Emotions in practice

A study of Balint seminar training
as experiential learning for qualified nurses

Contents

Acknowledgements

This study has been a collaborative venture, following an invitation from members of a Balint seminar group to explore the application of Balint's work to psychosexual nursing by studying a seminar group at work. It has been a wonderful opportunity, and a highly challenging and enjoyable process. For reasons of confidentiality I cannot name the group members individually, but would like to record my sincere thanks to them all. I hope that this report, future publications and any debate about the merits of Balint seminar training for nurses and nursing, will go some way towards matching the group members' time, openness, interest and support.

I would also like to thank Di Wells and Kate Seers, for valuable insights and support throughout the research process, and Cherill Scott for her insightful comments on the draft of this report.

Proviso

Psychosexual problems generally remain private concerns, and so it is easily assumed that they are rare. However, many people will have experienced sexual difficulties at some point in their life. This report is concerned with the work undertaken by nurses offering psychosexual counselling to clients who are experiencing sexual problems. It explores one of the forms of professional support and development available to nurses working in this area, namely Balint seminar training. In order to indicate the nature of this training, the report draws on extracts from case studies and group discussions that were recorded during Balint seminars. To maintain the anonymity of the nurses involved, and the clients they worked with, details of case studies and conversations have been edited, in some cases quite extensively, so that virtually all features hinting at individual identity have been removed or changed. Any correspondence found between readers' personal circumstances and those described in the report are therefore coincidental, but may serve to suggest how common these problems can be.

Executive summary

This study arose from an invitation to document the work of a long-standing group of expert nurses who are referred patients with psychosexual problems for short-term counselling. The group is comprised of eight participants and a group leader who meet once a month to reflect on, and develop, their practice, using an experiential approach to learning known as Balint seminar training. Their focus is on recognising the emotions informing the nurse–patient relationship, with a view to using these emotions therapeutically.

Aims of the study

a) To describe the process of experiential learning taking place in a Balint seminar programme;

b) to explore the potential of nurses' emotional experience as a form of nursing knowledge;

c) to explore the role of the seminar leader, and the skills required for this role;

d) to begin to explore the potential offered by Balint training as a developmental model for nurses' clinical supervision.

Approach

An ethnographic approach included participant observation and recording of the seminar group over the course of one training year; interviews with all members; and attendance at relevant additional activities attended by seminar members, such as study days.

Summary of findings

Findings are presented with reference to the aims outlined above:

a) The process of experiential learning

Balint seminar training was understood as one of a number of ways of working within psychosexual medicine or nursing. It was described by group members to be non-prescriptive, not concerned with advice, cure or the application of techniques (as with more behavioural approaches) but with an emphasis on understanding relationships, and a focus on understanding the patient's world, through the nurse's experience.

Although there were no set rules, a number of principles informed the learning that took place. The most significant of these were:

✦ feeling rather than thinking

Emotions, and the relationship between feeling and knowing, were of primary interest. Participants were encouraged to tolerate 'not-knowing', while the intellectualisation of problems and the role of theory were given secondary consideration.

✦ discovery rather than instruction

Seminar participants were encouraged to learn for themselves, to 'think on their feet' and not expect to be taught.

✦ the moral value of emotions

Emotions were not regarded as value-free, but were ordered into a hierarchy in which some emotions were more difficult to accept and work with than others.

✦ clues are available from the body

Nurses drew on the knowledge gained through physical (and often genital) examination of the patient, on the assumption that the body provided a route to the patient's emotional world. This ready access to emotion allowed by the body was important given the relative speed of the work, generally over no more than six sessions.

✦ ambivalence towards language

Nurses were aware of a problem of thinking with words, rather than through feelings, and that it was difficult to find the right words for the emotions that they encountered. At the same time, there was often a lack of fit between the words used in seminar discussions and any objective meaning that assisted nurses in making new discoveries about their practice.

✦ avoiding reassurance

Many of the emotions encountered in practice were painful in nature, and nurses had to be aware of the temptation to take flight from these by offering reassurance.

◆ focusing on the here and now

It was considered important to concentrate on what was known directly rather than what might have happened elsewhere (such as possible family dynamics).

◆ reflected emotions

It was assumed that the feelings experienced by the nurse and conveyed to the group during the case presentation of a clinical encounter were generally those of the patient (a process referred to elsewhere as 'psychic infection' or 'parallel process').

◆ the use of self

A distinction was drawn between a professional self, that could be used as a therapeutic tool, and a personal self, which should play no part in the nurse–patient encounter or seminar process.

Shaped by these principles, the learning that took place in the seminar group was characterised by a degree of uncertainty that was often distressing for participants. There was also a degree of tension within the process, between set rules (such as the necessity to focus on feelings rather than thinking) and non-directedness.

In addition, learning was painful because of the distress that emerged in the seminar process through case presentation and discussion. The seminars were a place where participants were vulnerable in the way that they made their practice available to scrutiny and sometimes revealed practices that fell below the standards they set for themselves.

b) Nurses' emotional experience as a form of nursing knowledge

Nurses' engagement with emotion, as described in this study, is very different to the kind of emotional 'work' referred to in the literature on emotional labour. Emotional experience was used by seminar members as a way of gaining insight into their clients' worlds, on the basis that the emotions that nurses were experiencing were those of their clients. In this sense, it was not the emotional experience *per se* that represented a form of nursing knowledge. Instead the knowledge these nurses were developing was concerned with understanding the nature and source of the emotions experienced during practice, together with how to use such emotions to therapeutic effect.

c) The role of the seminar leader and the skills required for this role

The main components of the leader's role were:

◆ to facilitate the process of discovery amongst seminar participants, rather than teaching or directing them;

◆ to maintain focus (for example, to return attention to the nurse–patient relationship; to remind group members to stay in the 'here and now'; and to help them to resist fleeing from the emotional distress that they experienced on behalf of their clients, and in response to challenges to their professional selves); and

◆ to acknowledge and contain (or hold) the distress of seminar participants.

Although there may be a number of possible approaches to working as a group leader, in this group, the leader demonstrated a range of skills including:

◆ being able to maintain a boundary between a professional and a private self;

◆ being able to maintain a sufficient boundary between the role of the group leader and that of participant;

◆ knowing when to leave participants to struggle and when to intervene (in terms of emotion, direction and theory);

◆ being able to offer challenge and support as circumstances required.

d) The potential offered by Balint seminar training as a developmental model for nurses' clinical supervision

The appropriateness of Balint seminar training as a way of providing nurses' clinical supervision may depend on the kind of clinical supervision required. The remit of seminar training is not concerned with purging nurses of the emotional detritus associated with nursing practice, but with understanding and making use of the emotions they experience in the course of their work. Findings from this pilot study suggest that this process is lengthy and challenging, and needs the facilitation of a highly skilled leader with sound experience in group work. Patient outcomes are currently unclear. Balint seminar training none the less requires managerial support for regular and long-term attendance. It also demands considerable commitment from participants,

given the relatively unstructured, undirected approach to learning and the distress that is an inherent part of the process. These factors suggest that, even if Balint seminar training can become a model of clinical supervision for nurses working beyond psychosexual nursing, it may prove difficult to provide in the current climate of health service provision. Before considering any expansion of the remit of Balint training, there are also a number of areas that need further inquiry (see Recommendations).

Limitations of study

◆ While participants in this study view Balint seminars as invaluable for their psychosexual practice, no attention has been given to the evaluation of patients' or clients' experience of psychosexual counselling where this has been supported by Balint seminar training, or to the effectiveness of such counselling.

◆ The study focused on an advanced practice seminar, and greater understanding of the experiential learning process associated with Balint work might be gained by the study of a basic seminar group.

◆ This study focused on nurses who had persevered with Balint seminar training despite the difficulties encountered either as neophytes or advanced practitioners. A fuller picture of the value of Balint seminar training, and its possible application to a variety of areas of practice, would be gained from a study exploring why nurses discontinued training, and why nurses who might be aware of its availability do not consider it further.

◆ The findings are possibly limited by the understanding of emotion that underpinned the research process and determined the methodological approach.

Recommendations

◆ Further understanding of the effectiveness of psychosexual counselling by nurses through evaluation of clients' experience and their perceptions of its effectiveness;

◆ Further work which explores the role of group leaders in more detail, and the different styles of leadership that they employ.

◆ Further work which explores the experiences of those attending basic Balint seminar training, and documents whether, or in what ways, their practice changes over the first year of practice.

◆ Further research which explores why nurses do not take up, or discontinue, Balint seminar training.

◆ Theoretical work to consider the methodological issues raised where emotion is understood to be constituted in and through relationships, rather than an intrinsic feature of individuals.

1. Introduction

1.1 The research focus

This study arose from an invitation to document the work of a long-standing group of expert nurses who are referred patients with psychosexual problems for short-term counselling. The group is comprised of eight participants and a group leader who meet once a month to reflect on, and develop, their practice, using a Balint seminar approach. Members of this group have been active in the development of psychosexual nursing in Britain, and were anxious that the potential of a Balint seminar training approach might be harnessed to develop practice in psychosexual care and beyond. In this respect, the study was concerned with describing the process of experiential learning taking place in the seminar, with a view to promoting the Balint approach as a form of clinical supervision that might be relevant to other groups of nurses.

In addition, the work of this group was important because of its focus on emotion in the nurse–patient relationship. Emotions within nursing have largely been explored in terms of the influence of gender and the management of feelings. The work of these nurses however was not concerned with containing or defusing emotion, but instead aimed to recognise the emotions informing the clinical encounter, and to use these emotions therapeutically. A study of these nurses' work therefore offered the potential of exploring areas of nursing knowledge and practice that had previously received little attention.

1.2 Relevance of the study

Recent changes in health policy encourage health workers to work in partnership with patients or clients and to relate to them as individuals with unique needs (for example, Department of Health 1991). For many nurses this approach is encapsulated in the term 'individualised nursing care', a concept used without precise definition but generally equated with quality of care (Reed 1992). Its roots can be traced to Menzies' (1970) work, specifically her findings that the use of task allocation was associated with problems of distance and de-personalisation in the nurse–patient

relationship (Reed 1992). Nurses' avoidance of closeness with patients came to be recognised as a potential threat to an embryonic profession, which claimed a unique field of practice through the altruistic and intimate nature of its work (White 1984). More recently, forms of nursing (such as 'new nursing') have emphasised the importance of 'closeness' for high-quality care and the therapeutic use of self (Savage 1995).

Individualised care is predicated on some degree of understanding of the client's background, personality, feelings, values and beliefs; thus it is essentially an interpersonal process requiring the integration of clinical and humanistic skills (Chapman and Fields 1996). However, this process can arouse powerful emotions. This, together with the need for the nurse to monitor the giving of self and the constraints often placed on relationship work with patients, combine to suggest that individualised care requires emotionally skilled practitioners (de Lambert 1998).

Emotions within nursing have largely been explored in terms of gendered perceptions of care, the management of feelings and the effects of nurses' experience of powerful and distressing emotions which lead to stress and burnout (James 1989; Smith 1992; Rafferty 1998). What has received less attention is the way that nurses can learn through their emotions: there is increasing recognition in non-nursing literature of the way that emotions, and the body from which they are inseparable (Lupton 1998), are valid, if undervalued, sources of knowledge (e.g. Henderson 1997).

Clinical supervision has been heralded as a way of working with issues associated with individualised care and the emotions this can prompt. It has been seen to hold the potential to improve quality of care (Wilkin, Bowers and Monk 1997), increase practitioner autonomy and accountability (Heath and Freshwater 2000), reduce burnout (Berg, Hansson and Hallberg 1994), and put meaning back into nurses' work (Wilkin, Bowers and Monk 1997). There is some conceptual confusion however about clinical supervision and its boundaries, particularly the extent to which it focuses on professional development or personal growth and whether it represents support or therapy for practitioners (Yegdich 1999). An exploration of Balint seminar training, which draws on psychoanalytic principles and the use of self in client–practitioner interaction but does not aim to offer therapy for the practitioner, may therefore be helpful in the development of new, less ambiguous models of clinical supervision.

1.3 Aims of the study

The aims of the study were thus:

◆ to describe the process of experiential learning taking place in a Balint seminar programme;

◆ to explore the potential of nurses' emotional experience as a form of nursing knowledge;

◆ to explore the role of the seminar leader, and the skills required in this role;

◆ to begin to explore the potential offered by Balint training as a developmental model for nurses' clinical supervision.

1.4 Research approach

To meet these aims, the study adopted an ethnographic approach involving participant observation of the seminar group over the course of one training year, interviews of all members and attendance at relevant additional activities attended by seminar members such as study days. As explained in section 3.2, this report is based predominantly on findings from interviews, augmented by my experience of participation in the seminars.

1.5 Outline of report

Balint seminar training is underpinned by the view that learning should be a process of discovery rather than instruction. In line with this approach, I entered the field very much as a novice seminar participant, with little theoretical understanding of Balint work. This report reflects the process of gradual discovery that I underwent. The following chapter gives only brief background information to contextualise the study prior to a discussion of the methodological approach, study design and presentation of the findings. A more focused look at theoretical and practice issues that emerged during the study will be found in the Discussion chapter.

2. Background to the study

This chapter provides background information about the main issues or areas that frame the study, namely clinical supervision, Balint seminar training, psychosexual nursing and emotion.

2.1 Clinical supervision

The nature of nurses' and other health professionals' interpersonal relationships represents the 'swampy lowland' of practice in which problems are often not responsive to rational intervention (Schon 1987). It has been recognised, for example, that those nurses who come in contact with the emotional needs of patients have a need for small group discussions that offer time for support and reflection (Franks, Watts and Fabricius 1994.) Experiential learning, or learning through reflecting on direct experience (Burnard and Chapman 1990), has been seen as a way of developing nurses' capacity to work effectively in the 'swampy lowlands of practice', with clinical supervision as one form of experiential learning that offers staff the opportunity to reflect on and develop clinical practice (Wilkin, Bowers and Monk 1997).

Clinical supervision in nursing has been viewed as providing a range of different outcomes. It may represent a means of support, a risk management tool, an aid to clinical governance, personal development or ethical integrity, and a way of reducing stress, sickness levels or burnout (Sloan, White and Coit 2000). The traditional premise underlying clinical supervision however has been the teaching of therapeutic skills (Sloan, White and Coit 2000).

Although the UKCC made it clear that clinical supervisors should be properly prepared and evaluated (UKCC 1996), it has also been suggested that clinical supervision is ill defined (Wolsey and Leach 1997; Sloan, White and Coit 2000). Severinsson and Hallberg (1996) suggest that there are two specific styles of clinical supervision: the cognitive and the emotional supervisory styles, Cognitive therapy supervision has

been described as focused, structured, educational and collaborative, with the aim of increasing awareness of how cognitions, emotion and behaviour can influence the therapeutic encounter and teach therapeutic skills (Sloan, White and Coit 2000).

Within the emotional supervisory approach, clinical supervision has been seen as a way of washing off 'the emotional grime of the job' (Wilkin, Bowers and Monk 1997:48). However, viewed as more than a method for emotional debriefing, it can represent an opportunity for nurses to acknowledge and work with their emotional experiences (Rafferty 1998). One example of this approach is provided by nurses using a psychosocial approach, drawing on techniques of experiential learning developed by Michael and Enid Balint and, later, Tom Main (Barnes, Griffiths, Ord and Wells 1998).

2.2 Balint seminar training

Michael Balint was a Hungarian psychoanalyst who first developed his seminar approach to experiential learning in Hungary in the 1930s. He later moved to the Tavistock Institute, London, where he first worked with non-medical professionals, and later with family planning doctors who asked him for help in developing skills to cope with the sexual anxieties of patients. This work led to the development of the Institute of Psychosexual Medicine. Balint also worked with general practitioners who wanted to understand the doctor–patient relationship in more depth (Balint 1963). The aim was to understand a patient's emotional conflict and how this related to their illness and the doctor–patient relationship. This meant examining

> the relationship between the doctor and the patient, to look at the feelings generated in the doctor as possibly being part of the patient's world, and then use this to help the patients.
>
> (Balint et al.1993: 47)

The Balint approach, which gained international recognition, particularly in Germany, Japan and the United States of America, is characterised by its participatory and non-didactic character and allows critique of habitual ways of working. It offers the potential for therapeutic intervention where this is understood as bringing to the fore an emotional factor in the client–practitioner relationship and enables the client to recognise something new about him or herself.

2.2.1 The seminar process

In most instances, a Balint group has six to 14 participants who are involved in clinical work and make a commitment to attend regular seminars for one to two years (about 30–36 seminars). A leader who either has psychoanalytic training, experience of group work or a similar clinical background to the participants facilitates the seminar.

Participants describe their encounters with patients, particularly where they feel uneasy or dissatisfied with their work. They present case histories from memory on the basis that this will allow them to speak more freely than if they offered a prepared account. It allows them to forget and later remember things, or contradict themselves, and these features of their account are seen as significant indicators of important feelings that the participant may have that remain hidden to them. The group is expected to listen carefully and non-judgementally to such descriptions, and to explore the nature of the practitioner–client relationship with a view to supporting the practitioner in developing new understandings and skills (Clifford 1998).

Participants do not require any theoretical knowledge about psychoanalysis. Quite the opposite: any anxiety about 'knowing things' is seen as counterproductive and an impediment to spontaneity. The learning that takes place is not the progressive acquisition of intellectual knowledge or the result of instruction: 'It cannot be taught, only discovered' (Balint et al. 1993). The Balint group creates an atmosphere of exploration in which participants can look and listen 'to what is going on inside as well as outside themselves' (Balint et al. 1993: 48). The approach aims to help practitioners make their own discoveries for themselves through sharing events in their own practice, rather than providing them with theories or standard guidelines (Wells 1998).

2.2.2 The use of Balint seminars in health care

Historically, in the health care context, members of Balint groups have largely been medical practitioners, who have had mixed intentions and mixed experiences of the approach. Rabin et al. (1999), for example, describe how Balint seminar training provides a legitimate forum for doctors to engage in the discussion of patients' stories in an unconditional manner. They

found that insightful listening could help them move from a biomedical mode to a narrative one with a view to changing or repairing both their patients' and their own personal narratives. Similarly, Botelho et al. (1990) describe the way a Balint approach contrasts with traditional continuing medical education which they believe overemphasises content and avoids emotional issues common in physicians' relationships with difficult clients. Instead they document how the learner-centred, process-oriented long-term membership of a Balint-style group helped physicians to explore emotions informing their encounters with clients. Brock and Stock (1990) in a study of almost 400 family practice residencies in the US offering Balint group training, found that the major objectives were support for residents and resolution of professional role conflict. Leaders in these groups observed that the main outcomes appeared to be greater understanding of feelings generated in the physician–client relationship, and an enhanced sense of professional self-worth. Brock and Salinsky (1993) found Balint seminar training to be one way of developing practitioners' empathic skills.

A study by Musham and Brock (1994) found that Balint work improved the effectiveness of participants in their work as family physicians, particularly with troubling patients. However, the usefulness of the Balint work depended on regular attendance and a strong interest in the psychodynamics of the doctor–client relationship, suggesting that the approach is appropriate only for some practitioners. Similarly, Balint work demands a certain kind of leader: Merenstein and Chillag's (1999) study of 12 US groups found that these were generally hierarchical in nature, with the leader acting as teacher. These groups functioned largely as support groups in which participants attempted to reduce their levels of anxiety rather than develop their therapeutic potential.

2.2.3 Balint seminars and nursing

During discussions with nurses in the seminar, it was suggested that nurses might be interpreting Balint's work rather differently to doctors, with a stronger emphasis on emotion and a greater informality in the seminar group.

There are however few reported instances of Balint group work amongst nurses (Franks, Watts and Fabricius 1994). None the less, there are indications that

it can offer a forum for nurses to present and attempt to resolve stressful situations with patients, co-workers and other professionals. Von Klitzing (1999), for example, describes the use of a Balint group in a one-year postgraduate training in patient-centred nursing for gynaecology nurses. She describes the Balint approach as a psychodynamic process in which the client–practitioner relationship is cognitively examined while trying to understand emotionally the dynamics of the relationship. Rabinowitz, Kushnir and Ribak (1994) found that a Balint group for primary care nurses led to heightened awareness of mental health and psychosocial issues, while a study by Rabinowitz et al. (1996) found significant increases in awareness and reduced emotional exhaustion as a result of Balint group work. Penman (1998) has also viewed Balint seminars as a form of action research, in which the experiences of practitioner–client interaction can be reflected on critically and used to develop theory. Finally, Selby (2000a) has outlined the learning outcomes as identified by a group of practitioners involved in Balint seminars (see Appendix A for details of these), and the relevance of this approach for psychosexual nursing.

2.3 Psychosexual medicine/nursing

The Balint approach, primarily associated with general practice, has also been applied to other fields, such as psychosexual medicine and, more recently, psychosexual nursing. Both of these fields of practice are concerned with the development of pyschosexual awareness and the skills to use such awareness therapeutically. More specifically,

> Psychosexual awareness is the integration into one's practice of the facts of human sexuality and its vulnerability. The skill is to learn to balance this aspect of the person alongside the multiplicity of other necessary clinical data that we need to make clinical decisions.
>
> (Clifford 2000: 20)

The English National Board has recognised a course in the principles of psychosexual counselling for nurses, midwives and health visitors (ENB 985), of which Balint seminar training is a central component and for which the specific learning outcomes are to:

◆   acquire and develop listening skills to perceive the

patient's/client's feelings;

- ✦ understand and make use of the verbal information from the patient/client;

- ✦ observe and make use of non-verbal information from the patient/client such as appearance, mannerism, posture;

- ✦ understand and make use of the feelings generated in the nurse with a patient/client during an encounter;

- ✦ understand that a problem presented cannot always be solved;

- ✦ recognise that the presenting problem may not be the actual problem;

- ✦ acquire knowledge and skills to use genital examination, where appropriate, to reveal the patient's sexual anxieties;

- ✦ recognise the patient's/client's resistance to looking at the actual problem;

- ✦ recognise and acknowledge the defences used in dealing with psychosexual encounters in day-to-day clinical practice;

- ✦ acquire knowledge to determine when referral is appropriate;

- ✦ evaluate the development of the nurse's own clinical practice in psychosexual nursing.

(unpublished ENB 985 course information)

From these is it evident that a psychosexual approach is holistic in that it seeks to provide the physical, psychological and emotional care of clients with sexual health needs. What is particularly significantly for this study is the way in which psychosexual practitioners work from the premise that 'an almost limitless expanse of emotions can enhance or subdue arousal and sexual activity' (Skrine 1997: 1).

Put another way, poor sexual health can be understood as the writing of unwelcome emotions on the sexual body.

2.4 Emotion

From the discussion so far, it becomes clear that the significance of emotion is common to the practice of clinical supervision, Balint seminar training and psychosexual nursing. Over recent years, interest in

emotion as an idiom for understanding issues of social relationship has grown rapidly in the social and behavioural sciences (Lutz and White 1986). There is, however, no agreed understanding of emotion. The following section sets out some of the ways that emotion has been theorised, with a view to locating the approach underpinning the study, and the methodological issues that it may pose.

2.4.1 Theoretical tensions

A series of overlapping theoretical tensions characterise the literature on emotion, largely around the extent to which emotions are bodily or social phenomena. These tensions have been organised in an anthropological review of emotion (Lutz and White 1986) as a series of dichotomies, providing a useful framework for clarifying the perceptions of emotion informing this study. The dichotomies Lutz and White identify are set out below:

- ✦ *Materialism and idealism*

The dominant paradigm in the study of emotion in the social sciences has been a materialist one. Emotions are considered material things, constituted biologically as movements of facial muscles, raised blood pressure or neurochemical processes. Although culture might be seen to influence the expression of emotion, 'individuals and societies are primarily seen as "coping with" emotion's given materiality' (Lutz and White 1986: 407). In contrast, emotions have been understood as ideas or evaluative judgements, often with little relationship to the body. In this view, emotions as judgements require a degree of social endorsement or negotiation and, as such, are not divorced from issues of power and social structure.

- ✦ *Interpretivism and positivism*

In an interpretivist perspective, knowledge is constructed by people in relationship to each other. In terms of understanding emotions, this has led to an emphasis on the negotiation of emotional meaning, the way in which the meaning of emotion is problematic because of the way that it is embedded within socially constructed categories, and the extent to which emotion is mediated by language. In the more traditional positivist stance still dominant in disciplines such as psychology, the focus is often on the emotional or motivational causes of behaviour.

◆ *Universalism and relativism*

Universalist approaches focus on emotion as a pan-human phenomenon, typically defined as an internal feeling state. Recognition of cultural variance is restricted to phenomena that are tangential to the essence of emotion, such as the language available for describing it. Quite differently, relativists see emotion, or many aspects of emotion, as culture-specific, tending to view emotion in terms of socially endorsed judgements, rather than internal states of the individual.

◆ *Individual or social*

In evolutionary and psychodynamic approaches, the individual remains the ultimate source of emotions that either conform with or contradict social expectations. Others make a slightly different distinction, in which emotions are defined as private feelings that bear little relationship to culturally shaped or socially articulated norms and sentiments, which conform to social expectations.

◆ *Romanticism and rationalism*

For rationalists, emotions are identified with the irrational, the disordered and the problematic. In the romantic view, the capacity to feel emotion defines what is human, and provides meaning in individual and social life.

2.4.2 Implications of approach

According to Lutz and White (1986), these basic stances have implications for the way that emotions are investigated. Emotion can be seen as:

◆ something to be explained by other variables (such as the body, social structure);

◆ something that can explain cultural institutions (such as hospitality, participation in religious ritual); or

◆ an inseparable part of cultural meaning and social systems.

How emotion is understood will influence:

◆ whether a researcher will claim to study emotion directly, or ideas about emotion - or both;

◆ the types of methods used, including observation of behaviour, analysis of language, empathy or reflection;

◆ the focus of investigation (such as emotional development to learn about cultural norms, the incidence of emotional pathology such as depression, or the parallels between the structure of society and the structure of emotion).

According to these authors, the dominant view of emotion has been one that gives primacy to inner bodily experiences, partly, they believe, because it is consistent with Western concepts about the person as individual. Such a view of emotion, however, is seen as restrictive, limiting theoretical understanding of both emotion and social life. Instead, they suggest we need a different theoretical understanding of emotion which does not assume a stark opposition between rational and irrational, individual and society, or public and private.

The way emotion is conceptualised has further implications for the research process, particularly with approaches that stress the researcher's emotional response to fieldwork, and include these in the research findings. Areas to consider in this instance include:

◆ the ethnographer's own cultural assumptions about self and emotion, and

◆ the characteristics of the ethnographer's social relationships, such as inequalities in power and social competence, or the possibilities of loss, danger or alienation. (Lutz and White 1986).

2.4.3 Understandings of emotion informing the research

2.4.3.1 The interactionist view of emotion

The concept of emotion underpinning this study is an interactionist one. It aims to overcome the restrictions of both organismic approaches, in which emotions are understood as largely visceral or physiological responses, and social constructionist approaches, which argue that emotions are not in our bodies but our actions, that feelings are social and sustained by group rather than individual processes (Williams and Bendelow 1996). Thus in one approach social influences are downplayed, and in the other the relevance of the body is largely ignored. An interactionist approach,

however, is situated between organismic and social constructionist accounts, and seeks to link biological and social factors in a dynamic rather than reductionist way.

2.4.3.2 The political economy of emotion

Scheper-Hughes and Lock (1987) argue for a mindful body, in which emotions mediate between individual, social and political realities. One area where the political connotations of emotion are relevant to this study concerns gender and the gendering of such occupations as nursing. It has been observed how highly prized ideas of rationality and objectivity are set in opposition to, and exclude, the attributes and experiences commonly associated with femaleness and underclass social status, such as emotion, practicality and connection (Lupton 1998). The way in which reason and emotion, or thought and emotion, have been understood in dichotomous terms has been significant in the development and, arguably, the marginalisation or subordination of nursing as a profession (Davies 1995). The dominance of rationality in Western thought has led to the relative neglect of emotions, or to the view of them as irrational, private inner sensations, tied historically to women, their 'hysterical' bodies and such feminised activities as caring (Lupton 1998). The identification of women with emotion has been seen to undermine the professional standing of nursing (Davies 1995) and shape the content of nursing practice in terms of the emotion work[1] and the emotional labour[2] expected of nurses. However, despite recognition of the role of emotion in nursing (see, for example, James 1989; Smith 1992), there has been little examination of the kind of **_knowledge_** that emotion represents in nursing practice. Although this study does not deal with nursing as a whole, and does not seek to address the question of nursing's subordination, it does aim to indicate the significance of emotion in one area of nursing, and explore the potential of nurses' capacity to recognise and develop emotional knowledge.

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1 'Emotion work' has been described as the self-management entailed in expressing culturally appropriate emotions (Lupton 1998).

2 The term 'emotional labour' generally refers to the way that the feelings of others are responded to or managed, particularly in a social unit or workplace, with the intention of maintaining harmony (Lupton 1998).

3. The study

This chapter describes the methodological approach and methods adopted for the study, in addition to discussing the particular issues raised by the focus and approach of the study. It also presents details of the Balint seminar group, including its history and background information about its participants.

3.1 Methodology

An ethnographic approach was chosen to allow the study of what happens in the seminar, and to explore participants' perceptions of seminar training. The term 'ethnography' can be applied to much small-scale social research that is carried out in everyday settings, uses a number of methods, evolves in design throughout the study and focuses on the meanings of individuals' actions and explanations rather than their quantification (Hammersley 1990). In addition, ethnography is viewed as contextual and reflexive: it emphasises the importance of context in understanding events and meanings, and takes into account the effects of the researcher and the research strategy on findings (Boyle 1994). Ethnography also derives data from etic and emic viewpoints, or combines the perspectives of both the researcher and the researched (Boyle 1994).

The way in which ethnography is applied, however, depends on a number of factors, such as the philosophical stance of the researcher (Atkinson and Hammersley 1994). There is, for example, no single epistemology or theory of knowledge underpinning all ethnographies. Instead, different kinds of ethnographies rest on different ideas of what constitutes legitimate knowledge (Atkinson and Hammersley 1994).

In addition, in the context of health care research, ethnographers generally have to adopt the narrower focus associated with a mini-ethnography. This, like more traditional ethnography, allows the understanding of a local world and the structure and flow of interpersonal experience within this, but makes allowances for the constraints placed on the ethnographer in health services research and the difficulties preventing long-term immersion in the field (Kleinman 1992).

3.1.1 Trustworthiness

The diversity of epistemological stances informing modern ethnographies raises questions about the evaluation of ethnographic research and the appropriateness of such criteria as relevance and validity. Reaching agreement within the qualitative research community on the appropriate criteria for assessing ethnographic research has been notoriously difficult (Hammersley 1990). Attempts to ensure the trustworthiness of this study rested on the following aims adapted from Popay, Rogers and Williams (1998):

✦ that the research will give voice to the subjective views and experiences of participants and researchers;

✦ that decisions taken at all stages of the research process are clear;

✦ that the values informing the research are clear;

✦ that appropriate participants are involved;

✦ that there is sufficient and appropriate information (thick description) to be able to follow interpretation;

✦ that there is due attention to ethical considerations; and

✦ that consideration is given to the relationship between findings and their relevance to other groups.

The rest of section 3 (and to some extent, section 5.3 onwards) gives details of how these intentions were addressed.

3.1.2 The advisory group

In addition to feedback from the seminar group members at different points in the study, an advisory group was set up that included some members of the seminar group and others experienced in using the Balint approach. This group gave advice on issues that arose during the study (such as how to ensure confidentiality of clients). In addition, advisory group meetings were times when it was possible to discuss questions and impressions generated by the research (such as the role of theory).

3.2 Methods

Data were collected through

✦ *participant observation of Balint seminars:*

10 out of 11 monthly seminars (11 represents the full training year) were observed and recorded.

✦ *semi-structured interviews with participants*

Tape-recorded interviews were carried out with all seminar participants (8) and the seminar leader once a number of seminars had been observed. Interviews were shaped by questions formulated as a result of participant observation at seminars and through discussions at the advisory group meetings. Interviews ranged from 45 minutes to two hours, and generally took place in the same centre as seminars. On one occasion, when this was not possible, the interview was conducted in the participant's home.

✦ *attendance at associated events*

Data collection was augmented by

i) Attendance at a psychosexual demonstration seminar held at an international conference. The participants were a different group of nurses who worked with the same group leader, Sylvia. These nurses were less experienced in the use of the Balint approach and did not take psychosexual referrals. Instead they used their training to identify psychosexual problems with clients whom they met during their everyday practice (for example, as practice nurses in health centres).

ii) Attendance at psychosexual study days, set up by members of the seminar group and others, which aimed to inform nurses of the potential of a Balint approach, and support those working with psychosexual issues.

Attendance at different types of meetings was extremely helpful in clarifying that members of the seminar group that I was observing were very much among the leaders of the psychosexual nursing movement and were highly motivated and energetic in promoting a Balint seminar approach.

- *group discussions after initial analysis of findings*

These meetings were with seminar participants, who commented on an interim and then draft version of the final research report.

3.3 Analysis

Wolcott (1994) makes a useful distinction between the research activities of description, analysis and interpretation, while careful to emphasise that they are not mutually exclusive ways of exploring data. With description, Wolcott suggests, the data are treated as fact, and allowed to speak for themselves. With analysis, the role of the researcher extends beyond a purely descriptive account to the systematic elucidation of key factors and the relationships between these. Interpretation, he argues, goes beyond the degree of certainty often assumed with analysis, and represents an attempt to reach an understanding about meaning, particularly in relation to context.

In this study, a certain amount of descriptive data is presented, such as the backgrounds of the seminar participants, the setting in which they work, and an indication of the work of the group as understood from participant observation. Interview data are subjected to thematic analysis, more as a way of managing and thinking about the data than applying some tight form of analysis. Data from the seminars, and additional sources such as the advisory group, are used to expand the analysis and assist with some level of interpretation.

It is only recently that social scientists have begun to reflect critically on the way that they produce texts and the way that these are read (Coffey and Atkinson 1996). There is a move towards greater subjectivity, more reflexive authorship and experiments with forms of writing that give expression to a broader range of voices or perspectives (Atkinson 1990), and awareness of the sets of relations that bring texts into production (Clifford 1986). This has led to accounts of fieldwork that are acutely self-conscious of the researcher's role in the generation of data (see, for example, Okely and Callaway 1992). In addition, it is now more widely recognised that 'knowing' involves different kinds of activities and different relationships to language. People may speak more, for example, about the atypical and less about what is assumed to be shared knowledge: there is, therefore, a need to acknowledge the different

emphases and modulations, indeed the spoken and the unspoken 'voices' of a single speaker (Bloch 1998). This point seems particularly relevant to this study, where it seems that in the seminars, much of the meaning intimated by members of the groups seems to reside in what I refer to as 'the spaces between the words', rather than within the words themselves (see section 4.1.1).

3.4 Research setting: the seminars

3.4.1 History of the seminar

In the 1970s the Family Planning Association recognised that family planning practitioners were meeting clients with psychosexual problems and needed some training in this area. The Department of Health was approached to help fund this training. Balint training was already well established for doctors at this time, but the Department of Health was unwilling to see this training extended to nurses without the evaluation of a pilot scheme. Three seminar groups were set up to run initially over one year, then two years. Sylvia, the leader of the advanced seminar today, led one of these pilot seminars. This original seminar group was followed by one specifically for group leaders, and for those who had undertaken the ENB 985 course in psychosexual counselling. Once the leaders' group was running, a number of nurses who had used the Balint approach for some time suggested an advanced practice group and this was set up about eight years ago. Membership was by invitation and, in contrast to existing groups which offered support to those doing psychosexual work within other fields of practice (e.g. practice nurses or family planning nurses), this group was provided for nurses who were taking psychosexual referrals or working specifically as psychosexual counsellors.

The nurses that I studied were amongst the pioneers of psychosexual nursing in the UK. These eight nurses had a varied history, practising for many years in areas such as family planning, midwifery or general practice, where they had identified and worked with patients' psychosexual problems as part of a wider clinical remit. Now, all but one of these nurses acted as psychosexual counsellors, taking referrals from a range of sources, including general practitioners, mental health services and, to a lesser extent, sexual health clinics. Their clients

were predominantly heterosexual, of various ages, with a range of sexual problems, such as impotence, loss of libido or the non-consumation of a long-term relationship by penetrative sex.

The participants were highly motivated, often travelling long distances to attend seminars, and were centrally involved in the promotion of the specialty through the activities of the Association of Psychosexual Nursing. News about new seminar groups or study days was easy to disseminate or access. This meant that, despite the small number of seminars in existence, nurses in the field could move in and out of seminar groups at different stages of their development with relative ease, if there were groups near their area.

3.4.2 Members of the seminar

Seminar participants had a variety of backgrounds but held in common the drive to offer the best possible psychosexual care for clients and to promote the acceptance of psychosexual nursing and the use of a Balint approach. They were a group of warm, humorous, plain-speaking and energetic women who, despite numerous demands on their time, were strongly committed to the seminar group and tolerated cramped and often uncomfortable conditions during the seminar without complaint.

Using pseudonyms to disguise individuals, members of the group are described below.

Ruth

Ruth trained first as a children's nurse and then as a general nurse, spending her first year as a staff nurse in psychiatry and casualty. She then attended a ward sister's training at the 'Rooks Centre', a therapeutic community for individuals and families with severe emotional problems, based on psychodynamic ideas and experiential learning. From here Ruth was appointed Sister at a day centre for emotionally disturbed children where she worked for five years. Following a short spell as a health visitor, she returned to the Rooks' families unit. It was here, influenced by a major proponent of Balint's work, that the seeds of Ruth's interest in psychosexual nursing were sown. After a break to have children, Ruth's way back into nursing was through sessional work in family planning and the promotion of sexual health, which she later came to combine with practice nursing.

Miriam

Miriam's interest in psychosexual nursing began some 15 years ago when she was working in a family planning clinic. The doctor who provided psychosexual counselling was retiring and suggested that she took over. This prompted her to join a basic seminar run by the Institute of Psychosexual Medicine, which she continued to attend for two years before being advised to join an advanced group, this time comprised of nurses. Miriam currently combines her work as a psychosexual counsellor at a genito-urinary medicine clinic with practice nursing and acting as a family planning instructing nurse.

Joan

Joan trained as a midwife and later as a family planning nurse. Working in a general practice setting, she became aware of the number of patients who had psychosexual difficulties and attended a seminar group run by Carol until this was disbanded. She then took a psychosexual course (part of a degree course) and trained to work with men with erectile dysfunction, before joining the advanced seminar group.

Gill

Gill trained as a general nurse and worked as a staff nurse before leaving nursing for six years to have children. Family planning nursing provided a route back into work and through this she met a doctor at the Institute of Psychosexual Medicine with whom she first discussed the psychosexual care of patients. In the mid-70s Gill joined a seminar group run by Sylvia. She also trained as a nurse specialist in family planning before working in an Infertility clinic, initially in a clinical capacity, but later as a counsellor. She currently works at this clinic three half days a week, works as a Nurse Specialist in family planning and at a well woman clinic. Gill also provides clinical supervision for family planning nurses.

Agnes

After general nurse training, Agnes left nursing for a while to go overseas, and be a full-time mother, before returning to various part-time jobs and then eventually to gynaecological nursing. The consultant she worked with for many years was retiring and suggested Agnes tried family planning work. Her role as a family planning advice Sister meant that she began to meet clients seeking advice for psychosexual problems, and this prompted her to join a training seminar run by

Sylvia. The work led her to take a diploma in psychology and later a diploma in sexuality and health care. She then saw patients privately and joined the advanced seminar for supervision.

Carol

Carol has worked in family planning for 38 years and originally joined a seminar group in the late 70s because she felt unable to answer many of the questions posed by her clients about their sexual problems. She became a clinical teacher for family planning and developed a JBCNS 985 course with seminar training. She led this seminar group for some years. She has subsequently run a number of groups, and currently works as a psychosexual counsellor in a family planning clinic. She made supervision through an advanced seminar a precondition of her appointment.

Alice

Alice's background included working as a nurse in a mountaineering team, before becoming a mother and training as a family planning nurse. She became aware of the narrowness of family planning training before working with a doctor trained in psychosexual medicine who inspired her to develop her skills in psychosexual nursing. She undertook the JBCNS 985 course run by Carol, and later helped in running this. She was a member of a Balint seminar group for some years before joining the advanced seminar. The GPs she currently works with refer patients to her, but she does not work specifically as a psychosexual counsellor.

Margaret

Margaret's background included working in acute care, with a particular interest in intensive care, and then palliative care, including work as a member of a pain relief and symptom control team. Later, after health visitor training, a doctor in Margaret's family with an interest in psychosexual medicine suggested that she took the JBCNS 985 course. She has subsequently helped set up a psychosexual service locally with a Balint-trained doctor, and takes referrals for psychosexual counselling.

Sylvia

Sylvia, the group leader, first trained as a general nurse and midwife and worked as a midwife on the district for three years, before taking her Midwife Teacher Diploma and becoming interested in how groups work. She took the ward sisters' course at the 'Rooks Centre' and

eventually became the Matron there, running a range of groups for staff of different disciplines. By this time a number of family planning doctors had been in Balint groups and Sylvia was encouraged by a major proponent of this work to set up something similar for nurses. On a trial basis, three seminar groups were funded by the Department of Health, one of which was run by Sylvia. This experiment led to recommendations to the Joint Board of Clinical Nursing Studies for a course in psychosexual counselling for nurses (the 985). Sylvia has been leading psychosexual seminars ever since.

3.4.3 Context of the seminar

Data collection included participation in, and recording of, 10 psychosexual seminars over a period of 11 months. These seminars took place monthly in a meeting room at an inner city centre for birth control and infertility services. While the centre had a nurse-led psychosexual clinic and provided free accommodation for the seminar, the seminar group was essentially independent of the centre.

The meeting room was relatively small (about 8 x 12 feet) and was usually used as a library for clinic staff. A table normally placed in the centre of the room would be pushed to the back and a circle of chairs drawn up in the remaining space: participants sat very close together, almost touching. Several participants commented during interviews that this closeness seemed to help the work of the group – on the odd occasion when they had to use a larger room, they felt the extra space had a negative effect on their work. There was a degree of informality about the seminar: tea or coffee was made on arrival, and occasionally participants ate sandwiches during the seminar if they had had no time for lunch.

The existence of the group was well known to clinic staff, such as administrative staff and researchers working on the same floor. There was a slight tension between these staff and the group: the library became inaccessible during seminars; the confidential nature of seminar work was also a little discomforting to other staff – if the door was left open for air, they felt uneasy about using the adjacent kitchen. Generally, however, there was a lot of good will between members of the seminar group and the permanent staff, which I experienced, for example, when trying to find space in the clinic for interviews.

My role in the group was decided in advance by discussion with the group: I would be an active observer, with freedom to contribute as felt appropriate. I had, many years previously, been a novice member of a similar group with some of the participants in the current study. I therefore had some familiarity with the process, although little understanding: I had never reached a point at which I felt comfortable in my participation, and I was rather in awe of the group leader. This time around, my role was very much more comfortable – I had been invited to work with the group, I was received with great warmth, I was a little older and wiser perhaps, and there was no expectation that I would present any clinical work for discussion. I did not become a highly vocal member of the group and, without a clinical base and without the experience of the other participants, was always aware of being more of an outsider than an insider. However, becoming a participant of sorts meant that I was able to enter into and thus learn something about the learning process.

In terms of the broader context, this seminar group, as indicated elsewhere, met the supervision needs of advanced practitioners who were active in the promotion of psychosexual nursing and the use of Balint seminar training. After practising for years in relative obscurity, the work of these nurses may become less marginal following the publication of the Department of Health's strategy on sexual health. In addition, recent years have seen the establishment of the Association of Psychosexual Nursing, and publications such as <u>Face to Face with Distress</u> (Barnes et al. 1998) and <u>Caring for Sexuality in Health and Illness</u> (Wells 2000), which demonstrate the value of Balint seminar work.

3.5 Ethical issues

3.5.1 Ethics committee consent

Ethical approval was obtained from the RCN Institute Ethics sub-committee, which considers proposals from staff or students at the Institute for research where there is no obvious, alternative, local ethics committee to apply to.

The main issues for consideration were:

❖ *The protection of the anonymity of research participants and their clients.*

Pseudonyms are used for participants, and where extracts of case studies are reported, the details of clients and their circumstances are disguised.

❖ *Informed consent for seminar observation and recording.*

Written information (see Appendix B) about the study was provided to participants who were initially approached by the group leader. As the group expressed interest in the study, we then met to discuss the nature of the research and appropriate ground rules. Group members were given time to think over whether to participate or not, and fed back their response to the group leader. Once it was clear that there was collective agreement, members were asked to sign a consent form for recording and observation of the seminars (see Appendix Ci), and for the recording of individual interviews (see Appendix Cii).

❖ *Informed consent for the use of case histories.*

The use of case histories by members of the group, and subsequently within this report, raises issues around informed consent. The discussion of case histories is a regular part of clinical supervision, and their retrospective use, without agreement, can be justified as part of a move to improve patient care. However, the use of such case studies as research data, where the link to improved patient care is less direct, is more difficult to defend. While it is hard to see how the research process could have been managed differently, I remain uneasy about the use of information about clients without their consent. Johnson (1992) has argued that medical literature often uses case histories without patients' consent, and that it is often not until after the consultation that the doctor is aware that they have collected 'data' - in other words, informed consent is not always possible. Discussions with the nurses in the seminar group led to the decision that use of case history material was acceptable, providing anonymity is protected. However, the ethical issues raised by the research of clinical supervision needs further debate.

3.5.2 Ethical issues raised by participant observation

Participants were reminded on several occasions that if they became uneasy about the presence of the researcher at the seminar, they could discuss this with the group leader, and that the participant observation

element of the research could be discontinued. It might be argued that it would be difficult for individuals to withhold consent when this might impact on the wish of the rest of the group to continue, or to go against the wishes of the group leader, who was known to be in favour of the study. It is also the case that the nurses in this group were highly experienced in expressing their feelings and dealing with conflict or difficult situations. They were also given the contact details of an independent person who, if necessary, could mediate on their behalf.

3.6 Methodological issues

3.6.1 Studying emotion

Ethnography allows the study of interaction between nurses in Balint seminar training (including the researcher) through a multi-method approach to the collection of data that are verbal and non-verbal, observable and non-observable (such as the researcher's own experience of participation). However, understanding the seminar process was inevitably shaped by the way in which emotions – the focus and means of learning in the group – were conceptualised by both the regular participants and the researcher.

3.6.2 Emotion, use of self and participant observation

The complex issues regarding identity, selfhood and role for the fieldworker are now widely acknowledged, but largely in terms of how to manage these for the success of a research project. What is largely overlooked still is the way in which fieldwork shapes or constructs identities and impacts on the emotional and physical self (Coffey 1999). Emotions that arise for the fieldworker, when they are admitted, are generally presented in largely negative terms. However, in this study which drew upon a growing body of work in which the self is used as a source of data, one of the intentions was to attempt to draw upon emotions experienced in the field in much the same way as nurses in the Balint group drew on their emotions to understand practice.

 As described above, my role in this study was one of

novice group member, albeit a novice with no case studies to present, who was encouraged to contribute to the seminar in terms of sharing feelings and reactions. There seemed to be considerable overlap between being a participant observer and being a group participant, for example in terms of a profound sense of uncertainty about the significance of what was being observed or experienced.

Quite distinct from the emotions aroused by the discussion of specific case histories, my participation in the group was charged by a range of emotional responses. Unlike some of the 'real' participants in the group, I always looked forward to going to the seminar. Being a fieldworker usually entails the social unease of an outsider who works to become an insider. Here I had been invited to participate and felt warmly included by the group. I admired the participants for their perseverance and openness, for their readiness to make themselves vulnerable, and often for their wisdom. I found pleasure and affection in the frankness of their language, and the space they made for humour and spontaneity. However, I also felt fearful in a number of respects: fearful of not contributing enough or not matching the effort of others, fearful of saying the wrong thing and showing my lack of understanding, and fearful of letting down the members of the group who were so enthusiastic that I should describe their work.

In contrast to these emotional reactions to fieldwork, which I believe were relatively easy to identify, it proved hugely difficult to interpret or – sometimes it seemed even to experience – emotion prompted by case studies or their discussion. Just like a true seminar participant, I felt baffled for a long time by the process that I was there to study. After a number of sessions I did experience a turning point when things seemed to fall into place – a moment in which for the first time I became aware of a powerful feeling that I felt was not exclusively 'mine', but belonged to the group. However, this insight was also matched by an uncomfortable discovery that what I considered to be emotion was largely un-bidable. The group leader might ask us to describe our feelings at particular points, but I found it generally impossible to pin these down or sort them into discrete, recognisable categories that might answer to names such as sadness, disgust or relief. These issues will be explored in more depth is the following chapters.

4. Findings

The first part of this chapter describes the way in which the seminars run, as understood from participant observation. An outline of the seminar process is described, with examples from case studies. Findings or questions arising from participant observation informed the interviews with seminar members. The findings from these interviews are presented in Part two.

4.1 Part one: the seminars

4.1.1 Description of the seminar work

The seminars each last for two hours and the group leader, Sylvia, took responsibility for orchestrating the opening of the seminar, the selection, presentation and subsequent discussion of several case studies or follow-ups, and closure of the seminar.

Identifying practitioners' need

Selection of work to be presented was initiated by Sylvia but managed by the group. When asked who had work to present, participants negotiated between themselves, carefully stepping around each other, assessing who had the greatest need to discuss their work. In discussions with seminar members, I described this process as 'the dosey doe' to indicate its patterned nature and the way that it seems to be an element, or point of punctuation, in a larger performance, and the term seemed to strike a chord. A brief example of the verbal aspect of this process is as follows (although picking up on the needs of other participants appeared to be equally dependent on non-verbal signs):

S: So whose got some work they want to talk about?

P1:   I've got a follow-up.

P2:   Could wait

P3:   Mine could wait as well.

S: But yours is a follow-up? Well, shall we have some follow-ups or what do you want to do?

In addition to presenting case studies of consultations that were running aground, members of the group also provided follow-up information, describing the progress of work previously presented. These follow-ups could be very brief, or might be discussed in as much detail as a new case study. In addition, participants might occasionally describe unexpected breakthroughs or developments in their practice that they felt the other seminar participants might find useful.

Case studies

Case studies were presented without notes. During the presentation of the case study, it was rare for the speaker to be interrupted. This generally occurred only if the presenter ran into some difficulty, such as forgetting details of the clinical encounter.

Each participant had their own style of presentation. Some described their encounter with their client (or clients, if consulted by a couple) in a relatively detached manner, indicated by the use of reported speech (for instance 'She said that she had been married for five years'). In contrast, others appeared to be more directly involved through their use of direct speech ('She said "I have been married for five years"'). In some instances, participants were almost 'in character', or role playing, and seemed physically caught up in their story. Gill, for example was noticed to sink into her chair, rather as she described her client, and to speak in lower and lower tones while recounting increasingly difficult encounters with the same client. These case studies or stories therefore had a dramatalogical element.

Structure of presentation

While the content, style and detail of the case study varied, with different emphases on different elements, most case studies shared a similar structure:

a) Scene setting

This generally included a description of the client in terms of their route of referral, their problem, their appearance and manner, and occasional detail (for example, if the client has come for the first time with their partner). In the case of a follow-up, such description would be briefly restated.

b) The core of the consultation

Most of the case study was concerned with how the nurse telling the story explored issues with the patient.

This could be through:

- an exploration of feelings (for example, a patient's feelings about their partner, their body, the psychosexual work);

- an exploration of fears, anxieties and concerns (such as a patient's anxiety about their body, the meaning/effects of penetration, about the effect of seeking help);

- an exploration of sexuality and sexual fantasies.

Such exploration might include the introduction of certain techniques, such as the use of drawings to express the client's understanding or fears of their body, or the use of physical examination.

c) Reference to the future and future work

This included whether the patient would like to return for further work, and what the nature of future work might be.

d) The feelings of the narrator.

An example of the structure typically informing the case presentation is given below.

	Bill and Tina [psychosexual counsellor: Carol]
Scene setting	Descriptions – physical appearance, age, clothing, features. Original reason for referral: wanted a baby, absence of sexual relationship. Background: 10-year relationship, extra-marital relationships during this time (good sex), no sex between clients for five years. Characteristics: Bill says nothing, unsettling smile. Tina takes control. Carol usually very strict about time, but this session overran because of significant shift in work/progress. Carol had felt for some time that this couple needed to separate, things were going nowhere. Previous week they had arrived very late and Carol had not waited: no obvious resentment on anyone's part. Bill looked slimmer, Tina looked exhausted (as always). Couple took usual seats. Carol daunted about what to do, suspected there has been no progress, thought (hoped) that they might separate and thus not return.
Core of narrative	Tina asked Bill to start, and he agreed. Carol was surprised: Bill wanted to go back to original reason for referral – Carol - having a baby? Bill – 'no - because we're not having sex' – said as if annoyed – wanted a solution. Carol not offering solutions. Carol suggested that in the way Bill spoke, he was indicating feeling for Tina that had not been obvious before. Bill very assertive that he had always felt for Tina. Then reverted to his more usual manner - vague, apparently disinterested – often replying 'don't know'. Tina complained this is how he always was. Both claimed to be great friends, Bill wanted the relationship to continue as he loved Tina. Carol asked what is it about her that he loves 'She is beautiful' (surprised Carol by this answer) but has no sexual feelings for her. Carol asked why they came to see her – why were they still together after 10 years? Bill - 'We need each other.'

	Tina – 'I don't think I need you now.'
	Carol introduced the idea of the baby.
	Tina stated that she couldn't have a baby in this relationship; she didn't trust Bill.
	Couple then began to talk to each other in a way they had not before.
	Carol sat back and listened.
	Bill and Tina said very hurtful things to each other.
	Tina went into history of relationship and complained that he had affairs.
	Carol asks didn't she also?
	Yes, but Tina would not have come back if Bill hadn't lost his job.
	Carol asks Bill to describe his experience of being unemployed
	After some prompting he describes how awful it was and how Tina didn't understand.
	Came across as child, with Tina as mother.
	Carol shared this insight – described Bill as infantile.
	Bill is shocked by this description.
	Tina agrees with Carol, although she hadn't fully acknowledged this description before.
	Recalls how she told friends that she has a child, namely Bill.
	Bill is taken aback.
	Session is running out of time but important shift occurring so overruns.
Moving to future	Carol suggested that perhaps they need to part – they were no closer to a sexual relationship than ever.
	Bill said that he would feel guilty about leaving as Tina alone. Tina said she felt another relationship was possible.
[Implicit reference to feeling]	Carol asked if they wanted another appointment.
	Bill thought not.
	Tina less certain, felt it might be difficult to get one if she needed to see Carol.
	Carol made provisional appointment.
	Tina left door open to further work on her own. Carol seemed surprised, excited, relieved.

The discussion

The case study was often followed by a short silence, and then some initially tentative enquiries. However, once discussion got under way, the conventions of 'politeness' and waiting for a turn to speak often gave way to something of a free-for-all. This lapse in etiquette, however, appeared to be less about the promotion of [competing] sets of individuals' perspectives, and more a collective stirring or blending of viewpoints.

This example from another case study helps to show this. It refers to a young client who feared continuing with counselling, as it would involve facing issues about her cruel treatment by her mother that she would find very painful:

G:	She's told me... Her first words were almost 'I'm frightened to do the work because that's where it will bring me, to not being able to have a relationship with my mother.'
A:	Such a ...
S:	But her fear is of her anger, isn't it?
C:	That's the explosion though, I think, that's the explosion.
G:	Yes, yes, of course it has to be...
?:	Because how can a mother say that? Any mother say that to a child? Or anybody?
C:	In a way, she has a right to be angry.
?:	Of course.

> G: But you see what I'm saying is…
> C: She has a right…
> ?:   …absolutely…
> C: … but can we give her permission to have that right?

This extract demonstrates a constant feature of the seminars in that, as transcribed text, it does not convey a great deal of meaning. Participants are often interrupted and unable to make their point, and yet the discussion continues very often as if they have, or as if the other participants know what they were intending to say. Although this is a feature of conversations in general amongst individuals who know each other relatively well, it also may suggest that much of what occurs in the seminar is extra-verbal, or takes place in the spaces between words.[1]

To demonstrate this point, another case study is presented, followed by an indication of the ensuing discussion. The extract overall is additionally useful in giving a good indication of the issues that the seminar group tend to focus on, and the way in which they approach their work.

Example of a case history

Presenting features
Agnes described her work with a client called Elaine, someone she had seen several times. She described Elaine as a 'fierce looking lady', with sharp features and spiky hair: 'she reminds me of an electric light bulb, you know, she flickers like that'. At the last consultation, Elaine had appeared very angry because of confusion about her appointment, and she had been verbally aggressive towards Agnes. Quite out of character, Agnes had snapped back at her, and she still seemed angry in presenting details of her encounter with Elaine to the group.

Elaine was complaining of loss of libido. Two years ago, in her mid fifties, she had married a man several years older than herself. Before marriage they had a passionate sexual life. Then she suddenly went off sex. Without enquiring about any other symptoms, her GP had referred her to a menopause clinic.

Background
Agnes learnt that Elaine had been having a difficult time since her marriage. Her father, with whom she had been very close, was dying. Things had been difficult at work, the promotion that she had hoped for had been offered to someone younger than herself and she feared that she was not held with the same high regard amongst her colleagues as before. After selling her own house and moving in with her husband, she missed her own space.

Psychosexual work
Trying to remember the nature of the psychosexual work done during these sessions, Agnes told how she had suggested a physical examination, but Elaine had refused this on the basis that she knew there was nothing physically wrong. Agnes had asked about Elaine's husband and received the impression that there might be some ambivalence in Elaine's feelings towards him and his sexual needs.

The cry for help
Agnes concluded by saying that she didn't seem to have much to show for the number of times she had seen Elaine, but perhaps she would remember more as the group discussed her work with her.

Initial discussion
The ensuing discussion started with agreement about how hard it seemed to get close to Elaine, and how unclear the group was about her feelings for her husband. Agnes then added that Elaine's mother had died when she was a small child, which had led to her closeness to her father – he had brought her up. There was some discussion of whether the husband played a fatherly role for her.

The leader seeks focus
The group leader, Sylvia, then asked what the feelings were of people in the seminar – how did they respond to what Agnes had told them? There was much rather

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fruitless discussion and great difficulty in identifying what anyone felt, or if anyone felt anything. No one seemed to feel sad for Elaine despite hearing about the various losses she had sustained – her home, her libido, the potential loss of her job and the forthcoming loss of her father.

Sylvia suggested that the absence of feeling in the group probably reflected how difficult it was for Agnes to have any feeling about her patient. She asked Agnes to say more about what it was like to be with her. Agnes told how she was very anxious to help Elaine and this seemed to have made her talk more than usual – there were no silences: 'it was either her speaking or me speaking', as if they were afraid to stop. Agnes restated the way in which Elaine reminded her of a flickering light bulb, as if she represented a dangerous current. The highly charged nature of the consultations seemed to be mirrored by the behaviour of the group – there was a lot of talking, interrupting and a good deal of argument and irritation. It was suggested that Agnes seemed to be pushing away members of the group in the way that she kept talking, without listening to what they were saying.

Turning point
Then, suddenly Agnes remembered something that she was astounded she had overlooked. Elaine had told her she had become pregnant in a previous relationship, when she was in her late 30s. She realised that this was her last chance to have a child, and she really wanted to have the baby, but she miscarried. She never became pregnant again. There was then suddenly a surge of recognition in the group that Elaine's visit to her GP and his casual reference to the menopause represented the powerful trigger for a profound sense of loss.

Effects
The empathic response to this new information was palpable: one member of the group had even gasped, as if she had been hit, when Agnes had told this part of the story. As a member of the group, I certainly had a similar response of shock and regret. I recorded this rather inadequately in field notes as a sense that 'the penny had dropped' – more in reference to understanding the group process - but in terms of my own response to Elaine's distress, I was affected much more profoundly than the notes suggest.

With this new insight, the mood of the group changed

significantly. Helen described it as a 'gentling down'. Everyone became much quieter. It was observed how information about the miscarriage had been withheld from Agnes until her last meeting with Elaine, and Agnes had in turn withheld this from the group until relatively late in the discussion. The session ended with Agnes stating that she had begun to feel Elaine's loss – she had been able to feel it in the seminar in a way that had escaped her in the consultation, perhaps because of the anger in the nurse–patient relationship. Agnes thought that she now had some basis to work from.

In a later seminar, Agnes told the group of a further consultation during which she had acknowledged the different losses that Elaine was trying to cope with. Elaine wept for a long time. After this, she admitted that the anger Agnes had witnessed was a constant presence, and one that really made her doubt her sanity. In her discussion with Agnes, she was then able to consider her anger as a recognisable element of bereavement.

What had happened in this process might be understood very much in terms of the discursive construction of emotion, that the feelings that the group came to share about Elaine were produced through the process of the discussion of her encounter with Agnes. However, quite how this happens is not clear from the transcript of this session. To demonstrate this I take an extract from the transcript that starts just after Agnes has told the group about the miscarriage, and there has been a sudden change in feeling towards Elaine.

Extract from transcript
P1: Where did that come from [P.2]? Why did you suddenly get that feeling?

P2: Or was it an intellectual transfer, I don't know, it was about talking about the loss of the baby that she wanted…

P3: … and then realising about the implications of the menopause.

A: Yes.

P1: Just when you said she really wanted that baby …

A: Yes, she was devastated when she lost the baby.

P4: I mean, not only is the patient scary but all the heart-[…] is really scary because they've been held down for so long. No work really has been done on the loss of the pregnancy, stacking right up now into the

father, her only other emotional … I don't know if she really wants to work with the pain, she wants to put the sex right but not …

P3:   I'm sure she demonstrating it …

A: She certainly wants her libido back but whether she wants to work is another thing… or her fertility back.

P2:   … interesting in a way because she doesn't understand that. She has no insight …

S: No, how do we help her? How do we help Agnes?

A: Help me, I am the one who needs help!

P5:   How can Agnes get into this?

S: Not through her head because you'd just be put down.

P6:   It's interesting, because right at the beginning Agnes actually said a lot of the irritation came because she was an intelligent woman so she knows what's going on in her life.

S: Up there [pointing to head]

A: Up there, yes.

P6:   So she knows that cessation or irregularity of her periods is an […] of being very menopausal.

P5:   Or are you making it up?

A: No, she is paying an important…, [to P.5] , oh surely…!

General comments and interruptions

P5:   Isn't it interesting, we keep getting into fights and that's the area …

A: Yes we do and that's the area, you're right, it is …

S: But I'm not sure, only you made the point… No, you said it the other way round but I'm not sure the nurse really wants to work with this …

A: Well, I, I'm scared of her, it's terribly hard work, it's exhausting and you don't get anywhere.

P6:   The intellectual bit is exhausting. You're barking up the wrong tree.

A: Yes, exactly,

P5:   You've gone up the wrong arm!

A: I have. Anyway, I'm seeing her again tomorrow.

From this is can be seen that there appears to be no straightforward relationship between the language used by these psychosexual nurses and the meanings that were attributed to their words during the seminars. Emotion that was palpable in the seminars makes only a ghostly appearance in the transcripts. This point will be returned to later (see section 4.2.4.).

Closure
Usually, at the end of each presentation, the presenting nurse would be asked by the group leader if it would be all right to move on, and the nurse usually responded by thanking the group for their work. At the end of the seminar, the group leader would remind participants of the time, and initiate a brief review the work that had taken place and the main areas of learning. A volunteer would be identified to write up the seminar for participants' own records. At the end of the training year, the main themes would be revisited, and an evaluation of the year would take place.

Initially I understood the seminar work in terms of each seminar being a discrete or self-contained episode. However, over time it appeared that the work of the group was not punctuated neatly into two-hour sessions. Not only did participants continue to reflect on the seminar work after they left, but issues or insights that emerged in one seminar would reappear in others. The seminars were less like a chain of sequential episodes, than a continuing process in which different themes or strands became more or less evident.

4.1.2 Implicit rules guiding seminar work

All participants came to this group with a degree of expertise (see section 3.4.2). All had either undertaken previous training in psychosexual work, such as previous Balint seminar training, or had substantial experience of working in groups. Many of the nurses in this advanced group were group leaders for other groups, and most had worked with Sylvia, the group leader, before. Some of the connections between group members stretched over decades. There was then, for a variety of reasons, a level of implicit understanding regarding the rules governing seminar attendance.

I had some awareness of the nature of the seminar from my experience as a participant in a basic-level group

many years ago, although my recollections of this past group are dim. At the start of the study I had no instruction about what to expect or how to behave, and learnt very much by observing and participating, as this felt appropriate. This implicit, non-tutelage approach appears to be characteristic of the learning process that takes place within the group.

The implicit nature of any rules can be glimpsed by observing what happened when Joan joined the group during the study. Joan had been involved in a Balint group before, led by Carol. On her first attendance at the advanced seminar Joan was late because of difficulty with the trains. She therefore came into the group 'cold', while the seminar was in process, without meeting other participants first. She was immediately plunged into the work without any formal elaboration or explanation of the process. Had she arrived before the seminar, I believe that she would have been welcomed and introduced, but not instructed in the ways that group worked. The lack of discussion of rules did not, however, mean an absence of rules, some of which were articulated more clearly than others.

i) Etiquette

There was, for example, a set of conventions about etiquette. Participants were expected to attend as many seminars as possible, and not be deterred by disruptions in public transport or similar setbacks. Presenting a case study, as described earlier, was negotiated according to an implicit principle of need. Participants had to consider the urgency of their need to present work in relation to the needs of others, and assess this fairly rapidly at the outset of each seminar. At the same time, it was acknowledged that presenting clinical work, and the mistakes and inadequacies that this might contain, was a challenging process, and the responsibility of presenting was to be shouldered by all group members as far as possible. The exception to this rule was Alice, who was working in a new environment: it was not unusual for group members adjusting to new circumstances to take more of a back seat for a while.

Case presentations were generally not interrupted unless the speaker was in some difficulty. However, after a presentation, and a few moments of quiet reflection, there was often a period of exchange in which some of the more usual social conventions might be breached. I have already described how seminar members interrupted each other, or would speak more than one at a

time. In addition, while the participants were sensitive to each other's feelings, they could also be quite challenging. This was particularly the case with the group leader, who could be quite stern. In addition, social conventions about physical contact might be ignored. On the one hand, a fairly conventional use of touch was observed, such as a hand on someone's knee or arm to express common feeling, or to soften a comment. On the other hand, the group leader, in moments of frustration, would tap someone on the head occasionally, if they were near enough, to protest that they were thinking, rather than making use of their feelings.

In addition, outside the formal seminar, although there was little time for individuals to meet, there was usually a fair amount of activity, such as moving furniture, making tea and informing others of study days and similar events. During this time, individuals often needed to search their bags for diaries or purses. What seemed significant was the frequency with which they mistook and rummaged through each other's belongings. More importantly, these mistakes were hardly noticed and no one indicated any concern or irritation about such mistakes, suggesting something of the level of familiarity and trust that existed between members.

ii) Absence of private self

Participants were courageous in the way they presented their work for inspection. They freely admitted many of the actions or thoughts that they doubted or regretted, and they described many of the emotions that they experienced as an integral part of their practice. They described their clients' lives and problems with great attention to detail, often laying bare the areas of life that are usually kept private. This insight into the lives of others seemed to invite reflection on my own, and I found later that this was sometimes the case for other participants. However, a very clear line was drawn between the nurses' own private lives and personal experiences and the work that they discussed (see, for example, section 4.2.5).

4.1.3 Explicit principles informing seminar work

There were a number of principles underpinning the work of the group that emerged over time, most of which I understand to be associated with the Balint approach. These include:

- the importance of attending to feelings rather than thoughts;

- the importance of focusing on the here and now, rather than a potentially fictional past;

- the importance of relying on memory in the presentation of case studies, and not on a script;

- the importance of recognising a correspondence between what is happening or experienced in the group and what is happening in the nurse–client relationship (or client–client's partner/s relationship).

4.1.4 Emotions and psychosexual work

What is difficult to describe, and does not emerge strongly enough in the account of seminars so far, is the extent to which emotions, including quite painful emotions, are an intrinsic part of psychosexual nursing and Balint seminar training. The aim in this section is to indicate the painful nature of the nurses' work, and the way in which the distress that they experience can be a mélange of pain that the nurse is 'holding' on behalf of the patient, and the wretchedness that ensues where the nurse's professional self is destabilised. To illustrate this, a case presentation by Gill is provided in full, together with those extracts from the subsequent group discussion that seem to illustrate the entwined relationship between practitioners' and patients' emotions. The case study offered was particularly memorable in that it appeared that Gill's manner of presentation to the group, her way of being, came to embody the emotional world of her client. In addition, the personal distress that Gill experienced through the challenge this clinical encounter posed to her professional self also seemed to be written on the body.

Gill: I mean I do see quite a few couples and I find it very difficult. But these two came together for the first time. I've just seen them the once and they were referred to the infertility clinic because really they've got secondary infertility. They've got a little boy who's now, I can't remember, but he's certainly about 6…? but it's a while. And he was a spontaneous pregnancy - [it took a] long time to conceive him but it was a normal conception. And now, I think it's six years down the line, they haven't been able to have another child and somebody picked

up, some doctor who was seeing them, picked up that they weren't having sexual intercourse very often. So they came to me. He has dark hair, quite slim, very pleasant face. And she's not very attractive really… And they came in and she is much more retiring than he is. He began to talk and to stay quite in control of himself. Her name is Sarah, and he's called Tim. And so I said, I talked to them about the referral and they said they were wanting to have a child and they weren't making love very often and I said, we'll talk about that. And he began to talk and say he'd grown used to that, at first he felt very angry and upset about it and couldn't understand why but gradually over the years he got a busier job and he was quite tired and he didn't mind so much now. And I said, 'What do you feel about it, Sarah?' And she said, 'Well…I've never particularly wanted to and certainly since we've had the little boy (I've forgotten his name) I've really not wanted to at all.' And she said, 'Really the sex seems to have gone away altogether, except that we do want to have another baby.' So I said, 'Well, when are you having sex? Is sex happening at all?' And he said, 'Well perhaps once every few months.' And I said, 'Do you want to tell me what happens then?' He said, 'Well for me,' he said, 'it's I don't have the same feelings any more about it.' He said, 'I always know. I always feel I know what's going to happen.' He said, 'I've pushed and I get in there and it's all right and then,' he said, 'She pushes me out…And then it just ends.' And I said, 'Is there any ejaculation?' he said, 'Sometimes.' … So I said to Sarah, 'And so what is it like for you?' and she said, 'I know what's going to happen. I go along with it and then,' she said, 'I have to … I just want it to end. I just want it to stop.' And she said, 'And I push,' she said, 'and it stops.' And then she said, 'But I need to tell you something.' And she sort of turned away and started to look out of the window and she said, 'When I was 13,' she said, 'my step-brothers were horrible to me about how I was and about being overweight. They said very rude things about me and I hated them.' And then she said, 'One night one of them made me lie down and he said, I want to know what its like in there and he put his finger into my vagina and hurt my vagina,' and she said, 'nothing else happened.' And she said, 'It was so horrible after that and she imagined he'd told the other step-brothers about what it was like in her vagina and she was very, very upset about it. It was when she was 12 or 13. And she said, 'I thought I'd better tell my mother after a while, better tell my mother.' But she hesitated and she said, 'And she said, it's a good job he didn't do more than that, isn't it?' And there was a long silence and I felt the

awful hurt of it and I just didn't say anything and I said, 'How did that make you feel?' and she said, 'Oh I just felt awful. I didn't know what to do, how to sit and talk, look at my mother, look at my step-brothers,' she said. 'It was horrible at home.' So we then went on to, so I said after that, 'Gosh, what must have sex been like for you at the beginning?' So I asked her when she first had sex and she said, 'It was when I met Tim'. And he said, She did tell me about her step-brother later and I did know about it, and he said, 'We used to get soft porn videos and we used to watch them together,' and he said that they had had sex and he enjoyed it then, but he said that she never did. And I said, 'But what did you feel about it Sarah?' and she said, 'Well,' she said, 'it wasn't so bad,' she said, 'And I liked Tim. I liked him cuddling me. I never felt very sexy, but,' she said, 'I loved Time very much so you know, I had sex but I never felt sexy.' And then she said, 'I'd like to tell you something else.' She said, 'I went to train as a teacher,' and she said, 'I failed in my exams,' and I'm not sure how this next bit came out but it was in relation to that and she said, 'My mother … it was awful when I failed,' she said, 'My mother said, you've been a very bad girl. She said, I know what you've been doing and I know why you failed your exams'. And Sarah then began cry and Tim moved towards her and put his arm around her and he said, 'We've always had this awful thing with Sarah's family.' He said, 'They've never been kind to her at all.' And …em, so (pause) at that point Sarah dried her eyes and I said, 'Do you want to go on?' And it was fairly near the end by this time. So we'd managed to talk about a lot of things and I said, 'How does it feel?' and she said, 'Well I'm glad that I told you and I'm glad that you know.' And I said, 'Well, you know, I'd like to see you again if you'd like to come.' And she said, 'What will happen?' And I said, 'Well ,if you take up your session, we'll talk about how you feel about sex.' And I said, 'Maybe it would be helpful if I examined you, examined your vagina, see what you feel about your vagina. Sometimes that can help.' And as soon as I said it by the look on her face it was something that was really, really difficult. She said, 'I don't think I want to do that.' I said, 'If you don't want to do that we really don't have to. There's no-one going to force you.' And I said, so, I just said, 'Shall we make another appointment?' I tried to explain I wouldn't examine her if she didn't want me to. I said that several times differently. And I just felt quite anxious and so they did make another appointment and I think I'm seeing them next week. But I felt quite awful about it at the end. After they'd gone out, I felt I'd really damaged the relationship in telling her that

I would go into her vagina. It was horrible …because she must have felt it would be like her step-brother examining her vagina. And I just wished I hadn't said it. I don't know why I said it really. I sort of felt I wanted to know what we might be doing, what the work was. And I felt so awful after I'd done it, as if I'd blown it, let her down, as if I might assault her. I had all these horrible feelings about it.

This presentation by Gill was followed by a long silence, and then a long discussion of the issues it raised. What are highlighted here are those parts of the discussion that relate to Gill's distress following her reference to vaginal examination. This distress arose from Gill's feeling that she had undermined Sarah's trust by suggesting something that seemed to parallel the violation Sarah had already experienced.

Sylvia:	You felt she trusted you, didn't she?
Gill:	And that's what was so awful about it. I felt as if I'd ... Why did I say that? I wonder why I said it.
Sylvia:	She asked you, didn't she?
Gill:	She asked me what would happen, yes. Yes. She did.
Sylvia:	You couldn't have said you wouldn't examine her.
Carol:	Well, she might not have mentioned it.

(General inaudible discussion)

Gill:	I was thinking why did I say that? When I'd just heard this story. It was horrible.
?:	But it didn't seem to have any time… This story and this question - it seemed to come terribly fast. Because you said to her, would you like to continue? Would you like to come back? And I mean, I mean my head was reeling just listening to you telling us.

At this point there was acknowledgement of Sarah's style of conveying her story. It was pointed out that she had enlisted Gill's sympathy, and made her feel that she was entering privileged space, by implying on several occasions that she was going to share special information with Gill, saying 'Well I've got something *else* to tell you'. Members of the seminar commented on the fact that, during her presentation, as Gill had recounted this, she had sunk deeper and deeper into her chair: 'You were getting smaller and smaller and had your eyes shut the whole time.'

This observation not only suggests something about Gill's feelings about the material that she is presenting to the group but is interesting in another respect. In her comments on the couple she admits that while she finds Tim an attractive character, she has more ambivalent feelings about Sarah

Gill: I mean I'm not put off by her. I mean I don't not like her, but she is [unattractive]. He's quite attractive. She sits there shrivelled up. That story makes you think how shrivelled up she is.
Sylvia: You shrivelled up.
Gill: Yes, I [did].

The point was made in the discussion that suggesting a vaginal examination put Gill in the position of 'these awful people' in Sarah's family. Sylvia's response was to suggest that Gill had been forced to be compassionate, rather like Tim, who was full of compassion and protectiveness for the 'victim' in the relationship, namely Sarah. In response to one participant's comment, 'I can't get my head round thinking past the dreadful life she had', Sylvia commented on the passivity that characterised Sarah's account.

Sylvia: Okay, so play the scenario with a different person and it could well be a girl who said to her step-brother, 'No, you can't do that. Get out of my bedroom.' Another girl might have been able to say it.
?: Another girl?
Sylvia: Yes. A different girl. Or someone, another girl might have been able to say to her mother, 'That's a lousy, rotten thing to say. Don't you feel sorry for me at all that I failed?' Or, you know, there could have been a row between mother and daughter. This is a very passive victim.
Gill: Cowered.
Gill: It was like the second I saw her face when I said it, I thought, oh my God what have I done?
Sylvia: So that's her power then. Well, isn't she?
All: Yes, mm, yes.
Sylvia: You weren't able to say to her 'Oh dear that probably isn't a very appropriate thing' because you were so frightened you might frighten her again…
Carol: Yes…You retreated.

Gill: I retreated.

Further parallels were drawn between the power that Sarah had in the nurse–patient relationship, and what happened between her and her husband in any attempt to have sex.

Sylvia: …you describe very graphically that she does that, she pushes her hand away. He said, 'I know exactly what's going to happen.' And so there is that thing of you thinking 'little meek thing' but there is a power there, which she probably doesn't understand at all.
Gill: No, I hadn't seen that. I hadn't seen that about her at all.
Carol: Ah, whether she's powerful …She's able to put her hands up. She wasn't able to do that with her step-brother though.
?: But she did it with Gill.
Sylvia: Yes, and absolutely.
?: 'Get out of my vagina!' And she made you feel so bad.
Gill: Yes. Well,
?: For something very ordinary.
?: What's that poem? C. Day Lewis's poem … when he talks about the weak strength of grass, you know, how grass can actually move a paving stone and that's really very interesting how this weakness is a fantastic strength.
Carol: Oh Gill!
Sylvia: It was so painful for you to be there, wasn't it?
Gill: Oh, it was so agonising for me.
Sylvia: You gave us a clue about it directly you said, 'I must tell you something'.
All: Yes.
Sylvia: We all knew what was coming, as you must have done and held your breath and thought 'What am I going to hear?'
Gill: Yes….
Sylvia: It's so difficult isn't it that the pain that she has faced in the past, that's what you've brought here and what we all heard, and we didn't hear anything really about what it's like to be a member of this couple ***now*** in terms of what it's like, we heard that she pushes him away.

This pain, Sylvia suggested, had prevented Gill from using her professional self, and taken her away from a

focus on the here and now. Although it seems that this pain originated in Sarah's teenage years, it had become as it were transcribed onto Gill, and made evident through her body language. As one participant observed, during her presentation, Gill could not have made herself smaller or retreated lower into her chair without falling off.

4.1.5 Emotion and participant observation

Theoretical understanding of the nature and origin of the painful emotions made evident in the seminar group will be considered later (see, for example section 5). What is relevant here, in considering the experience of participant observation of seminars, is how or whether the emotions that practitioners brought to, or perhaps constituted within, the group were experienced by the researcher.

I have already indicated the difficulties participants experienced in identifying emotion during the seminars, and the way in which they were encouraged not to mistake feeling for thought. At the same time, a strong association was assumed between emotions and the body. This suggested that some variant of a mind/body dichotomy underpinned the seminar work, although I knew such a dichotomy was not consistent with the views espoused by seminar members during interviews and other opportunities for discussion.

As a participant observer, I found myself trying to distinguish what were thoughts and what were feelings, and anticipated becoming aware of any feelings through the body. However, my body was often annoyingly silent or numb. I believe that this experience (or lack of experience) was part of the process of learning that other participants struggled with, particularly in earlier groups. However, as a researcher, it also raised questions for me about the methodological approaches that are appropriate to study emotion, and the links between methodology and understandings of emotion prior to research that inevitably shape the research process. These questions are returned to in section 5.

4.2 Part two: the interviews

This section reports findings from interviews with seminar participants. As might be expected, there were

some areas where a consensus existed amongst participants and others where individuals provided a range of different perspectives. What I have attempted here is to draw out the main themes to emerge, while giving a sense of divergent opinion where this exists. First I outline the participants' experience of basic seminar training and previous groups, before setting out their comments on advanced seminar training and the principles that underlie their practice.

4.2.1 Basic seminars

4.2.1.1 The need for a seminar group

Nurses in the group had different backgrounds and different paths to psychosexual work. For many, a break in career to have children seemed a catalyst for a change in direction, with several entering family planning nursing because of the ease of combining part-time clinic work with childcare. They then became aware of the incidence of sexual problems such as vaginismus, the non-consummation of sexual relationships, or erectile dysfunction. It was notable that all members of the group referred to influential figures, generally in their work place and often doctors, who had suggested either that they take on psychosexual work or Balint seminar training. What appeared pivotal, whether in family planning, practice nursing or any other field, however, was a realisation of the need to gain confidence to ask questions about sexuality, and to accept the possibility of rejection. For example, this nurse suggests how talking with colleagues about particular 'cases' helped to show that most practitioners were struggling in this area.

> It raised my confidence in taking the next step with a patient and opening up their feelings and not being concerned that I would say something to someone who may say 'Oh I don't want to talk about this, it's not your business.'

Some nurses, however, suggested that psychosexual work, or the use of Balint seminar training to support this, was not appropriate for everyone. Psychosexual work was seen as highly demanding and requiring a great deal of courage. One nurse said, for example:

> I can remember the first time somebody said 'Can I ask you something?' and I thought 'God,

this is going to be awful!' and I can remember sitting back in my chair and putting everything down and trying to look relaxed and saying 'Yes, please do,' but my heart was choking me really.

The training helped to make practitioners a little braver, to try things differently, to accept that they would not know the answers, that they would continue to feel awkward and uncertain in many situations, and that their interventions would not always work.

> I actually do not think that the work gets any easier in some ways. It is such a mystery, I think, psychosexual work. What is it that happens to somebody where they have such a block and what have you? You think of all the backgrounds that people have, the same experiences with ghastly things happening to them, and yet they are not affected. What is that thing that affects somebody?

Beyond being prepared to work in this way, it was thought that practitioners would need to feel comfortable talking about sex, and to have a certain maturity. One nurse raised the question of whether it was necessary to be sexually active, hinting at the importance of the role of self in the work (see section 4.2.5 and the use of self). This suggestion is also interesting in that it highlights an implicit assumption that appears to inform the work of the advanced group. While there is a positive and liberal view of heterosexual, penetrative sex, there was less indication of a similar regard for other forms of sexual expression, or that celibacy might be a positive choice for some individuals.

Participants had a range of reasons for first coming to a seminar group. For some, working in the field of psychosexual nursing had happened by chance and, as they began to work in this area, they felt they were 'working in the dark'. Participants spoke of getting 'stuck' or unable to move beyond a certain point with specific patients, and feeling in danger of being overcome by the distress of the clients they were seeing. For example, one group member said:

> Well I know I was certainly looking for a way to work with [women with psychosexual problems], especially the ones that I came across who really could not cope with any kind of penetration, either whether it was a speculum or in their own relationship, and I was really at a loss really how to move on with women who

often … It was one case that really triggered it. It was a woman who was married for five years and could not have any children or wanted children, but could never consummate and she was really unhappy. Her tears and her weeping and her misery and her background she felt with her strict parents that caused this. Really – the GP had sent her to me – it was a dreadful weekend. I saw her on the Saturday and I remember thinking 'If I see any like her …' as I just could not cope with this woman. I mean, I could say things like 'It feels like your vagina is not yours to do with what you want. It feels as if it is your mother's' – I am familiar with saying things like that, but I felt I could not move on from there. I did not know where to go and how often I was going to see people again who are so distressed.

Some participants referred to the professional responsibility of ensuring supervision for the kind of work they were undertaking. There was, however, a shortage of forums in which to discuss this kind of work, and much of the training that was available was found prescriptive or judgmental.

4.2.1.2 Experience of other groups

Almost everyone had experience of other groups aimed at those working in the psychosexual field, but not all of these were informed by a Balint approach. One nurse, for example, referred to a multidisciplinary group that she attended for health professionals and those involved in pastoral care, which was dominated by the leader who organised role play, handouts and discussions of video material, rather than facilitating the exploration of group members' practice. Another nurse spoke of the need for additional input, beyond Balint seminar training, such as formal education around specific issues. Others had experience of groups for behavioural therapy, and more directive ways of working.

A number of the group had first entered Balint seminars in which they were the only nurses and found themselves struggling, not only with the training process, but also with professional boundary issues. For instance, one participant said

> In the beginning…there were times I had a 40 to 50 minute drive to […] every fortnight and I

often felt 'Do I really want this, because every time I try to make a comment or to say how I feel …!' I would get one or the other of the doctors – and it was usually two in particular – who would say 'And what do you know? You're a nurse and you don't do vaginal examinations.'

Relationships between participants in multidisciplinary groups appeared more formal. For example, one nurse described how members in a group that she attended called each other by their titles and surnames during the seminar, regardless of how well they knew each other, in what seemed like an attempt to remind everyone of professional roles and hierarchies.

While multidisciplinary work had been dispiriting, it also seems that these nurses were forged by this kind of experience, and saw it as very much as part of their development to work towards enabling other professionals to acknowledge them as equals.

One participant noted that the focus of medically-dominated groups and seminars for nurses was different: the nursing seminars focused on the nurse–patient relationship, and did not attempt to understand the patient's relationships beyond the therapeutic encounter (see 4.2.5 and focusing on the here and now).

4.2.1.3 Early experience of Balint seminars

Most members of the seminar group in the study had begun in a basic or beginners' group in which they reflected on work with patients encountered in everyday practice - in other words, they were not working specifically as psychosexual nurses. While these patients might directly refer to psychosexual problems, it was often the case that these problems would emerge indirectly, under the cover of other enquiries or investigations.

Their recollections of their first Balint group were remarkably similar in terms of the unease and bewilderment they experienced. The following quote is fairly representative of what I was told:

> I used not to want to go to seminars in a way, but then I did want to go. I sometimes felt very confused and I couldn't make sense sometimes

of what was going on and I didn't know … it all seemed very woolly as though I was swimming against the tide and wanting to push things away to make it clear. I felt there were a lot of things in the way and that I didn't want them to be there. I wanted [the leader] to be much more into telling me what to do and getting on with it and it's this sort of knowledge thing – 'If only we could learn something that we could really put into practice!' There was nothing to hold on to, everything was not joined up somehow. You had to make your own way through this mess and so I was very ambivalent.

Nurses remembered how lost they initially felt when they were not offered concrete information. One member said of her experience of her first, basic seminar group, for example:

> One of my biggest problems with the group was that I wanted answers to specific problems which I didn't get and that became a bone of contention between [the group leader] and I in that I would say 'I want to know how to handle vaginismus' and she would say 'When you find a case, you can present it.'

The lack of obvious process or knowledge was often infuriating at this stage. According to another nurse whose first seminar group was led by Sylvia:

> I stuck it out. I must have been interested. I was obviously interested but I can remember thinking that … I am getting an element of rage when I talk about this … I can see us sitting there now in the group. it's funny how you can see it, isn't it, yourself sitting there. And I know Sylvia used to be very particular about leaving [first] and then we used to rage and say 'Damn nursing!' 'What was it all about?' And 'What was she doing?' So there was a lot of … The actual experience is quite far away but I do remember it was two and a half years and I am not sure what I did in that two and a half years.

However, this sense of achieving very little is probably exacerbated by the fact that these early experiences took place a long time ago. According to Joan, who was now leading a basic group, evaluation of the first year of work by her group suggested a number of important outcomes. Nurses were, for example:

- resorting to fewer treatments;

- more accepting that it is not possible to solve everyone's problems;

- able to stand back and stop offering solutions and instead enable the patient to consider their options; and

- appreciating having time set aside that was committed to reflecting on practice.

4.2.2 The advanced seminar

4.2.2.1 The experience of being in the seminar

An established network of psychosexual nurses meant that new members of the group were generally already well known to other members. They also had previous experience of the Balint approach. Joan's almost seamless insertion into the group during the research period suggests that this degree of familiarity with method and participants make finding one's feet easier in an advanced group than in a basic one.

This is not to say that remaining in the group was always a comfortable experience. As one nurse said:

> It's not an easy thing to come to. You do not look forward to it and […] there is always that kind of anxiousness before you come. I do not quite understand what that is about, but there is …there is something about 'Is it going to be my turn to present as I have not done it the last two times?' There is always this expectation that I should. Anxious if I am going to have enough material, will I ask the right questions. They might say to me 'Why didn't I do that?' or 'It is amazing why you missed that out!' I get very anxious… but sometimes you feel better afterwards than you do coming. Not always but most of the time I think you feel better for coming than not.

A different nurse said:

> I enjoy it although it's terribly hard. I come away feeling that I'm absolutely battered sometimes, but I am still learning and I am sure I always will.

Despite these difficulties, the group was viewed in very positive terms. It was felt that members were highly committed to their work and to the group, and were very supportive or giving. It was thought that the nature of psychosexual work and Balint training meant that nurses often felt vulnerable, so trust was an important characteristic of the group. As one nurse said:

> Somehow there is an understood atmosphere that people have been in this work a long time and somehow one can trust making a mess and presenting something that is a mess and that you did not actually feel very happy with.

4.2.2.2 The nature of the advanced seminar

The advanced seminar arose from the needs of nurses who were relatively experienced in psychosexual work. Yet perhaps because of the way in which the group evolved and its relationship to pioneers of the Association of Psychosexual Nursing, not all members felt as central or integrated as others appeared to be. As one nurse said:

> It's just a professional relationship. I don't think you get to know people on a kind of social level at all. I don't think I have any idea where people come from, what their backgrounds are and I don't really have any feelings about what they are like.

What she was clear of, however, was the shared commitment to caring for clients that brought people to the group and of the efforts that they made to provide this care.

Similarly, another member said:

> As far as my relationship with the members of the group … I feel that they have all got things they have done together, doing their posters, and they often go off to lectures together and they do other things. I do not feel anger but possibly an outsider because I am not in this work they are in … It does not move on in terms of the personal relationship, but the professional relationship works in the group without anything to do with outside.

In contrast, a participant with a different experience of the group spoke of how it was important to 'come back

into yourself' after the seminar, and how sometimes at least some group members would 'stagger off' for a meal afterwards to help them to do this.

The sense of marginality – although this term may overstate the difference or strength of feeling that existed within the group – that some members referred to did not simply concern social relationships. There was also a sense that some individuals, or perhaps most individuals at different points in their training, felt marginalised in their approach to their work and in terms of whether their struggle was sufficiently understood by others in the group. An example of this was noted during participant observation, when one nurse spoke to the group leader outside of the seminar because she felt that the group had not listened sufficiently carefully to what she was trying to say and had misinterpreted the work that she was doing. This disappointment was apparently resolved when the group leader took the matter back to the group for discussion and I was told 'I think now people do say 'You're just not listening to me.'

As this example suggests, the group was not always free from tension. However, there was a general feeling of respect. One member, for example, talked about relationships within the group saying 'We don't have any flies in the ointment. It's strange, isn't it? We all get on very well.' She described how she personally liked members of the group and indicated that there might be a collective sense about potential members and that those who did not seem right would not join.

> I think we recognise each other. Other nurses recognise someone who would be a good therapist or counsellor. I think you recognise people who wouldn't be. I do take quite violent dislikes to people so I don't know [if someone joined that she disliked] who would leave, whether it would be them or me. I rather think it would be me. So we must be a special type mustn't we? We're not like each other – there isn't one you could say that she is like her – we are all very different but we must have something in common. I don't know what it is.

At another point in the interview, however, she did identify certain features that she believed were held in common among group members. These similarities could be found in the way that participants' varying need to present work was understood (see for example, section 4.1.1) and how the manner of decision-making

suggested that group members shared a certain humility. There was also a sense that members were not pressurised to present, that there was something very gentle in the way that the group generally operated that perhaps mirrored the way they were as individuals with their clients. It was thought that members looked after each other to a large extent, and if someone was feeling desperate about their work, invariably this distress would be picked up by someone.

4.2.3 Psychosexual work

Basic psychosexual training equips nurses to look at psychosexual issues with patients in the context of everyday practice, giving them confidence to ask difficult questions and hear what the client is saying. As mentioned earlier, at a more advanced level, nurses with advanced psychosexual training may take referrals and act as psychosexual counsellors.

Speed was an important element of the work for those nurses acting as psychosexual counsellors. Most practitioners taking psychosexual referrals were restricted to seeing clients for a limited number of sessions (generally six), but it was also considered an important feature of the approach, a part of the method, for the work to move at a relatively fast speed. 'Getting stuck' was significant, not only in terms of jeopardising the chance of any improvement for the client within their allotted course of sessions, but in that it suggested problems of process within the therapeutic encounter.

Physical examination was seen as a helpful and relatively speedy way of understanding the nature of the client's problems, and provided a rationale for restricting the role of psychosexual counsellor to those with clinical training. One nurse said, for example:

> It's important that we can touch bodies, so at the moment it's a doctor or a nurse that has the way in for intimate procedures … that could apply to physio's as well … I think the difference essentially is that there is this clinical training and the counselling or the psychodynamic work that can go alongside it. I think that's what makes it unique and it makes the body available so that we can cut through loads of time by doing the examinations, whereas somebody who's not [clinically] trained, they can't touch the body at all, can they?

The use of the physical examination as a shortcut was underpinned by an assumption about the way that the body allowed access to the emotions, or how these were intertwined. In addition, the individual was understood to have the potential to experience the emotions of others, or that some kind of parallel process existed. As one nurse put it:

> It's body/mind work, because sex is about being in a relationship with somebody else as well. That makes it intense, doesn't it, because what we are doing is also seeing how our relationship mirrors other relationships.

The following extract from one nurse's account of a consultation provides an example of how the psychosexual examination might draw on this parallel process, and indicates something of the nature of the work. The consultation is with a couple for whom penetrative intercourse had been impossible because of vaginismus.

> Normally I would do the vaginal examination and ask them what they are feeling but **for some reason** I thought 'No, she's got to do this'. So I said to her, 'Can you explain to me when you touch your labia what you can feel, what it feels like to you?' She gave me some lovely feedback and then I said, 'Now are you brave enough to put fingers inside your vagina?' and [her partner] said 'I bloody well doubt it, because she has never let me put fingers in and she doesn't use tampons.' She first of all put one finger in, and then whipped it out as quickly as anything, And I said, 'Why did you do that?' and she said 'I was frightened.' So I said 'What are you frightened of?' and she said 'I don't know'. So I said, 'Try and put your finger back and see what it was that frightened you. What does it feel like now that its back inside?' She said 'It's gone warm again, it was really cold when I took my finger out'. She then went on to describe how warm and moist her vagina was and that it was really quite big and that she could feel something at the top which felt really strange. And she was relaying this to [her partner] who sat there completely in silence, amazed, I think, that she had achieved anything. She finished and I said, 'What has this experience done for you?' and she said, 'I can't believe that I have done this'.... And when I wrote up my notes I actually made a

comment that I felt that she needed to own her own vagina rather than being told to use it. [my emphasis]

Here the process of vaginal examination was spontaneously adapted on the basis of the nurse's sense that it was important for her female client to take ownership of her own body and her own sexuality. This impression was confirmed on a subsequent visit when the woman returned on her own. She said that she had come to realise that the problem was not about sexual penetration per se, but that she had not wanted sexual intercourse with a particular man, now her ex-partner. As the nurse put it, 'She had gone from being this young girl looking for a sexual experience to a woman who values her sexuality.'

The nature of psychosexual work became particularly clear when participants attempted to differentiate it from other kinds of therapeutic encounter. One nurse gave the example of bereavement counselling, for instance, suggesting that sexual dysfunction and bereavement, while both emotionally intense, represented different kinds of experience. The psychosexual, it was suggested, perhaps more than any other realm, was an inescapably integrated mind/body experience. Psychosexual work meant 'putting that [mind/body experience] between you in the room and then using yourself to understand the way they affect the relationships that they have.'

At the same time, psychosexual work was suggested as a logical extension of a holistic approach to health care. One group member for example, found that when she began to work with four male GPs as a practice nurse, she appeared to encounter a much larger number of patients with sexual difficulties than her colleagues. She began to realise that while the GPs were interested in meeting targets (for example, for cervical screening), she had a different emphasis and used cervical screening as an opportunity to raise broader issues, such as sexual health.

4.2.4 The Balint approach

Nurses in the group saw the Balint approach as only one of a number of ways of working within psychosexual medicine or nursing. Some participants had experience of using other approaches, such as behavioural methods, or of mixing different approaches as

necessary. In general though, the Balint approach was valued for its emphasis on understanding relationships rather than applying techniques. As one nurse said:

> One of the criticisms I have with the behaviour therapy was that they used to focus far too soon in therapy. You didn't find out enough about the relationship, and it was, 'This is what you do, you ban all intercourse and you go away and you touch each other and you massage each other and then come back and tell me what happens.' Sometimes that works, sometimes it doesn't, but you've got to find out what the problem is, otherwise it doesn't work.

Participants described the Balint approach as non-prescriptive and, unlike a medical approach, it was not focused on advice or cure. As one nurse said:

> It's not your job to make things better. I think that's something [Balint] was quite strong on… [not] to cure people and give them a bottle of medicine. And if you had found yourself wanting to give a book or something then you must stop that because its not about therapeutic medicine, its about listening and other skills.

In addition, I was told that:

> There are different levels of communication really … And it seems to me that the Balint training offers you another level at which to work with all the theories and emotions and the study of what is happening between you and the patient … so its very focused on that – the nurse–patient relationship.

There was very little reference to the theory underpinning the work of seminar members. When asked what made this specifically a Balint seminar, for example, I was told it differed from a reflective practice seminar in that the latter would take a clinical situation and consider how it affected you and what different sort of approach to take – with a clear outcome. There would be a plan of action that would be implemented and then reviewed:

> The work in reflective practice is not about staying with the unknown – it is about understanding yourself in the context of the work and coming across whatever situation and then finding a solution and then checking out whether it works.

In contrast:

> At the Balint seminar you are bringing a case scenario that troubled you or that is successful and you are examining your relationship with that patient in order to understand the patient. You are not expecting to have X, Y or Z to go away with a neat solution. So the process is much more about personal awareness, about the therapeutic use of your self.

One nurse told how she found the process of seminar training was very long and hard going – 'because you do think "What am I doing? What is going on? What is the leader doing? Why isn't she directing us a bit more?" And learning is slow.' What kept her going was that she knew someone who had worked successfully with the method, and had seen its value for practice, and so she persevered. But the way in which these nurses' work was characterised by uncertainty came across powerfully. One nurse commented on the way that a Balint approach meant:

> not knowing where you are going to go with the patient and allowing that to happen, you know, to feel that you can be out of control and you give your control to the patient.

She noted that not all nurses would want to work in this way.

4.2.4.1. The nature of learning

Contributing to the uncertainty was the nature of learning. Both the learning process and the practice of group members were indirect in character. As one nurse said:

> Well, first of all you're not aware that you are learning. It is not as if you are studying, you've got a book and you're memorising it or your thinking about it and you're writing notes. I think it's about seeing other people in a similar situation to you and seeing them either do it badly or do it well…it's sorting out the way that people are presenting and making yourself feel that you are presenting that case, but you would have done it better… you would ask different questions. …And if they have done it very well that's when you would think to yourself 'She did that very well - I could do that.'

Another nurse observed how it takes people a long time to learn what is going on, particularly as the process is not made easy for participants:

> …they don't make it easy, they don't worry that you have got to travel a long way or that you have got to organise your work to actually come. You are expected to come, you're not expected to come one to three times - You are expected to come and it kind of weeds out people who are not particularly interested and then you end up with people who are really committed.

This commitment to the group was seen as central, with the expectation that members would make every effort to attend. For example, those coming some distance might travel up the day before and stay more locally overnight, in order to ensure attendance.

The way in which the non-directive style of learning raised problems for participants became apparent in relation to the use of physical examination. I was told, for example:

> I understood about the presentation and the understanding of how you are feeling, and looking at how you are made to feel in a situation with a patient, and I've been quite used to being in seminars where one can present cases and quite a lot of my experiences have been like that. However, what I think I did not know was really the use of the vaginal examination and just how … and I never actually said to any of them 'Look, did you ever learn this, what actually is the procedure?'… I must say that this is something that I've quietly picked up, when or why you did that. And just when people have introduced it, and at what time and 'Why did you miss that out, why did you never…?' So that is something that I've picked up along the way.

Another factor that made the seminar process difficult was its painful nature. Nurses spoke about learning through pain. Learning was painful partly because it highlighted areas of their practice that fell below the standards that practitioners had set for themselves. In addition, practitioners took on the pain that their clients emanated during the clinical encounter, and seminar participants took on this pain as it emerged in the Balint group through the case presentation and its subsequent discussion. As one nurse said 'I think we are all learning in the group to stay with the pain. Rather than jumping to offer an observation, to stay with the

pain of the presenter and to acknowledge it.' She went on to say that this kind of work took its toll and that if she was going to continue, she would need to find ways of 'having her own pain held.'

4.2.4.2 The nature of the Balint seminar process

According to at least one seminar member, the work done in the group was not supervision. 'It is the fact that you are sharing a struggle with a client/patient and you bring it to the group and other people are going to try and help understand what on earth is going on between them.' Yet the purpose underlying this focus on the nurse–client relationship was, at root, to understand the patient's world, rather than the nurse's world, through the nurse's experience.

Clinical supervision was seen to centre on the management of a problem – a way of tidying up or despatching something that was messy or worrying in practice, or that was stressful for the practitioner. However, there was widespread recognition among nurses in this study that pain was very much an integral and necessary part of the seminar process, both a result of and a focus for learning. For example, one participant said:

> I think the pain for me is practising in a certain way and being quite successful but knowing that you get stuck at certain points around the psychosexual because I have got the opportunity to look at that. Yes that is an issue, knowing that you work in a different way and the pain is realising and recognising that what you have been trying to do with psychosexual issues actually does not help the patient and that's what you reveal when you bring the case.

Another noted that the process was based less on knowledge and confidence in practice:

> What counted was the relationship that you had with the patients, but nobody ever explained that to you, you kind of had to grow into it and so there is all the misery of knowing nothing and the pain of that is incredible. And I think that is the pain that happens to people when they come into seminars where they feel they know nothing. They don't understand what is going on, it's rubbish, they've got their own skills and

they're not welcome in this place and I think that is one of the reasons why some people find it so hard to stay.

All nurses found the work very hard, if not harrowing. One nurse, for example, became so tense during seminars that, 'When I go away I have to have a bar of chocolate, and I have headaches as well, terrible headaches.' Part of the difficulty that nurses had to come to terms with was that there was no fixed way of working:

> No, it's sort of different every time, so there isn't a format. And I suppose, reflecting on that there can never be a format really – 'this is what you do, and then you have this situation…'

Similarly, from the group leader's perspective, there were no set rules for ordering the way that the group ran, for when to rein the group in, for example, or when to give individuals their head. Sylvia acknowledged that her understanding of what was happening in the group was highly subjective. However, the following extract shows that, while there was no predetermined way of working, there were certain principles underlying her approach, such as the need to challenge the participants' tendency to intellectualise. She refers to the discussion of a case presentation in which each time the client came to her appointment, she brought a number of rucksacks or similar bags which she arranged like a barrier between herself and the nurse. This 'baggage' caught the attention of group members, prompting observations of a parallel between the client's use of the bags and her psychological defences, much to Sylvia's annoyance. In response to a question about why she sometimes did nothing to steer the course of discussion and sometimes moved to shape its direction, she replied:

> You're saying something to me like 'Why is it that you let the idea of baggage run and sometimes you're much tighter with the group?' and I think that maybe it is whether there is any work going on or whether work is being avoided… I mean I was aware two or three times ago that you looked at me quite surprisingly when I said 'Come on, get out of your head' because I thought that work was really being avoided by a great deal of intellectualisation and people wondering about this that and the other, and I thought that the

real work – which was the misery between the nurse and the patient – was not being looked at. And I was irritated really … I can remember that afternoon and being really fed up that I thought that the work was being avoided. So I mean I do think that there is a place for this woman who brings all her baggage but builds it round her like a castle instead of having it on offer. I think there is a place for that kind of wondering, so long as it doesn't become a game which is avoiding the work really.

This quote from Sylvia is interesting in a number of respects. First, her challenge of group members' tendency to intellectualise is itself couched in terms of thinking rather than feeling (as in 'I thought that the work was being avoided'). This might suggest that it is relentlessly difficult to consistently engage in feeling rather than thinking, or to distinguish between the two. Alternatively, it might also suggest that beyond attempts to analyse feelings within the group, there is a metalevel of analysis carried out by the group leader that rests on thinking rather than feeling. Second, there is a suggestion that thinking is associated with the head, and feeling with the rest of the body (a version of the classic Western body–mind dichotomy), which seems to be juxtaposed with a view of psychosexual issues as integrative of mind, body and emotion. Thirdly, there is a strong emphasis on the nature of the group's activity as 'work', as opposed to 'support', or 'discussion'. Not only does this reflect the strong ethic of toil and industry evident in the way that members are committed to the group, but that this toil is akin to bodily labour in that it is hard, painful and requiring strength.[2] In other words, the emphasis on 'work' can be viewed as another indication of the way that the group's members integrate mind, body and emotion.

4.2.4.3 The role of the presentation

The presentation was seen as a pivotal part of the seminar. Everyone was expected to present work, although there was no set pattern, and if a seminar participant had not presented work for a while, it was usually her, rather than others in the group, who felt uncomfortable. Having said that, presenting work was

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2 Thanks, again, to Kate Seers for helping to unpack this statement.

seen as the key to learning. It was also the most dreaded part of the learning process. Participants felt at their most vulnerable when they presented work: gaining the views of others could be encouraging but it also entailed exposing their practice to scrutiny and, as indicated earlier, might lead to feelings of being misunderstood.

> Sometimes you think 'That is a real relief to discuss that. That really helps me a lot'. But sometimes you go away and you think 'They have got hold of the wrong end of the stick and they did not know really what it was like to be with that person' …It's not always the relief of thinking 'Yes I have some more ideas after a group meeting', because people can get stuck as much as you are for ideas.

Presenting from memory was often difficult and the reason for doing so was not apparent to all members of the group:

> This is something I have often wondered about – whether I would be better if I wrote my case history and did it. Then I would remember the steps I made. I often present and then think 'Oh no, I didn't say that, that happened at the beginning' or 'That happened at the end' and jump about.

4.2.4.4 The leader's role

The leader was seen to help the group remain focused, to stay with the feelings generated within the group and resist the tendency to flee from emotional distress. For example:

> You are sitting in the group and passing comments and it can be a bit nerve-wracking I think - a bit - at the beginning when you enter into a group: [you think] 'What did that comment really mean? Are they getting at me? Did I say that too harshly?' But I think you accept that, we are here to work, we are not here to criticise or do harm, but to understand. So what shapes the group – the leader shapes the group, and of course the group shapes the group. But I don't know whether you've seen but one or two people have a large caring element – I think we all do – but we need to take care of others and that comes out, but I think sometimes it takes

away from the work that we can do. We don't hear the pain clearly enough or you're not left with it clearly enough. I am sometimes on the receiving end of that – you think well, OK you can reassure me, that's all right but I know that I can't be reassured. [Instead] I need to work on this, and it's awful, but I need to get to grips with what's awful and why.

> I think the very difficult task of the group leader is to contain that distress or allow it to be there …letting the group contain the distress rather than the leader feeling that they have to. And so when the leader might appear then a bit uncaring having seen the distress, in fact that has to be part of her role.

> So much of the work of the leader is shaping it and letting distress be… And the more we can allow that for each other then the more work I think we do, the more in-depth work we do. And I suppose the more focused the learner is I feel the more work can be done – but there are different views on that and different behaviour in different groups I think. I mean because of the original idea that you don't teach and you don't direct – you let them come and you try to help people focus but you don't focus them.

Similarly, another nurse said that the leader's role was to help restrict work to the understanding of relationships, rather than becoming distracted – for example by clinical issues. The leader was seen to listen with enormous concentration. Part of this listening was concerned with ensuring that the group focused on emotion, without becoming overwhelmed by it:

> I think it's for the leader whose job is to observe the effect of a story on the group and help the group to observe that together and to keep focused. If that doesn't have an ending in the seminar, if is not neat, then it's OK, it doesn't matter – although it feels horrible.

Perhaps because the group leader did not rush to soothe distress, she seemed to be viewed, or had been viewed in earlier years, with some ambivalence - a respected and experienced group leader but also a powerful and sometimes stern figure. Yet Sylvia was seen to have changed over time. Her style could still occasionally be daunting or fierce, but it was thought that there was more acceptance of the vulnerability of some group members:

I think that Sylvia has changed over the years [to realise] that we are rather fragile, some of us, not everybody, but some of us were more fragile than others and I think that she has changed enormously. She is still a bit powerful, a bit daunting, but certainly over the years she has been extremely helpful to me.

While it was suggested that the group leader could be authoritarian, it was also thought that such a group needed a leader with authority. It had to be someone who could help people keep their faith in the process, who kept participants focussed and reminded them to consider if they had the right skills for a particular patient, or if they needed to refer the patient on.

Similarly, Sylvia thought that the leader's role was to try to stay at the heart of the work and keep the focus on the nurse–patient relationship:

It's so much easier to think about the patient and the psychology of the patient than to really stay with the really difficult task of understanding what it feels like to be with the patient now.

It was part of the leader's role to ensure that she did not provide answers for group members, but let them do the work and find such answers as there might be for themselves. To do this, she had to juggle with a range of concerns and questions that she might become aware of throughout the seminar. Sylvia described the kinds of questions this might include as follows:

Why am I so discomfited by this, why am I dropping speed, why are people going to this person who presented and why are they nagging at her? Is that what happened between her and the patient? Why do I want to get up and hit so and so? Why do I feel so overwhelmed by this and why am I feeling sad or weepy or angry or really trying to think what is this, am I bringing it in because I am tired today or am I tired because I really don't want to hear this, it's painful.

Her task was then to try to find a way of taking those issues to the group to see if they make any sense to the participants.

4.2.5 Principles informing the seminar process

Despite the uncertainty and variation in approach that characterised seminars, there were certain principles that appeared to guide the work of the group, some of which were identified through participant observation (see sections 4.1.3 and 4.1.4) while some only emerged during interview. These principles include:

- clues from the body,
- the power of language,
- keeping focused,
- staying in the here and now,
- be open to criticism,
- accepting vulnerability,
- the continuing nature of the process,
- the significance of remembering and forgetting,
- feeling rather than thinking,
- mirroring feeling,
- the moral value of emotion,
- the role of theory, and
- use of self.

In the next section, in order to provide a more in-depth sense of how the group worked, and to indicate how the above principles were at work during the seminar, one case presentation and its subsequent discussion is presented in full. Because of the problems of 'reading' the transcripts identified earlier, and the need to hear the tape to make sense of the data (see section 4.1.1), and because of the need to disguise participants and their clients, the extract presented here has been edited.

4.2.5.1 Presentation of a clinical encounter and subsequent group discussion

Agnes: You remember my girl Joanna who had painful intercourse who let me know that she got pregnant after seven years? Well …I'm seeing her again. And as far as the sexual problems are concerned it seems okay

because she's having intercourse and it's comfortable. But she's terrified of the delivery and I don't think she's been able to tell anybody about this and I know that's not …– I wondered if any of you could tell me, or help me, I just don't know what to advise – ring the midwife, talk to the GP or what. She really seems to me to be more scared than I think is normal.

Sylvia: Why don't you tell us about your meeting with her?

Agnes: Yes, she looks gorgeous, you know. She's got lovely cheeks and her hair's all shiny and ...

Sylvia: This is the one with the wonderful husband?

Agnes: Yes, that's right. You have got a good memory. She is married to a stockbroker and they've been married for, I think, 14 years and trying to get pregnant…And she's … she describes herself as the homemaker and that's all she's ever wanted, just to become a mum and it was her ambition. She had chronic gynae problems and great difficulty in conceiving, and also had very painful intercourse. I've been seeing her for, oh I think three or four times and she told me how she first felt very inferior to her husband because he was so much cleverer and she sort of felt like a mouse and she said when he was with all his stockbroker friends she always felt awful. And then she got pregnant: she **bloomed**, you know. This was what she wanted. I wrote it up. No, Gill wrote it up for me. After I read it and I could see her in Gill's eyes and you could see how terribly vulnerable she was and although maybe I realised it, I hadn't **really** got hold of it but I could see after reading Gill's paper how enormously…

Sylvia: But you felt very vulnerable and had to cope with that.

Agnes: I did, yes.

Sylvia: Because you felt very… quite damaged by having spoken about her, didn't you? You felt quite rejected by the group.

Agnes: Oh that's right! Yes I **did**. I remember.

Sylvia: […], wasn't it? Very vulnerable.

Agnes: Yes, I thought, they know me, they really … here I am and I've got this girl. She's, you know, she's years of painful intercourse and wanting to get pregnant and after seeing me she's having good sexual intercourse and she's pregnant. What more do they want? I was really fed up with you all!

Sylvia: Because you were hurt?

Agnes: I was a bit, yes, yes. I really was. Quite miffed is the word. Did I – I must have picked up on that?

Sylvia: I don't know. You must have been upset.

Agnes: It wasn't all that difficult to see. Anyway …

Sylvia: The reason I was saying that is because you're talking about her vulnerability and then linking it with …

Agnes: With my own.

Sylvia;   … to how vulnerable **you** felt having spoken in the group about it.

Agnes: Yes, yes I did. I felt, I suppose I must have felt exactly like **she** felt with her husband

Sylvia: …and all his clever friends.

Agnes: All his clever friends, yes exactly. Exactly.

Gill: I think what we felt was that somehow the work wasn't finished.

Agnes: Yes, that's right.

Gill: That it was all tied up and fine but there was still a vulnerability.

(Inaudible discussion)

Agnes: I thought I'd finished it. She was pregnant. She was having sex and that was it. But you all felt that there was a lot more.

Ruth: And will you see her again?

Agnes: Will I see her again? She wanted to see me again and I wanted to see her again.

Sylvia: So, this time now …

Agnes: This time round I've seen her and she does look more […] and she's frightened of her mother-in-law. She's afraid that she won't be able to …

Carol: But how did she tell you that?

Agnes: I asked her. I said, you know, 'How do you feel?' I said, 'After seven years you've got what you wanted out of ….' She said, 'It's interesting you say I've got what I wanted, because' she said, 'I'm feeling very scared now about whether I'll be able to, you know, cope.' … And I said […] and put her down a bit I think. And I let her talk and I let her talk about her fears and she said that …I said 'How do you feel about the delivery?' and it was then that she said how scared she was. She said 'I'm really… I wake up at night and tremble about it' and she said 'I really am frightened.' I was thinking of books – what could she read - Sheila Kitzinger – and I thought 'I don't know what to do with somebody who's scared of labour. I'll ask you. I'm scared. […] And what I'm … as you were so clever last time!

Sylvia: But Agnes, tell us what you actually did. Because I think you're being a bit shy about telling us about the work that you did with her.

Agnes: Well, I think that she hasn't got anybody else to tell.

Sylvia: Could you tell us what you did with her, rather than your thinking about it? Just can you tell us a bit more about the conversation?

Agnes: I can't really remember what we said all that much except we talked about how she was getting on and how she spends her day and how she says she gets very tired and things like that. I don't think I was doing counselling. All I was doing was talking to her actually as a sort of friend. It wasn't a psychosexual consultation as such. You know, I couldn't really remember that I said more than I told you.

Sylvia: OK, so …

Agnes: As you're talking perhaps I'll think of what else I said to her.

Alice: Agnes, what's she frightened of?

Agnes: Well, she's scared of not being able to cope, she's afraid that her mother-in-law will interfere because the mother-in-law has …

Alice: With her labour?

Agnes: No, no with bringing up the baby and feeding and things like that. But she's frightened of what it will be like when she actually goes into labour. Honestly I didn't know what to say.

Carol: Can I take you up on this business of it not being a psychosexual encounter because it seems to me an enormously important psychosexual encounter actually. Because this is going to affect her, isn't it? Going into her delivery, and motherhood, which is the other thing, which seems to be worrying her. I mean that seems to me an essence of what our work, a lot of our work might be about. Because I think we sometimes see the damage that comes afterwards. I think […] but maybe the others don't agree.

(Pause)

Ruth: She's terrified she's not going to be able to cope with the pain?

Agnes: She's frightened of pain, yes. Yes, she is frightened of the pain and what she'll be like when she's in labour.

Alice: Come on then. What does that mean to her? What does she say?

Agnes: I didn't really ask her.

Alice: Because I think it's this sort of control …

Agnes: And you know, I'm scared for her. I think that's part of …

(Inaudible discussion)

Carol: But also her fantasies.

Agnes: Yes.

Carol: Which weren't really explored, I mean it may be reality but there is some fantasy as well for her, which is a frightening fantasy.

Agnes: I didn't see that as my job somehow.

Alice: I feel frightened. You've made me feel quite frightened.

Agnes: Well I am scared too. You're quite right Alice. I am scared for her. I didn't feel it was my job. I thought it was the midwife, you know,

dealing with the labour. I **did** honestly! I'm out of my depth here.

Ruth: How did you feel?

Agnes: This girl won't be able to ask. She won't be able to say… She won't be able to say that she's terrified of this and what can she have. She feels totally unprepared for this terrible thing that's going to be out of control.

Carol: She must have met her midwife before.

Agnes: That's how I feel. I don't know if that's how she feels.

Sylvia: But doesn't it ring any bells?

(slight pause)

Sylvia: Well, doesn't it ring any bells with you about the story?

Agnes: It's all about not being able to cope, isn't it? And not being able to cope with her life and her sexuality.

Sylvia: And the pain. I'm thinking about the pain of intercourse.

Agnes: Yes. Yes.

Carol: And it's mirrored in the pain of birthing, isn't it?

Agnes: Yes.

Sylvia: Yes, but this is … [what's] quite interesting is how remote you felt from the …

Agnes: …pain…

Sylvia …panic she presented you. I mean, that somehow you were left feeling remote rather than involved. And this is so different to your way, isn't it?

Agnes: I think it's something to do with… I feel out of my depth as far as her having a baby is concerned. It's a long time since I did any midder and I just …

All: Oh!!

Agnes: I mean I feel 'I can't help you.' I don't know what to say.

Alice: You could know everything but it wouldn't be …

?: It's incredible. The memories…

(Inaudible discussion)

Agnes: And I thought, 'what could she read?'. And I was thinking all these things.

Carol: What's **your** panic about?

Agnes: I'm scared that she won't … I'm scared that she …

Carol: But what is your panic about? Not for her, but your panic as a nurse.

Agnes: I suppose that I couldn't cope with her, that I couldn't cope with her, that I wont be able to cope with her fears.

Sylvia: You don't **know** enough.

Agnes: I don't know enough. I suppose that's what it's about.

Carol: Yes, 'I haven't done midwifery for a long time.'

Agnes: Ages and ages.

Sylvia: Whereas the rest of us do it every day!

(Discussion and laughter)

?: We could deliver it as well!

Agnes; I can absolutely see now and I was transfixed in that room. I was so glad when the hour was over.

Carol: How can you say it was bad because I kept thinking – what did she (Agnes) say – 'Well, I'll go to the group… and when I come back …She didn't actually offer her that!

Agnes: I didn't offer her that. I knew what I'd be told if I came here and said that. They'd murder me!

(laughter)

?: No, but it went through her mind.

Carol: Well of course it did.

Agnes: Shall I ring the midwife?

Alice: But then you started to think , didn't you…?

(laughter)

Agnes I don't think I did!

Carol: Who else is active in this woman's care? Isn't there a midwife…?

?: But she must have met a midwife or…

Agnes: Of course.

Sylvia: But look, we're talking about good, practical things and it isn't about good common sense stuff. Let's not get caught up in the midwives. Let's stick with this nurse and this patient because that, if you like, that's outside our realm, isn't it? And the interesting thing is how it seems to me that the presentation that you're making now is [sigh] somehow reflecting the early work that you did and which enabled her to have fulfilling intercourse and […] body before. But it seems to me that the panic that she brought you which alienates the two of you was only a repetition of that, but **this** time she'd managed to **blind** you to what you have to offer.

Agnes: She **smiles** an awful lot and she always… she always smiles. Now the only time I've ever got her not to smile is when I asked about the relationship with her husband and her feeling that somehow she was inferior to him intellectually. And then I got a little bit of crying on the shoulder, but immediately her smile took over. She smiles all the time and I can imagine she's gone to the midwife and she hasn't been able to say …

Sylvia: Could we leave the midwife out!

(laughter)

Agnes: All right.

Sylvia: Because I think it's avoiding what went on between you and her really. And how she sent you off into retreat.

Agnes: Yes, she did. She's very difficult to get to behind this smiling.

Gill: So, very difficult to show that to him. Perhaps it feeds into her feelings of in…inferiority.

Agnes: She feels inferior to her husband and the mother who's going to be giving advice. She's OK, …her own mother's fine but she's frightened…

Carol: I was just going to say she's very frightened, isn't she …

Agnes: Oh, very, very. But **smiling** throughout it.

Sylvia: Gill, you stumbled on 'inferiority' and I thought you were going to say 'infantilism.'

Agnes: Yes. Yes.

Sylvia: That's so interesting because I was surprised when it went on to becoming 'inferiority.'

Agnes: She's like a little girl.

Gill: She is like a little girl, yes. Oh yes.

Agnes: I think we talked about that.

Sylvia: I'm thinking about this smiling and the placatory small girl. I wonder why she does that.

(Pause)

Alice: It's like a defence, isn't it really? 'If I look okay you won't… know.'

Agnes: She dresses very … she's co-ordinated.

Alice: She likes perfection.

Agnes: She does, yes, she does.

Carol: But how do you … you see, she is behaving in really quite a childlike way, isn't she. I mean, even with Agnes and that vulnerability …and something about not being able to grow up.

Sylvia: But interestingly that didn't capture Agnes you see and you're a sucker for being caught by vulnerable people, aren't you? And what fascinates me is how she sent you into retreat. 'Well, I don't know anything about this, but you really must get her to the midwife' and really retreated from the presentation of this woman's anguish about labour and delivery as though you've got to know something…

Agnes: As though I've got to be a practising midwife!

Sylvia: …to offer her some understanding or some offer to try to understand what the anxiety is. And yet it seems so like the anxiety that she presented to you about intercourse. And the loss of control.

Agnes: Of course, of course.

Gill: But Carol asked you Agnes - what is your anxiety about this woman? What is your fear about her?

Agnes: Well, I'm a bit … well I think I said this, it's about getting what you want. If you long for something so very much that when you do get it you find it's not what you wanted and that it isn't …everything's not going to be hunkey dory and it's not going to …

Alice: Or it is what she wants, but it brings with it …

(General, inaudible discussion)

Agnes: Whether she's going to be the perfect mother …the baby might do awful things, it might cry. She might not be a very good … be able to cope.

Gill: So she's going to be ..she feels like she's going to be a *failure* with the birth, the motherhood, the whole lot.

Sylvia: What lay behind your question?

Carol: Well, because I was looking at what … yes I think really… I think you picked up in a way what I was saying that I think there's also… and I think you used loss of control to start with just now Sylvia – and I think there's something there about you losing control within this nurse–patient relationship and you actually … you ran away and she really… I mean giving birth is about losing control to a certain extent, isn't it? And I wonder … and losing control looking after the baby, being a mother, …the mother-in-law. And that was the first thing that seemed to have stuck there for you and therefore she said, 'Well I can't control even looking after the baby.'

Sylvia: Anyone noticed an absent figure?

Carol: Yes, I have, I have noticed. I've kept very quiet.

Sylvia: She can't tell *him* any of this.

Gill: Oh, she couldn't possibly though.

Carol: But did you enquire?

Agnes: I think that I …

Carol: What did you say?

Agnes: I think 'Have you discussed this with James?' I think I did ask her that. I don't know. I can't

remember.

Sylvia: Because of course you were in flight.

Agnes: I can't remember whether I did. I have a feeling I… we talked about James and they're very into local politics and James does a lot of speaking and, you know, she likes to sit and listen to him. And he's one of these terribly busy men that never seem to be there.

Sylvia: And he's really fond of her!

Agnes: I don't like him. He's never there for *her*, I would suggest. This is the other thing. You know – all these clever friends that he…

Sylvia: Where do you get that information from?

Agnes: Mm.

Gill: So, it is a frightening story.

Agnes: It is, isn't it? Yes.

Alice: Panic, I think she is in panic.

Agnes: Yes she does panic, yes.

Carol: Is she going to be at the birth?

Agnes: Is he going to be at the birth? Yes he is.

Carol: With mother?

Agnes: No, no, no, no!

Alice: I'm sorry. I'm not sure. Are we imminent? I mean you…

Agnes: June, she said.

Gill: All that she's ever hoped for.

Agnes: That's the thing Gill, that's the scary bit. I'm scared that it's all going to go, all going to go wrong. Well, it must, it must, mustn't it? The panic will certainly…

Sylvia: But is the panic and fear about the labour? I mean, do you know?

(Pause)

Sylvia: Do you know? Do you mean, you don't really know? Right?

Agnes: I don't really know but I think so, but I think it's… *I* think so…. I didn't ask.

Carol: So that's your assumption really?

Sylvia: You see, because I thought that other people were making assumptions about the panic feeling about the birth and I didn't think we'd heard that from Agnes.

Agnes: No, no, I do know the panic is about the mother-in-law. Will *she* be able to cope and afraid that the mother-in-law will interfere.

Sylvia: Well, you could rephrase that and say that the panic that you did understand was the panic of being criticised or not being good enough, which for her is called mother-in-law. But might be called husband or might be called midwife or might be called a health visitor. But this time it's called mother-in-law. Is this right?

Agnes: Mm, I mean you're right to … no, no, no, that's right.

Sylvia: You see I think this is important to understand because it does seem to me to be in the head in this nurse–patient relationship because you felt it clearly, is this sense of criticism, of not being understood and being interfered with.

Agnes: Yes, yes. And not being, perhaps not being praised enough as well. 'Yes, well done Joanna, you got pregnant. How marvellous.' You know. Perhaps that aspect …

Sylvia: That's what we do to children, to encourage them, isn't it? You know it's really quite interesting…

Agnes: Do you know, the first time I saw her - when she came - I could see she was pregnant. I put my arm around her shoulders and said 'It's just as you wanted.' It's not the sort of thing I could say to any of my friends who got pregnant. I don't know what I would say, but I don't think I would say that.

Carol: Agnes, I'm interested you use the word 'friend' there because you've used that before I think when you were talking about your interactions, you know, what you were saying to each other. You used the word 'friend' then …and early on today you used something… 'I felt I wasn't doing psycho-sexual work, I was talking to a friend.'

Agnes: Oh, yes, yes, yes.

Carol: And just now you used that again and I wondered if that's also getting in the way. Because you don't actually allow your friends to…[mention of being 'protective']

Agnes: That's right, that's right. Yes. Yes, I do feel that - protective.

?: Well perhaps that's why it's not psychosexual work.

Agnes: Yes. It didn't feel like that at all.

(Long pause)

Agnes: Well, I'm seeing her again.

Sylvia: Before the birth?

Agnes: Yes, I'll probably have to see her, whether I want to see her…

Sylvia: Good girl!

Agnes: Thank you! Well done!

Sylvia: It's interesting though…

Agnes: That's exactly what she was like – like a child.

Sylvia: …so does it give us any clue about the suffering of this woman, having to cope….

Agnes: No, I don't think I've been able to see how much pain she's been in. I don't think I've got through the smile except that once.

Sylvia: Alice used another nasty word as well as pain. Because Gill was talking about something and you said…

(Pause)

Sylvia: You said 'anger.'.

Gill: Oh, anger, anger, sorry.

Sylvia: Because you felt that the only time that she did pierce that smile…

Gill: Yes that's right that's right.

Agnes: It didn't last long.

?: Is one therefore to allow her to think she's really quite angry within herself? I mean could that be acknowledged with her, that there might be something there?

Gill: Or is it that?… I just wondered whether it's anger with herself or just about herself in

general terms and …

Agnes: She's certainly felt terribly vulnerable about her gynae problems and having to make these enormous trips, you know, frequent trips to see gynaecologists and all that gynae business over the years has been awful for her.

Alice: Now other people are [poking her body?]: it's not good enough.

Sylvia: It's interesting because if this was somebody talking about her anxiety about having intercourse, the fear of the pain, and fear of letting go with intercourse, I think you would be exploring what her *fantasies* were, about what was going to happen. I mean, isn't that right?

Agnes: Of course. Yes.

Sylvia: So, – not why didn't you – but I wonder if this would be available to you? It wasn't last time because her panic was so great that it drove you away from her, and so we need to respect the strength of her defences against the feelings that she has about her labour. And I want to stick with labour before looking after the baby because that's perhaps another … When you told that story about people poking her and everything…

Gill: It is about her body, isn't it. Because any child that's born you can cope with and care. It could be that her feeling about her body is maybe damaged, very vulnerable - you know – 'What's going to happen?'

Agnes: Because she took so long to get pregnant. And that was criticised. The mother-in-law wanted to know 'why aren't you getting pregnant?' She must have been asked every month in years.

Sylvia: The other fantasy is what about her vagina? Can it cope?

Gill: But I think that's what Ruth was saying earlier about your need to protect her.

Agnes: I do, yes. Yes, I do feel that.

Gill: And then how difficult it is to do because if you're thinking of her as a young child.

Agnes: Yes, yes.

Sylvia: It raises another question. I'm thinking that again if this is somebody talking about their anxieties about intercourse, one of the things we would be looking at – because what happens in the nurse–patient relationship … – is that the nurse might give us a clue about the couple. And I wonder about this protectiveness, this treating her like a child and about your retreat, which I feel great respect for because I think it's different. I wonder if this gives us a clue about what's happening between her and James. Treating her like a child. In full flight from the facts of her terror. I mean if she can do it to you in one meeting, what's it like to be her sexual partner? I wonder how much he gets of that and feeds into that.

Carole: Maybe he feels he doesn't have a sexual partner at the moment.

Agnes: They have had sex. I did ask. They did have a sexual relationship. It's beginning to get a little bit difficult now because she's getting bigger but they have managed.

Sylvia: Some people have wonderful orgasms, of course, when they're very large. As the head comes down. Yes.

Agnes: Isn't that strange I couldn't see that it was a similar problem. I think you're quite right about the baby and about the loss of control.

(Pause)

Carol: But we've only made assumptions, haven't we, at the moment? It might never come out from her.

Sylvia: Oh, but the evidence we've had is what happens to Agnes.

Agnes: Yes, it really was like looking for books…

(Inaudible discussion)

Carol: I mean she is running away from possibly the reality of what is going to happen to her in a few weeks time. I mean they're so *close*, that's what's so terrifying in a way. I mean it's upon you really. I mean you're not going to see her in the next couple of weeks are you? I mean, you know…

Agnes: No, I'm seeing her this Friday… I will see her. I think she needs somebody. I don't know whether I can pass this over. I was wondering about being at the birth actually.

(Laughter)

Agnes: No!

Sylvia: You need experience!

(Inaudible discussion)

Alice: But it's the smile, I can't…

Agnes: The smile is really bad.

Alice: You know that song: Never smile at a crocodile. And behind that smile…

Agnes: It's irritating, it is irritating.

Alice: I'm sure that can't help you.

Agnes: Or the husband, or the mother-in-law either.

Sylvia: But I think the mother-in-law thing is really to see that she is the receptacle for all the criticism, all the interference, all the loss of control that this young woman feels. I mean, isn't she lucky to have a mother-in-law to blame. I mean, who else could it be?

Carol: She does make her husband …

Sylvia: So you've got a real clue about what…

Agnes: I have, I have now. Thank you very much. I have **now**. Thank you.

Clues from the body

The description of the clinical encounter above is unusual in that, because the client has been discussed before in the group, a description of first impressions has been omitted. Generally, the work with clients was understood to start from the first moment of contact, with the practitioner drawing upon 'whatever you are given' by the patient. This might include something that was noticed about clients as they were waiting to be seen, or how they greeted the practitioner, rather than the outcome of formal assessment. The importance attached to first impressions, including those gained before the start of any real verbal dialogue suggests the importance of non-verbal communication in the nurses' work. This attention to the non-verbal continues throughout the encounter. In the example above, for example, Joanna's smile, Agnes' gesture of putting an arm around Joanna when she realises Joanna is pregnant, the link drawn between Joanna's co-ordinated attire and her emphasis on control were all seen as important signs to seminar participants. Physical examination was also seen as central to much of the nurses' work, as described earlier (section 4.2.3).

This use of all available sources of information was seen by participants as one way in which the approach used was different to psychodynamic work. It did not only rest on verbal interaction – 'the verbal clues that you could wait months for,' but also on clues from the body, the physical interaction in the practitioner–client encounter. This other source of insight was useful as the nurses' work with clients was short term: 'if we haven't had a shift in three sessions, then we are not going to get one.' This emphasis on the body was not explicitly related to Balint's approach by participants, but seemed to be an adaptation or adjunct to this, influenced by the holistic nature of psychosexual work.

The power of language

The importance of non-verbal information, and the emphasis on understanding the emotions informing clinical encounters, meant that finding a way of articulating emotions and clues from the body was of central concern for nurses in the study. The example above is again unusual in that the emotions in this case seemed easier to recognise and describe than is often the case: Joanna is scared of labour and of losing control; Agnes is scared that she does not have the knowledge to help her, and this fear is experienced by seminar participants (although it is not clear if their fear is entirely for the patient or, given the tensions that emerged when Agnes presented her work with this patient earlier, that they are fearful of not being able to help her this time).

It was more often the case that participants found difficulty in identifying or finding the right language for the emotions that they experienced or encountered during practice. As one nurse said:

> I think that's another hard thing to discover, to think quickly how you are feeling, to sort of put a word on it. Its really hard and all the words you are whizzing through and thinking 'None of the words are right' – that's not how you are feeling. It's very difficult – and other times its very clear.

Sometimes they are very muddy, it's a whole lot of things really.

At the same time, trying hard to find words had the effect of objectifying or distancing the emotions that the practitioner was trying to get to grips with, so that she became 'guilty of thinking words rather than feelings'.[3]

The issue was not only about finding the right language to make emotions in the clinical encounter or the seminar group more concrete, but also about structuring words appropriately:

> I think the language is terribly important because I think that empowers you then to talk with your patient. I used to worry about how to access some feeling from a patient. I mean how do you ask a question that isn't a question? How do you say to somebody without sounding absolutely stupid, who is in great distress about something, saying something like 'Oh it must have been awful for you' that allows them space but shows them that you have recognised their pain?

Nurses were aware that language itself could powerfully shape the nurses' work. For example, one group member spoke of the way that, if the group leader used a certain word which implied judgement, such as 'contempt,' this in itself provoked certain emotions in the group.[4] Naming the group's feelings – which might be an accurate description or not – offered a way of moving the group on, making them look at what was happening from a different perspective which they could then accept or reject:

> It happens sometimes that Sylvia uses a word and I think 'Well that's not really right' and I sometimes say something and sometimes I don't.

Keeping focused

Just as the group leader's role is to keep the participants focused on work, so part of nurses' practice was to keep the patient from evading the issue they had come to discuss, to 'bring them back' to the essence of their problem. In the example of Agnes' work given above, Agnes is reminded to focus on what *her* fear is about, rather than try to interpret Joanna's fear, on the assumption that this will give Agnes a better

understanding of Joanna's world. Agnes is also helped to see that the focus of her work with Joanna is not her fear of labour *per se* but Joanna's fears of losing control, fears written in or on the body in terms of her anxieties about labour or sexual intercourse.

Keeping focused was necessary to ensure that the nurses' practice did not become side-tracked into offering simple reassurance. One nurse explained the significance of focus through the hypothetical scenario of a consultation in which a woman might come to her and say that her husband 'wanted too much sex,' while she did not want sex very often. In the past, this nurse might have seen her role as providing reassurance, and would therefore have said to the client that such differences were commonplace. Now, however, she would see it important to explore what the underlying concerns might be for this woman, and why she had come to see her.

Remaining focused was thus central to these nurses' work, but also inordinately difficult. As one participant said:

> …when things are painful, its very, very easy to just talk about something else, and that is something I fell into because it was so painful. I was quite happy when the patient talked about something else and the skill of bringing them back is something I have learned. I have learned over the years because it's essential, otherwise you get nowhere.

Staying in the here and now

A good example of focusing on the here and now can be found in the group's work with Agnes described above, and the way in which she is encouraged to restrict herself to those areas of which she has direct experience. One element of this is to focus on understanding the nature of her own fears. More broadly, it would be to concentrate on what Agnes knows directly through her encounter with Joanna (the panic that Joanna arouses in her, Joanna's childlike traits) rather than other aspects known only indirectly, such as the nature of Joanna's relationships with her mother-in-law, with her husband or with her husband's friends.

Although focusing on the 'here and now' could be interpreted as a focus on the present rather than the

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3 This sense of guilt about working in the wrong way, or in the wrong medium, will be returned to in the Discussion chapter.
4 See also Carol's use of 'infantile' in the case presentation example given in section 4.1.1, which was immensely powerful for both Bill and seminar participants.

past, the 'here and now' more commonly referred to was immediate space of the nurse–patient relationship. It was generally acknowledged by group participants that it was very tempting when patients told them about their family background or their sexual history to start to analyse the nature of the patient's relationships, and the characteristics of their partners or of members of their family. Part of the seminar training was to emphasise that the only reliable information that the nurse could work with was what she knew from the dynamics of the nurse–patient encounter. One group member for example told of how she had learnt to bracket off what patients told her about significant figures in their lives:

> When I first started I'd be told that the mother was a monster and all kinds of things like that. I would immediately start to think of the mother and it was Sylvia who taught me that may be relevant but what is really relevant is you and the patient – not the mother who is out there in the distance. What you are looking at is the nurse–patient relationship… In the beginning I was totally convinced that it was developmental practice that mattered and this is why she [the client] is like she is - because her mother never told her anything about sex.

Being open to criticism

The example of Agnes' work above shows the importance of constructive criticism in the group's work. It is clear from this example that the group had been trying to indicate to Agnes earlier that her work with Joanna was not finished, and that there were issues that remained unexplored. It was also apparent that, previously, Agnes had found others in the group unsupportive in that they seemed to be failing to acknowledge what she had achieved. With this presentation, it appears from the dialogue that these earlier criticisms have been accepted and built upon.

This example also hints that being open to challenge, a necessary part of the seminar process, was not easy for its participants, and something that they had to struggle with. As one nurse said, when describing her earlier experiences of the Balint approach:

> It was slightly scary and we had to present cases and I was never ever sure whether I should. Sylvia didn't want us to read, she wanted us to present it from memory and I found that very difficult. And I said 'Could I read' and she said 'I

would rather you didn't' and I suppose because we are used to reading case histories out, you know, I found that very, very dismal and I found criticism something very difficult to take.

Accepting vulnerability

Clearly, being open to challenge also implied the acceptance of vulnerability:

> At the beginning of groups you don't want to appear stupid and share yourself out with these people here. You make assumptions about how to do it and you seem very stupid and silly, but after a while that goes and I suppose that's partly about understanding the nature of the work. But it's also about knowing there are other people and seeing that they say silly things as well and that they do silly things and so it's – well, we're all in this together that gives you a very close feeling really … I suppose that it's trying to respond to these vulnerabilities that are important to me – you know, people showing those things underneath that are really scary, that's the real interest somehow, that's the nitty gritty of it. It's about vulnerability and I suppose if you think about what nursing is, when a patient goes into hospital, its about his vulnerability isn't it, that one needs to get in touch with. That, I feel, is one of the essences of nursing.

It is evident in the case study of Agnes' work how she embraces this vulnerability.

She presents her own practice and what she sees as her own inadequacies (such as feeling 'out of her depth') very directly. At the same time, it might be said that she cushions herself, and perhaps other group members, from the full impact of this directness by her use of humour (see, for example the section in which it is suggested by Alice 'But then you started to think, didn't you…,' to which Agnes replied 'I don't think I did!') This resort to humour is also evident in much of the way the group handles the discussion of Agnes' 'full flight' from Joanna's terror.

The continuing nature of the process

Each seminar was not a discrete entity. As Agnes' case study suggests, once particular encounters with clients had been discussed in one seminar, there would be news of progress or further struggle in later seminars. Besides working with individual patients over time,

themes that arose in one seminar, such as the difficulties of working with couples, would often re-emerge in subsequent seminars. Nor was work confined to the duration of the consultation or seminar. For example, one nurse described how she would process what she had learnt, and how it might be applied to her practice, during her journey home:

> When I'm travelling home and I am thinking about it, it's like I am standing at the station and all the flicker boards go over and I always felt after seminar as I am going home, that's how my mind is going. I am starting to move forward, you know, on all the work I am doing at the moment. Although I may not have presented it, its kind of giving me ideas and kind of re-sorted it a little bit. It's a very hard process but it seems that you sit there for two hours solid thinking and feeling hard and in a way it just helps to refile the cabinets.

Similarly another group member described how she reflected on the work once she was at home:

> It's taking the lot home and thinking about it – either violently disagreeing and thinking 'They're a load of idiots and they don't know what they are talking about,' or 'They didn't listen to me properly and what do they know?' And once you've gone through all that, then sometimes things will totally make sense and you think 'That's absolutely right, why did I miss that?' and you will take that bit with you. [5]

The process is perhaps best understood in terms of the overall training year, and as a continuous process of learning, integrating and revisiting. This elongated process however was one reason why it was very difficult to recognise the changes taking place in seminar participants as a result of the Balint work.

The significance of remembering and forgetting

Presentation of work was based on memory because what was forgotten, or what was recovered after being forgotten, was seen to be indicative of something important that needed further examination.

> Sometimes you cannot remember what you said [to a client] as you do not have recall, but things do come back to you when you tell your story.

> … It is understood that it comes out of your head in a free way, just the way it comes to you as you sit there [with the client]. … When I had a piece of paper last time – people said 'You have written it down!' – there was a joke about it but I thought that was very interesting that they noticed. I had written something down before because it was the dates that something had happened and 18 months had passed in between. It is not exactly frowned on, but it is definitely a chance for a bit of ridicule and I think that is very interesting. It is as if you have got to be freethinking about this and if your story comes out in a muddle, this might be an indication about something that went on.

Agnes' work is interesting in this respect in that it seems she can remember very little in her initial description of the encounter. There is no careful description of the patient or the work that was done, but rather a sense of rush, reminiscent of the panic and flight from fear that emerged in the discussion.

Feeling rather than thinking

Looking at the example offered by Agnes' presentation, although there is strong impression of the panic aroused by this patient, some of this panic also seems to stem from Agnes' fear that she does not know enough to help this patient. This interrelationship – the way that knowledge and emotion are both intertwined and juxtaposed – appears to be a central theme in this research.

As described in Part One of this chapter, the group leader might often suggest to participants that they were thinking rather than feeling, or occasionally tap people on the head to indicate this. This distinction between thought and feeling seemed at odds with the holistic mind/body approach that underpinned much of the seminar work. However, in other contexts, such as study days organised by the Association of Psychosexual Nursing, regularly attended by seminar participants, there was no apparent distinction drawn between thought and feeling in that emotion was referred to as a way of knowing. The interrelatedness of thought (head) and feeling (body) was also suggested by one nurse who spoke of a technique that had been suggested by the leader of another Balint seminar group that she had

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5 This quote needs to be considered in context: the speaker is perhaps more blunt than most of the seminar members, but also expresses herself with great humour. What she is saying here did not come across as critical in tone as the transcript alone might suggest. However, what she says none the less indicates something of the divisions that can exist within the group despite its overall cohesiveness.

attended:

> I thought it was brilliant when I first did it and then when I tried to apply it, it didn't work. When somebody speaks to you or tells you something, you have a gut feeling and you can either speak with your guts or you can take the gut feeling up into your head and speak with your head.

With hindsight, it may be that the distinction being drawn might be less one between thought and feeling, than between varying emphases on different kinds of thought, namely between rational and non-rational ways of thinking or knowing. Rationalising or intellectualising was considered a way of avoiding the challenge of focusing on the emotional work to be done (see Section 4.2.4.4, for example, and the meanings attributed to the bags the patient brought to her appointment). In contrast, value was placed on the knowledge that derived from previous experience. For example, the way that nurses worked, or the knowledge that they drew on, was described by one of the seminar members in the following terms:

> It's like if you were looking after a person with a physical condition and you know they are about to have a fit… because you've seen people [fit] so many times before and you know what to expect, and I think this is similar in that you have seen people with these problems before and there is a similarity about them. It's like child abuse. You start to hear what they are saying and you know at the end of the day that there is child abuse behind it because you are starting to pick out things that people are saying [such as] 'Lock the door when I lie on the couch', or 'Please close the curtains.' You're doing this sort of click, click, click and decision-making, but I think a lot of it is that you have heard it before.

Significantly, participants, including myself, found it very difficult to know if they were thinking or feeling. One member said of another group leader, for example:

> She would say 'Is that a thought or a feeling?' I don't know, I thought it was a thought but it turned out to be a feeling, it's terribly, terribly difficult. And she would say things like 'Take the thought into your head' and I never understood. I find even to this day to try and say exactly what I"m feeling …

Another participant would struggle on after the

seminar, trying to distinguish thoughts from feelings as she lay in bed at night:

> I have to be on my own in the dark. I certainly couldn't sort it out in front [of everyone], I would get confused and embarrassed, especially if somebody says to me 'Is that a thought or a feeling?' My mind would go blank and I wouldn't be able to think, but going back to my home at night and lying in bed I can remember how I felt so I can sort it out sometimes – not always – sometimes its so difficult to know which is which.

It is possible that, as it is so difficult to distinguish between the two, that there is really little difference to be determined. This possibility will be considered further in the Discussion chapter.

Mirroring feeling

As suggested earlier, what happened in the nurse–patient relationship was the focus or substance of these nurses' work. This was largely because of an assumption that feelings experienced by the nurse and reiterated in the presentation of the clinical encounter during seminar were often those of the patient rather than the nurse. As one said:

> It has taken me such a long time to realise the feelings that this [work] engendered in you were exactly the same [as for the patient]. I think when you really take that on board for all it's worth… for me it should be written in letters of fire: '**Don't ever forget the nurse–patient relationship!**'

According to the group leader:

> It does seem to me to be so intertwined…what happens between the patient and their partner, what happens between the patient and the practitioner, what happens between the practitioner and the group and what happens between [the group and] the leader of the group. Feelings are there for examination if there is a space to do so and sometimes one is alerted by it and manages it well and other times not, because we are all just people aren't we, and we are all just who we are.

One example of this mirroring is provided by the case study of Agnes' work. What comes across strongly is her fear and panic, as well as the fear and panic expressed

by Joanna, and also felt to some extent by seminar group members during the discussion of Agnes' presentation. Agnes' fear is eventually understood to be about not having the right knowledge to help Joanna, while Joanna's fear is partly about not having the right knowledge either in her husband's social arena, or in the arena of motherhood. But for both it seemed that their fears were essentially the same in that they are about being helpless or losing control.

Identifying the feelings of the group or the practitioner were seen to provide an important route to understanding the nature of the clinical encounter and of the presenting problem. However, the theoretical basis for assuming such a link, or mirroring, was not clear. Sylvia thought that this notion about reflected feeling came from psychoanalytic understandings developed in the work of Klein, Winnicott and perhaps Main. However, she went on to say:

> …but that's too clever as well because I think these things don't come first, you know. You don't have a set of theoretical assumptions from which the work flows.

Mirroring appeared to be a one-way process in that what was felt by the nurse in the nurse–patient relationship were not the feelings of the nurse but of the patient. There was no suggestion that some of what the patient might be feeling originated with the nurse. According to one participant:

> It is almost as if it is an understood thing in this group that you are meant to feel things but you are not to voice them.

She gave the example of a woman who originally came to her for help with non-consummation, was helped to cope with penetrative intercourse sufficiently for her to have two children, but apparently had no interest in working towards a continuing sexual relationship after having her desired number of children. Any suggestion that she needed to do more work made the client very angry and the nurse very anxious. Yet the nurse would not convey her own emotions back to the client:

> You may voice to her what **she** is feeling in terms of 'I wonder why you are angry?' You would never share how a patient makes you feel.

(See also 'Use of self', below.)

The moral value of emotion

At its core, the work of the group was about dealing with the distress that was prompted by unwelcome or difficult emotions. These emotions were either those, such as anger, that were seen to belong to the patient but experienced by the nurse (or group); or of the nurse who felt overcome by the pain she encountered, or inadequate in terms of how to respond.

For some of the group, such as the group leader, the way in which individuals responded to emotion was influenced by the fact that emotion was not value-free. As Sylvia said:

> It seems to me that there is a hierarchy of feelings from laudable and acceptable things like feeling compassion and feeling close… having understanding, and then there's a kind of middle ground, not being sure if you like someone and if you don't, what's that about and being irritated by someone or burdened by them. And then I think 'below' that is a whole area of feelings like anger and disgust and distrust and fear and hatred and really difficult feelings which only really experienced people can accept and tolerate.

The group leader went on to say that just as Winnicott and Klein considered that the infant projects fury and fear onto the mother who needs to hold or contain this, so nursing was partly about the holding of difficult feelings, although nurses rarely get the opportunity to discuss these. Moreover, when individuals are feeling relatively good about themselves, they can do better work with the 'lower' order of emotions, those that it is difficult to accept that they hold, but when they are themselves distressed, they tend to work at a different level. In this way, what happens in the group will vary, depending on the circumstances of individuals in the group.

The role of theory

The seminar work was characterised by little formal theoretical instruction. One participant, for example, told how in her first seminar group they had examined human emotions from birth to death, and had subsequently found Benner's work to be helpful. She had, however, read very little about the Balint approach. Another said:

> There wasn't anything told but we were asked to read about Balint training, so I read that. Sylvia advised us which book to read but she didn't tell us. Sometimes during the session a bit would come into it, and she would say something about

the Balint seminars and several people whose names I cannot remember. And Sylvia talked very much about the nurse–patient relationship which she is very keen on, and [it] made perfect sense when I read about it, having heard it from her.

In the group leader's experience it has been 'doing the work,' rather than considering theoretical approaches, that had led to insight:

> It's a slow process of learning and growth and I think its only lately in the last few years really that I have begun to put the psychoanalytic understanding that I have [to use] to make sense of what goes on. And I guess you can tell from the way I am saying this it is very tentative, so I think my underpinning is much more about the work that Balint did which is the study of the doctor, the patient and his illness, and the recognition of the wholeness of people.

Use of self

According to the group leader, the nurse's personal experience should not be allowed to enter into the nurse–patient relationship. She gave the example of a seminar member who listened to a patient, experienced her pain because she had been in a similar situation, and indicated as much to the patient. This apparently had stopped the patient in her tracks. Sylvia said:

> There's a lovely quotation from Winnicott … where he says something like friendliness of approach and kindness is really important in the work with patients, but there has to be a space between the patient and the practitioner for the patient's pain and this must not be impinged upon by the practitioner…I think that's what we're talking about – this danger from time to time that one's own feelings occupy one's own experience, occupies the space …

Thus one seminar member told how she had been 'ticked off' by the group leader for talking about herself:

> I said to a patient 'Oh I wouldn't like that to happen to me,' and [the group leader] said 'You're not here to talk about what you would like and what you wouldn't like, it's what your patient would like.' And I realised then that she was quite right.

This was not to say that there was no 'fellow feeling', or empathy with a patient's situation. It was more a question of how this was handled in the nurse–client encounter. However, there were occasions where this same nurse's experience of powerful emotion in the past had helped her to understand what a patient might be experiencing: 'yes, its useful using your own emotions as long as you realise they are your own and even though they were strong, they are not the same.'

Others suggested that there was a delicate balance between fostering 'closeness' and 'openness' between the client and practitioner on the one hand and keeping a space available between the nurse and the client in which therapeutic work could take place.

One factor shaping the particular use of self in the seminar appeared to be the field of work – in other words, working in the psychosexual field was different to other areas. As one nurse said, comparing psychosexual counselling with bereavement counselling:

> Yes it is different because you don't use yourself therapeutically in the same way. You gain knowledge with bereavement counselling and you have an understanding of where people are at, and your job is to hear, to listen and not necessarily give any insight whatsoever, but is just to be there supportively. But psychosexual work is monitoring your self at the same time as being with the patient and using that. It's another layer on top of it, and its about using your self.

With bereavement work, although it was hard, there was a framework to guide practice. With psychosexual work however, there was no framework, only 'this internal supervision going on.'

Another nurse commented on the way that, although she knew some of the seminar members outside the group, on arrival at the seminar, they leave these relationships very much outside. It is part of the training to learn how to focus on the work and forget the outside world for those two hours. This was the same for personal feelings and experiences. According to one nurse, recognising personal issues and how they might impinge on practice could be handled in one of two ways:

> …you can either say it aloud and say 'look, I find this area very difficult' or you can say it to yourself and pack it away as your business and

that's one of the things that takes a long time to learn, I think.

However, although early on it became clear that personal disclosures were not welcome contributions within the context of the seminar, some group members did get to know each other and could hazard a guess at what their personal reactions might be in certain circumstances. They often had a sense of why another participant might be unusually quiet during discussion. This idea that feelings could, on the one hand be exchanged or transferred between client and practitioner, or between practitioner and group, but on the other, if personal, could be more or less hermetically sealed within the practitioner, suggests something about the concepts of emotion and self that underpin this work (see section 5).

It was clear that the group was not there as a therapy group for individuals or personal issues. It was none the less recognised though that there needed to be some acknowledgement of the difficult nature of the work, and of the pain that it often entailed for the practitioner. As one nurse said, 'The nature of the work is exhausting – I know what I am feeling myself and I am watching other people and thinking "they are near the edge."'

4.2.6 Outcomes

Nurses acknowledged that they could not be sure about the long-term impact of their work with clients. Because clients did not return after a series of consultations it did not mean that their problems had necessarily resolved. Nurses only had hunches about whether their work had been successful, or what might have been counted as 'success.'

However, outcomes for nurses were clearer. One of the main effects of their seminar work was increased understanding of the reasons why they became 'stuck' in their work with particular clients, and increased insight into their relationships with clients. For example:

> I think that what you learn in the seminar is about what you got caught up with, what your responses were about …it's sometimes what is the block for the nurse.

Using Agnes' work again, she had become stuck and unable to help her patient to work on fears about labour and motherhood because she herself was in flight from her patient's terror, and her own need to feel competent

and in control. The sense of not knowing enough, fear of making things worse for the patient, fear of work being influenced by a dislike of the patient were amongst the commonest themes that seemed to 'block' the nurse.

Seminar training was also found to be helpful in helping to locate responsibility for patient's emotions. One nurse, for example, had come to realise that the angry patients she saw were not directing anger towards her personally, and this realisation allowed her to 'give the anger back to the patient,' and use it more therapeutically. Moreover, rather than giving any set formulas for practice, the seminar work helped this nurse to 'think on her feet' and gave her the energy to carry on with this kind of work.

Finally, learning from other participants' successes and failures, for example developing new techniques such as drawing, or taking flight from a client's pain by suggesting reading material, and incorporating what was learnt into individual practice was viewed as enormously helpful. This was put by one nurse in the following terms:

> Also what is really useful is observing how other people get caught up in behaviours and I think 'They are really good in practice and yet look at what has happened to her.' It's all right and it's good to observe – I wouldn't say reassuring – but it's good to observe that this is part of the work and we *will* get caught up – it's a part of what we are exploring, and it's only when we come out to a seminar that we know its happening.

Seminar training could usually be described as a process of 'high challenge, high support' which recognises the vulnerability of practitioners and the importance of remaining realistic.

4.3 Summary

This chapter has provided an indication of why participants attended Balint seminar training, and the role of the group leader. It has also articulated some of the principles, processes and assumptions that informed the work of the seminar group, not all of which are consistent with each other.

There is, for example, a correspondence between on the one hand, the way that rationality is downplayed in favour of an emphasis on the intertwined nature of

thought and emotion, and on the other, a lack of emphasis on theory. Yet the holistic approach of the seminar training in terms of its assumptions about the inseparable nature of body and emotions coexists with a distinction between thought and feeling during seminars when participants struggle to distinguish between the two.

These issues are discussed in the final chapter of the report, in which they are organised under a number of themes, namely:

- perceptions of emotion and its relationship to thought or knowledge;

- the nature of the learning process underpinning the seminar group's work;

- theoretical underpinnings of the work;

- the articulation of emotion;

- nurses and therapeutic work.

5. Discussion

5.1 Introduction

This chapter presents an initial discussion of the themes identified at the end of Chapter 4. In addition to suggesting the relationship of the study's findings to existing work, the forthcoming discussion aims to provide the basis for ways of exploring the interpretation of data and the methodological issues raised by the study in more depth. The final part of this chapter deals with limitations of the study and recommendations for further work.

5.2 Discussion of themes

5.2.1 Perceptions of emotion and its relation to thought or knowledge

Within Western culture there has been a tendency to contrast emotion with reason and from this position, to view emotions as subjective states that are the responsibility of the individual, and which at the time of their expression, relate to that individual alone (Parkin 1985). In this view, emotions have been identified with the individual body and either symbolically understood as physical images such as heartbreak or a knot in the stomach, or as concrete, physiological responses (Lutz 1986). In contrast, social constructionists have argued that emotions are not in our bodies but our actions, particularly verbal actions. According to this view, feelings are social phenomena that are constituted and sustained by group, rather than individual, processes (Williams and Bendelow 1996), to the point that some suggest emotion to be a form of discursive practice (Abu-Lugnod and Lutz 1990). Jaggar (1989:148), for example, has stated that:

> 'We have no access to our own emotions or those of others, independent or unmediated by the discourse of our culture.'

Craib (1995), both a sociologist and psychoanalyst, is well known for his critique of social constructionist approaches to emotion, arguing that these are based on an assumption that discourse describes 'real' emotion. He suggests that it is possible to know the social rules concerning emotional experience and expression without any knowledge of the emotional life of people who abide by these rules, and then to 'mistake the social scaffolding of emotions for emotional life itself' (1995: 154). According to Craib, a sociology of emotions as shaped by social constructionists will reduce emotions to ideas without autonomy from the rational world in which they exist. (He makes little reference to a sociology of emotions informed by an interactionist approach that gives recognition to the role of the body and the social in generating emotion.)

Craib's view is interesting in that, while he argues against giving priority to cognition, he none the less opposes emotion and cognition, emotion and rationality. Craib suggests, for example, that the opposing nature of emotion and cognition helps to explain why it is that we have feelings that we cannot express to our satisfaction, or why we might experience a contradiction between our thoughts and feelings. He does not seem to consider emotion as a **_form_** of cognition, a view very different, for example, to that of Rosaldo (1984:43) who suggests that:

> Emotions are **_thoughts_** somehow 'felt' in flushes, pulses, 'movements' of our livers, minds, hearts, stomachs, skin. They are **_embodied_** thought, thoughts seeped with the apprehension that 'I am involved.' [my emphasis]

Similarly, Mitchell (1997), in arguing for different forms of cognition, has distinguished between

- the semiotic – relating to language or language-like phenomena;

- the practical – relating to forms of embodied knowledge; and

- the emotional, which relates to people's feelings.

He notes that while many social scientists are keen to break down a Cartesian mind–body duality and perceive embodied practices as cognitive processes (as with the work of Bourdieu), 'they have been less willing to interrogate a similar duality between cognition and emotion' (1997: 80). Mitchell argues that emotional knowledge represents 'cognitive events **_of the same order_** as semiotic and practical cognitions' (p.80). At the

same time, he recognises that the interpretation of personal experience is mediated by feelings, which, although they seem entirely personal, are always framed by social conditions, a point that seems of particular significance for this paper, and more generally in terms of feelings generated through participant observation (see section 3.6).

The work of the nurses in this study, and the premises underlying psychosexual nursing, appear significant in this context. Psychosexual skills include listening, only giving advice and reassurance sparingly, and tolerating not knowing what to do – skills that are similar to those acquired in the Balint seminar. In addition, however, the role of physical examination is seen to be crucial with many clients. Skrine (1997), for example, notes that all patients become vulnerable when being examined, but if examination is of the more intimate parts of the body, the vulnerability is increased. The experience of psychosexual practitioners, quite consistent with a holistic approach, suggests that a parallel exists between exposure of the body and exposure of emotion: 'as the clothes come off and the body becomes more naked and exposed, so do the feelings' (Skrine 1997: 16), particularly when the genitals are examined. Thus in contrast to the more usual practice of trying to distract patients from their unease arising from physical examination, psychosexual practitioners use examination - or what they call 'psychosomatic examination' – to try to explore this disquiet and enable the patient to reveal anxieties or fantasies (Selby 2000b). As Skrine (1997:17) puts it:

> It has been found that people in this vulnerable and exposed position sometimes blurt out things that surprise not just the doctor, but themselves as well. It is as if the removal of clothes removes a defence, a wall, a barrier that has prevented them saying something, or even letting themselves feel it.

The link between exposure of the body and exposure of emotion is most readily understood in terms of an interactionist view that recognises the role of both bodily and social factors in emotion, as opposed to organismic or social constructionist views (see section 2.4.2.1). In addition, the knowledge used by practitioners who employ psychosomatic examination appears consonant with Mitchell's (1997) view of emotion as a form of cognition. Skrine (1997: 18) notes, for example, that psychosomatic examination is attended by:

a heightened awareness, a more concentrated listening to spoken and unspoken communications, during an examination that has a genuine physical content and justification.

It was suggested above that the distinction between thought and feeling might refer to a distinction between different forms of knowledge (rational and experiential/intuitive) rather than indicating an opposition between mind (thought) and body (feeling). Mitchell's work would seem to suggest extending this view of nurses' knowledge to include an emotional form of cognition. This suggestion is supported to some extent by findings from participant observation indicating that it was necessary to acquire competence in the use of emotion as knowledge (see section 4.1.5).

5.2.2 Nature of the learning process

Nurses themselves did not often theorise about the nature of the knowledge they employed, and at times seemed ambivalent about the role of theory to their work (see Sylvia in section 4.2.5: 'theoretical underpinnings'). At first sight it seemed that there was a rather idiosyncratic relationship between practice and a range of theoretical frameworks. Much of this could be attributed to Michael Balint's emphasis on the process rather than the content of training, and on the necessity of training rather than teaching. His approach was later elaborated by Tom Main, who helped to disseminate and develop the work of Balint, and had directly influenced the practice development of the group leader and some of the group's participants. Taking a psychodynamic perspective, Main (1966) suggests that knowledge is always in danger of being put to perverse use, 'now in the service of the Id, and now of the Super-Ego' (1966: 5). It is never certain that a student understands the information offered by a trainer in the manner intended, or will use this information for independent work, or simply become more dependant on the trainer for passive instruction: according to Main, the phrase 'well-taught' can have sinister overtones.

He suggests that the learning process is problematic in a number of respects, including the difficulty of training methods and the nature of the trainer–trainee relationship. Main gives the example of a decision amongst staff working at a therapeutic community to make it possible for patients to go home at weekends, if

they so wished. The aim was to reduce the patients' dependency on the hospital and the severing of other relationships. The experiment went well and became part of practice. After several years however, attitudes changed. Main realised what had happened when he overhead how one nurse had tried to **_persuade_** a patient to go home. It was now thought that it was preferable for patients to go home, especially as the staffing cover could be reduced. An initiative that had been premised on patient choice had become a matter of staff choice. For Main this shows how:

> an idea passed from one individual to another, by teaching, can change its mental residence moving from the experimental and thinking areas of the ego of one generation into the fixed morality areas, the ego ideal and the super-ego of the next. (Main 1966: 11)

What had happened was that those who had introduced the initiative had the opportunity to employ problem-solving, active learning, while those who followed after did not have to address the original problem and so in this area at least become passive and obedient learners.

Main describes the way in which ideas, in their passage from one person to another, are liable to become sets of unquestionable rules that handicap further thought as **_the hierarchical promotion of ideas_** between the generations. He argues that hierarchical promotion is a fate that threatens all knowledge and one that is hard to glimpse. For example, it is tempting for group leaders to be pleased with trainees who adopt their ideas. At the same time it is hard to distinguish between those who take up an idea and those who are possessed by it. On this basis, the form of training is as important as the content. Main suggests that the trainer should avoid creating dependency and instead listen to trainees' difficulties, and help them recognise and think about these for themselves. To this end, training needs to be characterised by a number of features such as:

✦ training is extended over time to allow digestion of thought and the development of new hungers;

✦ scholarship is sparingly exhibited and discussion is kept to immediate clinical work of trainees;

✦ trainees are not force fed. They are not given general principles or rescued from uncertainty. Instead they are kept hungry, helped to use their own experience, and recognise thinking as their appropriate contribution to the learning process.

The work of the nurses' group in this study clearly demonstrates these principles in action.

5.2.3 Theoretical underpinnings of the seminar work

The lack of systematic reference to theory in the seminar and associated discussions of practice also appeared to be linked to the way that seminar participants were encouraged to explore theoretical issues at their own pace and according to their own needs. Theory was therefore implicit within the seminar work and given different weight by participants in interviews and other forums of discussion. Most importantly, the extensive experience of these nurses meant that they were to a large degree ***generating*** theory from their practice in combination with existing theories that seemed to have relevance, [1] rather like bricoleurs. For example, in a meeting with participants to discuss the study's findings, Margaret suggested that one of the main features of this work was the way in which nurses facilitated openness and flexibility. Clients and fellow seminar participants were not told what to do, but helped to learn more about what they were experiencing. This meant that both clinical encounters and seminars were occasions marked by chaos and 'not knowing,' in which the nurse (in the clinical encounter) and other participants (in the seminar) accepted the role of managing this chaos or 'holding' the pain of the participants. Margaret saw this very much in terms of Klein's object-relations theory, particularly the idea of 'reverie' and the way that mothers 'hold' the chaos in which the infant exists until he or she can make more sense of their world. It was clear, however, that other participants had not located their practice within this particular framework.

Although there was no single theoretical tradition, the most common reference to theory was that of psychoanalysis. This next section therefore briefly explores the way in which psychoanalytic theory underpinned these nurses' work, particularly with respect to the assumption of 'mirroring.'

5.2.3.1 Mirroring

There is growing recognition that the healer–client encounter is a transaction informed by the conscious and unconscious meanings that each participant brings to the encounter, and by those meanings evoked in each participant by the other (Stein 1982). These responses have been described in terms of 'transference' and 'countertransference.' representing two sides of the same coin:

> They refer to how human beings unconsciously use one another displacively and projectively… Transference denotes the patient's (or informant's) displacement and projection onto the clinician (or investigator); countertransference denotes the reverse. That is, people often apperceive and respond to others not as they realistically are in the current relationship. Instead, they experience others in terms of feelings and conflicts about persons from their childhood, or as though these others were representations of whole persons from their past, or as 'parts' of their own personality.

> (Stein 1982: 169).

In addition, not only is it possible for feelings to be transposed from one individual to another, but there is an assumption that the method of transposure is in, or through, the body. As Kast (1995: 38-9) puts it:

> A mysterious relationship or fusion appears to exist between the unconscious of the analyst and that of the analysand…The shared unconscious is sensed in the atmosphere of the relationship. It is the ground for psychic 'infection,' an example of which is the experience the analyst has when she ***feels in her body*** the unperceived and un-expressed anxiety of the analysand. [my emphasis]

According to Davidson (1986), there are two views about the usefulness of countertransference. One, the 'classical position', regards countertransference as an adverse by-product that ought to be eliminated as much as possible from the therapeutic encounter. For Freud, for example, countertransference is a form of resistance on the part of the psychoanalyst, due to the emergence of unconscious conflicts prompted by what the patient does or represents for the analyst. The other view of countertransference –

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1 I am indebted to 'Gill', who helped me to understand this.

the 'totalist position' – broadens the concept of transference to include the range of the therapist's feelings towards the patient, not merely those kindled by transference. Moreover, rather than being a process to avoid, countertransference might provide important insights. For example, for Stein (1982), the concepts of countertransference suggest powerful tools in understanding the therapeutic encounter, revealing the unconscious motivations beneath the clinical performance. He also suggests that the analysis of countertransference provides a key to the internal experience of the healer role and thereby to the healing encounter itself, not only in the psychoanalytic encounter but in health care relationships more generally. Finally, Stein suggests that the understanding of counter-transference is a powerful clinical tool for patient care:

> For one's emotional response to a patient is an indication of the patient's own emotional state. In order to be able to tap into what the patient is experiencing, the clinician must first be able to accept and recognise what he/she is experiencing towards the patient.
>
> (Stein 1982: 167)

According to Stein, who supported physicians with problems of 'patient management', they often understood the patient better once they recognised the feelings that patient evoked in them or what it was that made them uncomfortable with the patient.

The suggestion that emotions present in the practitioner–client relationship will be mirrored in the seminar group appears to correspond with the phenomenon identified by Searles (1955) as 'parallel process.' This refers to the way in which phenomena present in the relationship between therapist and patient are reflected in that between the supervisor and supervisee. This process, in which often forgotten information about the client is manifested by the supervisee through similar actions or ways of being during supervision, provides an indirect means of understanding the client. According to Yegdich (1999), the absence of parallel process restricts the progress of the supervisory process as there is no experiential route to the supervisee's clinical work. In addition, the existence of parallel process helps in distinguishing supervision from therapy: one of the characteristic features of parallel process is its tripartite nature, involving as it does, the client, the practitioner and their supervisor, compared to therapy which is bipartite (Yegdich 1999). The tripartite nature of parallel process

may also help to differentiate it from the phenomenon of countertransference.

Balint's work is informed by psychoanalytic understandings, and both concepts of transference/couuntertransference and parallel process assume that a therapeutic encounter between client and practitioner is a transaction informed by the conscious and unconscious meanings that each brings to the relationship. However, it seems that there is a closer correspondence between the Balint seminar training undertaken by nurses in the study and the theoretical construct of parallel process, given the tripartite nature that they share.

5.2.4 Articulating meaning and emotion

5.2.4.1 Understanding experience through narrative

As discussed earlier (section 4.2.5), participants often found it difficult to recognise the nature of their own emotions or to articulate what these were. At the same time, discussions of case studies were often without meaning once transcribed as written text, although they made sense as aural data. It seemed that the work of the group was often done in the space between words, in a discussion that wove the different participants' voices together in a continuous, but not entirely linear, form. One way of understanding this phenomenon may be to consider the seminars in terms of narratives.

Narrative has been viewed as perhaps the primary mechanism by which human understanding of experience is registered (Brock and Kleiber 1994). Interest in narrative has risen with the emergence of post-modernism and its scepticism about the unified nature of scientific theory and knowledge (Lyotard 1984). Such scepticism led to a shift towards everyday knowledge based on very different kinds of testimony, such as technical or ethical statements (Lash 1990). In response, many social researchers have turned to more local narratives which are multivoical and in which no one interpretation is given precedence (Denzin 1997).

Analysis of local narrative can be understood as 'doing research with first-person accounts of experiences' (Coffey and Atkinson 1996). Although much narrative analysis in health care research is concerned with

understanding the experience of illness and suffering (see, for example, Kleinman 1988), there are other applications. Narratives are recognised as offering ways of going beyond description to exploring aspirations and moral imperatives: as May and Fleming (1997:1098) have put it, narratives can be 'constitutive of self and professional identity.'

A narrative is not the same as a story. Stories refer to a sequence of events, a simple and chronological account which can be reconstructed from narrative discourse. Narrative, on the other hand, refers to the actual discourse that tells of the events, discourse in which crucial events are almost invariably out of linear order (Mattingly 1998). According to Mattingly (1998), narrative possesses certain features that make it particularly appropriate for dealing with the experiences associated with ill health or healing. These features are that:

❖ narratives are event-centred, and typically deal with human interaction;

❖ narratives are experience-centred and offer a glimpse of what it feels like to be in the world described by the narrative.

❖ For some (the performative position), narratives not only refer to past experience but create experiences for their audience. The relationship between narrative and experience is not direct but emerges as the narrative is being performed and offer meaning through image, evocation and what Mattingly describes as 'the mastery of the unsaid.'

This last feature, the performative nature of narrative, is consonant with the way in which seminar members sometimes appeared to present their accounts of clinical encounters dramatologically (see the example of Gill, shrinking into her chair). This, and the way in which much was left unsaid, suggests further exploration of the data using a narrative analysis would be fruitful.

5.2.4.2 Understanding the moral nature of emotion through narrative

Significantly, the study of emotions involves focusing on certain kinds of social act within a broader moral and cultural order (Harre 1991). Seen in these terms, Harre suggests that there is no such thing as 'an emotion', only various ways of acting and feeling emotionally, of displaying judgements, attitudes and opinions dramatistically in certain appropriate bodily ways (Harre 1991: 142). There is a tendency to think that an emotion such as anger is located inside a person, exerting an invisible influence on their actions. However, Harre suggests that:

> to be angry is to have taken on the angry role on a particular occasion as the expression of a moral position. This role may involve the feeling of appropriate feelings as well as indulging in suitable public conduct. The bodily feeling is often the somatic expression to oneself of the taking of a moral standpoint.
>
> (Harre 1991: 142-3)

This approach to emotion, which shares some correspondence with interactionist views of emotion (see section 5.2.1), may suggest an appropriate methodological approach for future research in this area to gain more insight into the complex relationship between emotion, performance and ways of knowing.

The moral nature of seminar work was hinted at by Sylvia when she referred to a hierarchy of emotions (see section 4.2.5). This aspect of nurses' work might again benefit by exploration using a narrative approach: narrative and story have been understood as aesthetic and moral forms underlying clinical action (Mattingly 1998). According to Mattingly, the practical knowledge of experts is not only a matter of technical knowledge about the means to bring about particular results, but also a wisdom about moral questions concerning which ends should be pursued. This led her to explore the way in which people not only solved problems, but how they set them and she found in studies of professional groups that problem setting often occurred through the use of narrative. People were particularly likely to use narrative when they were in need of understanding difficult relationships with individuals whose behaviour directly affected their work.

5.2.5 Nurses and therapeutic work

This study has reported on one way that nurses are engaged in therapeutic work in which they focus on the vulnerability of their clients and on 'holding their pain.' The therapeutic nature of this work, however, is in some

ways different to the kind of therapeutic nursing advocated by proponents of primary nursing or the 'new nursing,' (for example Meutzel 1988) who highlight the importance of reciprocity (Morse 1991), or 'closeness' (Pearson 1988) in the nurse–patient relationship.

Nurses in the study did not aim for a form of reciprocal relationship with their clients, and any 'closeness' they developed was with an eye to the need to maintain a therapeutic space (see section 4.2.5: use of self). They gained intimate insight into their clients' worlds, and they sometimes entered into a physically close relationship with clients through examination. However, the introduction of nurses' own experience or feelings into the encounter was not a feature of their clinical relationships. The same could be said of the relationship between participants in the seminar. They gained intimate insight into each other's practice but there was an absence of private selves. Instead their aim was to create a therapeutic space between the nurse and client (and a similar one between seminar participants) in which the client can make clear their needs and preoccupations, and the nurse can listen and respond. It was considered that 'closeness' and moving into the patient's space undermined the opportunity for therapeutic work.

5.3 Methodological considerations

This study has raised issues about participant observation and the importance of taking an epistemologically congruent approach for the study of emotion. There is a school of thought amongst ethnographers that assumes physical immersion in the actions of research participants will provide cognitive insights into their world. According to Mitchell (1997: 83), for example:

> When we engage in this type of fieldwork, we become involved in a process of cultural mimesis. By taking part in particular cultural practices, we hope to make them explicable. But adoption of local practices can also take one beyond simple mimesis, and into the realm of felt experience. This type of experience should not be ignored. Rather it can give us further, deeper insights into the practices that provoke them, and into the interpretations that are made of them.

In attempting to copy the cultural practices of the group, I anticipated that I would share some of the felt experience of the group and use this experience as data. The study was built on a premise of radical empiricism (Jackson 1989), which demands the use of all the senses in data collection on the assumption of a close connection between the cognitive and bodily experience in the everyday world. However, the focus of the study did not offer many opportunities for this kind of approach. Fieldwork involved little action and depended largely on sitting, listening and talking. I found embodied experience was difficult to access without physical action. The relationship between embodied and emotional forms of cognition could be further explored.

During fieldwork I also assumed at some level that to understand emotion I should be looking 'within' myself, that emotion was a personal matter and, as such, that I would have as much experience of it as anyone else. In other words, I had allowed everyday cultural assumptions about emotion to steal into the data collection and analysis. Although I was open to the idea that emotions were not necessarily individualised feelings, I was none the less anticipating that they would be 'internal' experiences. I now think it would probably be more helpful to have taken a relational view to emotion. Burkitt (1997), for example argues that, while research on emotions focuses on relationships, practices and discourse, and on the relationship between these, the central focus of studies on emotion should be relationships, as both practices and discourses are both structured and take their meaning from these. He suggests that, rather than emotions being the external expression of an internal process, emotions, if they convey anything, are expressive of the relations and interdependencies of which they have become an integral part. They are expressions occurring between people, not inside a single person. This approach might offer a useful starting point for further enquiry.

5.4 Summary of conclusions

This section explores the main conclusions of the study, in relation to its original aims.

Aim 1: to describe the process of experiential learning taking place in a Balint seminar programme

i) Principles underpinning the learning process

The process of experiential learning was informed by a range of explicit, but not always internally consistent,

principles. These included:

- the importance of attending to feelings rather than thoughts;

- the importance of focusing on the hear and now (and what could be known directly through the nurse–patient relationship);

- the importance of relying on memory, and the significance of what was forgotten;

- the importance of maintaining a private self, and a clear boundary between personal experience and seminar work;

- the importance of acknowledging 'psychic infection,' or the way that emotions might be transposed from client to nurse, and subsequently to seminar group members;

- the importance of attending to missing persons (such as a partner or child);

- the importance of non-directed learning.

ii) *the tension between order and chaos*

These principles were drawn together in bricoleur fashion from a variety of sources, principally from the work of Balint, the world of psychoanalysis and the domains of psychosexual nursing and medicine, but also generated by nurses in the seminar group. Together, they gave rise to a degree of tension between order and chaos. On the one hand, the seminar was conducted in line with clear rules. Presentations, for example, were made in line with set conventions - they were linear in nature, and listened to without interruption. In contrast, discussions following case–presentations were non-linear, and interruptions were common. Similarly, the learning process was non-directive, and no definitive solutions were sought. In addition to the use of routine interventions, such as psychosexual examination, considerable weight was given to the value of 'not knowing,' and experimentation with new approaches (such as drawing). The relatively inflexible nature of rules (including, for example, the requirement to feel and not think) and the contrasting openness and plasticity of the learning process was a combination that many participants found difficult or frustrating, particularly in preliminary training, although it also remained a feature of advanced practice.

iii) *The centrality of the concept of emotion*

Emotions were central to Balint seminar training in a

number of respects. First, emotion was understood as the focus of the work, providing access to the client's world. Close links were assumed between the body and emotion (eg psychosexual examination provided a means of 'releasing' emotion), with the implication that emotions were internal processes, rooted in the body. There were other ways, however, where it seemed that emotions were constituted through action or dialogue, as in the presentation of case studies that were dramatological in nature.

Second, the nature of the work was often highly painful. The source of the pain might be the patient (the nurse was 'holding' the patient's pain) or the nurse presenting the case study (in which case her pain might be 'held' by members of the group). Alternatively, pain arose from the vulnerability nurses felt in presenting work where they had not been able to meet their own professional standards or aspirations.

Aim 2: To explore the potential of nurses' emotional experience as a form of nursing knowledge

Nurses' engagement with emotion, as described in this study, is very different to the kind of emotional 'work' referred to in the literature on emotional labour. Emotional experience was used by seminar members as a way of gaining insight into their clients' worlds, on the basis that the emotions nurses were experiencing were those of their clients. In this sense, it was not the emotional experience *per se* that represented a form of nursing knowledge. Instead the knowledge these nurses were developing was concerned with understanding the nature and source of the emotions experienced during practice, together with how to use such emotions to therapeutic effect (see, for example, Agnes's case study in section 4.1.1).

Aim 3: to explore the role of the seminar leader and the skills required for this role

The main components of the leader's role were:

- to facilitate the process of discovery amongst seminar participants, rather than teaching or directing them;

- to maintain focus (for example, to return attention to the nurse–patient relationship);

- to help group participants to resist fleeing from the emotional distress that they experienced on behalf of their clients, and in response to challenges to their professional selves; and

◆ to acknowledge and contain (or hold) the distress of seminar participants.

There are probably a number of possible approaches to working as a group leader. Sylvia's approach, for example, was marked by a certain degree of authority, while other leaders (or groups) might put more stress on reducing differences in power or authority amongst seminar members. The skills demonstrated by Sylvia included:

◆ being able to maintain a boundary between a professional and a private self;

◆ being able to maintain a sufficient boundary between the role of the group leader and that of participant;

◆ being able to 'hold' the pain of group participants;

◆ knowing when to leave participants to struggle, and when to intervene (in terms of emotion, direction and theory);

◆ being able to offer challenge and support as circumstances required.

Aim 4: To explore the potential offered by Balint seminar training as a developmental model for nurses' clinical supervision

The potential of using Balint seminar training as a way of providing nurses' clinical supervision depends on the kind of clinical supervision required. Clinical supervision has been described as either a structured way of increasing awareness of the influences (including emotions) on the therapeutic encounter and teaching therapeutic skills, or as a way of dealing with, or washing away, the emotions associated with nursing practice (section 2.1). In contrast, Balint seminar training is centrally concerned with understanding and making use of the emotions experienced by seminar participants in the course of their everyday practice, working on the assumption that these emotions are primarily those of the clients encountered in practice. Findings from this study suggest that this process is long-term, challenging and often painful. In addition to managerial support for regular and long-term attendance, it requires the facilitation of a leader who is highly skilled in group work, and the ability of participants to accept a relatively unstructured, undirected approach to learning.

As such, Balint seminar training requires considerable commitment from participants, and a stability of group membership that may prove difficult to achieve in the current climate of health service provision. Having said that, given the diverse areas of practice in which the emotional world of the client may influence their general health status, it is important to identify those areas where Balint seminar training is feasible.

5.5 Limitations of the study

◆ While participants in this study view Balint seminars as invaluable for their psychosexual practice, there has been little to no evaluation of patients' or clients' experience of psychosexual counselling supported by this approach, or of the effectiveness of such counselling.

◆ The study focused on an advanced practice seminar, and greater understanding of the experiential learning process associated with Balint work might be gained by the study of a basic seminar group.

◆ This study focused on nurses who had persevered with Balint seminar training despite the difficulties encountered, either as neophytes or advanced practitioners. A fuller picture of the value of Balint seminar training, and is possible application to a variety of areas of practice, would be gained from a study exploring why nurses discontinued training, and why nurses who might be aware of its availability do not consider it further.

5.6 Recommendations

◆ Further understanding of the effectiveness of psychosexual counselling by nurses through evaluation of clients' experience and their perceptions of its effectiveness.

◆ Further work which explores the role of group leaders in more detail, and the different styles of leadership that are used by leaders of Balint seminar groups.

◆ Further work which explores the experiences of those attending basic Balint seminar training, and documents whether, or in what ways, their practice changes over a their first year of practice.

◆ Further research which explores why nurses do not take up, or discontinue, Balint seminar training.

- ✦ Theoretical work to consider the methodological issues raised where emotion is understood to be constituted in and through relationships, rather than an intrinsic feature of individuals.

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Appendix A

Learning outcomes identified by Balint seminar attenders

(Selby 2000b)

- ❖ Awareness of how the patient presents

- ❖ Insight into what happened in the here and now

- ❖ An understanding of feelings - both the practitioner's and the patient's

- ❖ Exploration of what the practitioner finds difficult

- ❖ Understanding of what the patient finds difficult

- ❖ Understanding how the practitioner works with different patients

- ❖ Development of skills of listening, responding and reflecting to have an increased understanding of the sexual needs of patients

Appendix B

Information sheet

The research in which you have been asked to take part is interested in describing the process of experiential learning that takes place with Balint seminar training. This would be a first step in designing a broader study that would evaluate the appropriateness of this approach as a model for clinical supervision in a range of nursing settings. This pilot study is additionally interested in developing theoretical understanding of the role of emotions in nurses' knowledge and practice.

The pilot study takes a focused ethnographic approach. Ethnography is a way of describing and analysing the way people act and interpret experience within a particular cultural context through long-term participation of the researcher. Characteristics associated with health services, such as financial constraints and rapid change, have led to the development of focused ethnography, that is, more condensed projects made possible by the development of pre-defined research questions. In this study, the researcher will work with one established seminar group over a period of nine months. The primary methods employed will be observation (with limited participation, depending on the views of the group), and individual interviews with group members.

The researcher, Jan Savage, is a nurse and social anthropologist. She is currently a Senior Research Fellow at the Royal College of Nursing Institute.

You are under no obligation to take part in this research, nor is it necessary for you to explain why you might not want to be involved. If you do decide to take part, your wishes concerning confidentiality will be strictly honoured. The researcher is hoping to tape record seminars and interviews if all members of the group agree. If you are happy for these activities to be recorded, you will be asked to sign a consent form, outlining your rights. Given the nature of the seminars, it is important that all members of the group feel comfortable about the presence of a researcher, and a

tape recorder, and you are free to withdraw at any time without explanation. Consent will be sought before each seminar and interview.

The research is overseen by a steering group composed largely of nurses with a background in psychosocial nursing. If all members of your group agree to take part, you will be given the name of one of these members to contact if you have any concerns before or during the study. The researcher will also be pleased to answer any questions you might have. She can be contacted by mail at the Royal College of Nursing Institute, by voice mail at 0207 647 3662 or by e mail at jan.savage@rcn.org.uk.

If you feel able to take part, your help will be greatly appreciated.

Appendix Ci

Consent form: seminars

The research in which you have been asked to take part is interested in describing the process of experiential learning that takes place with Balint seminar training. This would be a first step in designing a broader study which would evaluate the appropriateness of this approach as a model for clinical supervision in a range of nursing settings. This pilot study is also interested in developing theoretical understanding of the role of emotions in nurses' knowledge and practice. Further details are to be found on the information sheet you have been given.

If you agree to take part, this will involve the presence of the researcher during nine seminars (later increased to 10 seminars with consent of participants), and tape recording of the proceedings. These tapes will only be available to the researcher and an independent transcriber. You will be free to stop the recording at any point in the proceedings, or to ask the researcher to leave for all or part of any seminar. Agreement at the outset of the study does not assume consent will continue, and you will be asked before each seminar if you wish to participate or withdraw from the study. No reason for withdrawal need to be given. Any tapes used will be wiped clean at your request. In all cases, your confidentiality will be strictly respected.

Consent

Appendix Cii

I have read the information sheet concerning the study and I understand what will be required of me if I take part in this study. I am aware of who I can contact if I have any questions concerning this study as it progresses.

Consent form: interviews

I understand that I can withdraw from this study at any point without detriment to myself.

The research in which you have been asked to take part is interested in describing the process of experiential learning that takes place with Balint seminar training. This would be a first step in designing a broader study which would evaluate the appropriateness of this approach as a model for clinical supervision in a range of nursing settings. This pilot study is also interested in developing theoretical understanding of the role of emotions in nurses' knowledge and practice. Further details are to be found on the information sheet you have been given.

I agree to take part in this study.

Signed: ....

Researcher...

Date ....

If you agree to take part, this will involve discussing your experience of seminar training with the researcher. If you agree, the researcher would like to tape record this discussion. These tapes will only be available to the researcher and an independent transcriber. You will be free to stop the recording at any point in the interview, and no reason need be given. Any tapes used will be wiped clean at your request. In all cases, your anonymity will be strictly respected.

Consent

I have read the information sheet concerning the study and I understand what will be required of me if I take part in this study. I am aware of who I can contact if I have any questions concerning this study.

I understand that I can withdraw from this study at any point without detriment to myself.

I agree to take part in this study.

Signed: ....

Researcher..

Date ....