeting where both parties are equal. The Swedish model may be one of the main elements reinforcing the discourse of informed consent shown in our analysis. The social practice of being "reasonable" becomes tangible for patients as they search for advice regarding their own health on healthcare providers' websites. Simultaneously, they are discursively disciplined in accordance with these expectations of reasonability from the healthcare system. This means that patients should possess the necessary emotional, intellectual, social and material resources to be a rational, realistic and worthy patient in the meeting with the healthcare system. This third dimension of CDA includes explanation of how the discourse under study relates to social practice, how the analysed discourse leads to different actions and how, in this way, the discursive understanding has social consequences.

Step 3. Explanation

- How can the discourse you are styding relate to social practice?

By using the reserach notes from your text description and ideas and arguments from your intepretation you will now draft the body of text that will answer the study aim, still utilising a critical undulating reflexivity. The text procuced in this step can be insertet into, or written directly in, the result section of your paper. Consider what parts of the description and interpretation phases could be used to reinforce your explanation.

SUMMARY OF THE PROCESS

When the three dimensions of description, interpretation and explanation as described earlier have been made clear (in line with the systematic undulating reflexivity as described in Figure 2), the discourse is encircled. It is this encircled discourse that is presented in the results section of the article. Returning to the "the reasonable patient", when presenting the socially accepted norm of a patient as "reasonable" in the results, we could also identify what was left unspoken—inherent—in this encircled discourse. Social practices that this dominant discourse of reasonableness contrasted with were to mentally break down, acting outside agreed social norms, and not having the resources needed to act as expected [17].

DISCUSSION

This article has introduced some basic principles for discourse analysis, a method for exploring the construction of taken for granted dimensions in caring and nursing contexts. Specifically, the CDA methodology was introduced, with its interest in power relationships and in uncovering completely obvious, as well as hidden, agendas that form our view of the world and make us take it for granted. Discourse analysis can make researchers aware of how health, treatment, professional relationships, healthcare organisations and other phenomena can be effects of language use. The potential for caring and nursing research if it were to embrace the power of language is tremendous.

Reflexivity needs to be highlighted in the context of discourse analysis. According to Winther Jørgensen and Phillips [2], researchers must try to explain their position in relation to the discourses they are investigating and what consequences their contribution to the discursive construction has had. Discourse analysis captures the construction and the becoming of the world and the phenomena that constitute caring and its context. In the step-by-step guide that we propose, a reflexive approach is essential for text analysis (description), process analysis (interpretation) and social analysis (explanation). The reflexive process needs to be transparent. Providing a substantial basis for making a statement about the discourses and their relationship, that is, a rigorous scientific presentation, is as important for discourse analytical studies as for other qualitative methods. To ensure quality, there should be alignment between theory, research questions, data collection, analysis and results, while the sampling strategy, the depth and volume of data, and the analytical steps taken must be appropriate within that framework.

Analysing discourse offers an important perspective on our time. The increasing use of the method shown

in Figure 1 indicates that caring and nursing scholars increasingly see the construction of social phenomena, such as power, as meaningful to describe. The use of the method seems to mirror an increasing interest in power relations in healthcare. With the increasing online discourse around issues of health and disease, the traditional power asymmetry between care-seeker and caregiver has been disturbed, as patients themselves often research their health status on the internet [8]. The doctor's elevated position is not taken for granted anymore. At the same time, online discourse can govern patients at a distance, offering healthcare professionals an even more powerful tool of control. Motivating patients to be more involved in their own care is a way to obtain consent from these patients to participate in their own governance, and to make the 'right' and expected health choices [18]. This, too, represents a shift in power relations, from authoritarian healthcare to much subtler governance. These patterns in power relations can be explored in depth using discourse analysis.

Critical discourse analysis is about describing, interpreting and explaining social phenomena and is thereby useful for exploring the field of healthcare. The analysis can uncover contradictions between what is claimed and expected in written discourse versus its consequence in social practice. Through the three dimensions of analysis, it is possible to show how these contradictions are caused by and are parts of, a wider social reality [14]. The abstraction that takes place through the analysis is a condition for critiquing the transformation of discourse into social reality.

From a caring and nursing perspective, this transformation must be recontextualised into concrete actions within healthcare contexts. Here, we can again use the discourse of the reasonable patient as an example: the discourse and social practice of being "reasonable" is transformed into guidance for patients' actions in their search for health advice [17]. CDA can be seen as a form of practical argumentation which advocates a form of action based on an explanatory critique of the social reality, identified in the third dimension of analysis.

Research in caring science requires, in addition to individual-focused patient research, studies of the conditions for care, for example, legislation, communication and policy. As early as 1995, White [19] highlighted that sociopolitical knowledge is an important knowledge domain within nursing. Also, knowledge of the environment, one of the nursing's meta-concepts is part of nursing competence. Environmental factors for health include law texts and policy documents as well as institutional and societal structures, which directly and indirectly affect how hands-on care can be provided. Chinn [20] argues for the importance of adopting a critical normative approach in nursing, which implies to study how and where care is given and to whom [21]. According to Kim [22], nursing needs to develop and apply methods that draw from the situated, individual instances of nursing practice in order to develop and augment the knowledge necessary to improve its practice' (p. 1205). Discourse analysis can be used to study and critically examine how 'desirable' care is constructed and promoted, and what obstacles may be hindering it. We argue that CDA can develop knowledge necessary to improve the practice of nursing.

CONCLUSION

Since the 2010s, discourse analysis has established itself as a possible method in the toolbox of caring and nursing researchers. Despite this, discussions about the epistemological starting points, about validity and methodological steps have rarely been presented and discussed within caring science. Each generation of caring researchers has somehow had to interpret their own way of working with discourse analysis in the field. This article offers a clarification of discourses, presents their epistemological boundaries, and present guidance how they are encircled in a CDA research process. It is important that discourse analysis is easily available and accessible to nursing and caring researchers, as its results give vital knowledge into the fields that otherwise would be lost or would not be available. Therefore, our final and summary stance is that discourse analysis, as it is presented in this article is strongly advisable for use in nursing and caring sciences.

AUTHOR CONTRIBUTIONS

All authors participated in the analysis work, writing and critical readings of the drafts. All authors approved the final version.

ACKNOWLEDGEMENTS

We would like to thank librarian Jessica Thorn for her valuable and constructive input on the manuscript.

FUNDING INFORMATION

No funding to report.

CONFLICT OF INTEREST STATEMENT

All authors declare that they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

No human subjects were involved as participants in this study.

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How to cite this article: Dahlborg E, Boman Å, Eriksson H, Tengelin E. Encircling discourses—A guide to critical discourse analysis in caring science. Scand J Caring Sci. 2023;00:1–8. https://doi.org/10.1111/scs.13194