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**Living Bereavement: An Exploration of
Health Care Workers' Responses to Loss and
Grief in an NHS Continuing Care Ward for
Older People**

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**A thesis submitted to City University in accordance with the
requirements of the degree of PhD**

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For My Mum and Dad

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DECLARATION

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

ABSTRACT

The continuing care for older people is an important but often overlooked area of health care. This thesis is concerned with how care staff work with residents and their relatives in an NHS continuing care ward. It focuses on the care staff's perceptions and responses to the losses experienced by the residents and their families in their care. The research is rooted in a work based education project and the theme of loss was chosen by the participating care staff who felt it was central to their work. They coined the phrase "living bereavement" meaning the complex responses and grief reactions of those experiencing and bearing witness to the multiple losses endured in continuing care environments.

The literature review suggested that the body of knowledge related to loss in continuing care is fragmented and the research aimed to explore the relationship between some of the fragmented issues. For example, by blending social and psychological methods it was possible to research the interaction between the cultural and emotional aspects of loss in continuing care. Psychoanalytically informed data collection and analysis strategies were built into the methods so that formulations could be made about the role of emotions and psychological defences in shaping the customs and practices on the ward.

A key message from the thesis is that there is an intense emotional demand in care work related to loss and grief in continuing care environments. This demand consists of the care staff's own feelings as well as their experience of other people's emotional responses. I propose that care staff used psychological defences to avoid or gloss over aspects of the emotional demand that stirred up unbearable emotions and feelings that are usually considered unacceptable, particularly for people in care work. Social systems in the organisation of work supported the psychological defences and prevented any changes in working with emotions becoming custom and practice in the everyday work.

The study makes its unique contribution by articulating the nature of the emotional demand, psychological defences and social systems that are related to having close contact with very dependent older people living and dying in continuing care environments. The thesis concludes by making specific recommendations about integrating the emotion work related to living bereavement for the participants in the study. Broader considerations are also suggested for similar continuing care environments such as care homes.

ABBREVIATIONS

HIF	Health Inequality Fund
NHS	National Health Service
PCT	Primary Care Trust
RWG	Reflective Work Group
TSG	Tavistock Supervision Group
UK	United Kingdom

CHAPTER 1 - INTRODUCTION: LIVING BEREAVEMENT IN A CONTINUING CARE WARD FOR OLDER PEOPLE

I have taken on the central tenets of Menzies Lyth's (1959/1988) study and applied them to a particular area of work, the long-term care provision for dependent older people. This has enabled me to develop an original thesis about the nature of the emotional demand of this work and the particular sets of emotions, psychological defences and social systems that dominate it. Although the principles are similar to Menzies Lyth's (1959/1988), this thesis differs because it comments on the distinct nature of dependent old age and the experience of caring for people in that particular stage of life.

This thesis is concerned with a group of care staff working on a National Health Service continuing care ward for older people (Willow Ward). It focuses on the complexities of loss and grief in this type of care environment. The research is unique because it combines social and psychoanalytic methods in a particular nursing context. In Menzies Lyth's (1959/1988) seminal work, she researched the world of nursing. She used her expertise as a psychoanalyst to describe how social systems in nursing supported nurses (understandable) psychological defences. Casting an empathic light on the role of the nurse she described how nurses have unusually high levels of contact with people who, for example, were in pain or dying. She suggested that this stirred up feelings that had their roots in very early life. These primitive feelings involved the conflicts of love and hate, compassion and aggression and hope and despair. She argued that nurses not only had to deal with their own primitive forms of anxieties raised in the work but also the feelings of other people such as

patients, relatives and colleagues. These people were seen to “push” their feelings into the nurses through a psychic communication inherent in the close contact of their work. Her suggestion was that the nurses protected themselves from such an overwhelming situation with psychological defences and that systems of working were developed to support these.

The methodology differs from Menzies Lyth’s, because it not only focused on the exploration and development of participants in the field, but it also developed the researcher’s capacity for a psychoanalytic approach to work with emotions. By combining participant observation (Fielding 2001) with psychoanalytic observation methods (Hinshelwood and Skogstad 2000) and the Tavistock approach to learning about emotions (Rustin 2003) the research method integrates a psychoanalytic and social methodology.

Key messages from the research

This research makes a unique contribution to the body of knowledge by developing a psychoanalytically informed understanding and technique in the specific context of continuing care for older people. It offers a model of how psychoanalysis can be used to promote a more sensitive approach to the long term needs of dependent older people and suggests how social systems can operate to prevent this. It is the conclusion of this thesis that for any developments in the capacity for working with emotions in this field to be sustained, it is essential to address the deeply disturbing aspects of the work and support care staff at all levels to acknowledge their emotions. This includes those that may be perceived as negative (Department of Health 2006), but none the less exist.

The research explored the emotional component of the care staff's work and their responses to it. It uncovered the psychosocial processes that inhibited their potential to use the research to develop their capacity for care that is more emotionally "in tune".

The key messages of this research are:

- There is an intense emotional demand in care work related to loss and grief in continuing care environments. This demand consists of the care staff's emotional experience and responses.
- The fact that residents rarely "got better" and anxieties about lifelessness and non-existence related to working with people who were profoundly dependent were key elements in the emotional demand. I propose that care staff used psychological defences to avoid or gloss over aspects of the emotional demand that stirred up unbearable and unacceptable feelings connected to these key elements.
- It was possible, using methods of containment, to facilitate care staff in understanding a fuller picture of the emotional aspects of their work and to develop their capacity for working with emotions. In this context containment refers to a specific type of relationship where emotional learning can take place. This will be explained further in Chapter Four.

- These new ways of working were prevented from becoming custom and practice in the ward by social systems that supported the psychological defences that avoided and glossed over aspects of the emotional demand that caused unbearable and unacceptable feelings.
- The social systems within the ward were replicated throughout the whole organisation.

The research model that has produced these key messages reflects the researcher's background and interests in care for older people, social research and psychoanalytically informed approaches to nurse education and old age. The methodology was driven by psychoanalytic theory and technique and aimed to uncover aspects of care for older people that are often ignored or taken for granted. In order to do this, the research methods were designed to encourage the care staff to try out new ways of thinking about their work and offered them the opportunity to develop a greater sensitivity to the emotions contained in it. I have decided to call the research model *psychoanalytic participant observation* because the term encompasses the appropriate theoretical underpinnings and methods. The research model combines a psychoanalytic method of observation that fosters emotional engagement with an environment with participant observation that explores sociocultural aspects of a setting.

BACKGROUND TO THE STUDY

The quality of care being offered to older people has been subject to recent Government scrutiny and policy (Great Britain Royal Commission on Long Term Care 1999; Department of Health 2001a; Department of Health 2006). The emphasis on dignified care, particularly at the end of life has become a central driver for those planning and allocating resources (Department of Health 2006). The overarching aims of this work are in keeping with these themes and the desire to modernise the care for older people in order to deliver a more person centred service. It is important to this study not to underestimate the difficulties this involves and to acknowledge that these are the aims and desires of most individuals working in the speciality.

Following changes in the continuing care policy, it is unusual for continuing care to be provided in an NHS hospital ward (Davies and Seymour 2002) and residents were only admitted to Willow Ward when their needs exceeded the local care homes' admission criteria. This might mean that the resident population experienced an unusually high level of dependence and challenging behaviours compared with some continuing care facilities. Not all areas of the country have NHS continuing care provision; therefore level of health care provision has become more intense (Davies and Seymour 2002). The core principles of the thesis are likely to resonate with people who have experienced or witnessed loss and grief in residential or nursing home settings and I suggest despite Willow Ward's uniqueness, the findings of this study will be recognisable to many people who have been involved in the long-term care provision for older people.

The work based education project that preceded the research

The research is rooted in a work-based education project. The original commission for this work was in 1997 and aimed to provide practice based education for the staff in the continuing care unit, with an emphasis on improving team work and skills in personal and social care. The unit had a reputation for providing good physical care but the staff seemed to lack the interpersonal skills to cope with the complex emotional and social problems residents and their families presented with. The staff themselves suggested the focus of the education should be *living bereavement*. Although no definitions of this term were found in the literature at that time, a working definition was established with the staff:

“The feelings and behaviours demonstrated by residents and their carers [both formal and informal] following loss in the continuing care unit”

(Holman and Jackson 2001, p99)

The work-based education project aimed to be interdisciplinary, encouraging reflection on practice and links with theory. It involved educational strategies such as group work relating practical examples to theory and supervised practice of clinical work such as care planning. From the start it was difficult to get all members of the team to attend and few disciplines other than nursing participated. People who declined to take part or only attended once either said that continuing care was not an allocated aspect of their work or that they saw it as a nurses' group and therefore not relevant to them. Although the evaluation

of the programme failed to demonstrate measurable outcomes of change, the staff reported satisfaction with the process orientation of the project work and felt it was important to have someone hear "their side of things" (Holman and Jackson 2001). The project was regularly recommissioned and was the antecedent to the aims of the research reported in this thesis.

From 2000 the project was coordinated by the continuing care manager and involved registered nurses, nursing auxiliaries, a psychologist, an occupational therapy assistant, the hospital nurse researcher and myself. The two consultants in geriatric medicine with time allocated to continuing care agreed to the research and development projects taking place but declined to be involved. The activities of the project led by the continuing care manager were aimed at improving the personal and social skills of the care staff working on Willow Ward. It involved enabling more social contact for the residents, adopting more direct and effective communication practices as well as trying to include more personal and biographical information from and about the residents in the care processes. The mechanisms of the practice development project were deliberately integrated into the ordinary work of the ward. For example the continuing care manager developed a more personal and individualised performance review system for staff and audited and developed care planning systems to develop the level of biographical detail known about the residents.

The research project

The data collection for the research started in 2001. By this time there had been considerable organisational change related to the reduction of inpatient continuing care and the local demographic (Chapter Two). The Care for Older

People Unit became part of the Primary Health Care Trust in April 2001 and the nurse managers who previously managed the three continuing care wards had left. One continuing care ward became part of the Mental Health Trust and one was closed in order to be converted into an intermediate care ward. This left Willow Ward as the only continuing care ward in the Care for Older People Unit. The newly appointed manager for continuing care was also responsible for care assessments and developing services throughout the Primary Care Trust. Although the continuing care manager had other responsibilities, he was the lead clinician in Willow Ward and was referred to as the Charge Nurse of the ward. This custom is adopted throughout this thesis.

It was agreed with the care staff on Willow Ward that the psychologist and I would co-facilitate a Reflective Work Group. The purpose of the Reflective Work Group was to support the change initiated by the Charge Nurse and help develop the care staff's capacity for understanding and working with the emotional demands of their work. The Reflective Work group became an important method of data collection and analysis in the research. In the Reflective Work Group, the care staff were encouraged to discuss any aspects of their work they thought was important and relevant. Their initial suggestion that living bereavement was central was supported by the pervasiveness of loss and grief in the group sessions. My research commenced in 2001 and specifically aimed to identify the emotional demand of living bereavement and to explore and develop care staff's capacity to work with it. Following the literature review, which will be discussed later, the following objectives were identified:

- To explore care staff's perspectives and emotional responses related to loss in the continuing care ward.
- To support and develop the participants' (including my own) capacity for working with the emotions attached to loss
- To uncover how the emotional responses impact on the overall social organisation of care.
- To recommend ways that the overall social organisation of care could improve the capacity of its staff to work with the emotions linked to loss in continuing care.

Concepts of loss and grief were central to this study and are applied to the specific and complex conditions of continuing care environments for dependent older people.

The complexity of loss and grief

The concepts of loss and grief were considered an appropriate focus for the research because they care staff identified them as important. They are fundamental to issues of care because they are central to an understanding of the personal and social experience of being ill, dependent and dying (Robinson and McKenna 1998).

The term loss is difficult to define as its use has different nuances and emphasis depending on the context. Robinson and McKenna (1998) suggest that an individual experiences loss only when they value the person, thing or experience that has been lost. It could be said that a loss has occurred when grief is a consequence (Robinson and McKenna 1998). The concept of loss is

fundamentally linked with the process of grief (Cowles and Rodgers 1991; Jacob 1993).

Terms such as bereavement and mourning are often used interchangeably but they have evolved differently. Mourning is a term used to describe the processing of loss and is fundamental to the psychoanalytic perspective on the development of personality (Milton *et al* 2004). Freud (1917) made the distinction between mourning and melancholia. He suggested people with melancholia experienced distinctive self punishing and persecutory feelings which were the result of what might now be called abnormal grief and referred to as depression (Davenhill 2006). Mourning is the working through of loss and not necessarily related to actual death. Klein (1940) suggested the template for how we deal with loss is formed very early in life. She claimed a baby's experiences of absence or separation from a loved person or object, typically a mother, are the foundations for the way loss is processed throughout life. This has implications for this study because it means the loss and grief experience in a continuing care ward is not just about external circumstances but also relates to how each individual's template for processing grief interacts with the external environment.

The concept of bereavement is founded on attachment theory and is a process of recovery from external loss such as a death of a loved one (Bowlby 1998; Parkes 1972) and grief is understood to be a dynamic process that follows the experience of loss often articulated as "working through" issues (Worden 1983). More broadly speaking all three concepts (bereavement, loss and grief), are individualised, pervasive and normal, involving a non-linear complex of

emotions, thoughts and behaviours (Cowles and Rodgers 1991; Jacob 1993). There is a wide range of emotional experiences that make up grief which can include anger, denial, yearning, sadness, relief, bitterness and despair (Scrutton 1995). Bereavement theorists such as Parkes (1972) describes how processing a loss often involves shock or numbness at the initial stages. The bereaved person often goes through a painful sense of yearning and searching for the lost person and this can result in depression. The bereaved person's life can feel like it is falling apart but the final phase of the process allows a gradual reorganisation of a person's thoughts and the depression subsides. This enables the individual to get back to their life having fully realised the extent of their loss (Scrutton 1999). It has been suggested that people experience feelings and demonstrate behaviours as part of the bereavement process following death (Parkes 1998), divorce (Weiss 1998), loss of body parts (Maguire and Parkes 1998), loss of senses and cognitive function (Fitzgerald and Parkes 1998), being made redundant (Fagin 1998) and following loss brought about by abrupt changes in whole communities (Marris 1986).

Thompson (2002) says traditional bereavement theories have been criticised for not acknowledging the complexity of the grieving process especially its social dimensions. He argues that to describe the process in terms of phases or stages is too simplistic. He supports the notion that people oscillate between emotional states following a loss. Some feelings are attached to the loss whilst others are orientated to moving on and rebuilding. These competing forces produce a tension and complicated internal struggle for the bereaved. Klass and Walter (2001) are critical of how bereavement theories have been interpreted in clinical practice. They suggest there has been an overemphasis on "letting go"

rather than an acknowledging the continued importance of relationship bonds and the integration of the lost person into the survivor's ongoing life.

Thompson (2002) claims these broader perspectives are appropriate and more readily lend themselves to cultural and socio-political understandings instead of the narrow psychological definitions of traditional bereavement theories. This is relevant to this study as ageist attitudes affect how older people are perceived and affect the way resources are distributed. For example, assumptions that older people are less sensitive to loss (Scrutton 1999) or losses other than death don't count fit with Doka's (2001) social view that some experiences of loss and grief are less valued or "disenfranchised" in some societies.

Sapey (2004) has argued that application of loss theories to disability have been oversimplified by adopting exclusively psychological definitions. He suggests that too frequently non-disabled people have focused solely on the individual's need to process what is automatically assumed to be a loss, rather than challenging stereotypical social assumptions and practices that are prejudiced against people with disability and impairment. Although Sapey (2004) emphasises the importance of social factors in understanding the experience of disability and impairment he also recognises that disabled people do experience distress and that an exclusively socio-political explanation can also be restricting. The social and emotional context is important to this study which perceives loss of health as a relevant factor in the grief experience of continuing care (Holman and Jackson 2001).

The notion that people in continuing care settings might simply work through stages of grief is rejected here. The complexity of the individual's experience is seen in the context of social factors such as the relevance of ageism and the importance of organisational culture of continuing care environments. Traditional and recent bereavement theorists offer a range of understandings about the feelings, behaviours and processes involved following loss. A broad spectrum of loss and grief are included in this study. This includes the varied reactions and experiences identified as relevant by the individuals involved in the study.

Living bereavement

The defining features of what the care staff in this study originally referred to as living bereavement have been refined in the thesis. It is suggested that there are two components to living bereavement. Firstly the actual grief experience of the multiple and concurrent losses endured by someone living through the end stage of chronic illness in a continuing care setting. This relates to the person going through the end stage of the chronic illness and those who bear witness to the experience. This is an individualised grief like any other but the prolonged time frame, proximity to death and association with dependence caused by degeneration of physical and mental health can produce unbearable and unacceptable emotions which can provoke anxieties. The second component of living bereavement relates to the unconscious psychological responses people sometimes employ to gloss over or avoid feelings that are disturbing or raise anxieties. Living bereavement is defined in this research as the interrelationship of loss and grief experienced whilst living through the end

stages of chronic illness with the unconscious psychological glossing over or avoidance of feelings that are disturbing or raise anxieties.

The experience of living bereavement impacts on residents, their families and care staff. The foci of this study are the perspectives of care staff and the development of their capacity for understanding and working with the emotional demand in their work. In this context, the emotional demand in this type of care work is understood to be both the care staff's own emotional experience and response as well as the feelings that get "pushed into them" by others, for example residents, relatives and other colleagues (Menzies Lyth 1959/1988). There is evidence in this research that if living bereavement is not acknowledged and processed in continuing care environments, it can become ingrained in the customs and practices of the organisation, producing a culture that prevents care staff fulfilling their potential to provide care that is sensitive to emotions.

Psychoanalysis and emotions

The role emotions play in personal and social life is central to the loss and grief experience and the organisation of care work. Williams and Bendelow (1996) suggest emotions are fundamental to the research project because they are on a juncture between mind and body, nature and culture, public and private and of particular relevance to this study, they suggest emotions provide the link between personal trouble and public issues. She describes theoretical perspectives on emotions. She suggests a traditional understanding of emotions is that they are located within the individual and understood as inherent and natural. In contrast, they can be viewed as sociocultural constructions which are

always experienced, understood and named via sociocultural processes. Although she acknowledges the role played by discourse in constructing emotional experience, she takes the view that embodiment of emotion is vital because it is reflected in the “ontological state of being and having a body” (ibid. p32).

Lupton (1998) suggests psychoanalytic perspectives offer valuable insights for understanding unconscious aspects of emotions. She attributes this to the therapeutic and theoretical interest in delving below the surface of experience. She places a psychoanalytic understanding of emotion in the “emotion as sociocultural construction” perspective. This is interesting as others have described psychoanalysis or at least Freud within the “emotions as inherent” tradition (Hochschild 2003; Fineman 2005). Lupton (1998) justifies her suggestion by pointing out that although psychoanalysis is concerned with the treatment of individuals, psychoanalytic approaches to groups have been concerned with the political and cultural nuance. It could also be argued that the central role of the carer (typically mother) on the development of mind is an example of how internal world interacts with the external and therefore social environment.

Perhaps the clearest link between psychoanalysis and the social and cultural aspects of life is in understanding organisations. Systems theory and organisation consultancy offer an understanding of how individuals’ internal psychological processes and the organisation of the external environment are linked (Halton 1994). Hinshelwood and Skogstad (2000) argue that people form psychological defences to protect themselves from the anxiety connected

to difficult issues and feelings in their work. They identify three key ways this shapes the organisation:

- Specific anxieties are associated with particular types of work
- People cooperate with social systems that support their own unconscious psychological defences
- The way personal anxieties are dealt with affects the culture of an organisation.

This understanding of how emotions and unconscious psychological defences connected with them influence organisational culture, is fundamental to this research. According to Hinshelwood and Skogstad (2000) principles, the participants in the study (including myself) were likely to cooperate with social systems that support their unconscious psychological defences to avoid the emotions that are the subject of the exploratory aspect of the research. It was therefore important to design research methods that were orientated to development and provided a framework for exploring unconscious processes including identifying when psychological defences were alive in the work. The links with the team of psychoanalysts who run the Psychodynamic Approaches to Old Age course at the Tavistock centre are fundamental to providing a system of supervision and development that ensured an authentic approach to *unconscious* aspects of the work such as *psychological defences*. This process is integrated throughout the thesis but explained more fully in Chapter Five. The psychoanalytic theory underpinning the thesis is discussed in Chapter Three and specific psychoanalytic terms have been identified in italics and are defined in a glossary of terms in Appendix One.

A combined social and psychoanalytic model

Fineman (2000) argues against bolting together different “staunchly defended” theoretical approaches to studying emotion, preferring theory that collapses individual, organisational and social distinctions from the outset and builds explanations that are interrelational. This study seeks to uncover the issues that exist at the margins of pre-existing concepts and favours Fineman’s (2000) interdisciplinary eclecticism. By identifying relevant traditions that do not seem “staunchly defended” it is possible to blend methods to frame a cross-discipline and eclectic approach whilst still acknowledging areas of distinct difference (Fineman 2000).

The research approach combined methods to explore the social and psychological dynamic of experience. This was considered important because it was a way of generating understanding that addressed gaps in the body of knowledge. The combined approach also attempted to understand the complexity practitioners have to negotiate in their everyday work with a view to supporting development and possible change. For example, in this context, the issues that relate to personal experience of loss are interwoven with the social and environmental conditions for those living, working and visiting the continuing care ward. In the early stages of the work, staff identified significant losses for residents related to separation from their home and from the wider community (Holman and Jackson 2001). Adjustment to this change may not only be about the resident’s psychological ability to process grief but also whether the social organisation of the ward encourages relevant external links, in particular with residents’ families.

Although the study was about staff and their ability to perform care, the combined methods approach needed to acknowledge a broad range of views. It was important to adopt a research gaze that not only saw staff as “providers” of care for those experiencing loss, but also as the subjects of the experience. It was clear from the start of the work that the loss of intimate relationships through widowhood for example, was a significant factor for residents (Holman and Jackson 2001), but it became apparent that the nature and longevity of relationships between staff and residents meant staff feel a sense of primary grief when a resident dies. The emotional demand of working with loss in continuing care not only involves managing one’s own experience but also the projected feelings of other people. Menzies Lyth (1969/1988) suggested that such a lot of nursing work related to emotions involved care staff being on the end of other people’s *psychological projections* and this also needed to be accounted for in the research design.

Conversely, it was also important to develop methods that recognise that although the staff’s perspective on a situation was being explored, they were also the subject of the perspectives of others; such as residents and their families and other work colleagues. Using an example from the work-based education project, it is possible to see how a minor issue can trigger strong feelings reflective of a conflict in perspective:

“An auxiliary nurse described how he was helping a very dependent resident wash and dress. The resident was unable to express his individual needs verbally, but the nurse knew him well and was able to

provide careful personal care. The nurse had spent a lot of time with the resident and spoke with pride about how he had helped the resident look smart. Later that day, the resident's wife came in to visit him. She approached the nurse and angrily complained that he had parted the resident's hair on the wrong side. The nurse saw this as a minor mistake..."

Holman and Jackson (2001, p101)

In the extract the nurse and the resident's wife had a different view of the care carried out by the nurse. The psychoanalytic approach offered the opportunity of understanding behaviour as a symbol of underlying emotion and possibly *psychological defence*. By encouraging the staff to explore both perspectives, greater understanding about how conflict arose and the possibilities for resolution could be achieved. In this instance, the nurse seemed frustrated and angry about the wife's lack of appreciation of his work. The group speculated about the wife's position. They said it sometimes felt like relatives feel guilty about not providing the care themselves or even jealous of the nurses' intimate contact with the residents.

The developments made through the research were emotionally charged, repetitive and learning often seemed slow. It was central to the presentation of this thesis not to avoid the quality of these processes. This has meant some breaks with tradition in the structure of the findings chapters (Chapters Seven, Eight and Nine). The inclusion of fine grain detail of data and the integration of links with theory will substantiate the claim that this research was embedded in the principles of psychoanalysis. Throughout the thesis data are presented to

illustrate and support suggestions. In the data that records conversations in the field, I made notes after the events. I wrote down the words of the participants as I recalled them or I paraphrased the discussion. Participants' names have been changed to protect anonymity, but where possible I maintained appropriate naming and accents according to a person's cultural heritage. A feature of this study is the cultural diversity in the participants. I have tried to describe people's ethnicity as accurately as possible. It has not been possible to adopt a consistent approach in this. For example, I refer to white English people to identify people who originate from England and were white. In contrast I sometimes refer to individuals as originating from countries outside the UK. This may mean some people who were born in the UK but speak of their identity in terms of their cultural heritage may be misrepresented in the data. In general I have tried to respect the participants' own perspective and use the most accurate descriptions available that are relevant to the issues being discussed.

OVERVIEW OF THE THESIS

The observation methods based in psychoanalysis and sociological methodologies such as ethnography share a commitment to holism and exploring a broad view of "the landscape" before making analytic formulations (Hollway and Jefferson 2000; Murphy *et al* 1998). Hollway and Jefferson (2000) describe how in their psychosocial interview method they tried to bear in mind the "whole story" whilst simultaneously being aware of first impressions, important emerging concepts and links between them.

It was important to the data analysis in this study that the researcher had a good understanding of the background of Willow Ward, the area it was situated in and the historic development of the service. This provided important context to the current situation and enabled a preliminary understanding of the cultural practices of the ward. In Chapter Two I have provided a detailed description of these features so that the reader can have a good grasp of the setting from the outset. I have included data extracts to support and inform the background discussion. This will contribute to the vivid description of the setting.

It is important to give the reader a qualitative sense of Willow Ward and the people who visit, live and work there. This understanding of personal lives within the social setting is true to the spirit of the research that sits with one foot in the affective domain and the other in the social. Equipped with this intimate knowledge of the setting, the reader will have enough reference points to evaluate the substance of analytic claims made later in the thesis and be able to judge where the thesis is relevant to their own particular work setting.

In Chapter Three I have detailed the background to the psychoanalytic ideas that underpin the thesis. The foundations of psychoanalysis are described and related to the study. I will discuss the philosophy and theory I have used to frame my argument. Key psychoanalytic concepts that are central to the study are explained and placed in the context of the research. This chapter will be a corner stone for the psychoanalytically informed findings. Later, in the findings chapters I will be able to substantiate my claims in the context of these key concepts. This will validate my findings and allow readers who are unfamiliar with psychoanalysis to judge the rigour of my use of the theory.

The findings from the literature review substantiate my decisions about the focus of the research and the choice of methods. Chapter Four describes how a literature search and review was carried out. I will argue that there are splits in the body of literature related to loss and grief in continuing care environments and that these splits are dependent on the different methodologies employed by the researchers. This means that although practitioners were frequently criticised for not provided appropriate care, the full complexity of working with loss and grief in continuing care environments was rarely explored. The findings from the literature review and related psychoanalytic theory will be drawn on in the findings chapters. This will place my findings in a theoretical frame and allow a better flow of the thesis.

In Chapter Five, I will describe the methods adopted in the psychoanalytic participant observation. I will discuss the social and psychoanalytic observation methods used to generate, collect and analyse data. I will describe the Tavistock approach to leaning about emotions and how it forms the basis of the iterative data analysis process. I will specifically focus on the roles of the Reflective Work Groups carried out in Willow Ward, the Tavistock Supervision Group (which included methods of supervision and education about emotions) and myself as a research instrument. I will describe how these formed a chain of containment that allowed access to data at different levels and enabled participants (including myself) to develop their capacity for working with emotions. Both work groups also offered opportunity for feedback either to the researcher in the Tavistock Supervision Group or the care staff in the Reflective Work Group. All participants could apply their new ways

of understanding and responding to emotions in their own practice area. In this way, the data generation, analysis, testing and feedback was cyclical throughout the research.

Chapter Six is the introduction to the findings chapters. It outlines the main thrust of the arguments that will be set out in the findings chapters. In the first of the findings chapters (Chapter Seven), I will describe the themes that were evident in care staff's perceptions of loss and grief in continuing care. I will discuss the emotional demands of their work related to a trajectory of living bereavement. By this I mean the complex and intense feelings they experience on behalf of themselves and others; for example residents, relatives and colleagues. I noticed aspects of the emotional demand that were either missing or glossed over in the care staff's accounts. Adopting a psychoanalytic perspective I interpreted this as a sign that the feelings associated with aspects of the emotional demand were so difficult or disturbing that they remained hidden below the surface of experience. Applying the theory that people adopt psychological defences to protect themselves from anxiety provoking emotions, the links in the chain of containment embedded in the research methods were used to explore the emotional demand in order to gain a more complete picture. In Chapter Eight I illustrate this process and identify the techniques the care staff used to avoid or gloss over the unbearable and unacceptable elements of the emotional demand.

In Chapter Eight I will make a detailed discussion of findings related to the emotional experience that was not usually spoken about and therefore remained hidden. I will argue that the care staff protected themselves from emotions such

as anger, hatred, envy, guilt and despair. The chapter is an in depth discussion of one Reflective Work Group which was selected because it illustrates the psychological defences I identified as significant using the processes contained in the links of containment described in Chapter Four. The discussion of data in such detail will give texture to the emotional experience and allow the reader to evaluate my interpretation of the care staff's behaviours as psychological defences. These will be clearly identified and I will suggest they link to the most disturbing aspects of the emotional demand that include the caring for profoundly dependent residents who experience the physical and mental degeneration of chronic illness, not having the reward and satisfaction of seeing people get better and close contact with people in states that are reminiscent of a primitive sense of non-existence.

In Chapter Nine I will illustrate how the care staff could develop some capacity for working with emotions. It will demonstrate how the participants (including myself) were able to use the containing features of the research to gain a more complete understanding of the emotional demand of the work and develop capacity for a sensitive approach to working with emotions. An in depth discussion of a case that continued over eighteen months illustrates the developmental potential of the methods. I will argue that care staff had the potential to develop their capacity for working with emotions.

In Chapter Ten I will suggest that although individuals were able to develop their capacity for working with emotions by using the containing function of the research to learn and grow, this way of working did not become part of the custom and practice of Willow Ward. It is my suggestion that the situation

arose because there were social systems in operation that supported the care staff's psychological defences. These systems broke up the roles and responsibilities of the care staff and the different levels of activity and ability of the residents, which then formed a hierarchy. This process of separation prevented confrontation of conflicting feelings and allowed the unbearable and unacceptable aspects of the emotional demand to be pushed down the hierarchy. At the bottom of the hierarchy, with little importance attached to them it was possible to avoid and gloss over them. I propose that this system was replicated throughout the whole organisation and Willow Ward was most closely identified with the most disturbing aspects of the emotional demand. This produced a situation where continuing care needs could be avoided and glossed over within the organisation.

I have integrated the links between data and theory throughout the findings chapters. In Chapter Eleven I will assimilate the findings and make conclusions based on them and the discussion of literature. I will make recommendations that are specific to the case of Willow Ward and suggest that within the limitations of this in-depth qualitative study there are principles that can be applied to other continuing care settings such as care homes.

CHAPTER 2 - NHS CONTINUING CARE IN EAST LONDON: DISCOVERING A HIDDEN COMMUNITY

This thesis is about the delivery of continuing care in a National Health Service ward in a Care for Older People Unit situated in a hospital complex that formed part of an East London Primary Care Trust. Whilst institutional continuing care is accepted as an essential and important component of contemporary life in the UK, (Great Britain Royal Commission on Long Term Care 1999), the way the institutions are organised has led to a situation where they remain separate from the rest of society and still little is known about their internal workings (Hockey and James 1993). This chapter will argue that social circumstances in East London have exacerbated the sense of isolation for an NHS continuing care ward (Willow Ward) and added to a sense of it being “out of sight” and consequently out of the “strategic mind” when local policy decisions have been made. The rapid changes in the ethnic profile of the area have also meant there is an unusual situation. That is that the white English older people form a minority in a population dominated by a cultural group usually considered to be an ethnic minority in this country. This adds to the unknown quality of the ward.

In this chapter, I will explain how the provision of continuing care for older people in the UK over the last hundred years has changed from a position where dependent older people were cared for in a workhouse to the current situation where frail older people are encouraged to live at home with support services or to move to a care home. I will argue that the historic events in East London have exacerbated difficulties in planning for the needs of older people

in the area. Firstly, the relatively few numbers of older people in the area has meant they have become an overlooked minority and secondly that the competing priorities in the rest of the population are so great that they overshadow any strategic planning for the continuing care needs for older people.

Having made the case that little is known about the particular culture of continuing care for older people in Willow Ward I will give a detailed qualitative description of the people and the ward itself. Murphy *et al* (1998) suggest that holism is an important concern for the qualitative researcher; consequently a rich description of Willow Ward, its geographical situation and socio-political history is given so that the reader can gain a more complete understanding of the study context. It is impossible to encompass everything that goes on in the setting, so issues considered relevant to the study have been represented to enable the reader to evaluate this case in the light of their own experience and clinical practice (Sharp 1998).

THE NATIONAL POLICY FOR CONTINUING CARE FOR OLDER PEOPLE

In many ways the continuing care unit is an anomaly. It provides continuing care in a homely environment, but it is situated in a hospital complex, therefore not at home or in a care home. It does not fit with the hospital's plans to target rehabilitation and stroke care in keeping with the principles laid down in the National Service Framework for Older People (Department of Health 2001a) and it is not subject to the registration regulations laid down in the National

Care Standards that apply to care homes providing similar care (Department of Health 2000b). This situation has arisen because the demographics of the locality are out of step with the rest of the country and policy has frequently failed to make the intended impact, possibly due to the ongoing deprivation of resources in the area.

The roots of continuing care for older people

The tradition of providing continuing care for Older People in East London has been shaped by social and political circumstances. The distinctive cultural qualities of this area have been captured in fiction throughout history, for example in the works of Charles Dickens (Palmer 1989). The Care for Older People Unit is in a locality where access to resources seriously affects the population's health, housing and vulnerability to crime¹.

Health and social care in the area are rooted in impoverished circumstances. Services can be traced back to the time when the institution was a workhouse and all inmates were provided with meagre support in the harshest of conditions (www.aim25.ac.uk; Peace *et al* 1997). A lack of provision for those who were unable to support themselves financially in old age resulted in older people representing nearly half of those living in institutions (Peace *et al* 1997). Although the conditions of the then infirmary were improved when it was taken over by the military authorities in the First World War, it was not until the National Assistance Act of 1948 and the formation of the National Health Service that legislation was introduced to develop health and social care provision for all (www.aim25.ac.uk; Davies and Seymour 2002).

¹ Local health report not referenced to protect anonymity

The infirmary became one of a group of hospitals providing the local community with medical care including Care for Older People (www.aim25.ac.uk). Continuing care provision was introduced through the National Assistance Act (Davies and Seymour 2002) and made a distinction between those needing continuous nursing care and those requiring care or supervision. The latter group were entitled to care in local authority residential homes and the others could get continuous nursing care in long-stay geriatric wards in NHS hospitals or fund themselves in a private nursing home (Davies and Seymour 2002).

These policy changes produced shifts in attitudes about old age. Harper and Thane (1989) argue that it was the twenty years following the Second World War that consolidated “old age” as a phase of life. They suggest social factors such as mandatory retirement and the gradual increase in representations of the older age group at that time (in 1901, 3.5% over 65 and in 1951, 12% over 65) began to reinforce the image of older people as having legitimate needs but also increased the perception of them as a burden.

Despite the apparent increase in resources aimed at social and health care these remained austere times for ordinary people (Palmer 1989). Young and Willmott's (1957) study of family life of East Londoners in the 1950s draws a picture of close-knit families with minimal resources. The family usually revolved around a husband and wife, plus the wife's family and the husband's family. They described a situation where although the women's role in the family was changing it remained central to the everyday running of households. Townsend's (1963) argued that the problems of old age that required state

intervention were due to social isolation rather than illness. He described East London families supporting their older relatives at home. Although some older people did receive care in hospitals, residential homes and state funded domiciliary support, these people's situations were not representative of the local population. People required institutional care or support in their homes when they had no access to family – particularly female relatives. In Townsend (1963) study this position was presented as an organic phenomenon and he saw the solutions to the problems of old age as focused on social policy aimed at improving housing and support directed at keeping the family together.

At the same time these studies were carried out, housing policy was aimed at reducing overcrowding and improving basic amenities such as electricity supplies and sanitation. A central principle was to build better housing in the suburbs of the city to encourage people to move away from the poorer conditions of places like East London, but this reduced the size of the population and was a significant factor in the changes in kinship ties (Townsend 1963; Palmer 1989). The older people on Willow Ward would have provided care for their elderly relatives as described by Townsend (1963). However, many of their peers and their own families had moved out to the suburbs as Townsend (1963) described, leaving them reliant on public health care.

A move to home care and care at home

Throughout the 1960s and 70s there was a slow increase in different types of supportive housing such as sheltered housing and private nursing homes and a steady development of community services, however there was no coherent

overarching policy framework linking health and social care strategies (Peace *et al* 1997). Consequently medical and social services aimed at older people emerged separately and care practices became fragmented and the level of institutional care was criticised for lack of attention to people's social and psychological well-being (Bond and Bond 1987; Peace *et al* 1997). The Griffiths Report of 1988 criticised the lack of resources for community care and was followed by the NHS and Community Care Act of 1990 that aimed to improve flexibility and choice by introducing a culture of contracting arrangements for continuing care (Victor 1997). The system entailed social services assessing and managing individual cases and purchasing packages of care for them from a range of service providers (Davies and Seymour 2002). This system has been adapted by both Conservative and Labour Governments to include health and social care provision in care homes. Although the funding systems have evolved, the principle that most continuing care for older people should not take place in a hospital environment is the current ideology.

The policy decisions of the late twentieth century were based on the assumption that the numbers of older people would rapidly increase and consequently there would be a big demand for institutionalised continuing care. Across the country demographic change meant older people were outnumbering younger people and privately funded nursing homes was a growth industry (Peace *et al* 1997). In East London this was not the case.

Immigration, urban development and the trend for people to move away from poorer areas to the suburbs reduced the total population of the area, but

increased the proportion of younger people (Palmer 1989, ¹). Although there has been a shift in policy towards community care and a sharp reduction in NHS long-stay facilities, the development of privately funded institutional care is modest in the area. Since the closure of a larger neighbouring NHS geriatric hospital in 1990 (www.aim25.ac.uk) all NHS institutional continuing care was moved to the Care for Older People Unit in the study. In keeping with the policy changes, the philosophy of Willow Ward is to provide care for those individuals whose needs are so complex that they cannot be met in the care home environment or in the person's own home. The NHS continuing care service has been reduced and there is a sense that it is a minority speciality which is not a significant part of the local health care strategy.

A LOW PRIORITY IN THE LOCAL AREA

Indicators of poverty such as unemployment, income deprivation, low levels of education, and poor standards of housing suggest this area of East London is one of the most socially deprived in the country. The make up of the population is complex and subject to rapid change. Patterns of immigration and social mobility have a significant impact upon the age and ethnicity of the people in the area. According to the 2001 Census, the borough has a small, dynamic population (196,106) that is ethnically diverse and relatively young. There is a significantly higher proportion of people aged between 20-34 (37%) and a much smaller proportion of older people than the rest of the country; 9% of the local population were aged over 65 in the 2001 Census compared with 16% of England and Wales. Just under half of the population in the area (48%) belongs to ethnic communities other than white. One third of the population (34%) is

¹ Local health report not referenced to protect anonymity

from Bangladeshi heritage making it one of the largest single ethnic minority communities in London ¹.

Life expectancy at birth for people living in this area is 72.7 for men and 78.9 for women. This is 3.2 years and 1.7 years lower than England as a whole and means male life expectancy is in the bottom fifth of all areas in the country. The most common cause of death is circulatory disease followed by cancer. The death rate due to coronary heart disease, stroke and related disease is well above that for England and Wales. Poverty and deprivation along with high incidents of certain diseases in particular ethnic groups e.g. diabetes in the Asian community are said to account for this. ¹

The Health Inequalities Fund (HIF) and the health and illness strategies set out in the most recent local health report reflect priorities focused on the dominant groups in the population. For example maternal and child health, life expectancy, circulatory disorders, cancer, mental health, accidents and infectious diseases are highlighted as important areas in relation to health and illness. The issues of old age are alluded to in aspects of the HIF and health strategy, for example, primary care and life expectancy, but are not addressed as a specific issue. When the needs of older people are specifically addressed, for example in the local "Health Improvement and Modernisation Programme 2003/2006"², the expressed priorities are to develop a service that helps to maintain independence, and reduces the incidence of heart disease and strokes and there is no mention of continuing care needs.

¹ Local health report not referenced to protect anonymity

² Local HIMP not referenced to protect anonymity

These priorities are appropriate for the large proportion of the local population and have influenced the developments in older people's services in the Care for Older People Unit. In 2000 one of the continuing care wards was closed and converted into an intermediate care unit and in 2003 a stroke and rehabilitation unit was opened. The combined services are now referred to as "Older People and Rehabilitation Services". The fact that the continuing care unit is small and a low priority means it is invisible in the local strategic plans and occupies minimal space in the specific plans for older people's services.

The hidden population of Willow Ward

The longevity of the residents and the tendency for specialities such as the Care for Older People to attract an immigrant workforce has had an impact on the age and ethnicity profile of the residents and work force on Willow Ward (Ward 1993). The older residents were mainly white English people, but there were individuals with diverse cultural backgrounds. In the care staff most people were from ethnic minority groups with the senior nursing positions and people in other disciplines mainly having an English heritage.

A breakdown of the ethnic profile of the area by age shows that there are not only smaller numbers of older people but also the majority of the older population is made up of white people. As the substantial numbers of middle aged Bengali people grow older, this is likely to change. Although the majority of residents in the data are white and English, some were from diverse cultural backgrounds such as African countries like Nigeria and Somalia, Caribbean Islands such as Dominica and Montserrat, and some people of Bengali, Irish, Scottish and Jewish heritage.

Piecing together the residents' backgrounds

An understanding of an older person's life history has been considered an important therapeutic resource for some time (Coleman 1990). Although various attempts at implementing a systematic approach to finding out about a resident's life history were made during the data collection period, the personal information about residents' lives tended to be accessed in fragments from varied sources: residents and their families' stories, staff's knowledge and conversations, care plans, documents and photographs. Consequently knowledge of individual residents' backgrounds is often patchy, but an attempt at an understanding based on what is known is important to the context of the study and offers a representation of this group's collective background.

The oldest resident in the unit during data collection was aged 97 at her death in 2002, which meant nearly a hundred years of living history was contained in the resident population. Each individual resident had a unique cultural background and personal biography, but living in East London meant the effects of immigration were a common feature of their life histories. Those living on Willow Ward were representative of the long history of immigration in the area (see Table One). Palmer (1989) suggests East London's high level of immigration in the past was largely due to the position of the East London docks and the casual labour they provided. As other methods of international travel such as airplanes were developed, communities were not just settling close to the place of disembarkation but also joining established populations and accessing work and the cheaper housing of East London (Palmer 1989).

Residents' country of origin				
Country of origin / cultural heritage	Numbers of resident admitted			
	2001	2002	2003	Total
England	29	15	17	61
Jewish	8	1	2	11
Bangladesh	4	1	5	10
Caribbean	3	1	0	4
Ireland	2	0	1	3
Mixed race	0	0	3	3
Somalia	0	0	1	1
Chinese	1	0	0	1
Unknown	5	1	2	8
	52	19	31	<u>102</u>

Table 1: Country of origin / cultural heritage of residents admitted 2001-2003. (Data provided by the PCT Senior Information Analyst. Local source not identified to protect anonymity.)

Palmer's (1989) account describes Irish and Jewish communities as the oldest immigrant populations in East London. In terms of the residents' lifespan, those living in East London at the time would have witnessed or been part of huge increases in the numbers of Jewish immigrants before the First and Second World Wars. At that time, the Jewish residents of Willow Ward were small children. Their parents were part of a group of people who developed trades and industries such as clothing and established the Jewish quarter in the East End (Palmer 1989). For example, Sarah was a Jewish resident on Willow Ward. She was born in 1916 and did not remember the First World War. She did remember her childhood in the East End with affection. Later she married but did not have children. Her husband was a jeweller and she shared his passion for jewellery. She recalled how she had known her husband from an early age:

Resident Sarah: *"He lived in the same street as me. We played together when we were littler; he knew my brother and although he was a bit younger than me we became sweethearts and that was it for life."*

Field notes 1.6.01

The First and Second World Wars had a devastating effect on the structure and people of East London. The bombings changed the landscape and forced people to move away from the area. Cyril was a resident on the ward who had lived all his life in the local area. A conversation with Cyril, his wife Phyllis, and his brother-in-law Frank revealed their experiences of wartime:

"As Phyllis was talking she stroked and held Cyril's hand to include him. She talked about her mother and how she used to have a cellar and if there were anything to be hustled from the docks it would go in her cellar. She said that during the blitz the skies and the docks were constantly alight. Frank [her brother] and she remembered looking up into the sky and seeing planes fighting and they watched bits of plane falling from the sky"

Field notes: 3.4.02

During the three-year data collection period, there were eleven Jewish residents admitted to Willow Ward and three Irish people. During the data collection period, sixty-one of the one hundred and two admissions to Willow Ward were from a white English background making them the largest ethnic group of elders on the ward (see Table One). The Jewish, Irish, and white English residents of Willow Ward had remained in, or returned to the area. The post

war years however, not only saw the start of white East Londoners moving out to the suburbs but also the Jewish and other minority communities such as the Chinese resettled in areas such as North London and China Town (Palmer 1989).

The white East Londoners on the ward were working class and had lived in the local area all their lives. They had names and lifestyles symbolic of their era and backgrounds: Queenie had worked hard to bring up her two children on her own after her husband had been killed during the war, Harry used to be a pigeon fancier and had a catalogue of all the birds he had raced, according to Bill's friend he had been a bit of "wide boy" in his day and was handy with his fists and Maud was so proud of the photograph of her boys who were now all black cab drivers. Cyril and his wife Phyllis were typical of this group. She recalled how life used to be and observed that her own children had moved away:

"Phyllis [Resident Cyril's wife] was reminiscing about how good things used to be. How everyone lived locally and knew each other. She said about how people used to be proud to be from the East End. She said people who left to go to Essex and Dagenham became snobby and didn't want to come back. She said even their own children say they couldn't live in the East End."

Field notes 3.4.02

The population who remained in the East End witnessed another change in the ethnic profile of the area. The country needed to rebuild and redevelop itself, so there was recruitment of people from the British colonies of the time and the 1950s and 1960s saw a peak in immigration. Black and Asian people came to

Britain and settled in port communities such as Cardiff, Liverpool and East London (Blakemore and Boneham 1994). In the study, there were four residents admitted to Willow Ward who originated from the Caribbean, three were mixed race, one was from Somalia and one Chinese person (see Table One). Some Willow Ward residents who immigrated at this time settled in East London and grew old there like resident Constance. She was discussed in a care plan meeting:

"We discussed Constance [resident] and reviewed her notes. She is an 82 year old lady who grew up in Montserrat. She came to this country in the 50s and was a cleaner in this hospital until she retired. Gloria [auxiliary nurse] says one of the other cleaners upstairs recognised her. She had a partner who died and three sons. One is in America, one is estranged but lives in London and the other died but no one has found out how."

Field notes 14.3.02

In other cases residents had spent much more of their life in their home country and immigrated at a later time to join the younger members of their families who were, by then, established in the UK. Mrs Begum was one of ten Bengali people admitted, (see Table One). Mrs Begum's grandson, who was in his early twenties, said his grandparents came over in the 1980s when they retired. I recorded the following notes after a period of participant observation:

"Later I went to see Mrs Begum who was very unwell. Her husband and grandson were there. The older man was in full Muslim dress

appropriate for a Bengali man. The younger man was dressed in a more English style. The grandson explained what a lovely woman his grandmother was and he had known her all his life. He talked about his grandparents' relationship with each other with a lot of affection. Mr Begum did not seem to understand English and sat quite still resting both hands on his walking stick."

Field notes 22.3.02

Mr and Mrs Begum senior had lived in East London for about twenty years but had come to live in the UK relatively late in life. Amina had come from Somalia as an elderly woman and had been in the country for less than five years. Her husband had more than one wife and as she had got older she had lost status in her family, she joined her only son who was established with a family in East London. Her admission to the unit was very frightening and strange to her:

Nursing auxilliary Wei-Kong: *"Amina is a Somali woman who was admitted a couple of months ago. She is Muslim and observes Muslim diet and dress. When she first came here she said she didn't mind me caring for her as a man. Then on one occasion she was in her room with her son and someone asked me to help move her up a chair and she refused my help completely."*

Reflective Work Group 16.7.03

The admission data suggested that over half of those admitted to the unit (61/102) had white English backgrounds and had lived most of their lives in the

local area. The other residents came from a range of ethnic backgrounds. The resident population was varied and complex. Looking back, all the residents had individual histories and individual identities. In their current situation they shared the end stage of their lives with each other.

Piecing together the staff's backgrounds

The care staff had a different age and ethnicity profile to the residents. There is a tradition of immigrant workers in public services such as health. The National Health Service is the biggest employer of people from black and ethnic minorities in Britain and specialities such as the Care for Older People attract minority groups (Ward 1993) so it is not surprising many of the care staff have a cultural heritage that originates overseas. Some came to the country in the 60s and 70s as children. For example the following emerged in a conversation with a member of the care staff:

"Nursing auxiliary Patience said that she could not remember what it was like when she first came here from Jamaica, she was just a little girl. She had always lived here but goes back home to visit as much as she can. Her Mother used to go on the visits too, but she was getting too tired to travel very much now."

Field notes 6.2.02

Some of the staff came to the country as young adults and made a life for themselves without the support of their families. Nursing auxiliary Gloria originates from Ghana. She and her husband came to London and settled. Her children are established in this country and she notices cultural differences

between them and her family in Ghana particularly when they visit. The following data was taken from a conversation that took place in the staff room:

Nursing auxillary Gloria: *"My children get spoilt here; they don't like it when we go home and they have to be quiet and do what the adults say. They won't go there for birthdays now because even if it's the children's birthday the adults play their music and dance and the children end up sitting out. They don't like it. [Laughing]"*.

Field notes 8.5.02

Others came specifically to train to be nurses. For example Paula and her sister came from the Philippines to train to be enrolled nurses. According to Ward (1993), this was a typical situation for overseas nurses at the time who were perceived to be more appropriate for the second level training and indeed many worked in low status work such as the Care for Older People. Unlike her sister, who also worked on the unit until she retired, Paula converted to be a Registered Nurse and worked as a senior staff nurse until she retired during the data collection period. She told me her plans for her retirement:

Staff nurse Paula: *"I'm planning a big holiday back home after I retire. Then I might come back and maybe do a bit of agency nursing. Then I'll spend time between here and home. Probably not here in the winter!"*

Field notes 23.5.03

Other nurses came to convert their overseas qualifications or to train to be Registered Nurses. A few had left their country to escape persecuting political regimes. For example Wei-Kong came to London in the 1980s as one of the "Vietnamese boat people". In his own country he had been a doctor, but had settled in East London and worked as a nursing auxiliary. I asked him in a Reflective Work Group why he hadn't tried to work in medicine here.

"Wei-Kong explained how he first came to the country. He had to go to immigration and queue for a very long time. When he got there he felt humiliated because he didn't speak any English and the people couldn't understand him. He said he felt so embarrassed. He went to work in the geriatric hospital, which he liked. The people were nice and friendly and he stayed there until they moved to Willow Ward."

Field notes 19.11.03

The typical nurse on the unit was a middle aged woman who has worked in continuing care for a long time and who is from an ethnic minority group. Two staff nurses and one nursing auxiliary retired during the data collection period. Except for the continuing care manager, only one of the permanent care staff was male. The nursing staff cultural heritage is rooted in Bolivia, the Caribbean, China, England, Ghana, India, Nigeria, the Philippines, Sri Lanka, Vietnam and Zimbabwe. By contrast, the continuing care Charge Nurse was the only white English male and under forty. The other staff group who were consistently present on the ward were domestic staff. Three women worked as domestic staff on the unit. Two were older: one who originated from the Caribbean and the other an Eastern European Jewish woman. The younger woman had more recently emigrated from Eastern Europe.

Other professional disciplines had clinical time allotted to the unit, for example, there were two consultant physicians in the Care for Older People. Both consultant Geriatricians were men and younger; one was English, the other Indian. Other regular multidisciplinary team members included a psychologist who originated from the Channel Islands, an occupational therapy assistant and me, the nurse researcher, who both originated from England. The junior doctors who visited the ward and other professionals in physiotherapy, speech and language therapy are not allocated to the ward and are referred to on a case-by-case basis.

Cultural diversity in Willow Ward

The residents on Willow Ward were mainly from a white English heritage, with some individuals from other ethnic backgrounds. They were cared for by a staff group who were mainly from a black African and Caribbean heritage with some individuals from other ethnic backgrounds.

The cultural differences between the care staff and residents in Willow Ward had to be acknowledged and worked with. The concepts of life history and relationship-centred care are important in institutionalised care for older people (Ashburner *et al* 2004). The lack of shared heritage between staff and residents presented complex situations. The staff regularly experienced ethnocentric comments and attitudes. This ranged from affectionate stereotyping:

Nursing auxiliary Wei-Kong: *"He always calls me "Charlie Chan"*

Researcher Cheryl: *How do you feel about that?*

Wei-Kong: *Oh I don't mind. It makes him laugh and he knows me. I'm not even Chinese [laughing]"*

Reflective Work Group 27.9.01

To racial abuse:

Nursing auxiliary Gloria: *"You heard Molly [resident], what she call us. You black whores, you black this and that."*

Reflective Work Group 3.4.02

The staff accepted this as part of their work and dealt with it on a daily basis. The issues of difference were managed, but they were not straightforward. Staff often said they did not mind residents being abusive because they "can't help it", in other words the insults were laughed off and lost their potency. In contrast, issues of difference between staff and relatives were far more likely to cause anger in the staff. For example in the following extract the care staff felt the behaviour of two young Bengali girls was offensive. The care staff were offended by what they perceived as a lack of respect:

Nursing auxiliary Celia: *"Mr Choudhury's two daughters [Cheryl's note: These are young Bengali girls in their teens and Celia is a Nigerian woman probably in her 50s] asked me to clean up Mr Choudhury. They said he had been sick after his feed. I went to clean him up but the girls were shouting at me. It wasn't fair, they're so disrespectful. I don't know what they're saying."*

Nursing auxiliary Mina: *They are like that. The mother and eldest sister are ok but these two. They wave their hands [making a gesture]. I think it is something rude in their country. [Cheryl's note: We discussed what it meant and as none of us were from the same culture as them we could only speculate that the movement looked dismissive]."*

Reflective Work Group 24.7.02

The circumstances of Willow Ward brought together a group of individuals to form a unique community made up of people who had varied and diverse backgrounds. They had to negotiate their differences in order to make relationships that were mediated by profound dependence and a need for care over relatively long periods of time. These circumstances were not explicit in the national policy agenda or recognised in their local interpretation (Department of Health 2001a,²) adding to the sense that the people in the unit were hidden away and that work of caring for this group of elders by this group of workers was poorly understood.

OPENING THE DOORS TO WILLOW WARD

It is easy to recognise the issues described in the local health report in the environment surrounding the Care for Older People Unit. The high road that runs close to the hospital is typical of a busy urban landscape: the untidy tube station, smell of car fumes and sounds of sirens are facts of life. Facilities reflect the youthfulness of the area, the dominant Bengali community and the East End roots in trade, poverty and diversity. The take away shops and grocery stores are always open, sell Halal food and are run by members of the local

³ Local key aims and targets not referenced to protect anonymity

Bengali population. At certain times of the day the young students from the local college seem to dominate the pavements; walking in groups and talking in the many different accents from their varied cultural backgrounds. Local amenities include: a library that specialises in local history, a cinema, an urban park, gastro-pubs, a sub post-office, co-op store, charity shop and Bengali restaurants. Further down the high road it gets busier still with the people going to and from the mosque, supermarket, clothing retail outlets, general hospital and the market.

In contrast, the area on the other side of the Care for Older People Unit is mainly residential. Some roads are lined by rows of Victorian town houses; whilst other areas are dominated by social housing such as more modern red brick buildings with their regulation windows and hard wood front doors or large blocks of flats with external balconies running the full length of each floor that are characteristic of the 1960s era. A few smaller businesses seem to thrive in these areas, often under the railway arches. On occasions these seem to be arranged according to broad ethnic group such as the African and Caribbean mechanics at the garage and the white assistants at the garden centre, whereas other businesses seemed to have a range of accents and appearances that make it impossible to characterise them by cultural background.

The hospital is situated between the residential area and the high road. During the data collection period, buildings on the hospital site were upgraded to accommodate the new Primary Care Trust. Some of the old large Victorian blocks and subsidiary buildings that had been clinical and staff accommodation or had lain empty, were either demolished or adapted into offices for the

administration staff, education facilities, offices and clinical rooms for the range of clinical departments such as Psychology, Ophthalmics and Chiropody.

Taking a look at the unique community downstairs

The inpatient wards and the day hospital that form the Care for Older People Unit are housed in the main hospital. Willow Ward had previously been one of two continuing care wards on the ground floor, but one had been converted into an intermediate care unit. Two mental health wards are also situated on the ground floor. The administration offices for the Care for Older People Services are located on the first floor. This included management and the medical consultant offices plus their support staff. There are also four rehabilitation wards and a stroke unit located on the first and second floors.

There was a sense that the continuing care unit was separate from the rest of the older people's services. In Willow Ward, the more acute wards, management and medical offices are collectively known as "upstairs" and Willow was frequently referred to by those staffing the rehabilitation wards as "downstairs". Security doors at the entrance to Willow Ward reinforced the feeling that the continuing care unit was cut off from the outside environment. Staff had a code number, which allowed them to enter. Visitors and non-permanent members of staff had to buzz and wait for a staff member to press a release button to allow them entry.

The lack of representation of continuing care in the formal documentation, the geographical position of the ward and the steady reduction of numbers of long-stay beds might lead to the conclusion that Willow Ward was being "pushed" into the margins, but this was not the complete picture. The staff also played an

active role in keeping them-selves separated from the rest of the services. The nurses preferred to take their breaks in their own staff room rather than going “upstairs” to the communal facilities. They had to fight very hard for this and felt it was important because they wanted a place of their own and going upstairs reduced the length of their breaks (RWG 17.4.02). This separation of the unit from the rest of the services was an important feature of the unit that is relevant to the findings of this study (Chapters Nine and Ten).

The tension between homely and hospital

The ward itself had been designed to provide a homely atmosphere. The colour scheme was light and bright, the pretty curtains matched the duvet covers. The residents’ sleeping areas allowed privacy and natural light. The rooms came off the corridor and were arranged in a kind of cul-de-sac fashion. Each of these areas was similar but geographically separate. The residents shared bathroom and toilet facilities and the individual bedrooms were designed so that the hospital garden was easily accessible to most residents. Some residents had a room each whilst others shared. Each resident was provided with a bed, armchair, table, wardrobe and portable television. Some residents brought in personal effects such as small items of furniture; radios and pictures that made the rooms feel more personal.

Despite the thoughtful design, the sense of a hospital ward prevailed. For example the colour scheme, decor and the black and white photographs of “East Enders” holidaying or hop picking in the 1950s were supposed to bring individuality; but the lack of diversity and the wear and tear from constant use produced the unmistakeably uniformed and worn look of care institutions. In

addition, there was no disguising the purpose of the unit, which was to care for very dependent older people. In the residents' rooms evidence of care such as kidney dishes, plastic gloves and aprons, urinals, special beds, thickening powders for drinks, call bells and wheel-chairs tended to dominate the environment and personal effects, such as ornaments, family photographs and birthday cards seemed to disappear into the background.

The procedures required for caring for large numbers of dependent people had an effect on the environment. There was a need to balance the creation of a homely environment and the logistics of communal care. As regulations and technical aspects of care advanced there was an impact on the use of space in institutional care. Manual handling equipment, drinking water bottles, special mattresses and other therapeutic equipment all needed to be stored, and defending space for "non-essential" aspects of care such as discussion, art therapy and residents' personal items became more difficult. A telling symbol of this process was observed a short time after the occupational therapy assistant left:

"When I came on the ward today I noticed the cabinet that June [Occupational therapy assistant] had set up to display the residents' art work had become completely hidden by the boxes of PEG feed [artificial nutrition] that had been delivered in the last couple of weeks. It seemed so sad that all June's work with the residents has just disappeared."

Field notes 30.7.03

The conflict between the sense of homeliness and the care function of the unit is observable in the environment but rooted in tensions about the status of the residents as frail dependent older people.

The residents' profound dependence

The changes in policy directed at moving Care for Older People away from NHS hospitals and towards community care and care homes had a direct impact on the level of dependence and needs of the client group admitted to Willow Ward. The assessment process was designed to ensure that only people with complex needs and profound dependence were cared for in the NHS continuing care unit. The effects of this policy were observed by staff:

Nursing auxiliary Patience: *"We [pointing to herself and NA Meena] would be willing to take residents out as long as we had enough time to organise [their own] child care. But one of the staff nurses would have to organise the dial- a- ride bus.*

Staff nurse Elizabeth: *But who would you take there's only Robert [resident] who can go out really and he's not well enough to go far. Our residents aren't well enough to enjoy going out. All the good residents go elsewhere.*

Patience: *It was nice when we used to take people like Rebecca [deceased resident] and Mary [deceased resident] to the park and on trips."*

Reflective Work Group 13.9.01

Frail, dependent older people have become marginalised from society, often being kept out of sight (Hockey and James 1993). Examples are given here of how issues of dependence mediated the residents' relationships with those around them. Although the importance of seeing the person beyond their care needs was acknowledged, on meeting some of the residents it was sometimes hard not to be shocked by their dependence and to focus on their frailty:

"We [researcher and student nurse] went to help Mary [resident] get out of bed. I have seen Mary before in quizzes and although she appears to not be able to speak, I know she is thoughtful and able to communicate to people who know her. She has very little hair, she is pale and her skin is almost transparent. She is crooked – her head is bent over and she looks up at you as if she is looking over glasses. She dribbles all of the time. I find her appearance shocking ... A bit like a zombie in a horror film."

Field notes 29.5.01

As with the example above, the provision of intimate care such as washing a person or feeding someone was a different experience from social interaction and the provider of care was made aware of the recipient's vulnerabilities during the former.

There were usually between five and ten residents who were so frail they needed to stay in their rooms. They either stayed in bed – often on electrical airbeds designed to prevent pressure sores or sat out for short periods in their armchairs next to their beds. Staff often put on the television or music for these residents although they frequently appeared to be sleeping rather than engaging

with their surroundings. When residents had little ability to communicate, and few or no visitors, it was very difficult to get to know them. However, care provision could provide some form of connection:

"I looked after Ted this morning. He's a big man, who was very stiff and difficult to get to move. He spends most of the day in his bed or in the armchair in his room. He had little comprehension but he could say if I was hurting him when I tried to straighten his arms and at one point he followed my instructions to straighten his legs when I was washing him."

Field notes 1.6.01

Seven residents were recorded in the data as preferring to stay in their rooms, not because they were too frail to sit in the communal areas, but because they or their families preferred privacy. When residents were more alert and engaged with their surroundings it was easier to get to know their personalities and preferences, even if they had communication difficulties. Robert was a resident who had lived in East London all his life. He had a stroke and was admitted to the unit in his late sixties. He preferred to stay in his own room. He had no visitors and despite bouts of depression and physical disabilities had made relationships with staff, being known for his love of classical music, short temper and sense of humour:

Nursing auxillary Geeta: *"I get a bit scared of Robert [resident] sometimes, he has such a temper, but yesterday he wanted something and he pointed out on his communication board. I thought he wanted to*

ask June [Occupational therapy assistant] about getting his lottery ticket but she had gone, so I had to get Steve [Charge Nurse] to see if he could understand. In the end I got his chicken and chips from the canteen and he was happy with that."

Reflective Work Group 27.9.01

It seemed easier for care staff to make relationships beyond care needs when residents had less mental frailty and could communicate in some form. The impact of the residents as a group was felt when people came together in the communal sitting room. Sometimes the sitting room felt like a pleasant area where residents came for meals, to watch television, sit with their families and other residents or to watch entertainers.

"Kath [an entertainer] was setting up her accordion and taking her position whilst Jack [who accompanied her] sat to the side... When Kath got going she approached Betty [resident] which made Betty much more sociable. On one occasion Betty sang a solo into the microphone and we [staff and residents] clapped. Betty was much more comfortable taking the lead rather than watching. There was a real flavour of the old Betty – the landlady."

Field notes 24.4.02

At other times in the day however the room was quite still and less animated. With no staff or family to stimulate interaction residents fell asleep. On these occasions the sound of the television dominated, although no one was watching it:

"After the group I walked through the ward to say hello. I put my head in the sitting room. I could see the domestic in the kitchen washing up and the telly was on really loud, but otherwise there was little movement. Eight residents were in the room and all of them had their heads dropped as they slept. Five people were all in the large supportive armchairs Steven [Charge Nurse] had ordered. They had their feet up and blankets over their knees. Mary and Nellie were in their wheel chairs and Ben was sat at the table sleeping, I turned the telly down a bit but no one noticed."

Field notes 10.10.01

The sitting room could have quite a different atmosphere if one or more resident became agitated and confused. On these occasions the noise and sense of distress could be very disturbing:

"The residents in the sitting room were, Irene and Sarah, who were drifting in and out of sleep. Biddy and Mary were watching television. Muriel was sitting slightly behind everyone else. Muriel has the type of dementia where she is constantly worried. She was calling out as if she were seeing things. She was leant forward in her chair, half crying, half talking. Sometimes she rocked backwards and forwards. It was distressing to see. I sat down and went to hold her hand but she pulled away. Sometimes she let me hold her hand and sometimes I rubbed her back or put my arm around her. None of these things made a difference.

She continued to call for help, when I asked her what she wanted she said, "Mummy"."

Field notes 28.2.02

The residents' mental and physical disabilities not only resulted in practical care needs but also mediated their relationships and affected how others perceived them both as individuals and as a collective group. The pattern of where residents spent their time became established and the routine and activities involved in achieving the pattern is relevant to the thesis. This will be discussed in detail in the findings chapters (Chapters Nine and Ten). Another significant factor in the research was the presence of residents' relatives. The ongoing nature of the care meant relatives were often a significant factor in the ward relationships and activities.

Residents and their families

Townsend (1963) suggests that in the 1950s people accessed state help in old age when they did not have a family – particularly females. This was sometimes the case in Willow Ward, but many families had extended kinship ties similar to those described in the 1950s. The reasons people were admitted to the NHS continuing care unit always involved them being dependent on nursing care over prolonged periods. Some residents had no visitors and no living relatives or they had become estranged from their families. Irene was an Irish resident who was well known in the area and had lived a long time in NHS continuing care:

Nursing auxilliary Maria: *"We have known her from way back. In the old hospital she used to go to the psychiatric wards. She lived on the streets and in the Salvation Army. When she was young she went to prison and she lost her baby, sometimes she cries for her baby now. She's always had alcohol problems and she can get aggressive but she is very loving."*

Reflective Work Group 6.12.02

Even when residents did have close female relatives their relationships were often more complex than the situation described by Townsend in 1963. Although Enid (resident) had been cared for by her daughter for many years prior to her admission theirs was not a straightforward relationship. Enid's daughter had found her mother very difficult and bossy throughout her life. This got worse as her mother developed dementia following Parkinson's Disease. She said she was pleased not to have to care for her mother anymore and said it caused a dreadful strain on her family and now her husband was ill. She had cared for her mother out of a sense of duty rather than desire, but she had not passed this on to her own daughter. She elaborated in one conversation:

Enid's daughter: *"My name is Enid, my mother and my grandmother were called Enid. I hated the name so I didn't call my daughter it and her daughter's named Abigail. I hope it never comes to it, but I've told her I don't want her to look after me when I'm old"*

Field notes 31.5.01

The issue of providing care for dependent family members is complicated by the pre-existing relationship whether it was negative as in Enid's case or positive as in the case of Rosie's sister. Family ties may be strong but the desire or ability to provide practical and emotional support such as visiting was stressful. Rosie's sister told me her feelings about visiting during a conversation in the sitting room:

Rosie's sister: *"We all grew up together round here you know Rosie was always so lively, it breaks my heart to see her like this. I can't bear to see it and the others [looking around the sitting room at the other residents and spoken in a hushed voice].*

If Joan [her older sister] didn't come so often I suppose I'd have to. But I know she's all right cos Joan tells me and my girl comes in every now and then, but I just can't do it. Do you think I'm callous?"

Field notes 1.6.01

Although a minority of residents had no visitors, many kept in touch with their families. Patience had occasional visits from her nephews but her son who lived in America kept in contact by telephone and she received one visit from him during the data collection period. Sarah had no children and her friends and family had died, but she had a weekly visit from someone from Jewish visiting service. She told me what Sarah used to be like as we walked out of the ward together one day:

Sarah's Friend Natalie: *"She [Sarah] never recovered from when her husband died. They'd been together for so long. I used to visit her in the*

residential home and then carried on when she came here. We became friends"

Field notes 19.11.03

At any one time there were a small group of residents (3-4) who had visitors from someone every day. These visitors became part of the ward population and frequently seemed to need a lot of care and attention themselves. These relationships were usually close, for example, husband and wife or mother and son. Often the attachment between the visitor and the resident was complicated:

Nursing auxillary Gloria: *"Emma's [resident] son comes in everyday. He's not quite right. He always brings her lots of things - magazines and fruit and stuff. But she never says thank you and she can be rude to him in front of us, but he keeps on coming. He's always very chatty, talking with everyone. I don't know how he'll cope when she dies."*

Reflective Work Group 10.10.01

There is an assumption that people from non-western cultures are more likely to care for their elders, but the continuing care needs for people from varied cultural backgrounds were found to be complex in this study. There were residents from African, Bengali and Caribbean heritage on the ward, but the issues related to family care were often similar to those white people who had lived in East London all their lives. Sometimes the severity of the resident's dependence meant it was very difficult to care for a person at home. Also the person whose role it was to care had to be willing and able to do so. When

Bruce had a stroke his elderly sister could not provide the level of practical care he needed but still cared about him:

Nursing auxiliary Angela: *"Bruce is from Dominica and speaks French like Patience [nursing auxiliary]. She speaks to him in his own language. He has had two wives and both of them died. His sister visits regularly. He loves her being here and doesn't like it when she goes. He has three nephews all big boys who visit regularly."*

Reflective Work Group 6.2.02

Staff noted the large numbers of visitors in Bengali families and the fact that relatives wanted to stay for long periods, sometimes overnight:

Nursing auxiliary Angela: *"Sometimes there are so many people in his room we can't get in. And one of his sons doesn't go home till really late. The night staff have asked him not to stay over because that can't go on for ever."*

Reflective Work Group 8.10.03

The kinship networks were more varied than those described by Young and Wilmott (1957) and were a product of the rapid social changes in the local area. The people who visited the residents of Willow Ward not only provided support and care for their relative or friend, but they contributed to the well being of the unit as a whole. They witnessed an area that was predominantly "out of sight" of the majority of people and they brought a flavour of the local population to people who could be cut off from the external environment.

SUMMARY

The historic development of East London, the changing ethnic profile of the area and the national policy promoting community care and independent care homes has marginalised the NHS continuing care services. This chapter has discussed how the uniqueness of Willow Ward led to a situation where it was invisible to national and local policy makers, unknown to the local community and isolated from the other staff and patients in the hospital. It provides a rich description of the context of this study in order that the reader can judge the relevance of the findings to their own experience and area of practice. For those readers who do not recognise the context it provides an insight into the hidden world of NHS continuing care. This is an area that presents some of the greatest challenges for residents and staff and a community that is often marginalised from the rest of society. This issue is known (Hockey and James 1993), but the complexity of NHS continuing care in London, in particular, is not described elsewhere.

I have provided a description of Willow Ward and some of the significant features including its unknown quality, the lack of strategic planning for continuing care in the locality, the ethnic profile of residents and care staff and the customs and practices of Willow Ward life. These aspects are important to the main thesis and will be returned to in the findings chapters.

I have already stated that the research was informed by psychoanalytic theory and technique. In order to orientate the reader to the relevant theoretical

framework I will give an overview of significant historic psychoanalytic perspectives and relate them to the current issues of the research in Chapter Three. Having read Chapters Two and Three the reader should be equipped with an intimate knowledge of the study location and the theory that drives the method used to research it.

CHAPTER 3 - THEORETICAL PERSPECTIVE: EXPLORING PSYCHOANALYTIC APPROACHES TO INDIVIDUALS AND ORGANISATIONS

This chapter locates the research theoretically by showing how I have used psychoanalytic technique and theory to further an understanding of nursing work related to complex loss and grief in continuing care for older people. The reasons for adopting this theoretical approach rather than having ontological roots in sociology will be analysed. I will outline key psychoanalytic concepts such as a psychoanalytic understanding of emotional growth and psychological defences because they underpin the central thesis of this study. I will describe containment and psychoanalytic approaches to organisations and link them to the research design and suggest that psychoanalysis offers a framework for understanding how emotions and responses to emotions can shape social customs and practices. I will discuss in more detail how I have applied the framework to the research methods in Chapter Five.

RATIONALE FOR ADOPTING A PSYCHOANALYTIC APPROACH

My background is in nursing care for older people, and it was important to me that this research not only articulated the problems in the speciality but also offered a creative response to them. I have chosen to view emotion work through a psychoanalytic lens because it offers a constructive approach to working with emotions in an area of health care that is frequently criticised for the way it relates to its clients (Batty 2006). The psychoanalytic processes were well evaluated in the early work and seemed appropriate considering the

complexity of loss in continuing care identified by the staff (Holman and Jackson 2001). The research model has allowed the development of insights and understandings that could be useful to participants in the research as well as producing knowledge that could be shared outside the setting (Menzies Lyth 1969/1988; Hinshelwood and Skogstad 2000).

I decided to locate the study in a psychoanalytic theory rather than the sociology of emotion because I wanted to prioritise the experience of feeling, both in terms of a legitimate research topic and a means of data generation (Hunt 1989). Fineman (2005) argues that psychological and psychodynamic researchers locate emotion “in” the individual, which is different from those studies more closely wedded to socially constructed emotions which suggest that whatever people “have” inside is overlaid and made meaningful by external factors such as culture and social interactions. Hochschild (2003) for example suggests the management of feelings is central to certain types of work and emotional labour has become a feature of the modern work place. Her central tenet is that there is a cycle of emotional exploitation of workers who are expected to perform their feelings in order to carry out their work in compliance with company policy or the espoused philosophy of the organisation. I do not contest this position but tried to explore a different aspect of the emotional experience and how it related to the social context. Lee Treweek (1996) for example applies Hochschild’s (2003) concept of emotional labour in her study of residential care. She suggests care staff ordered and monitored residents’ emotions because they were experienced as dangerous. This is a fitting conclusion to make from her study, but it does not attempt to

describe the “texture” of the emotions or explain the psychological impact they might have.

It was of primary importance to this study to try to articulate the quality of the emotional experience in order to have a more empathic understanding of the complexity of the care staff’s work. This understanding seemed appropriate if any development in the way participants worked with emotions was to take place. A psychoanalytic perspective offered explanations about why people behave in certain ways in relation to their feelings and prioritises being emotional rather than doing emotions (Milton *et al* 2004).

The roots of psychoanalytic and sociological research about emotions are some distance apart, yet as the disciplines have grown there are some branches that have become close. Hochschild (2003) discusses the differences between the organismic and a sociological interactionist perspective of emotion. She locates the psychoanalytic tradition, and specifically the work of Freud, in the organismic model. For Hochschild (2003) psychoanalytic theory views emotions as having an existence separate from one’s environment. She suggests this perspective sees emotions as instinctual and emanating from within a person. In contrast interactionists are concerned with how the external environment shapes emotions and the social rules that govern the way feelings are labelled, assessed and managed. A psychoanalytic theorist might be concerned with uncovering the experience of a feeling whereas an interactionist is interested in the social meaning that psychological processes take on.

However, over time some researchers have come to draw on both perspectives. For instance, in the articulation of her own perspective, Hochschild (2003) argues that we can learn from the interactionists about how feelings are managed and also how they influence thoughts and actions. She suggests we can learn about the feelings that are managed using an organismic perspective. Theodosius (2006) suggests that Hochschild (2003) makes her closest links with psychoanalytic theory in her discussion of surface acting and deep acting. This is when people present what they are supposed to feel in a given situation. This can involve choosing to express one emotion over another (surface acting) or working on internal emotions to produce a feeling (deep acting). Hochschild (2003) draws on psychoanalytic understanding and suggests the unconscious mind acts as a mediator between instinctual feelings and the individual's understanding of the social significance of the feeling (Theodosius 2006). The values attached to emotions are socially determined and affect how feelings are interpreted and expressed, which are described as feeling rules. Theodosius (2006) argues that studies underpinned by this understanding of emotions focus on the visible and socially expressed emotions which is limiting. She proposes using psychoanalytic techniques to access less overt emotional experience.

The focus of this study was an exploration of the internal world of Willow Ward, but the multifaceted power dynamic where care staff were both powerless and powerful was a vital consideration in the development of an ethical and applied methodology. Although I have adopted a method consistent with what Hochschild (2003) refers to as an organismic perspective where feelings originate from within, the importance of structural power and emotions is taken very seriously. The findings from this study suggest the care staff were

able to learn about emotions and could develop a capacity for emotionally sensitised care. In practice however this did not become the custom in the everyday work. Adopting Hochschild's (2003) view of emotional labour, it could be argued that the care staff can do complex emotion work, but chose not to. This might have been because the feeling rules that govern this type of care environment affected the emotional labour. For example the lack of status and financial reward attached to providing emotionally sensitive practical care were symbolic of the feeling rules that shaped the organisation.

I agree with Hochschild (2003) that emotion work is paid work and is associated with social structures such as class, gender and ethnicity. This research is similar to Hochschild's (2003) model because it links the occupational status of the care staff to the social systems that supported the unconscious avoidance of emotional pain (Chapter Ten). In this study emotions relate to the social environment because they drive individuals to behave and think in certain ways that minimise emotional pain and this has the potential to shape the cultural practices of an organisation (Hinshelwood and Skogstad 2000). These cultural practices in the work place are influenced by the power linked to the occupational status of those within the organisation (Hochschild 2003). However, this research differs significantly from Hochschild's (2003) model because it views the avoidance of emotion work as unconscious and associated with the emotional pain caused by anxiety and conflict. This study also places a great emphasis on the quality of emotions involved in the personal interactions that were fundamental to the work.

I was originally commissioned to work with the continuing care unit by managers of the older people's services. The prevailing view of the unit at that time was consistent with the critique that care in continuing care environments is routinised and that there are inadequacies in the staff's personal interaction with residents (Hockey and James 1993). Lee Treweek (1996) articulates the power held by care workers. She suggests care workers lack strategic power, but are very powerful in their relationships with residents. She argues that emotional skills are harnessed by workers to allow them to get through their difficult work and create order in care homes. This draws attention to the complexities behind the aims of this study where care staff were both powerful and subject to the power of others such as the managers and senior members of staff. The motivation was to explore the emotional world of staff but this is inextricably linked with the power dynamic within and between significant groups. This had ethical implications for the methodology which will be discussed in Chapter Five.

PSYCHOANALYTIC CONCEPTS THAT ARE CENTRAL TO THE THESIS

This study did not seek to provoke specific procedural change but explored the psychodynamic culture of an organisation. The aim was to explore the emotional demand of loss and grief in a continuing care ward and to develop care staff's capacity to work with the emotional component of their work. It was important to this study to take into account the states of mind of the participating staff and the psychological defences that were likely to be alive in the work. The process of testing out new ways of thinking and relating was

designed to develop the staff group's capacity for emotional learning and emotion work. The psychoanalytic frame offered the opportunity to understand the relevance of staff's state of mind when considering the care for dependent older people and to recognise when psychological defences were alive in the work.

A psychoanalytic understanding of development

Psychoanalysis is one brand of psychotherapy that has been developed to provide a range of therapeutic approaches to treat mental health problems for individuals, couples, families, groups and organisations (Milton *et al* 2004). Psychoanalytic therapies are based on the idea that unconscious thoughts and feelings are central to our state of mind. Key figures such as Sigmund Freud, Melanie Klein and Wilfred Bion have described how internal conflicts produced by bodily impulses and moral demands have to be mediated by using psychological defences (Milton *et al* 2004). They stress how early relationships, even before a baby has learnt to speak, with a carer (typically a mother) influence the formation of an internal template that affects relationships and motivations (Waddell 2002). An understanding of how the template develops is important to this study because it underpins our psychic learning and development throughout life. Its relevance to forming relationships and facing the necessary psychological discomfort provoked by internal change make it fundamental to this study of nursing work in a continuing care environment.

According to the psychoanalytic view, a baby's needs to feed (take in) and defecate (expel) are significant to emotional development. The physical

processes involved in the ordinary care of the baby are packed with psychological meaning. The physical acts of caring are therefore also psychological communications. The baby projects (expels) feelings into his or her mother and introjects (takes in) her responses (Davenhill 2006). Taking into the self is described as *introjection* and expelling from the self is termed *projection*. These psychological interactions between a person's internal and external world are present throughout life. The quality of such interactions in very early life are fundamental to the growth of personality and can influence ongoing psychic development (Davenhill 2006). I do not wish to deny the importance of older people's adult experience or status, but an interesting feature of this study is the emotional communication between care staff and very dependent people via the practicalities of personal care. In this study personal care will be viewed as work that has both practical and emotional significance.

The concept of mourning is central to the psychoanalytic view of development. It is not necessarily related to an actual death, but to the sense of separation and loss experienced by a baby when things that symbolise warmth, goodness and safety are removed (Milton *et al* 2004). From an early age a pattern is formed in our minds that relates to how we tolerate the discomfort provoked by absence and loss and this affects our relationships and personal growth throughout our lives. The formation of a person's internal world is dependent on an individual's capacity to experience the pain of grief and internalise the lost person (object), or idea (Waddell 2002). The foundations of this perspective were set out in two seminal papers; Freud's 1917 paper "Mourning and Melancholia" and Klein's 1940 "Mourning and its Relation to Manic-Depressive States".

Freud suggested that mourning could be worked through so that the sense of the lost object (person) can be incorporated into a person's inner world (Davenhill 2006). He described what he thought had happened when a person was in a deeply melancholic state. He noticed particular aspects expressed by the melancholic including a devastating loss of self, relentless self-castigation and self-hatred. Couve (2006) suggests this is referred to in modern mental health care as psychotic depression or manic-depressive psychosis. Freud concluded that this was an unconscious hatred of a significant person who had been taken into the self (introjected) and then because of a sense of persecutory guilt, the person with severe melancholia or depression directed all their punishing feelings in on themselves instead of toward the significant other (Couve 2006). Klein developed her ideas following Freud. She provided insights into depression as both an extreme psychotic condition and, significantly, as an ordinary part of human development (Couve 2006).

Segal (1973) explains that for Klein the patterns of working through loss in order to grow are established as a small baby tries to negotiate a raw experience of living. The baby wants to keep an idealised safe and protective sense inside itself and keep out internal and external objects that feel harmful and frightening. This state is typified by an anxiety that bad things (objects and part objects) will invade and take over the baby. This is dealt with in early life by separating all bad and frightening representations in the mind from the safe and good ones. This is called *splitting* (Waddell 2002). Klein called this state of mind the *paranoid-schizoid* position.

Having negotiated the raw experiences of life by organizing them into good and bad, the small baby is left to occupy an idealised world in which terrifying bad things are completely disowned by projecting them elsewhere (Segal 1973). Psychological development is dependent on the ability to process the loss of this idealised state and tolerate more frightening aspects of the self and external life. This state of mind involves facing some harsh realities and is referred to as the *depressive position*. If the baby has received adequate care, he or she will have developed a secure enough sense of self to tolerate the ambivalence experienced through the work of the depressive position and achieve a more integrated view of the world. The infant needs to be able to experience both the love and the hatred felt for his or her mother to do this. Couve (2006) explains that when psychological growth goes well the infant is able to bear frustration, for example, when the mother is absent and this increases his or her capacity to feel separate, and be separated from his or her objects (carers). He suggests the psychic task of the depressive position is to gradually bear the guilt related to the hatred one has felt in order to engage in *reparation*. This can only come about when depressive guilt can be faced rather than retreating into omnipotent defences. Couve (2006) points out that the work of mourning is difficult because the loss invokes the conflicts of the depressive position.

The relevance of loss in continuing care is complex. Loss is important on many levels. The volume of external loss experienced by residents is significant. Loss of possessions and separation from family for example can have a profound effect (Scrutton 1995). It is also important to consider residents' ability to process internal loss. They may be vulnerable to depression and the presence of concurrent losses may have stirred up latent losses (Cadby 1996). Suffering a

degenerative condition such as dementia may also have an impact on a person's ability to work through internal processes (Waddell 2000).

The Oedipus complex goes hand in hand with Klein's working out of the depressive position (Britton 1989). It refers specifically to the recognition of the parental sexual relationship and involves giving up the idea of total possession of one's mother. This leads to a profound sense of loss, which, if not tolerated, can become a sense of persecution. Britton (1989) explains that as part of his or her development the child learns that the parental relationship is sexual and therefore different from the parent-child relationship. If the loss and envy provoked by this knowledge is intolerable for the child he or she may harbour a sense of grievance or self-denigration. The Oedipal situation is resolved when the child relinquishes his or her sexual claim on his parents by accepting the reality of the sexual parental couple. Waddell (2000) discusses the case of an older woman with dementia who seems tormented by jealousy having become convinced that her recently widowed friend was waiting for her to die so she could move in with her husband. Waddell (2000) suggests this can be viewed in psychoanalytic terms as a difficulty related to tolerating triangular relationships that are rooted in the Oedipal situation. She gives this as one example of psychoanalytic interpretation of anxiety in the last stage of life but suggests the fractured mental states of older people with debilitating illness such as dementia can be usefully compared with the raw experience of small babies. This makes it hard for frail older people to work through emotional dilemmas such as unresolved Oedipal situations.

Klein did not refer to a staged approach to development; she suggested we oscillate between the depressive and the paranoid schizoid position throughout life. The understanding of these states of mind and their centrality to the potential for growth is therefore important to this research. The depressive position is not presented as an ideal state which is reached when one achieves a certain maturity but a dimension of being that one moves in and out of depending on internal and external factors. In the depressive position, one is able to contemplate the world in a more balanced and multidimensional way and to accept "what we can have and what we can't have" (Milton *et al* 2004). The contrasting state of mind is often described as primitive and chaotic. In this state, one views the world in terms of good or bad and disowns any of our own "bad" qualities. In this state we lose the ability to see the other person's point of view and give ourselves an exaggerated sense of importance (Waddell 2002).

Waddell (2002) suggests that being aware of the autonomy of others and being able to acknowledge people's complex natures is part of an adult state of mind. In this state of mind, separateness from others is felt as bearable and not catastrophic. She argues that it is normal for human beings to fluctuate in and out of this mature state depending on the circumstances of their lives. On some occasions they are likely to regress to the protection of the confusion of a more infantile place. In the study setting there was a lot of emotional stress. The nature of a relationship that has care for dependent, sick and dying people at its heart, provokes high levels of anxiety (Hinshelwood and Skogstad 2002) and a dependent older client group have specific psychic challenges. In her discussion of the growth of personality Waddell (2002) discusses all stages of life including the adult world, the later years and the last years. She suggests

that the preoccupation with mental and physical decline and the fact that death itself is becoming more imminent challenges a person's capacity to sustain a mature state of mind in the last decades of life. An understanding of Klein's positions as potential states of mind is essential, because the requirement for self-examination in this research and the substantive topic of nursing work with dependent older people are emotionally charged and may provoke participants to retreat into a defensive more infantile place.

Psychological defences

For internal growth to take place in individuals, groups and organisations, people have to be able to find out about themselves and the world around them. Milton *et al* (2004) suggest we also need to protect ourselves from overwhelming feelings and frightening contradictions that come with the territory of self-discovery. They suggest that people use unconscious psychological defences in order to maintain a balance between the reality we can bear and the need to preserve psychic equilibrium. Issues central to this study: old age, death, dependence and care are likely to provoke difficult and unacceptable feelings for those involved and defence mechanisms need to be understood in order to gain a clearer picture.

Repression is a central defence where unbearable feelings are pushed from a conscious level. Sometimes repressed material can find a way out in the form of a coded disguise. Well-known examples of this are jokes or errors in speech known as "Freudian slips" (Milton *et al* 2004). A *reaction formation* is when a repressed feeling comes out in an opposite form such as when someone finds themselves being overly kind to a person they really don't like and *negation* is

when someone draws attention to something repressed by stressing its irrelevance (Milton *et al* 2004). For example someone who says: "It's not that I mind getting old" might deep down be very afraid of ageing. *Projection* is a defence that involves locating a feeling or part of the self in another and *denying* (unconsciously) a reality in order to gain relief from the feeling (Milton *et al* 2001). Craib (2001) described *projective identification* as a Kleinian modification of projection. He suggested that this not only involves locating the feeling in the other person but also calling out that particular feeling in them. I have adapted his example from psychotherapy. An example from a nurse patient interaction would be when a dependent patient insists the nurse carries out practical tasks, such as helping with washing, by following a detailed routine. In this way it is the nurse who experiences the frustration of being dependent and controlled.

The defence of *splitting* involves projection. The person avoids the pain of internal conflict by dividing feelings into different elements (Craib 2001). Splitting often involves the polarizing of an idealised and denigrated other. It is a strange phenomenon that the day nurses in hospitals often complain about the "bad behaviour" of the night staff even though most nurses do day and night shifts. The projection of anxieties about poor practice into one split off group avoids the doubts and worries about the consequences of inadequate care that are likely to exist in all staff.

The use of psychological defences is an appropriate form of psychic protection. In terms of developing an understanding of work practices *resistance* to considering what might be going on under the surface and *rationalising* an

alternative explanation. Unconscious processes have to be taken account of if work is going to progress in a different direction and this involves being able to let go of previously held views and examine established patterns of psychological defences. It is necessary to tolerate a level of psychological discomfort in order to try out new ways of thinking that allow emotional development.

In summary, for emotional development to take place people need to be able to tolerate facing difficult truths that may create in them a disturbing state of mind. Individuals need to be able to think about themselves, their feelings and their own potential for psychological defensiveness. They need to tolerate the separateness and loss of the comfort of old ways and previously held beliefs. These are difficult endeavours made more difficult by external anxiety and stress, such as staff providing care for dependent, frail and dying older people.

PSYCHOANALYTIC CONCEPTS THAT ARE CENTRAL TO THE RESEARCH DESIGN

In Chapter Five I will describe how I developed the psychoanalytic participant observation used in this study. I will describe how methods developed in the psychoanalytic tradition such as the use of work groups and psychoanalytic observations were combined with social observation to generate data. I will show that although I am a nurse researcher, robust structures for psychoanalytic supervision and appropriate learning about taking in and feeding back interpretations have ensured that data analysis and formulation of meaning is

within a psychoanalytic frame. In the next section I will explain the key psychoanalytic concepts that inform the research design.

The creative function of containment

The potential for psychic development in early life is dependent on the interactions between the internal and external world of the individual baby. A mother's capacity to stay in touch with these processes in her baby is called *containment*. Waddell (2002) describes containment as the relationship between mother (container) and her baby (contained). She suggests the mother is the receptacle for the baby's impulses and emotions, which are fragmented in the early stages of life. Referring to Bion's (1962) concept of reverie she explains that when a mother can be unconsciously emotionally engaged with her baby's disparate and confused sensations she may be able to:

"... savour them if calm and loving, or to modulate them if distressed and hating, and to hand them back to him in recognisable and now tolerable form"

(Waddell 2002, p34)

The way a mother responds to her baby's feelings and the baby's gradual introjection of the dynamics of their relationship results in the formation of an internal template of the personality. The container's ability to understand and honestly articulate what is understood is both creative and formative and has the potential to develop a sense of self that can be internally held (Waddell 2002). The container/containment relationship is significant for this study because the potential for growth in this way is life-long if the appropriate

external container is available. This has implications for the development of individuals, groups and organisations.

In psychoanalytic psychotherapy a container/contained relationship is formed. The therapeutic setting is arranged to promote a *holding* environment. Regularity of time, space and the therapist's focus on the client rather than allowing his or her own issues to be present are designed to make the boundaries of a therapy session feel secure (Milton *et al* 2004). The client is encouraged by the therapist's lack of directive talk to speak widely and freely (*free association*). The therapist pays attention to the content of what the client is saying but equally importantly allows his or her self to be open to the emotional atmosphere of a session. Craib (2001) described the therapist's attempt at being a blank screen onto which the client projects all his or her unconscious fantasies. These projections are referred to as *transference* feelings. The therapist notices the quality of the emotional dynamics in the here and now and relates them to the client's life in the present or the past.

Milton *et al* (2004) explain how the therapist tries to hold on to the client's uncomfortable and distressing feelings as well as his or her own and tries to bear them and understand them. It is important that the therapist tries to resist dissipating the feelings or pushing them back to the client. The therapist thinks about the feelings in order to find a helpful way to talk about them. It is then possible through interpretation to help the client make links and new insights about what is going on for them, thus completing the creative and formative process of containment (Waddell 2002; Milton *et al* 2004).

Whilst therapists attempt to be blank screens for the clients' transference feelings they also have to pay attention to the feelings stirred up in themselves. This is referred to as *counter-transference* (Craib 2001). Ideas about the significance of these *counter-transference* feelings have developed considerably. Heimann (1950) reinforced that *counter-transference* feelings are not a matter of the therapist's own feelings getting in the way, but an emotional response to what is going on for the client or in the session. Craib (2001) referring to Bion's (1961) suggestion that counter-transference feelings in groups have a distinctive "manipulative" quality suggested that in the therapy situation counter-transference is identifiable, normal and useful. Winnicott's (1949) paper about hate in the counter-transference demonstrated the importance of the therapist's attention to his or her own feelings. Winnicott (1949) suggested that, particularly with psychotic clients, no matter how much the therapist loves the client there will also be feelings of hatred. The more the therapist can be aware of them the less likely they are to influence the therapist's motivations and the more they are acknowledged the more the client will be able to bear his or her own feelings of hate.

Dartington (1994) suggests transference and counter-transference are not unique to the therapy situation and points out that patients often have transference feelings about and provoke counter-transference feelings in nurses. Hinshelwood and Skogstad (2000) make a similar case relating to observers and organisations. An example of this from this research relates to what Halton (1994) describes as the exploitation of the natural boundary between insiders and outsiders which every institution has. Willow Ward has locked doors to protect the residents' personal items from being stolen. In order to gain access

visitors need to press a bell and wait for a member of staff to activate a switch that unlocks the door. This in itself is unremarkable, but at the beginning of the research I found waiting for the staff to let me in would make me angry, which I later understood as *counter-transference*. These feelings indicated there might be issues related to maintenance of the boundary between those inside the ward and those outside. The relevance of the boundary between Willow Ward and the rest of the hospital was confirmed by other data as the research progressed and has become a significant feature of the thesis (Chapter Ten).

The principles of the therapeutic relationship can be applied to psychoanalytic work with couples, groups and organisations. Barnes *et al* (1999) claim that holding structures employed in group work are similar to when working with individuals. The person responsible for the psychodynamic administration of the group: therapist, coordinator or leader needs to pay attention to the structures that provoke a holding environment. *Holding* refers to providing a sense of security and trust through manipulating the external environment. For example, making sure there is a regular time and space for the group to meet and then adopting a relationship where the group members are the focus with the coordinator adopting a non-intrusive stance and withholding his or her personal details. The coordinator attempts to employ the same techniques and understandings as in individual therapy in order for the group to be creative and have the potential to provide *containment* for its members. Depending on the type of group, the coordinator may choose to adopt practices and group procedures to make the group a more robust container. This is particularly important as powerful psychological defences can easily preoccupy a group and

distract it from its purpose. Obholzer (1994a) stresses that this is a common assumption affecting group and organisational behaviour.

Psychoanalytic approaches to researching organisations

Miller and Trist and their colleagues at the Tavistock were interested in the tensions between an individuals and a group or organisation (Miller 1993). They saw the individual as both a product of and contributor to the group (Miller 1993). The development of this understanding about organisation was influenced by Lewin's (1951) field theory as well as Bion's (1961) work about group relations. They developed a theoretical framework called the open systems theory (Miller 1993). It assumes that like all living organisms, a group or organisation needs to exchange materials with its environment (Roberts 1994a). A closed system will not survive because it cannot do this. This makes understanding and managing the boundary to an organism a priority (Miller 1993). An illustrative example of this exists in Menzies Lyth (1987/1988) study of a long stay unit for children. She observed the undue business created by an open door that allowed access to the external hospital grounds. People not related to the unit would use it as a short cut to other departments. By restricting access to those within the children's unit it created a more robust and holding boundary akin to the security of home.

Another important aspect of understanding an open systems theory is the concept of primary task. This is the central purpose of having the group or organisation. This seems straightforward, but often an organisation has many stated purposes and yet some groups within it operate in ways that are contrary to it. If a group is in the sway of unconscious drivers it might engage in activity

that is irrelevant or counter to the primary purpose. This is called anti-task behaviour (Roberts 1994a).

Bion (1961) suggested that being in a group was inherently difficult for human beings and could provoke infantile states of mind. He set out the conscious and unconscious elements of group behaviour that Obholzer (1994b) describes as the counterparts in groups of the paranoid-schizoid and depressive positions in individuals. Bion (1961) called them the work group and the basic assumption group. The work group is a state of creative group functioning focused on the primary task (Milton *et al* 2004). In this state people contribute actively, sharing perspectives and responsibilities appropriately (Barnes *et al* 1999). In contrast, the basic assumption group is a state in which a group is in the grip of unconscious processes. In this state the group is focused on unconscious assumptions that distract it from its creative work (Obholzer 1994b). Bion (1961) formulated the basic assumptions as *dependence*, *pairing* and *fight or flight*.

Barnes *et al* (1999) describe these assumptions as metaphors for the psychological defences provoked by anxiety in the job or work undertaken by the group. They explain that people in a group or team act *as if* they all share the common assumption that they are there for something else. For example a group in dependence basic assumption will behave in a way that assumes its unofficial aim is to gain help and security from a powerful leader. It will expect its leader to act as their protector and not to face them with the challenges of the true purposes of their work (Stokes 1994).

A psychoanalytic understanding of groups and organisations was important to this study in two ways. Firstly it provided a rationale for organisational behaviour and secondly the methods of data generation, collection and analysis occurred in groups. I had to be aware of how unconscious drives can motivate groups and I had to learn techniques to contain and articulate emotions and processes as they occurred in the Reflective Work Groups. The experiential learning in the Tavistock Supervision Group enabled me to do this.

Action research studies relating to group defences and their impact on the social systems in organisations dominate the early research and practice in the Tavistock Institute (Neumann 2005). Menzies Lyth (1959/1988) was one of a group of psychoanalysts who developed an understanding of how large groups such as organisations can be treated as psychic entities. She developed a methodology for psychoanalytic consultation for organisations which she saw as action research and applied the notion of psychological defences to the whole social system. A well-known example from Menzies Lyth's (1959/1988) study was the way nursing work was allocated. She suggested that by allocating tasks to nurses rather than expecting them to provide care for individual patients, nurses' contact with patients was less intimate which protected them from the painful feelings provoked by getting close to patients. At the time this method of allocation was accepted as an efficient way of organising work and typical of hospital culture.

Menzies Lyth (1969/1988) describes a type of action research which is a therapeutic endeavour aimed at helping the organisation function in a healthier way. She refers to herself as a consultant but uses the terms researcher and

consultant interchangeably. She suggests the analytic process is complex and dependent on both the researcher's clinical and sociological acumen. Miller (1993) describes his methodology as a sociotherapeutic relationship with the organisation and its members. He suggests the long-term solutions to the management of change cannot depend on manipulative techniques. They must depend on helping the individual understand and manage the boundary between his inner world and the realities of the external environment. In this research I have tried to adopt a relationship with the study setting that reflects these principles. The methods and skills I have developed have been designed to form a creative or therapeutic relationship with Willow Ward in order to encourage greater understanding and support for the management of the boundary between the care staff's internal world and the external stresses of their work.

Hinshelwood and Skogstad (2002) describe how they used Menzies Lyth's (1959/1988) anxiety-defence model and the observation methods developed at the Tavistock to develop a method of psychoanalytic observation of institutions. They have used these methods and structured supervision strategies to facilitate non-psychoanalysts to make a psychoanalytic observation of their own place of work (Hinshelwood and Skogstad 2002). They argue that with appropriately controlled structures in place this is complementary, but different from, organisational consultancy or action research method. Hinshelwood and Skogstad (2000) identify three key ways that the organisation is shaped by anxiety and defences. Firstly specific kinds of anxiety are connected to particular types of work. Secondly people co-operate in aspects of the social systems to support their own defence systems and are in fact attracted to certain

roles and work in order to do so and lastly the way organisational and personal anxieties are dealt with affects the culture of the organisation.

A key feature of this type of observation is that the researcher remains separate from the practical aspects of the setting. The emphasis is on an emotional involvement rather than a practical one (Hinshelwood and Skogstad 2000). The participant observation methods in this study have more practical involvement than usual for a psychoanalytic observation. My relationship with the organisation was closer to Menzies Lyth's (1969/1988) therapeutic stance, but used the mechanisms of supervision and containment intrinsic to Hinshelwood and Skogstad's (2000) methods of observing organisations. The systematic observation of health care institutions has enabled Hinshelwood and Skogstad (2002) to take a position on unconscious culture. They argue that culture is a psychosocial process where anxiety and defence are recognised in defensive techniques and culture is formed as a result of collective unconscious emotional states. These are expressed as defensive aspects and assumptions in a social group (Hinshelwood and Skogstad 2002). In this version of the social world emotions have a key influence on the practices that formulate an organisational culture. This understanding of individuals and organisations underpinned the decisions made about the approach to the study.

In Chapter Five I will explain how the research methods were containing and enabled the care staff to explore their own emotional experience. I will describe how psychoanalytically informed participant observation explored the individuals' emotional response to the work in continuing care and how this impacted upon the cultural practices of care.

SUMMARY

In this chapter, I have set out the theoretical basis for understanding the issues that are central to this study. I have chosen to use a psychoanalytic frame because it not only offers a means of understanding social processes that influence work with emotions in organisations, but it can also be used to enhance development and growth. I have described key psychoanalytic concepts that are relevant to how I have viewed individuals, and groups and how factors such as loss and psychological defences have an impact upon capacity for development. I have argued that a psychoanalytic understanding of culture in organisations is a useful way of understanding how the affective experience of individuals relates to the social context of organisations. These theoretical positions will be applied and referred to throughout the practical processes of this research.

CHAPTER 4 - LITERATURE REVIEW: THE COMPLEXITY OF LOSS IN CONTINUING CARE INSTITUTIONS

Entry to continuing care involves many losses. For instance, there is the loss created by separation from home and local community. This loss is important for its own sake, but is also part of a complex system of losses around the older person's own health, attachment to others and proximity to their own death. This chapter analyses the findings of a literature review undertaken on loss in continuing care institutions. It suggests that research undertaken in continuing care institutions, such as care homes, can ignore the complexity and multiplicity of loss, depending on the methodological approach taken (e.g. qualitative field methods, survey research and intervention studies). It argues that different methodologies fragment and hide some aspects of loss in these settings. For instance, some methods capture the individual emotional component, whilst others focus solely on the social dynamic. This fragmentation and hiding of aspects of loss makes research findings of limited value to those working in practice. In effect, the findings of the review suggest that the decisions underpinning individual research designs and theoretical frameworks have led to an incomplete picture of loss in continuing care institutions.

When developing the aims and objectives of this study it was important to have a raised awareness of this tendency so that the research could examine the relationship between concepts that were divided in theory but merged in practice. This would enable the study to uncover new understandings of loss

that could be applied usefully to the continuing care setting. The chapter concludes by making it clear that this research aims to explore conceptual boundaries and justifying the decision to adopt a specific focus on one group of participants: the care staff.

METHOD

A search of the literature was carried out in December 2002 and repeated in July 2006. Hart's (1998) framework was used to review the literature. It aimed to find out what literature was available to describe and explain loss in continuing care institutions for older people. Articles were selected using the following criteria: items that focused on loss, grief, bereavement or mourning in the specific context of a continuing care unit for older people. Items that focused on other contexts of care such as hospitals or a person's own home were omitted from the search. However, if there was a comparison of a continuing care unit with another context of care, or if a continuing care unit was referred to as part of a total population, the paper was selected. The electronic databases used: CINAHL, Medline, Psychinfo, Nursing Collection, Embase, IBSS and Cancerlit were searched over the last twenty-six years. This time span allowed all classical references to be located along with the most up to date findings. The range of electronic databases was chosen to include items related to health, sociology, psychology, psychiatry, palliative care, end of life care and gerontology.

Search terms were combined to form three expanded categories:

- loss, grief, bereavement and mourning

- nursing home, residential care, care home, continuing care, long term care and long stay
- derivatives of old, elderly, geriatric and gerontology.

The search was further refined by combining these three categories together. The process was made more manageable by breaking the databases into blocks and then systematically searching each block using the relevant terms. The blocks of databases were formed according to time. Each search block was then saved electronically (including abstracts). In total, 136 abstracts were selected and categorised according to content and research methodology. At this point, items that only partially met the selection criteria or those that did not contain original data and analysis were set aside and the remaining research papers (49) were reviewed according to Burns and Grove (1997) guidelines for comparing and analysing research papers, alongside Hart's (1998) framework for argumentation analysis. Studies were then grouped according to their methodological approach (qualitative field methods, survey type research and intervention studies).

FINDINGS FROM QUALITATIVE FIELD METHODS

Nineteen of the studies used qualitative field methods, such as in-depth interviews, focus groups or participant observation. Within this section, the majority (13) used interviews and two of these adopted a grounded theory approach to the data (Matthiesen 1989; Sandberg *et al* 2001). Interviews ranged from being located in a specific methodology such as story telling or phenomenology and analysing data from a very small sample (Running 1997;

Newson 2003; Pilkington 2005) to Gladstone's (1995) work, where interviews with a large sample (161) were based on Likert type questions. Others describe their studies as ethnographies (Kelly 1991; Starck 1992; Costello 2001; Marquis *et al* 2004; Moss *et al* 2005).

None of the studies aimed to provide a view of all losses in continuing care institutions, although some of them assumed loss to be an important aspect of institutional life for older people (Starck 1992; Wilson and Daley 1999). Depending on the methodological approach used, different studies uncovered different dimensions of loss. This was due to the restrictions imposed by the studies' fragmented foci, such as the limitation of single perspectives, ignored temporal component and constraint of context.

Limitation of single perspectives

When individual interview or focus groups were used to generate data, there was a tendency to focus on only one perspective, for example, residents (Engel *et al* 1998; Newson 2003; Bickerstaff *et al* 2003; Pilkington 2005), spouses (Gladstone 1995; Sandberg *et al* 2001), daughters (Matthiesen 1989), close family members (Marquis *et al* 2004) and staff and residents (Bell 1984; Wilson and Daley 1999). Although Bell (1984) and Wilson and Daley (1999) compared residents' attitudes towards talking about dying with those of the staff, and some studies explored relatives' views about residents (Moss *et al* 2005) and staff (Marquis *et al* 2004), no studies considered the combined perspectives of staff, residents and family. As a result, a comprehensive understanding of the staff, resident and resident's family dynamic in continuing care settings was not uncovered.

Ignored temporal component

Admission to a nursing home is reported as a monumental change for residents and their families. It is the beginning of something new. However, for staff, nursing home life is continuous, with shift patterns and working practices remaining the same from week to week. Ignoring the temporal component in research probably reflects what goes on in practice. Each of the studies concentrated on different aspects of the loss experienced in continuing care institutions, for example, admission to a nursing home (Matthiesen 1989; Sandberg *et al* 2001), the loss experienced whilst living in the nursing home (Gladstone 1995; Moyle *et al* 2002; Pilkington 2005), and the end of the nursing home experience (dying) (Engel *et al* 1998; Moss *et al* 2005). However, there were no studies describing the experience and relationship between these different phases. Nor were there any studies that looked at the temporal divides for staff and residents.

Constraint of context

In the five studies labelled as ethnographies, the contextual unit of analysis was different for each study. This ranged from multiple sites (including a continuing care ward) (Costello 2001; Moss *et al* 2005), through to the study of a single nursing home resident (Kelly 1991). The constraint of context is likely to influence the data collection methods used and, in turn, the types of loss that can be explored. Costello (2001) used a combination of participant observation and interviews with patients, nurses and physicians and specifically focused on caring for dying patients. Starck (1992) did not use participant observation. Instead she made a series of visits to interview staff and residents of one

nursing home. Her study analysed participants' accounts of residents' suffering. Kelly's (1991) open-ended interviews with a single participant allowed her subject to express deep anxiety and yearning for the loss of her dead husband and also anger and sadness at losing her home and community. Kelly's study articulates the most complete version of loss in a nursing home from a resident's perspective, however it is one individual's account and there is no explanation of how the respondent's experiences were dealt with by the nursing home staff. The staff's experience of loss is thus ignored.

By contrast, Costello (2001) focuses on work practices and behaviours between nurses, physicians, patients and patients' families. However, despite the study's focus on caring for the dying, it ignores the emotional aspects of loss. By not exploring the emotional component of loss, potential misunderstandings can arise. For instance, Costello's (2001) work suggests that nurses tend to focus on the physical care rather than emotional care due to a lack of skills and their own emotional anxiety about death. It could be argued that physical care (e.g. bathing a patient, combing hair or dressing the resident) can be performed in a way that simultaneously expresses emotional care. However, Costello's broad contextual focus mitigates against any interpretation of feelings contained in actions observed.

The methodological approach and data collection methods thus constrain what can be stated about the nature of loss and as a result aspects of it remain hidden. For instance, Starck's (1992) ethnographic findings relate to an inventory of loss and suffering identified by nursing home staff. She constructs a typology of resident behaviour and staff response. The findings are conceptualised from

the staff's perspective and despite it being primarily a social study the categories seem to relate to a world that includes emotions. The focus on staff's behaviour as social action tends to omit their feelings and their impact on the provision of care. In contrast, Pilkington (2005) phenomenological study relates to a heuristic interpretation of residents' loss. These findings are conceptualised from the residents' perspective and are exclusively in an affective domain with no reference to the social aspects of living in a care home.

Starck (1992) uses the language of her respondents without making judgements about them. She suggests the care staff classify residents by their behaviour as: attention seekers (including overt complainers and covert complainers) and sufferers (including quiet sufferers). The nursing home staff's response is articulated as the "caretaker response" and includes three behavioural categories (placates, cajoles and ignores). Her central finding is that work around suffering is not acknowledged in the home, but she has classified the care staff's behaviour without trying to find about the emotions related to it. Pilkington (2005) expresses the views of the residents but synthesises it via a phenomenological process. Her main finding is that for the elders she interviewed in the residential care:

"Grieving a loss is aching solitude amid enduring cherished affiliations, as serene acquiescence arises with sorrowful curtailment."

Pilkington (2005, p241)

By focussing on feeling and using emotional language Pilkington (2005) produces a much more sympathetic view of the respondents. It is noticeable

that Pilkington's (2005) respondents make no reference to anger or resentment which is inconsistent with bereavement theories (Parkes 1998). Some investigation into the participants' social world, for example their family relationships may have revealed other aspects of their emotional world. Similarly, an investigation into the emotion underpinning Starck's (1992) respondents' use of social categories may have revealed a more complex version of their perspective.

It is interesting to note that Starck does not refer to death or dying as a loss or an aspect of suffering. She makes no comment about the absence of dying in her data and it is therefore difficult to gauge whether death really was not a feature of loss and suffering or whether Starck's (1992) work reflects the hidden nature of death and dying in nursing homes. In contrast, Pilkington's sensitive interviews with older people reported their feelings about the loss of loved ones and their own impending deaths. By focussing on different groups and either the social or emotional perspectives the body of knowledge fails to acknowledge the multiplicity and complexity of loss.

FINDINGS FROM THE SURVEY TYPE RESEARCH

The same issue can be seen in relation to survey type research. Fourteen of the papers reviewed were quantitative surveys ranging from a bereavement study using established grief tools and statistical tests (Leshner and Bergey 1988; Pruchno *et al* 1995; Rudd *et al* 1999) to a basic descriptive analysis of questionnaires (Murphy *et al* 1998). The survey type studies either measured bereavement or grief in relation to a resident in a nursing home (Leshner and

Bergey 1988; Pruchno *et al* 1995) or measured the effect of having a family member in a nursing home on the bereavement experience (Herth 1990; Moss *et al* 1993; Rudd *et al* 1999; Carr *et al* 2001). Hanson *et al* (1997), Murphy (1998) and Tolle *et al* (2000) analysed the quality of bereavement services in nursing homes, whereas Robbins *et al* (1992), DePaola *et al* (1994), Sumaya-Smith (1995), Lopez McCurdy (1999) and Rickerson *et al* (2005) measured the effect of working in a nursing home on staff. Findings suggest that losses are hidden in relation to qualitative method, but in the review of quantitative research there was less diversity, a bias towards death, acknowledgement of complexity, a need to focus on wider perspectives and an apparent focus on emotional response.

Less diversity

Within the review of qualitative studies it was possible to see how method within a particular paradigm fragmented what was studied and affected what was discovered about loss in continuing care institutions. However in the review of quantitative studies there was less diversity in approaches and findings. For instance, seven of the fourteen surveys used the psychological theory of bereavement as their conceptual framework (Bowlby 1998). It is interesting that none of these studies have used a more current psychological model such as Klass and Walter (2001). The most recent bereavement models place higher importance on the social context of grief and prefer to articulate living with a loss rather being solely focused on letting go of the lost person or object. This may have more to offer the specific context of continuing care.

Bias towards death

In the quantitative studies other biases were apparent. For instance unlike in the qualitative studies, death was the primary loss described, along with attachment (Sumaya-Smith 1995) and anticipatory loss (Carr *et al* 2001). However, the complexity of loss related to health, home and separation from family was largely absent. Nonetheless, there was some acknowledgement of the unique nature of the bereavement experience in the context of continuing care.

Acknowledgement of complexity

Rudd *et al* (1999) tested the respondents' experience of daughters' grief due to separation by their mother going to live in a nursing home, with the covariates of severity of dementia, spirituality and age. They showed that place of care and gender were the most powerful predictors of all the components of grief. Carr *et al* (2001) explored the impact of death forewarning (living with the expectation of death) on grief resolution. They found the established bereavement measures to be limited and tested for more components of bereavement (intrusive thoughts, anxiety, shock, anger, guilt and yearning). They found when a person had stayed in a nursing home it had an impact on some of the surviving relatives' grief resolution. They also found that death forewarning increases the anxiety levels of the bereaved spouses. They state that the harmful effects cannot be explained by couple communication styles, spouse's age at death or whether the spouse lived in a nursing home. They suggest further research should focus on why death forewarning has an effect.

Possible explanations for why daughters' bereavement were effected by their parent living in a care home but spouses were not, could relate to the difference

between spouse's and daughter's perceptions. It could also be that a more detailed analysis of living in a nursing home is required to explore what factors, including death forewarning, have an impact upon the experience after death.

Need for wider perspectives

The unit of analysis in the survey type studies tended to be individual research subjects. There were few studies where a continuing care institution was the unit of analysis (Leshner and Bergey 1988; Rudd *et al* 1999). Typically continuing care was a variable that was tested in its impact on bereavement of a person whose relative had died. Leshner and Bergey's (1988) paper was the only paper in this group to explore the residents' perspectives. The focus of the study was the residents' bereavement following the death of an adult child.

Four studies targeted the experience of the staff – predominantly nursing staff. For instance DePaola *et al* (1992) analysed the impact of death anxiety on staff in continuing care institutions and Robbins *et al* (1992) studied nursing home managers' perception of care assistants and the care assistants' perception of their own death anxiety related to the practical care of a dead person. The context was a residential care home and they found that the staff were encouraged to deal with painful feelings with stoicism and denial. They found young workers were particularly vulnerable to death anxiety, but levels of anxiety were similar in all ethnic groups.

Ethnicity was also acknowledged in Lopez McCurdy's (1999) study. This study was primarily about nurses' coping with residents' difficult behaviours and one of the categories included racist slurs. The issue of race and ethnicity of the

staff is rarely mentioned in any of the other types of studies. In fact there are few details of the staff as individuals, in terms of their personal background, career profiles or perspectives on their work with residents.

Focus on emotional response

Despite the relatively narrow focus of survey-type research (e.g. on death and bereavement) and unlike the findings generated from the qualitative field methods, there was a definite focus on the emotional response (e.g. coping styles of widows (Herth 1990)). Indeed, DePaola *et al* (1992) compare attitudes to death of nursing home staff with workers in non death related jobs. Contrary to expectation they found that non-death related workers had higher levels of death anxiety than nursing home staff. They suggest that it could be that nursing home work desensitises staff to death or that staff with low death anxiety levels actively select to work in nursing homes. Rickerson *et al* (2005) suggest care staff experienced a range of grief symptoms when a resident died. They found the longer and closer the relationship between staff member and the older person being care for, the more grief symptoms the staff member experienced when the older person died. Unlike DePaola *et al* (1992) they did not find evidence that care staff became desensitised to death.

The social circumstances that may have led to staff being desensitised to death or not were not explored so it is hard to evaluate whether this links to the criticism that nursing staff lack the skills to talk about death with residents and their families. It is worth noting that the qualitative work found relatives also tended to avoid talking about death with residents (Moss *et al* 2005), but residents seemed to be able to discuss openly with researchers their own fears

and desires about dying (Laufer 2000; Pilkington 2005). In addition, the temporal factor is important. In the qualitative work the focus was on admission, living in a nursing home and dying in a nursing home. However, quantitative studies of bereavement expand the period of loss to after the residents' deaths. This was missing from the qualitative work. The importance of this is evident in Pruchno *et al*'s (1995) work, which identified that the bereaved person's perceptions of nursing home care affected their grief resolution.

However it should be noted that, whilst the quantitative studies focused on emotional responses, they often omitted the personal and organisational factors that impact on staff's relationships with residents and their families.

INTERVENTION STUDIES

The remaining sixteen papers in the review reported on evaluations of interventions aimed at improving the therapeutic environments with specific reference to loss. There was a tendency for these papers to either use multi-methods (Baer and Hanson 2000) or to discuss a qualitative analysis of one or more (up to a maximum of four) case studies of the practice initiative being evaluated (Cadby 1996; Froggatt 2001; Davidson *et al* 2003). Five of the initiatives were psychotherapy based (Beck 1983; Kaplan and Gallagher-Thompson 1995; Cadby 1996; Laufer 2000; Porter 2000). Three were related to staff education or practice development programmes about loss (Drysdale *et al* 1993; Holman and Jackson 2001; Ashburner *et al* 2004) and two were education and practice development initiatives, aimed at introducing palliative

care principles to nursing homes (Baer and Hanson 2000; Froggatt 2001). The remaining four papers did not set out to have loss as a major theme in their work, but nonetheless issues of loss were raised as a consequence of their initiatives. In some cases loss was a theme, for example, Chichin *et al*'s (1994) programme to help Jewish Elders plan their own funeral and Wadensten and Carlsson's (2003) formation of guidelines to help staff facilitate personal development in old age. The merger of a nursing home and a residential care home on the other hand stirred up a surprising grief response in staff, for example staff missed their particular identities and uniforms (James and Dewhurst 1995).

Diversity of approach

There seemed to be less uniformity of approach in the intervention studies in terms of methodological stance. Often there were exceptions to methodological trends and mixing of theories and techniques. This may be because research that tries to influence practice has to be less conventional in its approach, in order to account for the messiness of the context.

All the psychodynamic interventions except one were focused on individual residents' perspective and related very little to the organisation. Only Ashburner *et al* (2004) used a psychodynamic approach to develop the customs and practices in care delivery. The remaining psychodynamic studies concentrated on the psychological growth of individuals. Porter's (2000) account of drama therapy related to losses experienced by two male residents. These losses included bereavement, loss of sexuality and youth. The paper details the therapeutic approach and suggests that participants achieved some

resolution. In contrast much of the work that had the organisation as a central aspect included analysis of relationship issues and personal perspectives (James and Dewhurst 1995; Froggatt 2001). The psychodynamic interventions were emotion orientated as one might expect (Beck 1983; Cadby 1996; Porter 2000), but so were the education and managerial programmes. For example Drysdale *et al's* (1993) education programme, aimed at residents' family members, allowed time for expression of feelings within the teaching programme. Similarly James and Dewhurst's (1995) managerial intervention, joining two continuing care units, prioritised the emotional impact upon the staff. Whilst Costello's (2001) ethnography, Froggatt's (2001) analysis remained focused on the social dynamic with little reference to emotion, Ashburner *et al's* (2004) action research keeps emotions in the foreground. With a focus on one aspect of loss, loss of personhood, Ashburner *et al* (2004) had success in promoting more person-centred care practices such as taking residents' life histories, by acknowledging the emotional needs of the care staff as well as the residents.

There was some evidence of temporal dimensions in the intervention studies. However, no intervention work focused on admission except reference to new residents in Drysdale *et al's* (1993) education programme for relatives. Two papers were about end of life care (Baer and Hanson 2000; Froggatt 2001) and two had living with loss as the central theme (Holman and Jackson 2001; Ashburner *et al* 2004). It does seem that acknowledging dying in a nursing home is difficult but recognised as important in the literature (Froggatt 2001), but caring for people's emotional loss during admission, death and after death seems not to be addressed at all. Perhaps these phases are only evident from an

outsider's perspective. Froggatt (2001) highlights the lack of definition of death in nursing homes.

This review of the literature suggests that both admissions and exits (death) in continuing care institutions are largely ignored. This may be due to a lack of focus on organisational issues, which might capture, for example, that shift work often means that individual staff members might miss the death of resident and the admission of a new resident on the staff's days off.

The intervention work is suggestive of heterogeneity in the resident population: some residents benefiting from dramatherapy (Porter 2000), others having profound needs or needing palliative care (Froggatt 2001; Ashburner *et al* 2004). This detail and apparent diversity is not available in the other methodologies or in other studies about groups of respondents, for example, staff and relatives.

CONCLUSIONS FROM THE LITERATURE REVIEW

Although continuing care for older people is well established, the increase in the ageing population means the speciality is growing. However, the inability of research to capture the multiplicity and complexity of loss in continuing care settings means that loss remains hidden, with practitioners unable to capture its meaning and devise appropriate interventions. In all three sections of the literature when the unit of analysis was the individual resident, resident's family member or member of staff there was more likely to be an emotional component to the research. However, this meant that work with emotions

tended to be accounted for from only one perspective. When work accounted for the interaction between all groups it tended to report exclusively on the social dynamic and omit the emotional component of loss. Similarly, work that studied the nursing home organisation tended to make an analysis of social processes and omit the emotional world. There were methodological trends in this.

Not only does this review suggest that there are divisions between groups of people and their social and emotional worlds in continuing care institutions, it also proposes that there is temporal fragmentation. Groups of studies include research about preadmission to nursing home, actual admission, living with loss in a continuing care unit, the living / dying experience, as well as dying and grieving the dead. However, none of the studies acknowledge the whole of this time frame. In particular this means that the losses incurred through admission to continuing care, living in continuing care and dying in continuing care units are analysed separately and the complexity of their relationship has yet to be fully explored.

Respondents and researchers cope with the painful, messy and overwhelming nature of loss in this context in similar ways. They adopt specific perspectives and focus on one issue in isolation. This is practically useful as it enables coping with the problems of life and also the research process in a manageable way. The consequence of this is a fragmentation of the experience. In this body of work these fragments are operationalised in the following ways:

- separating the individual from the organisation

- separating temporal phases: admission, living in a nursing home, dying and after death
- separating the social and emotional world
- separating each group of participants' perspective
- separating death as the principle loss from the complex and multiple losses experienced through living in a nursing home.

Researchers in the literature review drew boundaries to their studies in order to produce valid findings. This is academically sound and a practical necessity, but the consequence of this has been that the overall body of knowledge is fragmented and there has been a tendency for some dimensions of loss to remain hidden.

A missing component from the stock of literature is an in-depth understanding from the perspective of staff. I have suggested that when qualitative studies focus on staff it tends to relate to a social dynamic and frequently is critical of care staff's performance and does not demonstrate any real empathy for their perspective (Starck 1992; Costello 2001). The quantitative studies identified the care staff's feelings but without any real understanding of the particular social context. This made it difficult to evaluate the relevance of findings to a practical situation (DePaola 1994; Rickerson *et al* 2005). Ashburner *et al* (2004) had success in implementing a more person-centred approach to care by adopting a psychodynamic approach. They focused on the emotional world of residents and staff in a social context. They suggested future studies need to pay closer attention to the psychodynamic processes in order to account for the role of strong angry feelings in mediating relationships within the home.

Following the findings of the literature review, it is appropriate to focus on the care staff's perspective and to prioritise the role of emotions in the social context. The examination of the boundaries between the fragmented concepts and phases that exist in the literature is also important to this study. The primary drive is to achieve a more complete understanding in order to acknowledge the reality of the care staff's work with a view to making more helpful interventions and recommendations.

STUDY AIMS AND OBJECTIVES

The literature review has led to a heightened awareness of the need to adopt different methodological approaches in this context so that the complex relationships between time, people and the culture of organisations can be uncovered. The study design avoids oversimplification by using methods that cross the boundaries of sociology and psychology. It aims to explore all aspects of loss from the time a person is admitted to continuing care, through to the bereavement following their death so that the multiplicity of grief is acknowledged. The study is designed to explore the relationship between emotions and social practices involved in care, with a view to making a positive contribution to the development of the speciality and the particular study setting. The research therefore includes psychoanalytic participant observation in order to capture the complexity of loss in continuing care environments.

The aim of this research was: to identify the emotional demand of living bereavement and to explore and develop care staff's capacity to work with it. The objectives were:

- To explore care staff's perspectives and emotional responses related to loss in the continuing care ward.
- To support and develop the participants' (including my own) capacity for working with the emotions attached to loss
- To uncover how the emotional responses impact on the overall social organisation of care.
- To recommend ways that the overall social organisation of care could improve the capacity of its staff to work with the emotions linked to loss in continuing care.

SUMMARY

I have described the systematic process of searching the literature related to loss in continuing care. In this chapter I have argued that the literature tends to be fragmented because there are patterns in the methodological decisions made by researchers. I have suggested that there is an absence of literature that examines the care staff's perspective. This is the justification for the study's emphasis on them. The study aims have been developed to address some of the splits in the body of knowledge in order to acknowledge the complexity of loss and grief in the continuing care setting.

CHAPTER 5 - METHODOLOGY AND METHODS:

PSYCHOANALYTIC PARTICIPANT OBSERVATION

This chapter reflects my personal journey in developing a research model that is suited to exploring complex situations and concepts where participants are likely to be psychologically defensive. It provides *containment* for anxiety which enables a deeper exploration of feelings and can provoke development in the capacity to work with emotions. My personal learning has been influenced by my background in social research, psychoanalytically informed approaches to education and personal development and my past clinical experience as a ward manager in an NHS continuing care unit.

Researchers have studied how care staff work with emotions in the care for older people. Psychoanalysts have acted as organisational consultants (Miller 1993; Roberts 1994b) and other researchers have analysed how care staff manage their emotional work by using sociological methods (Starck 1992; Lee Treweek 1996). This study is unique because it combines these approaches. One distinct feature of the methods was that the researcher's own development in psychoanalytic understanding and technique was important to the study. The use of myself as a research instrument not only included paying attention to my own thoughts and feelings as part of a therapeutic approach to group work but also as primary data through participation in care practices that provoked the emotional responses being examined.

The literature review uncovered a tendency for research to focus on either the cultural aspect of the organisation or the emotional response of individuals

(Chapter Four and Holman *et al* 2004). This splitting in the body of knowledge missed the opportunity to examine the complexity of the link between the personal and the wider social context which seemed so fundamental to the issues the staff were grappling with (Williams and Bendelow 1996). Ashburner *et al* (2004) described how getting closer to residents stimulated unwelcome feelings in the participants of their study. They suggested that there was a tendency for some feelings to be displaced rather than acknowledged. It was considered important in this study to develop a method which tried to capture emotional experiences that were usually kept hidden by such tendencies.

This chapter concerns the development of *psychoanalytic participant observation* aimed deliberately at exploring the juncture between the psychological and social domains that staff have to negotiate in order to provide care related to loss and grief. My role as a psychoanalytic participant observer included actual involvement in care and I recorded field notes about my own social and emotional experience. Many data were generated in a discussion group that took place on the ward and focussed on the care staff's perspective on their work. This group is referred to as the Reflective Work Group. The methods draw heavily on the Tavistock approach to learning about emotions (Rustin 2003) combined with participant observation methods rooted in the ethnographic tradition and informed by psychoanalytic understandings (Fielding 2001; Hunt 1989). The chapter argues that psychoanalytic participant observation can inform research and development, particularly in organisations where staff are expected to cope with high levels of anxiety and stress. I suggest that strategies were deliberately built into the research that contained anxiety and examined psychological defences whilst at the same time

promoting emotional learning (Rustin 2003). The study maintained a critical edge by identifying the limitations imposed on the work by the structural hierarchy, power dynamics and psychological defences that affect the organisation (Hochschild 2003; Menzies Lyth 1988). The next section discusses the methods used in the psychoanalytic participant observation.

PSYCHOANALYTIC PARTICIPANT OBSERVATION

The research methods are founded on a psychoanalytic understanding that given the right conditions it is possible to explore aspects of emotional life that lie below the surface of experience (Milton *et al* 2004). In individual psychoanalytic psychotherapy this involves a particular kind of relationship between the therapist and the client. The therapist is responsible for maintaining distinct boundaries in the therapy sessions and the structure of the therapy is designed to maximize a feeling of being psychologically held (Milton *et al* 2004). The therapist tries to learn about the client by not only paying attention to what the client says but also the emotional atmosphere of the session. The therapist pays attention to his or her own feelings and understands them in the context of the client's state of mind. In psychoanalysis a particular quality of feelings provoked in the therapist is assumed to be a response to the client's unconscious inner world and is called a *counter-transference* (Craib 2001). Paying attention to *counter-transference* feelings is an essential tool in trying to formulate hypotheses about what is going on for the client. Any interventions made by the therapist are aimed at drawing the client's attention to an aspect of the psychodynamics of this situation either related to the here and now or connected with the past.

The timing and mode of such interventions are crucial to maximise growth (Milton *et al* 2004). Menzies Lyth (1969/1988) describes a similar process when exploring the setting in action research or organisational consultancy. She used free association groups and discussion with key individuals to get to know the organisation. She also paid attention to the emotional experience and described the importance of the timing of feedback to enhance a therapeutic effect. She suggests it is especially important to resist action that can be counter therapeutic, for example, being drawn into action rather than examining the emotional experience.

In this study I not only explored the emotional atmosphere via the containing processes of work groups but I also got involved in the practicalities of the care giving procedures in the participant observation. This is unusual in psychoanalytic approaches. Hinshelwood and Skogstad's (2000) participant observation methods advocate an emotional participation rather than a practical one. This enables the researcher to avoid being drawn into defensive actions and fully concentrate on their internal experience. In contrast, Hunt (1989) describes how she used her own emotional response in her "psychoanalytic anthropology" about policing in an American city. She included the recording of her own feelings as data and described how they informed the psychoanalytic interpretations she made. She used her own relationship to the field and the feelings and responses she had to it as primary data.

In this study I have engaged in practical participation and used psychoanalytic supervision strategies to examine when I have been drawn into defensive

thinking. The data set includes my observations of cultural practices, my own thoughts and feelings about my participation and the comments made in psychoanalytic supervision. For example, on one occasion I recorded helping a resident wash and dress in the morning. She became very distressed and angry and I seemed unable to contain her feelings. I recounted in a psychoanalytic supervision session how I felt useless and tried to think what I could have done differently. It was pointed out to me in the psychoanalytic supervision that I may have been receiving the resident's feelings of inadequacy related to her high levels of dependence. In this way the practical participation provided data about emotions that were provoked by the relationship between the residents and their carers.

In the first eighteen months of the data collection period I engaged in the practical participant observation and co-facilitated the Reflective Work Group with the psychologist. This group met fortnightly for one hour and participants discussed issues related to the residents. The purpose of the group was to give participants the opportunity to express how they felt about their work and to try and understand some of the emotional complexities of it. In the second half of the data collection period my role changed and I carried out very few participant observations and acted primarily as the Reflective Work Group facilitator. The experience in the Reflective Work Group was different at the end of the data collection period from when the research started. By the end of the data collection period a predominantly emotional participant observation, rather than a practical one, produced the data. In this study the change in my role is taken as a feature of the developmental aspect of the work. As my understanding of psychoanalytic technique and theory developed so did those

aspects of the methodology. The strength of this approach is that it has allowed me as a nurse researcher to use my own primary experience of the field as data. This has enabled me to make a comparison of my perceptions of my emotional and cultural experience of providing care for dependent older people with the care staff's. This contributed to the formulations I made in the Reflective Work Groups and the overall thesis (Chapters Seven, Eight and Nine). The comparison between the psychoanalytically informed explorations of culture and the data generated in the containing atmosphere of the Reflective Work Groups is a unique feature of the methodology.

In the next section I describe the methods used and argue that the supervision and learning provided by a team of psychoanalysts at the Tavistock Centre is central to the quality of the research. Links with the Psychodynamic Approaches to Old Age course at the Tavistock allowed me to develop a robust approach to the psychoanalytic treatment of the methods used to generate, collect and analyse data.

METHODS OF DATA GENERATION

I have incorporated the Tavistock methods of learning about emotions described by Rustin (2003) into the research methodology. There are six specific methods that make up the Tavistock approach: infant and young child observation, work discussion, personal analysis, clinical supervision, group relations events and linking theoretical and practical explanations (Rustin 2003). I describe how the methods used in this research are congruent with the principles underpinning the Tavistock methodology. This approach has enabled

me to clarify the emotional requirements necessary for working with very dependent older people and to propose a model that promotes learning about emotions.

Rustin (2003) suggests this is an appropriate focus for research exploring emotions in the work place. He describes how the Tavistock approach to learning about emotions enables professional workers to understand and contain their own and their clients' anxiety in the work situation. In the context of this research I learnt to understand and contain my anxious feelings. Here my clients were the participants in the study, particularly the care staff who attended the Reflective Work Groups. Rustin (2003) argues that the Tavistock methods are reliant on the learner having an actual experience of situations, events and people involved and there is a focus on the ordinary rather than exceptional as learning opportunities. This is consistent with the participant observation and Reflective Work Group in the research.

Participant Observation

Fielding (2001) suggests ethnographic methods such as participant observation can provide insights into the symbolic clues to the embedded culture that may remain undisclosed in a group discussion or spatially tucked away, out of sight of the observer. Hunt (1989) suggests that being involved in the fieldwork can produce conflicting feelings in a researcher which provide clues to unconscious elements of experience. When in the field, I was not only mindful of external symbols in customs and practices but also used my own feelings as symbolic clues to the emotional experiences that might lie beneath the surface experience.

Although I have worked as a nurse in a similar situation, the newness of this particular context and a relatively long time away from practice meant that I was able to adopt the position of an interested learner. This was congruent with the discovery nature of qualitative research and assumed humility on the part of the researcher (Murphy *et al* 1998). Fielding (2001) suggests the way the researcher learns the culture is to get involved in the natural setting in order to understand the participants' symbolic world. He suggests researchers need to learn about customs and practices that have symbolic meanings. These meanings are articulated through patterns of behaviour that are distinctive to them. I got involved in the natural setting by participating in the ordinary activities of the ward. My lack of recent experience in clinical practice also meant the intense contact with the residents and the customs and practices of care often had a big emotional impact on me. Hunt (1989) emphasises the importance of culture shock moments. These can stir up feelings connected to anxieties rooted in the researcher's past. It was important to the study to examine my subjective experience and seek useful explanations. My role as a research instrument will be discussed later in this chapter.

Over the three-year data collection period one hundred and forty-seven hours of fieldwork were recorded. Of those hours, ninety-eight included participation that involved contact with staff, residents and residents' families and forty-nine were Reflective Work Groups with care staff (see Table Two).

Hours of data collected by participant observation & Reflective Work Groups				
	Year 1	Year 2	Year 3	Total
Participant observation involving contact with staff, residents and their families	39	55	4	98
Reflective Work Groups	11	22	16	49
Total	50	77	20	<u>147</u>

Table 2: Modes of data collection recorded in hours

The periods of participant observation lasted between one and six hours. They occurred at different times of the day and were aimed at collecting data around significant events and activities that were assumed to contain aspects of loss and grief. These consisted of delivery of personal care in the morning and over lunchtime, the two hours after lunch when special events, staff meetings and social activities took place and the late evening, when relatives and friends visited and residents had their evening meal and went to bed.

The selection of the sample of people in the fieldwork was time and context specific. Residents were allocated to me for provision of care by the staff nurse in charge of a shift. There seemed to be a tendency for the staff nurses to avoid allocating residents they felt were too challenging for me or who did not like to be cared for by strangers. On other occasions when there were extra demands made on the nursing staff, I was called upon as a Registered Nurse to carry out specific activities, such as performing dressings. Other times when there was staff sickness I was asked to work as a full member of the nursing team and not as an extra. These occasions were rare, but they did offer an opportunity to experience being with a variety of residents and gave me first hand knowledge

of the organisational pressures on the nursing staff. The time spent with residents' relatives and friends depended on their visiting patterns. Conversation with regular visitors enabled the collection of data generated through a relationship formed over time. On other occasions a chance one-off conversation could be very revealing. Topics occurred naturally and usually related to issues that were current for the visitor and the resident or member of staff.

In the participant observation accounts were collected, observations made and experiences noted that related to every-day activities and social patterns. Spradley's (1980) checklist was used to guide recording a range of features that might be noted: space, actors, objects, activity, acts, events, time and goals. This was used as a way to prompt the researcher to look beyond initial impressions and not to become reliant on routine observations (Hammersley and Atkinson 1995). It would have been impossible to record purely descriptive data. Some level of analysis had to take place during data collection and during the recording process in order to select an appropriate focus. The checklist offered a systematic approach to collecting, analysing and generating data in a fluid and context driven way. Recordings were either made whilst in the field or soon afterwards (Fielding 2001). As the research was carried out in the context of my working day, it was not always possible to type up full notes until the end of the day. On these occasions key points were hand written whilst still in the field or spoken into a tape recorder shortly after leaving it. In the data that records conversations in the field, I made records after the event. I noted down the words of the participants as I recalled them or paraphrased the conversations. This means field notes record my recollections of participants'

words rather than a verbatim account. Data are only presented verbatim when they were tape recorded. Field notes were entered onto a computerised form. My thoughts and feelings were added in the margins during the writing up process and during or after the Tavistock Supervision Groups which will be discussed later.

The Reflective Work Groups

The Reflective Work Groups provided an emotional space where care staff's needs could be prioritised and it was a private time when they could speak about the intimacies of their work in an honest way. This served three purposes. Firstly it meant their feelings could be contained, by this I mean they could be heard, understood and given back to them in a verbal and manageable form (Craib 2001). Secondly the groups allowed participants to try out new ways of thinking and working with the emotions involved in their work in a safe environment. Finally it provided a different quality of data from those achieved in the social context of the participant observation (Chapters Eight and Nine).

The quality of the data was dependent on how safe the care staff felt to experience and describe their feelings. According to Barnes *et al* (1999) the psychodynamic administration can *hold* a group like a mother holds a baby. When I was the group facilitator, I was responsible for providing a regular space and time for the group to take place and the negotiation of appropriate boundaries related to attendance, privacy and trust. Barnes *et al* (1999) suggest these are the sorts of strategies that function as a holding framework for work in groups. The nature of shift work and *resistance* to this type of work meant the holding structures were frequently challenged. For example, the room

where the group was held was changed four times. During planning meetings and in the Reflective Work Groups the care staff expressed a need and desire for the groups so when, on individual occasions, staff said it was not possible for the group to go ahead because there were too many competing priorities, it was taken as a sign of ambivalence.

I found that by systematically following the same routine of setting up the room five minutes before the start of the group and taking a flexible approach to care staff's worry about time-keeping, the framework could be held.

Data were recorded from forty-nine Reflective Work Groups over the three-year period. They took place on alternate Wednesday afternoons and lasted one hour. They occurred in an allotted room which was kept as consistent as possible despite the complication of structural changes. For the first eighteen months they were co-facilitated by a psychologist and myself. During this time, my role was usually an observer and I only facilitated in the absence of the psychologist. When the psychologist left, I became the facilitator for the group. The group membership was not fixed and all care staff on duty were invited to attend. Although equal numbers of staff nurses and nursing auxiliaries participated, six individual nursing auxiliaries attended more frequently (see Table Three). In effect there was a core group of nursing auxiliaries and a smaller group of staff nurses who attended as regularly as their shift pattern would allow.

Numbers of Reflective Work Groups attended, by staff group and frequency				
Staff group	Frequency of attendance in Reflective Work Group			
	1-10 Times	11-20 times	21-30 times	Total in each staff group
Nursing auxiliaries	1	5	6	12
Staff nurses	11	1	0	12
Student nurses	9	0	0	9
Occupational therapy assistant	0	0	1	1
Psychologist	0	1	0	1
	29	7	7	35

Table 3: The nursing auxiliaries, staff nurses, student nurses, occupational therapy assistant, and psychologist's frequency of attendance in the Reflective Work Group

After the psychologist left, the majority of data were generated through the Reflective Work Group and in the final year of data collection I did not carry out participant observation except for attending four staff meetings. The Reflective Work Groups were recorded using field notes or a tape recorder. This involved writing as much detail down about the order and content of the work as soon after the group took place as possible. Six of the Reflective Work Groups were tape recorded, but this practice was terminated when in one group session the staff asked me to turn the tape off so they could discuss a particular issue. Following discussion in that session and liaison with the Charge Nurse and psychologist, it was decided that using the tape recorder compromised the group as part of the practice development so its use was terminated. This meant I recorded notes from the Reflective Work Group after the event. I sometimes paraphrased discussion and sometimes recorded the participants' words as I remembered them. The recording of these notes was inevitably subjective, but it was impossible to produce data in another way. The repetitive nature of the Reflective Group Work meant my understandings of the participants'

perspectives could be checked out and will be discussed later in relation to the data analysis.

The process of recording data, including thoughts and feelings stimulated by discussion in the Tavistock Supervision Group was similar to that in the participant observation. Analytic notes were added to the margin either during or following the Tavistock Supervision Group. An example of this is in Appendix Two. The Reflective Work Group has continued beyond the parameters of the research. There was therefore no need to include information about termination of the group.

The Tavistock Supervision Group

Throughout the thesis I refer to the Tavistock Supervision Group, this term encompasses a range of activities that supported my learning about emotions and the containing function of the research methods. There were strategies within the research that provided the components of the Tavistock approach to learning, for example, I had personal psychotherapy from 2002 from an independent psychoanalytic psychotherapist and attended and presented the research at conferences relevant to nursing and emotion work (Appendix Three). Personal therapy helped me identify and explore my own inner world separately from the research. This helped me to become sensitised to the personal significance of particular issues and to experience the emotional learning process I was aiming to provide for the participants in the study (Rustin 2003). Through links with the team of psychoanalysts who ran the Psychodynamic Approaches to Old Age course at the Tavistock, I was able to take part in a learning programme that incorporated the components outlined by

Rustin (2003) as applied to the specific context of old age: old age observation, work-based discussion, clinical supervision, linking theory and practice. For convenience these are referred to collectively as the Tavistock Supervision Group but I will address each individually now.

Old age observation

The old age observation was developed from the baby observation that is part of psychotherapy training. Baby observation provides the learner with an intense emotional experience (Rustin 2003). The principles of the observation exercise are based on specific psychoanalytic theory (Chapter Three) and the learning comes from the observer's experience of the baby's *projections* as well as her own feelings and the observation of others. These are the subject of discussion in seminars that are an integral part of the programme. Rustin (2003) suggests that the main aims of the baby observation are to "experience, remember, record and discriminate feelings." The student learns to recognise his or her own feelings as distinct from those of the people being observed. The observer does not watch the baby in isolation, but in relation to the people providing care, usually the mother. In particular the observer learns about the baby's emotional development through the process of containment (Chapter Three). In other words how the baby's parental figures take in his or her feelings and, as Rustin (2003) describes, "modulates their intensity" to make them more tolerable.

This sort of observation has been carried out in relation to older individuals and their families and carers (McKenzie-Smith 1992; Waddell 2000). Davenhill (2006) describes how observers can learn about the emotional experience of

older people and the nature of containing relationships between carers and dependent elders. In this situation, the observer's role is similar to the one described by Hinshelwood and Skogstad (2000) in their method for observing organisations. They suggest the observer needs to be systematic, observing at the same time for one hour once a week for three months. They describe how the observer needs to sit where they have a good view of proceedings and adopt a polite and friendly reserve. Through this experience the observer tries to tune in to objective events and the emotional atmosphere and pays attention to her inner experiences. Like baby observations, the method includes supporting seminars which link theory to the experience, provide support and a place to discuss and digest the observation material. The production of a final report completes the process.

I observed the sitting room of an Assessment Centre for Older People for three months and attended supporting seminars throughout the academic year (2000-2001). The Assessment Centre for Older People was not connected to the research setting and the exercise was used as training rather than data collection. The seminars were supervised by a psychoanalyst and the other members of the seminar group were from clinical disciplines related to the health care of older people.

Work based discussion

Rustin's (2003) suggests that work based discussion involves the learner adopting a more practical participation than an observer who resists becoming physically engaged with activity. He likens the process to participant observation in an anthropological tradition where the person has a practical and

emotional contact with participants. Even though there is a more practical involvement in the field, he emphasises the importance of a concern for the unconscious anxieties and their impact on the organisation. I have used the work-based discussion, writing of process reports and presentation to sustain an emphasis on the unconscious anxieties in all aspects of data collection, generation and analysis.

From 2002-2004 I attended modules from the Psychodynamic Approaches to Old Age course at the Tavistock Centre. For two years I was part of a work based discussion group facilitated by a psychoanalyst and attended by a care home manager, a mental health nurse, two psychiatrists, two psychologists, two psychotherapists and me. The work based discussion group ran alongside theory seminars. Students were given appropriate papers to read, discuss and link with the actual experiences discussed in the work-based discussion. The papers addressed psychoanalytic principles and covered classic as well as current work applied to the study of organisations, old age and the care for older people.

In accordance with the Tavistock approach we took turns to present and discuss aspects of our everyday work (Rustin 2003). I presented issues from the research and the group acted as a container for my anxieties. The Tavistock Supervision Group offered a space for me to digest the emotional experience, talk about it and have it heard and understood by the other members of the group. It was then possible to discuss their understandings so that I might try out new ways of thinking about working with emotions. Notes made during

presentations in the work based discussion groups were added to the computerised data collection forms (Appendices Two and Four).

The Reflective Work Groups and the Tavistock Supervision Groups were links in a containing chain that reached from the care staff's experience of working with the residents and families on Willow Ward to the containing structures within the Psychodynamic Approaches to Old Age Course at the Tavistock. This was fundamental to my capacity to contain the care staff's anxieties about their work with dependent older people and their families. I was required to examine my inner experience in order to identify when psychological defences were alive in the work and to recognise my own feelings as distinct from others in the research such as residents, their relatives and the care staff. This involved thinking about my feelings as I wrote up process notes and listening to the feedback given to me in the Tavistock Supervision Group. The psychoanalytic supervisors monitored and stimulated my progress in doing this.

The researcher as research instrument

Hinshelwood and Skogstad (2000) equate the position of the participant observer with the psychoanalytic psychotherapist. They suggest this means taking a stance that involves an evenly hovering attention and remaining open so as not to make premature judgements. The observer needs to use his or her own subjectivity and reflect on the experience as a whole. Often the observer or therapist feels drawn to behave in a certain way. These feelings have to be noted and not necessarily acted on. Fabricius (1995) captures her rule of thumb:

"At those times when you feel most pressure to act, to do something which seems logical, urgent and necessary [for this student], stop, take

space, and think. It may be that you are just about to be swept into an unconscious enactment of a [student's] problem."

Fabricius (1995, pp27-28)

Holding back from doing something can leave a space for the emotional atmosphere to take centre stage. Milton *et al* (2004) describe the analytic encounter as the therapist trying to experience and hold the emotional atmosphere in the therapy session. The therapist has to bear both his or her own (often distressing) feelings as well as the client's. This is how the therapist notes their own *counter-transference feelings*. The experience of having someone understand your feelings in this way is itself therapeutic and it also allows the therapist (or observer) to formulate interpretations about what is going on under the surface (Hinshelwood and Skogstad 2000). How and when these formulations are fed back is crucial to the therapeutic intervention for individuals (Milton *et al* 2004) and organisations (Menzies Lyth 1969/1988).

My development of these psychoanalytic skills and understanding has been fundamental to this research. My learning has centred on my capacity for containment in relation to the Reflective Work Groups and a particular type of involvement in the participant observation. From 2001-2002 I had one-to-one clinical supervision from a psychoanalyst who organised the Psychodynamic Approaches to Old Age course. The sessions ran over the academic year and helped me transfer my role from participant observer to facilitator of the Reflective Work Group. In principle the work in the one-to-one sessions was similar to that in the Tavistock group work, but the timing of this work and the intensity of the experience helped clarify role issues for me as the researcher

and had a stabilising effect on the research. The one-to-one supervision helped contain a very turbulent period for Willow Ward. A neighbouring ward that had previously been a continuing care ward had been closed and was reopened as an intermediate care facility. This was the end of a long process which resulted in the two continuing care teams being merged as one. At the same time, the Charge Nurse's new leadership style and changes that he introduced were having a real impact.

In the one-to-one supervision, I learnt some practical skills such as using a framework to structure discussion in order to strengthen the holding effect of the group and was able to try out new ways of being a group facilitator. My knowledge of acting as a psychological container and facilitator for groups was based on my experience as a client in personal psychotherapy, in a work supervision group facilitated by a psychoanalyst (Fabricius 1995) and my work as a nurse teacher. The one-to-one clinical supervision not only gave me the opportunity to focus on the purpose of the research and my role in it but it also gave me the confidence to be flexible and to draw on my experiences in order to develop my own personal facilitation style.

The use of myself as a research instrument to gather and analyse the data in the Reflective Work Groups and participant observation gives the study a distinct ethos. Like other qualitative researchers, for example Titchen (1999), I kept reflexive accounts about my experiences. I included my feelings and tried to be aware of my personal values, knowledge and influences. It was central to this study to view my subjective experience through a psychoanalytic lens. This required observation and monitoring of my inner experience with a view to

identifying *counter-transference* feelings and heightening my awareness of the potential for *psychological defensiveness*. Identifying *counter-transference* involves developing a sense of when an internal response is provoked by the unconscious projections of someone else. Craib (2001) describes this in relation to a therapy situation as an interaction having a manipulative quality. In my experience this was often accompanied by a hunch that the feelings or thoughts being expressed didn't add up. This could stimulate a warning that I was being asked to join in with some *psychologically defensive* behaviour or thinking and I could hold back and allow the feelings to take centre stage. As a novice I found that it was more likely that I would fall for it over and over again, but I became adept at noticing and pointing out to participants how we were repeating something and asked them to think about it with me. In this way, I adopted a position of an interested learner in the participant observation of both the cultural and psychic symbols and practices (Murphy *et al* 1998).

An example of the use of my *counter-transference* feeling in relation to the Reflective Work Groups may be useful here. When I first started to facilitate the Reflective Work Groups, I noticed staff would often say the ward was too busy for the group to take place. I also noticed that I dreaded going to the ward and would have to battle with myself, as I didn't want to leave my office and walk up the road to where the ward was situated. The feelings of dread conflicted with my knowledge that I had made a commitment to the group and it was important to the research. These were strong feelings that in a way didn't make sense. The Reflective Work Group was going well and often at the end of sessions I felt the participants (including myself) had enjoyed the learning and there was a sense of satisfaction between us.

One interpretation is that the care staff's anxiety about engaging with thoughts and feelings related to their work was being projected into me. I was being invited to join in with the defensive thinking that Willow Ward was too busy for being with feelings. I was being tempted into the thinking that it was impossible to make space and time to sit and think about the difficult emotional experiences that were integral to the doing of care. When I resisted the temptation to join in with the defensive thinking by preparing the room and sitting down as normal, it contained the care staff's unconscious anxieties about the group. I suggest these included a myriad of worries connected to individuals' own histories and the nature of the work. It was a key function of the group to contain anxiety, explore the work and allow feelings to come to the surface. The process of containment is completed by feeding back analytic formulations. This process overlaps with data collection and generation as described earlier. Therefore I will use the next section to make clear the salient points related to the connections between analysis, making formulations and feeding them back to participants.

DATA ANALYSIS AND FEEDBACK TO PARTICIPANTS

Psychoanalysis is one method of understanding emotions (Rustin 2003). The use of psychoanalytic theory and technique in this research has informed interpretations about the practice of caring for dependent older people. Like Rustin (2003), I do not want to try to convince others that this is the right way to understand emotions. Instead, I propose psychoanalytical interpretations which can be thought about, taken in, tried out or applied to practice or ignored.

This is the position I have taken in writing the overall thesis and giving feedback to participants within the research process.

Data analysis

Fielding (2001) suggests that ethnographic type data analysis starts whilst still in the field. The researcher takes a step back to reflect on meaning in the data in order to know where to direct their attention. Data gathering continues in the direction suggested by the provisional analysis. He suggests subsequent observations may lead the researcher to new paths some of which might reach a dead end. He or she then has to abandon the original formulation and pursue another way forward. This process was followed in this study but a different dimension was achieved by applying the psychoanalytic frame. For example, in recording field notes I followed Spradley’s (1980) checklist for the prompts in recording data, but added additional questions based on Hollway and Jefferson’s (2000) data collection method to provoke a more analytic approach to the data (see Table Four).

Frameworks used for recording and reviewing data adapted from Spradley (1980) and Hollway and Jefferson (2000)	
Prompts used for recording data after field work	Questions used in the first review of the whole data set
<p><i>Space</i>: the physical place or places</p> <p><i>Actor</i>: the people involved</p> <p><i>Activity</i>: a set of related acts people do</p> <p><i>Object</i>: the physical things that are present</p> <p><i>Act</i>: single actions that people do</p> <p><i>Event</i>: a set of related activities that people carry out</p> <p><i>Time</i>: the sequencing that takes place over time</p> <p><i>Goal</i>: the things people are trying to accomplish</p> <p><i>Feelings</i>: the emotions felt and expressed</p>	<p>What do we notice about...</p> <ul style="list-style-type: none"> • Loss in the data? • The staff in the data? • The resident in the data? • The relationship between the staff and resident in the data? • Why do we notice what we notice? <p>What are possible interpretations?</p>

Table 4: Frameworks used for recording and reviewing data

The questions adapted from Hollway and Jefferson (2000) were applied to the data in the first reading of the whole data set (Appendix Four). These different types of field notes informed the process reports presented in the Tavistock Supervision Groups and feedback was added to the data following group discussion (Appendix Two). Fielding (2001) refers to the process as sequential analysis and suggests it involves constructing an indexed data outline of preliminary themes and analytical ideas. I used the data, analytic notes I made through the Tavistock Supervision Group and my research diary to construct a mind map of preliminary themes linked by concepts and processes. I also constructed a timeline of events and issues. These two documents gave a comprehensive and holistic view of the data (Hollway and Jefferson 2000). On completion of the data collection, data were read for analytic themes, which were listed. Related items were placed together and condensed where possible (Fielding 2001). Themes were tested by returning to the data, mind map and time line to ensure all significant data were accounted for and that themes linked to form a cohesive whole. This process was repeated until a robust set of interlinked themes emerged. This process inevitably fragmented the data but gave a clear understanding of thematic representation of the care staff's perspective (Chapter Seven).

The psychoanalytic methods of data analysis were continuous throughout the research process. The Tavistock Supervision Group ensured the analytic process was rigorous and I identified my own personal issues separately from the research in my own psychotherapy. In the next section I discuss how links between data analysis and feedback in the Reflective Work Group and Tavistock Supervision Group were made. I describe how these links allowed

me to develop formulations or hypotheses about what might be going on at unconscious level. I will go on to discuss how formulations were tested over time and developed or adjusted in order to synthesise the new understandings that underpin the thrust of this thesis (Chapters Eight, Nine and Ten).

Links between analysis and feedback

The appropriateness of interpretations and formulations could only be evaluated in the context of psychoanalytic understanding of unconscious processes. These processes by their nature are difficult to pin down or recognise in concrete terms. It is therefore important not only to place importance on expressed opinions and attitudes but also to articulate interpretations of symbolic communication in the context of the psychoanalytic frame.

What was said for example has not been taken as evidence in isolation. Emotional atmosphere, changes of behaviour or shifts in ways of thinking following feedback lend weight to conclusions or change a direction of an interpretation. If, for example, someone said they disagreed with an interpretation I made in a Reflective Work Group, it could indicate that the issue being discussed was pertinent and discussing the disagreement might be a vehicle for growth. In contrast agreement between the researcher and the participants might indicate collusion with comfortable defensive thinking rather than accuracy. The analysis, formulations and feedback in the study are assessed in their usefulness to the therapeutic aim of developing understanding and new ways of working with emotions. It is important to this study to demonstrate how the care staff were able to work in the psychoanalytic frame,

discussing and taking in suggestions. They sometimes applied or tried out formulations and sometimes they ignored them.

I will develop the earlier example to demonstrate issues of analysis and feedback. As I have already described, I came to understand the care staff's suggestion that they were sometimes too busy for the Reflective Work Group as an unconscious psychological defence. At one level, this formulation was reached through analysis in the moment of the experience, for example, when I was thinking about not wanting to leave the office to go to Willow Ward. I also became aware of my feelings of frustration when a member of staff approached me and suggested they were too busy for the group. All these events happened so regularly that I was starting to be aware of a pattern and it irritated me. I did not stop and think about the feelings and digest them fully until I brought up my reluctance in a one-to-one clinical supervision. The psychoanalyst drew my attention to my irritation and we talked together about my tendency to be drawn into the defensive thinking - not wanting to leave the office.

As my way of thinking about these feelings changed, I fed back my formulation through my behaviour. I demonstrated confidence that the group would go ahead by sitting in the room even when the care staff said they were too busy and this provoked a shift in thinking and behaving in the care staff. This illustrates how paying attention to what is said and the emotional atmosphere (*counter-transference*) were used in the process analysis. I chose to feedback my interpretations and conclusions in my behaviour. My interpretations were not discussed with participants and I did not ask them if they thought I was right or wrong. I suggest my interpretations and formulations were useful

because they allowed the care staff to attend the Reflective Work Groups and prevented me carrying out non-therapeutic behaviours: I did not turn around and go back to my office.

Later in the Tavistock Supervision Group and some of the conferences run by the Tavistock and the Emotions Network when I spoke with people about my work they asked how I had managed to get a group of nurses and care staff to attend as they had found the staff were always too busy. I also read papers related to nurses and carers tendency to be driven to act rather than take time to think (Dartington 1994; Fabricius 1995). These contributed to a wider understanding of psychological defensiveness related to doing rather than being with thoughts and feelings associated with the work on Willow Ward (Chapters Seven, Eight and Nine).

Psychoanalytically informed data synthesis

Psychoanalytic suggestions or formulations were tested through the containing and repetitive processes in the Reflective Work Groups. This process included analysing data whilst discussing or participating in the practical experience, examining it through the processes of the Tavistock Supervision Group, formulating psychoanalytic suggestions, feeding back to participants, observing the emotional atmosphere, assessing for shifts in thinking and behaviour, analysing data in the discussion of experience and so on. The repetition of this process meant sustainable formulations could be built up over time. In other words the relevance of a formulation was indicated by its repeated presence and how interpretations could be digested or modified over time. For example when a resident was admitted to Willow Ward it was common for their relative's

behaviour to be discussed in the Reflective Work Group. This demonstrated the significance of the relatives' interactions with care staff during the admission process and offered the opportunity for ongoing learning about the emotional impact of admission on residents' relatives. These layers of analysis filtered out the irrelevant matters and identified interpretations or formulation as a significant aspect of the overall thesis. Relevant psychoanalytic themes or issues could then be linked together.

ETHICAL ISSUES

The relationships between staff and the managers and staff and the clients (residents and their families) are defined by issues of authority and control. Hochschild (2003) might argue that implicit in the management's commission for my work was a desire to deconstruct the staff's emotional labour in order to promote a philosophy of care held by the management. It is also important to recognise that in this particular research setting, race and ethnicity were significant social factors within the power dynamic. In Chapter Two I described the pattern of ethnicity that exists in Willow Ward. Institutional racism in health care has resulted in the situation where Black and Asian health care workers do not progress in the same way as their white colleagues (Ward 1993). This is reflected in the fact that wherever the few white people who work in Willow Ward feature in this research, they occupy senior positions and specialist roles which have authority (Ward 1993). This includes my authority over the methods, data generation and analysis. On the other hand, Lee Treweek's (1996) study of emotional labour in residential care, described a situation where care workers used routines, practices and infantilising language

to order and control emotions in the home demonstrating their own power in relationships with residents. The care staff were both subjects of the power of others and powerful. It was ethically important to recognise the power dynamics and to consider carefully their effects on the therapeutic aims of the research.

I was conscious of the power dynamics between the researcher and the organisation whilst having the care staff as the focus of the study. It was important to consider the care staff's needs in order to work with them in exploring their emotional world. It was also an ethical imperative to consider the well being of the clients. The structures of the research were developed to allow staff to consider their perspectives on the care they delivered. On occasions their perspective conflicted significantly with the views of other groups. In these instances, it was essential for the researcher to be aware of the power and psychic dynamics, but to resist making immediate judgements about them. It was the researcher's role to foster a sense of deliberation in order to prevent non-therapeutic action. As described earlier, the timing and method of feedback in these circumstances was designed to allow staff and managers to appreciate when high levels of emotions such as anxiety and fear were present in the decision making process. In this research, it was not the researcher's role to steer the direction of thinking and procedure, these were the responsibility of the staff (Menzies Lyth 1969/1988).

A clear example of this was when a member of the care staff was accused of abusing a resident by a relative. She discussed the issue and her related feelings in the Reflective Work Group. She felt hurt and unfairly accused. She said she

had not had the opportunity to talk about her side of things since the initiation of the investigation. In this instance it was not my role to make a judgement about the accusation, but to listen to discussion, take in the group members' feelings and give them back in a more manageable form. I also facilitated the care staff in communicating their feelings and thoughts to more senior members of staff by suggesting they invited relevant managers to a Reflective Work Group. They did this and a frank discussion took place about the accusation as well as the roles and responsibilities of those involved. Although I did not feel it was my role to influence the outcomes of the managers' investigations, I thought it was an appropriate aspect of the research to facilitate careful consideration of difficult issues such as abuse and acknowledge the feelings that they stir up at all levels of the organisation.

Negotiating consent and participation

According to Fielding (2001) the relationships developed with key individuals when gaining access to a research setting are important. He argues that gatekeepers may have their own agendas. This was quite explicit in the case of the Trust Lead and the continuing care Charge Nurse who welcomed my work as a support for practice development in the Willow Ward care staff. Other key participants also had agendas such as wanting to have someone hear their side of things or getting recognition of aspects of work they felt were unfair. When I started the data collection for the study I was already known to the care staff and many of the residents and the relatives because I had been working on Willow Ward as part of the work-based education project. In some ways this made issues of access and consent more straightforward but complicated

matters related to negotiating participation and appropriate boundaries to my role.

The formal avenues of consent and access to the setting were assessed as appropriate by the Ethics Committee. The Trust Lead and continuing care Charge Nurse agreed that I could carry out the research on Willow Ward and wanted to link it with the practice developments being led by the Charge Nurse. I met with all staff members who had a role on Willow Ward and explained the research aims and proposed methods. This was followed up by an information leaflet. The information leaflet was written in line with the Ethics Committee guidelines. I invited all staff members to participate in the study and explained that they could opt out. I placed posters up in the ward on the door at the main entrance. They explained my research and how people could opt out of taking part. The posters met the ethics committee guidelines and included my picture.

I explained the research and repeated information about consent and opting out of the study every time I carried out a formal interview or taped the Reflective Work Group. Each person was again offered the explanatory leaflet. All interviewees and Reflective Work Group participants gave written and taped consent. I was required to keep the Trust's Research and Development Board updated on a yearly basis.

Negotiating care staff participation

Although all those who were asked to take part in the study agreed that it was important and supported the research aims, it is noticeable that some groups of staff opted out of some aspects of the study. There was no involvement from

the medical team although I was given permission to observe the ward rounds. Both Consultant Geriatricians declined the offer to join the Reflective Work Groups. The Charge Nurse was very committed to the research and expressed the opinion that it was supportive of his work and leadership role. He was actively engaged with study but decided against attending the Reflective Work Group because he felt his senior position would inhibit the discussion.

The psychologist and occupational therapy assistant who worked on the ward had been involved in the earlier project work and were very enthusiastic participants until they left their jobs. The psychologist participated for eighteen months and the occupational therapy assistant for two years. Initially, the psychologist facilitated the Reflective Work Group and I was a participant observer. We both attended a work-based discussion group at the Tavistock at this time. The occupational therapy assistant was a regular participant in the Reflective Work Group and involved me in some of her work during the participant observation period. The contributions of the psychologist and occupational therapy assistant were important because, as they were not part of the care staff, they had a view from outside Willow Ward and they had a different type of contact with the residents.

The staff nurses were enthusiastic about the aims of the research and sometimes wanted to involve me in aspects of their work in the participant observation, such as to work on a care plan or to discuss a particular resident. It became apparent that some staff nurses did not want to attend the Reflective Work Group and there was a tendency for some of them to send the nursing auxiliaries. The rationale for staff nurses' non-attendance was that there were

fewer of them and that some tasks (especially the medicine round) could only be performed by them. The staff nurses who liked attending the group arranged their work so they could attend which suggests the non-attendance of some individuals also reflected *resistance* (an unconscious reluctance to engage with the issues related to the Reflective Work Group). Although the nursing auxiliaries sometimes complained about the lack of staff nurse representation it became apparent that a core group of nursing auxiliaries and a smaller group of staff nurses were arranging their work so that they could attend as regularly as their shift pattern allowed. This does mean the data from the Reflective Work Group reflects a certain group of care staff's perspective and is skewed towards the nursing auxiliary grade. This is reflective of the organisation of work with emotions and is discussed further in Chapter Nine.

Negotiating the boundaries to the research role

Issues of access and consent in the field were complex due to the nature of my participant observer role. I was acting both as a Registered Nurse and as a researcher. This duality mediated the relationship between the researcher and the residents and their families. Everyone I spoke to about the research seemed enthusiastic and supportive. People gave their informal consent willingly and seemed keen to tell their stories about loss and grief in the continuing care context. It was perhaps as important to negotiate carefully with residents and their families the balance between their needs for a Registered Nurse's perspective and my need to gain consent to use the data generated through an interaction.

When I first met individuals I explained who I was and the nature of the study. I also explained that they did not have to be part of the research. I reassured them that they could speak with me, the Charge Nurse or any of the nurses and opt out of the research at any time. There was ongoing informal negotiation of access and consent. I reminded people of the research and checked out if it was alright to use a story or example they had spoken about. Munhall (1991) describes this as process consent. Issues related to process consent were complicated by my dual role. For example, if, when caring for a resident or relative for the first time, something happened before I had the opportunity to explain the research, for example, if a person became upset, I acted primarily as their Registered Nurse. Even though I had not gained formal consent, I recorded the incident in my field notes. At a later more appropriate time, I explained the research and negotiated consent. On a few occasions this was not possible so the data were not included.

Residents who were cognitively impaired were unable to give their consent to participate in the research based on a full understanding of its methods and implications. In these circumstances I negotiated consent with a close relative or friend. I also liaised with the Charge Nurse, psychologist, occupational therapy assistant and key nurses and care staff about the appropriateness of participating with individual residents. It was also possible to negotiate the resident's consent to allow me in my role as researcher to provide their care. I did this by interpreting meaning in their behaviour. For example one resident with minimal comprehension gave implied consent to be cared for by me:

"Resident Bill was a big man in a night shirt who seemed to understand little conceptual talk but did understand the activities of the personal

care procedures. He did maintain eye contact and when I asked if he would like his back washed he clearly said yes. He wasn't really able carry out commands like lift your arms, but when I straightened his limbs it felt like we were working together. "

Participant observation 1.6.01

In contrast resident Mary seemed to be impatient with me as I cared for her:

"Student nurse Amy and I helped resident Mary wash and dress. She needed all care. We asked her permission before we did things, encouraged her to do what she could herself and spoke to her throughout the procedure. I got the feeling throughout the wash that she was just tolerating us. She recognised we were not her regulars. I thought she thought we were "pussy footing" around. Although she answered questions she did not smile and interact like I have seen her with other staff. It was my fantasy that she just wanted us to get on with it!"

Participant observation 29.5.01

When I checked this out with the staff they said she usually preferred the staff who knew her. I took this a preference not to participate and avoided giving her personal care again.

Although some issues of consent were complex, the use of Professional and ethical guidelines were applied to ensure residents and relatives' access to appropriate care was not compromised. I was clear about the purpose of the

research and open to discuss methods and principles related to the psychoanalytic approach. In practice, care staff, residents and their families seemed more concerned with having someone recognise and try to understand their experience. It was therefore important to treat the data with respect. This study involves my interpretations of the participants' experience, which has been articulated as clearly and honestly as possible.

ASSESSING THE QUALITY OF QUALITATIVE RESEARCH

There is a lot of debate about how qualitative research can be evaluated (Murphy *et al* 1998). Much of the discussion centres on whether it is possible or appropriate to assess the validity of qualitative research using the same principles that are applied to quantitative research. Murphy *et al* (1998) state that the argument against using criteria that run parallel to concepts of validity and reliability is that it is untenable to try to measure qualitative research when the paradigm reflects the relativist position that there are many and conflicting truths which can nevertheless all be true (Murphy *et al* 1998). They argue that this position is largely rejected in health care research and there is a need for qualitative researchers to demonstrate appropriately the validity and relevance of their work. In principle, I agree that it is important to demonstrate that this research is valid and relevant to health care. I have chosen Lincoln and Guba's (1985) terms as a framework for explaining the quality and appropriateness of the research, as they are more so insistent with the methodological approach I have taken. Concepts such as triangulation and member checking of data (Murphy *et al* 1998) seem inconsistent with the psychoanalytic lens through which I have viewed the data. Lincoln and Guba's (1985) concepts of

credibility, transferability, dependability and confirmability are more appropriate for articulating the trustworthiness of methods in generating, collecting and analysing the data in this psychoanalytically informed participant observation.

This study is informed by a particular theoretical position that places unconscious matters at the heart of the study (Chapter Three). It is not my intention to demonstrate the truth of the interpretations and formulations I have made but to show that I have been true to the principles of psychoanalysis and robust in the design of research methods that are appropriate to this particular theoretical framework.

Tobin and Begley (2004) argue that the literature on methodological rigour is concerned with a need for a new approach to issues of quality in qualitative research. They suggest reliability, validity and generalisability may not be the most appropriate tools for demonstrating robustness in naturalistic inquiry. They suggest that in qualitative research these principles apply throughout the research rather than being confined to a particular aspect of the methods. The trustworthiness and authenticity of the research methods and particularly the interpretative analysis have been an overarching concern for this study. Tobin and Begley (2004) view traditional approaches to triangulation as too narrow. They argue that taking different perspectives into account is related to completeness of explanation rather than confirmation of a truth. This is appropriate to this study and is integral to the Tavistock methodology (Rustin 2003). The quality of this research can be judged by assessing the completeness and robustness of the combined social and psychoanalytic methods that

explored the cultural and psychic symbols evident in the customs and practices of the care staff in Willow Ward. I will use Lincoln and Guba's (1985) criteria for trustworthiness to guide the reader to aspects of the thesis concerned with rigour and trustworthiness.

Credibility

Tobin and Begley (2004) suggest that credibility is comparable with internal validity and addresses issues of fit between respondents' views and the researcher's. However, it is not the purpose of this research to demonstrate that there was a fit between my interpretations and formulations and those of the participants. In fact a principle finding is that there were differences between the participants' views and mine. This research tried to explain the differences using the psychoanalytic concept of psychological defence. My credibility is demonstrated by a clear articulation of the psychoanalytic principles (Chapter Three) and my claim that I have incorporated in the research appropriate learning and supervision strategies to ensure my use of interpretative technique is within the bounds of the psychoanalytic tradition (Chapter Five). I have also presented findings using fine grain accounts of data which demonstrate the dialogue between researcher and participants as they processed issues of conflict (Chapter Eight). I suggest that the interpretations and formulations made in this study are not best judged by whether participants agree with them but whether they were useful and produced shifts in emotional atmosphere or behaviour. I have included an illustrative example of this in Chapter Nine.

Transferability

In naturalistic studies, transferability refers to case to case transfer (Tobin and Begley 2004). This is sometimes referred to as fittingness and allows the reader to recognise the similarity between two contexts. This study does not seek to make statements about the generalisability of findings. Instead I have provided enough description of the setting (Chapter Two) and analytic detail (Chapters Eight and Nine) for readers to recognise and apply the principles of the thesis in other contexts. This is especially important as more older people live out the end of their lives in continuing care institutions such as care homes (Davies and Seymour 2002). It has recently been recognised that continuing care settings are required to negotiate issues of loss related to debilitating chronic illness and end of life care in similar settings to Willow Ward (Department of Health 2006).

Dependability

I was responsible for ensuring the research methods are logical, traceable and clearly documented (Tobin and Begley 2004). In this chapter I described how the methods were designed to be consistent with the Tavistock approach to working and learning about emotions (Rustin 2003). I have articulated how the research methods functioned as a container for the anxieties provoked in providing care for dependent older people and that this affected the participants' development and the quality of data. In this research the processes used to record and analyse data are laid out so that the reader can judge the dependability of the research. An example of data is in Appendix Two and Chapter Eight illustrates how methods were used to construct meaning from it.

In the example in Appendix Two, the care staff discuss their feelings following the death of a resident. My field notes record that the care staff expressed feelings of sadness and guilt about the death. In the margins and in the text I have typed that I noticed the care staff were unable to let the residents die and that they seemed to have feelings for them as if they were their family. The hand-written notes were made following a discussion in the Tavistock Supervision Group and added to the ideas. I have added the feedback from the psychoanalytic supervisor and fellow group members which suggests staff may have been feeling rejected by the resident who appeared to give up on life and that in the material, there seemed to be a painful frustration of the care staff's reparative wishes. This is the seed of a formulation that has been revisited through the repetitive processes of the Reflective Work Groups and synthesised in the final parts of the data analysis process. A substantial part of the findings has been grown from these data (Chapters Nine and Ten).

Confirmability

Tobin and Begley (2004) suggest confirmability refers to establishing that the interpretation of data is not a figment of the researcher's imagination. In this chapter I have argued that the methods of supervision and application of theory appropriate to the theoretical perspective adopted are integral to the methodology. It has been fundamental to this research to use the Tavistock Supervision Groups and one-to-one supervision to identify when psychological defences were alive in the work. This has been especially important in identifying where I have been swept up in the events of the field and failed to recognise this (Chapter Eight). In ethnographic studies this might be viewed as going native (Fielding 2001), but in this context it has been a useful analytic

tool. The study is not preoccupied with demonstrating agreement about interpretations, preferring to concentrate on the usefulness of interpretations and effectiveness of introducing them to participants. In this chapter I have suggested that it is important in the context of the methodology that feedback was given in a therapeutic way, maximising its impact on understanding and participants' development. The findings chapters include a detailed analysis of data and present fine grain data extracts at length. This allows for a close examination of formulations made about psychological defences (Chapter Eight) and feedback of interpretations (Chapter Nine).

The thesis has been developed with an overarching concern for the quality of the research and its coherence within the psychoanalytic framework. In this chapter I have argued that psychoanalytic participant observation method I have developed uses appropriate principles in an effective way.

STRENGTHS AND LIMITATIONS OF THE METHOD

Earlier I argued that the body of knowledge about loss in continuing care is fragmented (Chapter Four). The methods were designed to explore how some of the fragmented issues related to one another. This has been achieved in relation to the margin between social and psychological aspects of emotion work in continuing care. In order to do this the research has focused on the care staff's perspective. This has been justified as there has been little attention paid to this perspective before. However, the important relationship between the care staff, residents and their relatives has not been explored from all of their

perspectives. This would be an important consideration for future study designs.

In order to explore the unconscious aspects of work with emotions and complex loss I have adopted a psychoanalytic lens. This was a well established tradition that offered a framework for understanding and working with psychological defences. Some researchers with roots more firmly in a sociological and pluralistic view of the world may find this limiting, others may consider other frameworks based in alternative psychological traditions more appropriate. The psychoanalytic frame offered a rigorous methodology for learning about emotions based in a theoretical tradition that offered understandings of loss and emotion work in organisations. The adoption of a particular theoretical perspective may be perceived as limiting by some, but it seemed congruent with the teaching and learning styles of the researcher and participants in the study.

It may be that those research participants who found the psychoanalytic frame difficult or unacceptable participated less in the study which may have influenced how the study evolved. Similarly, any repetition of the study is dependent upon future researchers adopting a psychoanalytic or compatible psychological frame. This may mean the work remains separate from other more sociological based studies and contributes to the fragmentation of the body of knowledge. There are strengths and limitations to the psychoanalytic participant observation method, but it has provided a useful way of understanding and developing emotion work with complex loss in a continuing care environment. This area has yet to be explored in depth and future studies

will support or challenge the appropriateness of the methods used, adding to the body of knowledge in respect of this methodology.

I have defined the research method as psychoanalytic participant observation because the underpinning theory and combined sociological and psychological observation methods are central to the methodology. The focus on a single and specific context also fits within the scope of case study research. Yin (2003) suggests case study methodology refers to an empirical inquiry that investigates a phenomenon within a real life context. The principles of Yin's (2003) technical definition of a case study apply to this research because I have explored the relationship of the phenomena of loss and grief in the specific context of a continuing care ward. The research therefore has the strengths and limitations of a single case study.

I have already argued that the research method is robust and I suggest this is also the case when assessing the research in the light of case study criteria. According to Bryar (1999) the rigour of case studies is dependent upon identifying clearly the defining features of the case and providing an account of the data collection and analysis process. In chapter Two I located the research in a particular social and historical context and earlier in this chapter I explained in detail how the data were generated and synthesised within a particular theoretical framework. The strengths and weaknesses of the research as a single case study and its relation to generalisation require further discussion.

Generalisation refers to the extent to which the findings of a study can be applied to situations, contexts and people not directly involved in the research. Sharp (1998) argues that generalisation of case study research is often underestimated because there is confusion between the logic behind empirical and theoretical generalisation. In empirical generalisation a case is typical of a population and generalisation depends upon its representativeness of other potential cases in a population. Willow Ward was not representative of a population of other continuing care environments such as care homes and this limits the potential to transfer directly the knowledge developed in the findings. Sharp (1998) suggests it is more appropriate for single case studies such as this research to draw on the logic of theoretical generalisation to make their case. He argues that in its simplest form this entails showing a correlation, which has been identified in a sample which is likely to be found in the population at large.

In this research I propose a relationship between the phenomena of loss and grief and some of the contextual factors in the environment and these are located in the psychoanalytic framework. The systematic and rigorous approach taken in my analysis led to the saturation of categories (Charmaz, 2005) and I have illustrated this through the presentation of in-depth cases within the findings chapters. I am confident that these findings are reasonably transferable to other NHS continuing care settings. However, I am not in a position to demonstrate that this relationship exists in other continuing care environments. For example, I will suggest that the care staff in Willow Ward employ psychological defences to protect themselves from the emotional demand of their work with dependent older people, but there are limits to the

extent to which this position can be generalised to other continuing care environments such as care homes.

The in-depth exploration of this single case is important and helpful because it illuminates contextual relationships not previously explored and attempts to explain the complexity of implementing change in a health care situation (Bryar 1999). It can be argued that developing knowledge in the reality of a case study situation is a useful to those concerned with developing and improving practice (Meyer et al 1999/2000). It is possible that the rich contextual detail given in this research will be recognisable to practitioners who can test out the knowledge in the practice situation, but this form of transferability is limited. It relies on the tacit expertise of those reading and interpreting the findings and is not necessarily accessible to those outside the discipline.

In the field of child psychoanalysis, Rustin (2006) suggests that it is important to understand the range and diversity of research activities and argues that observation techniques such as infant observation are important to discover and verify new understandings. The application of psychoanalytic principles to old age is relatively new however, and there are few psychoanalytically informed studies to compare with this thesis (Chapter Four). For the knowledge produced through this research to contribute to a more globally applied theory it will be necessary for future studies to validate or disconfirm the findings. This could take the form of more case studies underpinned by similar methodology and carried out in similar settings. Researchers might carry out these studies in different contexts for example, care homes, people's own home or hospices in order to develop more understanding of the organisational variables that are

related to the propositions made in this thesis. Other authors argue that psychoanalytically informed research should conform to more conventional research methodology in order to demonstrate the effectiveness of interventions (Fonagy 2003). For example Twemlow *et al* (2001) evaluated the use of containing methods in an elementary school in America. They demonstrated the effectiveness of an intervention underpinned by psychoanalytic principles in promoting a more positive learning. This approach would also strengthen the knowledge base.

It is important that researchers use a range of methods to explore the potential of psychoanalytic understanding of old age and the care for older people in order to generate a robust body of knowledge that contributes to meaningful policy that is useful to practitioners (Higgitt and Fonagy 2002). However this single case study is clearly helpful because it examines phenomena (loss and grief) and their relationship to a specific context in detail it thus illuminates an important area of health care that is usually hidden.

SUMMARY

I have used this chapter to argue that the research was of an appropriate quality because it had a coherent approach and was consistent with the theoretical framework that underpins it. I have described how the methods equate to the Tavistock approach to learning about emotions (Rustin 2003) and suggested that the method functioned as a chain of containment. This chain stretched from the practical experience of caring for older people in Willow Ward to the Tavistock Supervision Group. I have detailed my own supervision and learning

which has informed and monitored the analytic process. Interpretations and formulations will be presented in detail to demonstrate understanding the complex and difficult work related to loss and grief in continuing care environments (Chapters Seven, Eight and Nine). These interpretations and formulations were developed through a rigorous research process in the context of a well developed theoretical framework. I have provided a rich description of the setting and fine grain detail in the findings so that the reader can make informed judgments about the thesis. Chapter Six is an introduction to the findings. It will link some of the issues of quality to the findings and describe the structure of the findings chapters. This will orientate the reader and establish the direction of the overall thesis.

CHAPTER 6 - INTRODUCTION TO THE FINDINGS: THE EMOTIONAL DEMAND OF WORKING WITH COMPLEX LOSS IN CONTINUING CARE

In the findings chapters, I argue that there is an intense and complex emotional demand related to working with loss and grief in a continuing care environment. The care staff described a trajectory of living bereavement. I suggest that care staff seemed unaware or glossed over some aspects of the emotional demand in the trajectory. It is my suggestion that this was evidence that the care staff used psychological defences to protect themselves from unbearable and unacceptable elements of the emotional demand of their work. I argue that three elements are particularly disturbing. The first element relates to the residents' profound dependence caused by the physical and mental degenerative processes of chronic illnesses such as dementia and stroke. The second is that the care staff are deprived of the rewarding and satisfying feelings associated with witnessing the people they care for get better or improve enough to be discharged from their care. The third is that the work involves sustained contact with highly dependent residents who live in a non-responsive state and this stirs up feelings about a profound sense of emptiness or lifelessness which is universally feared.

I illustrate how the containing function of the research allowed the participants (including me) to develop their capacity for a more complete understanding of and a more creative response to the emotional demands of the work. I argue that the new ways of working with emotions did not become part of the customs and practices on the ward because there were social systems in the

organisation that supported psychological defences and the status quo. These systems worked by separating and ordering aspects of the emotional demand and related work. There was a hierarchical value attached to these systems. The people and type of work most closely associated with the most disturbing elements of the emotional demand were at the bottom of the hierarchy and received least emotionally sensitive contact. This system allowed the majority of individuals and groups within the organisation to avoid intimate contact with the most disturbing elements of loss and grief in continuing care. I have made connections with the literature in the findings chapters. This places my suggestions in an appropriate theoretical framework and assists the flow of the thesis.

In Chapter Seven, I suggest that the emotional demand described as an ordinary part of care staff's work with the residents in Willow Ward was complex and intense. I discuss the themes that arose from the care staff's perceptions of living bereavement in continuing care. Attached to living bereavement was an emotional demand that related to care staff's own feelings and an expectation of having to deal with the feelings of other people, such as residents, relatives and colleagues. The care staff described the trajectory of living bereavement and the associated emotional demand as:

- Working with shocked residents
- Working with grieving relatives
- Working with anxious residents and relatives
- Working with residents' degenerating bodies and minds
- Working with dying residents

In the participant observation I observed aspects of the emotional demand that were omitted or glossed over in the care staff's accounts. I identified aspects of the emotional demand that were missing from their accounts as:

- Working with non-responsive residents
- Working with self-doubt and guilt
- Working with hurtful residents
- Working in isolation

In the last part of the chapter I discuss the findings in the light of the literature. The nursing literature that relates to this type of work is rooted in sociology and discusses the practices carers use to deal with the messy and disordered experience of care for dependent older people. The findings in this study are consistent with the suggestion that residents who were dying and those whose bodies or behaviour were unbounded tended to be separated from other members of their communities. In this thesis I present a psychological explanation for this custom.

Through the containing function of the research design (see Chapter Three) a deeper level of data was achieved. In the Reflective Work Groups staff were able to explore further their emotional experience by trying to get closer to some of the issues that lay below the surface. They did this by articulating their feelings and testing out new ways of thinking about their work. This was a repetitive process involving oscillation between different states of mind and experiences and constitutes the action orientation of the research. This process

produced findings that were related to the texture of an emotional demand, rather than the thematic representation of the trajectory of living bereavement. The textured findings include a description of the quality and sense of the emotions being discussed rather than categorising them.

In Chapter Eight I argue that there are psychological explanations for the care staff's responses to the emotional demand. I claim there are unacceptable and unbearable feelings connected with the emotional demand of working with living bereavement in continuing care. I suggest that the care staff developed psychological defences to avoid and minimise the impact of these feelings. These findings are presented in detail to give a texture to the emotional experience and provide evidence of the psychoanalytically informed methodology. The textured findings are presented in an analysis of one Reflective Work Group. This group was selected because it focused on the key elements of the emotional demand that lay below the surface. These findings are data led and articulate the fine grain understandings produced in the Reflective Work Groups. This gives a textured representation of care staff's feelings and the process of testing out new ways of thinking about caring. It was important to present the thematic and textured findings in order to both describe the concept and to convey the quality of the emotional demand of working with complex loss in continuing care. By viewing the emotional demand through a psychoanalytic lens it has been possible to articulate its hidden and rarely spoken of aspects.

I illustrate the psychological defences that were identified as significant in the repetitive processes of the Reflective Work Groups, Tavistock Supervision

Group and my own self-reflection. I suggest the defensive techniques used by staff to protect themselves from unbearable and unacceptable feelings stirred up by their work were:

- Keeping out strangers
- Being on the offensive all the time
- Denying residents' capacity
- Valuing feistiness and ignoring non-responsiveness
- Believing in Willow Magic
- Being like a family

I argue that the types of feelings that the care staff avoided with these techniques were: anger, hatred, envy, guilt and despair. I propose that these feelings are associated with the unique nature of providing care for dependent older people with chronic degenerative illnesses until their death. In the last section I place the findings in a theoretical context and substantiate my claims that the disturbing aspects of care that provoked the most disturbing unacceptable and unbearable feelings were:

- The residents' profound dependent states caused by mental and physical degeneration
- Being denied the sense of reward and satisfaction when a person being care for gets better
- The sustained contact with a sense of lifeless void, which is most acutely represented in the non-responsive residents.

These issues are located in the psychoanalytic theory base. The suggestions are

discussed in the light of literature related to psychoanalysis and applied to the care staff's experience of continuing care.

In Chapter Nine I argue that care staff were able to use the containing function of the research to develop their capacity for working with emotions. I suggest that these new ways of working did not become custom and practice on the ward because there were social systems in place that supported psychological defensiveness. I propose these served all the individuals and groups in the whole organisation not just those within Willow Ward.

I make an in depth analysis of an illustrative case that continued for approximately two years. I demonstrate how the links of containment provoked shifts in participants' (including my own), ways of conceptualising their work with emotions. The practical outcomes of such changes may seem minimal, but there were significant developments in the care staff's capacity to be emotionally sensitive and creative. I discuss the benefits of the containing function of the research and link them to appropriate literature.

In Chapter Ten I propose that these new ways of working did not become integrated into the culture of the ward because social systems supported the psychological defences described in Chapter Eight. These systems are described as:

- Splitting up the residents
- Splitting up emotional roles and responsibilities
- The upstairs-downstairs effect

I argue that these systems protected individuals and groups in the whole organisation from the unbearable and unacceptable feelings connected to the most disturbing aspects of the work such as dealing with profound dependence, being deprived of feelings associated with getting better and the fears stirred up by prolonged contact with the lifeless void most acutely represented in the non-responsive residents. The findings in Chapter Ten will be located in theory, related to a psychoanalytic understanding of organisations. I will locate where my thesis sits in this body of knowledge and argue that the unique contribution of this study is to place the conflicts between liveliness and lifelessness centre stage in the emotion work related to continuing care for dependent older people.

CHAPTER 7 – A TRAJECTORY OF LIVING

BEREAVEMENT: THE CARE STAFF'S PERCEPTIONS OF THE EMOTIONAL DEMAND OF THEIR WORK

In this chapter I suggest that care staff perceived an intense and complex emotional demand in a trajectory of living bereavement contained in their work. I discuss the themes that emerged from the care staff's accounts and contrast them with my own observations of aspects of the emotional demand that seemed to be missing or glossed over. I argue that these issues are related to both emotional and social aspects of the care for residents in continuing care and go on to explain in Chapter Eight how the emotional demand described in this chapter shapes the customs and practices of providing care for the residents in Willow Ward.

Staff did not isolate the emotional component of their work. For example, they did not articulate a counselling element to their role and usually deferred to the medical team, psychologist or senior nurse if any direct communication with an obvious emotional component was required. Instead they described social interactions and practices that were emotionally demanding. From their perspective, the demands consisted of the impact the interaction or practice has on their ability to carry out aspects of their work and the emotional response this provoked in them. The emergent themes suggested staff were coping with the emotional demands of the residents' adjustment to living in a care institution, being dependent and preparing for death.

It has been possible to analyse the care staff's perspectives on loss and grief in continuing care and themes have emerged. This forms a coherent trajectory. It

is important to recognise that this is not the actual experience of the individuals but a synthesis of their perspectives. The actual experience is not linear, nor coherent. Care staff worked with an overwhelming volume of loss and their emotional responses fluctuated and changed. Sometimes the emotional atmosphere on the ward was chaotic and at others dull and lifeless (Chapter Two). This meant some of the emotional issues I observed and describe later were either omitted from the care staff's accounts or glossed over could easily go unrecognised. Customs and practices were built up omitting or glossing over aspects of the living bereavement experience. The care staff's perspective on living bereavement contained the following elements:

1. Working with shocked residents
2. Working with grieving relatives
3. Working with anxious residents and relatives
4. Working with residents' degenerating bodies and minds
5. Working with dying residents

Each element is discussed in turn below.

Working with shocked residents

The consultant geriatricians were ultimately responsible for admission to the continuing care ward and the senior nurse for the unit was responsible for assessment and coordination of the packages of care provided for the residents. The most usual route of admission to the continuing care ward was via the acute sector. Residents were frequently admitted to an acute hospital unit from their own homes or a care home. There followed a period of acute care,

rehabilitation and assessment to establish how continuing care needs would be met. If the assessment showed that their continuing care needs could not be met by community care or care in a residential or nursing home, an admission to Willow Ward was considered. This meant some residents had a series of acute admissions, as part of a slow deterioration process (e.g. residents with dementia) and finally came to Willow Ward; whilst others were admitted following a single acute episode that left them profoundly dependent (e.g. after a stroke). On some occasions residents were admitted following deterioration or death of a carer. In effect, the circumstances that necessitated admission to Willow Ward involved loss and trauma for the resident and this became part of the staff's work with newly admitted residents. The emotional demands of caring for a new resident who was already afraid, probably confused and needing practical care were complex. The care staff spoke of coping with the conflict in their human feelings for the resident and their feelings related to solving difficult practical problems.

The tensions involved in caring for shocked residents stirred up mixed feelings in the staff such as frustration at the difficulties involved in providing practical care and sadness for the residents who sometimes seemed bewildered on arrival to the unit. In the following example, the resident had experienced a sudden change in his health. He was an independent man who originated from the Caribbean and had been very fit prior to his admission. When he arrived on Willow Ward he was totally dependent on nursing care for his main activities of living. The staff described the resident as being in a daze and they found moving him around using the moving and handling equipment distressing. They tried to explain what they were trying to do and reassure him that they knew

what they were doing, but this had no effect. The staff were primarily concerned with the practicalities of the use of manual handling equipment, but they did realise the resident's behaviour related to his emotions:

"Nursing auxilliary Gloria: *Bruce is a big man and he had a stroke and is now completely paralysed. He is unable to get out of bed and when we try to get him out of bed he goes completely stiff [she demonstrates with her arms] ... It's so hard to move him, he just won't bend and it makes it difficult to use the slings without pushing his arms. It's not nice. It's not good for him or our backs. They should get the physio to see him.*

Later the group discussed why they thought he went stiff.

Researcher Cheryl: *Do you think he goes stiff because he doesn't want to get out of bed and maybe he's cross with you?*

Nursing auxilliary Patience: *No, I think it's because he's afraid of being moved and he doesn't trust us yet."*

Reflective Work Group 6.2.02

The account is typical of a situation where care staff were trying to provide personal care for a newly admitted resident who was deeply affected by changes in his health and traumatised by leaving his home. In this case, they understood that their interventions were distressing for the resident but they tended to focus on finding practical solutions to the problem. The tone of this account suggested that they were frustrated about not being able to provide the practical care without further distressing the resident. The staff seemed frustrated by the conflict of wanting to provide good care for new residents but

they seemed to find it difficult to deal with the disturbing emotions this sometimes involved.

Working with grieving relatives

There was a wide range of relationships between the residents and their relatives. Relatives who feature in the data include: spousal partners, adult children (many of whom are older people themselves), grand-children, great grand-children, siblings, nieces, nephews, friends, neighbours and visitors from voluntary organisations (see Chapter Two). Sometimes the level of relationship was superficial, for example, a distant family member may have been listed as next of kin and rarely made any contact with the resident. Mostly those who visited a resident had known them for a long time and there was usually an emotional bond between the resident and their visitor. Frequently the relatives who visited had provided care for the resident before they were admitted and they grieved the loss of the pre-existing relationship they had with them.

The care staff often reported difficulties in making relationships with new residents' relatives. The care staff felt scrutinised and criticised by relatives who were worried and wanted to ensure the resident received an adequate level of care. The next data extract relates to a discussion of a newly admitted resident's daughter who frequently asked the staff to move her mother's position in the bed when the care staff felt it was unnecessary:

"Nursing auxiliary Cella: *Some people are always finding fault, some people are like that.*

Nursing auxiliary Hortense: *Always finding fault never satisfied.*

Cella: *No matter the way we care [pause]*

Nursing auxiliary Maria: *Complaining at the end as if we are to be blamed."*

Reflective Work Group 13.3.03

In this Reflective Work Group, the care staff also expressed frustration at not being able to satisfy the relatives' expectations and were angry at being given too much responsibility. In the extract they referred to death as "at the end" and went on to suggest that people seemed to blame them for not doing enough when residents died. The care staff suggested they felt a lot of pressure to please and satisfy the residents' relatives. They suggested this was an impossible task because residents' relatives were bound up in their own feelings of guilt and grief about someone else caring for their loved one. The care staff seemed to find the weight of this responsibility both frustrating and burdensome.

Working with anxious residents and relatives

The process of adapting to living in Willow Ward was part of the admission period, but for some residents and their relatives the separation from each other continued to be a prevailing issue. Separation from the security of home often created a sense of loss and grief. When people became distressed and anxious by the loss of security provided by the emotional attachment to a loved one or home, the staff found it stressful and became frustrated if the anxiety continued.

A resident's wife was very anxious about her husband. He had advanced dementia and was dependent on the nursing staff for all care. His

communication and comprehension was very limited. He and his wife had been married for over fifty years and she did not like to be apart from him. When she went home in the evening she telephoned twice before she went to bed. The staff were frustrated by the relative's behaviour and her inability to take in any of their reassurances:

“Staff nurse Susan: *Sometime I say, “Oh what do you want?” “Oh this and that.” “Ok we’ll do it, don’t worry, that’s fine go home and rest and we’ll do it for him, we’ll put him to bed”. Not confronting her helps calm her. [said in a soothing tone]*

Nursing auxiliary Meena: *Then, five past seven every night she calls... [said in an agitated tone]*

Staff nurse Susan: *Every night she calls wanting to know about Cyril [resident], then again at ten past ten. You know at times she will ask if you’ve put him in the lounge and not to bed [laughter], I mean...*

Nursing auxiliary Patience: *And you can’t tell her anything, it just doesn’t go in”*

Reflective Work Group 9.4.03

The tone of the account (in brackets) reflected the tone of the interaction between the relative and the staff member. The staff nurse was able to hold the relative's anxious behaviour and soothe some of her distress, but this was only short lived. As the nursing auxiliary suggested, the relative phoned back in an equally anxious state just a few hours later. They felt unable to make an impact upon the relative; this was evident in the statement “nothing goes in”.

The data suggest staff picked up on the relatives' anxiety but found it frustrating and challenging when it was not possible to reassure them. The demand of working with anxious relatives was stressful and difficult and staff seemed to be over reliant on reassurance as a response and often did not have the range of skills and capacity required to manage the extreme emotions that they were forced to deal with.

Although many of the residents had severe communication problems, they too expressed their anxiety. This was often communicated in their actions rather than through speech. In principle, the residents' anxious behaviour presented the staff with the same emotional stresses.

“Occupational therapy assistant June: *Last week I felt dreadful, I just didn't want to come into work. I spent some time in the sitting room but the shouting was terrible, it was like bedlam and I just wanted to get away...*

Nursing auxilliary Gloria: *Last week was different, it was worse than ever. The noise in the sitting room was so bad I just couldn't take it. There are two new residents; Betty and Patrick and then Sarah who's been here quite a long time. Patrick starts shouting: “Help me, help me” and that starts off Betty asking to be taken home and then Sarah just screams.*

Nursing auxilliary Wei Kong: *Patrick seems to be seeing things that aren't there. He's frightened but there's nothing there. He's just so confused you can't reason with him.”*

Reflective Work Group 9.1.02

All three of the residents referred to in the example had dementia and severe physical frailty. The participants in the Reflective Work Group identified that something had disturbed the residents and made them anxious. Again the principal intervention was reassurance through reason, but this was even less effective with someone with confusion. This level of anxiety was extremely distressing for residents and staff. It was disturbing, which made it difficult to stay with the person, as indicated by the staff in the data who said they wanted to leave the area or not come to work. When residents displayed intensely anxious behaviours, particularly when mediated by states of confusion, the emotional pressure was intense. The care staff in the extract were aware of how difficult it was for them to meet the challenges of working with residents in these confused and anxious states. They recognised that this was disturbing for other residents and that this stretched further their emotional resources to deliver the care required.

Working with degenerating minds and bodies

All the residents who were admitted to Willow Ward were at the end stage of debilitating disease processes such as stroke and dementia. When residents were in the final stages of these degenerative conditions the boundary between them and their surroundings seemed less intact. This was evident in the physical care provided, for example, when someone was incontinent it was necessary to come into contact with body products and parts that are not normally shared with others. Psychological and social boundaries were also transgressed when providing care for people whose deterioration had impacted upon their state of mind, for example, dealing with residents whose behaviour broke the usual taboos such as being racist or inappropriately sexual.

Consequently, the type of care required frequently involved practices and interactions that crossed usual boundaries to human relationships such as taking someone to the toilet, helping someone wash and reassuring very confused people. This meant relationships involved a complex sense of intimacy between care staff and residents. This was made more ambiguous when residents who had dementia reverted to more primitive behaviours. Although the care staff realised that most people considered a lot of their work dirty and unpleasant they minimized the impact of this type of work by using strategies such as humour and stressing the ordinariness of such work in their situation:

“Nursing auxillary Gloria: *I had resident Irene to look after and when I went into her room she was covered. Covered in shit. So I called Celia [nursing auxiliary] to help me. We spent ages clearing her up. She had smeared it everywhere: sheets, walls ... we even had to send her curtains to the laundry because she had managed to get hold of them. [Gloria was making gestures about the extent of the mess and she and Celia broke into laughter]. We gave her a bath and sorted her out. Then Mr Choudhury's daughters came and found Celia who was supposed to be looking after their Dad. They called her to see Mr Choudhury who had vomited up his feed ... all over himself, the bed clothes everything needed changing... never mind, we're used to it. [Both Gloria and Celia sank down in their chairs and gave a shrug].”*

Reflective Work Group 24.7.02

In the data, nursing auxiliary Gloria recounted these incidents to demonstrate what a difficult day her colleague Celia had had. It was clear that they realised cleaning up other people's body waste was unpleasant, but the use of humour and a matter of fact delivery stressed the ordinariness of such events and reduced the sense of disgust in the account. This was a strategy the staff often used when discussing aspects of care that crossed normal boundaries in relationships.

Working with dying residents

The majority of residents who lived on Willow Ward died there (see Table Five). In Table Five, the numbers of residents who were discharged is confusing as it includes people who were admitted and discharged for respite care and people who were discharged for treatment in the local general hospital and were possibly readmitted at a later stage. In the qualitative data I was able to identify three residents discharged to go home or move to a care home. The quantitative data are clear that over the three year data collection period sixty seven residents died and that eight of these residents had been living on the ward for at least two years.

Length of time residents spent on the ward and how they left			
Length of stay	Reason for leaving the ward		
	Died	Discharged	Total
Between 0 & 4 weeks	8	13	21
Between 1 & 6 months	26	5	31
Between 6 months & 1 year	14	3	17
Between 1 & 2 years	11	3	14
Between 2 & 3 years	8	1	9
Number of residents who left the ward	67	25	<u>92</u>

Table 5: The length of stay of residents admitted 2001, 2002 and 2003

Table Five refers to residents who were admitted during the data collection period and indicates the longest length of stay as two years, but this does not include residents admitted before the data collection period. A few of these residents stayed on the ward for over five years. Most residents lived on the ward for months or years and staff frequently experienced the death and dying process of residents with whom they had formed emotional attachments. The anticipation of death and actual deaths of residents often provoked a grief response in staff. When a resident died, the staff's most frequently expressed feelings of grief were: shock, sadness and a sense of failure.

In the Reflective Work Groups when staff spoke about a resident's death, the mood was usually sombre and they clearly articulated feelings of sadness:

“Nursing auxilliary Celia: *We lost our Edward [resident] yesterday.*

OT assistant June: *Laughter*

Researcher Cheryl: *That sounds important*

Nursing auxiliary Celia: *mm*

Silence

Researcher Cheryl: *Yesterday, so yesterday Edward died, how does everybody feel about that?*

Nursing auxiliary Celia: *Oh it's very sad; it was very... the place is so quiet*

Nursing auxiliary Meena: *It's not quiet because Betty [resident] is keeping everybody going."*

Reflective Work Group 12.3.03

In the data extract, I interpreted various responses as significant: the laughter and the assertion that another resident was keeping everybody going seemed to be related to grief, but the dominant feeling in the room and the expression in the extract was sadness. The pace of speech was slow, the reference to sadness and quiet were all reflective of the depressed feelings expressed by the staff and linked with the resident's death and subsequent absence.

A less frequent response was shock. This may be because residents often had a period of acute illness before they died. Despite the old age, frailty and slow deterioration of residents' conditions, when there was no warning illness, staff expressed shock and searched for explanations as to why the resident died.

'Nursing auxiliary Rita: *She died so quickly no one was expecting it. They had moved her to a different room recently- that can sometimes be traumatic for old people, can't it?*

Nursing auxilliary Gloria: *We were on when it happened [pointing to another member of the group]. Rebecca [staff nurse] was on the night shift and came and got us as we were leaving after the late. She said, "Irene [resident] is dying".*

When we realised we just couldn't leave and we said our good-byes and she died very quickly, while we stood there. We just couldn't believe it. Maureen [staff nurse] said she had her bowels opened the day before so she wasn't constipated."

Reflective Work Group 18.11.03

In this data extract the staff expressed their sense of surprise at the sudden and unexpected nature of the resident's death. Later in the same Reflective Work Group we discussed how, although the resident was in her eighties, had severe dementia and had been bed bound due to physical frailty, the staff had been shocked by her death. They said there were no signs she might die because she had good skin, ate well and seemed to enjoy being cared for by them. The tone of the discussion not only related to their surprise but also a sense of searching for the reasons she had died.

Staff frequently expressed a sense of failure when someone died. This stemmed from their attitude towards the aims of their care. Although the residents were elderly, at the end stage of disease processes and living dependent lives, the staff focused on providing care that was life sustaining rather than palliative. This was despite the inevitability that residents would eventually die in their care.

'Nursing auxilliary Celia: *I wish we could have tried a PEG feed with Biddy [resident]. Just to try. [Silence]*

Researcher Cheryl: *How did Biddy's death make you feel?*

Celia: *Sad, she was a nice lady, no trouble.*

Nursing auxilliary Theresa: *She was a lovely lady.*

Researcher Cheryl: *Do you think Biddy would have wanted a PEG feed?*

[Silence]

Nursing auxilliary Celia: *She had given up because she was lonely and had nothing to live for.*

Researcher Cheryl: *If you all were Biddy would you have wanted a PEG?*

Nursing auxiliaries Gloria and Patience: *No*

Nursing auxilliary Theresa: *I feel like we have failed"*

Reflective Work Group 30.7.03

Although the staff here were able to acknowledge the resident had come to the end of her life and would not have wanted active treatment such as tube feeding, they still experienced a sense of failure when the resident did die. Unlike hospice nurses Willow staff did not define their aims of care in terms of a palliative care philosophy. In the data extract above for example, the issue of discussion is a long life and not a good death. Staff seemed to focus on their care as a means of sustaining life and on top of the usual grief emotions, felt a sense of failure when a resident died.

THE HIDDEN EMOTIONAL DEMANDS OF WORK WITH LIVING BEREAVEMENT

To some extent, I too am used to dealing with the emotional difficulties of complex loss in continuing care. As a practicing nurse I have worked in similar situations to Willow Ward. In my position as a nurse researcher however I was experiencing these activities for the first time after a considerable break from practice and had not been engaged with practical care in such a sustained and constant way as the staff. In my role as participant observer, I was struck by issues related to loss and grief that seemed to be missing or were glossed over in the regular discussions that were initiated by staff in the Reflective Work Groups. The emotional demands that I recorded in the participant observation that were missing from the staff's accounts were:

1. Working with non-responsive residents
2. Working with self-doubt and guilt
3. Working with hurtful residents
4. Working in isolation

Each aspect is discussed below.

Working with non-responsive residents

In my participant observation, I recorded the experience of caring for a group of residents within the unit who were very dependent and seemed to be living a life very close to death. I referred to this group of residents as non-responsive primarily because of their low levels of verbal and non-verbal communication skills.

In the participant observation I noted how close to death the non-responsive residents were, whilst not actually being treated as if they were in the process of dying. They lived in a stable but highly dependent state, sometimes for years and any sense of change in them was difficult to detect. It was evident in my use of descriptive imagery that I found it challenging to accept such a person's life as viable:

"Researcher Cheryl: On first meeting Emily [resident] I was shocked. Amy [student nurse] was unphased. Emily was sat upright. She was a lady in her 90s. She was very thin, her hair was white and sparse and she had no teeth. What struck me most was that she had her head back and her mouth was wide open in an oval shape [like the painting or the modern horror film "the Scream"]. As her neck was extended, the right side seemed thicker... I immediately wondered if she was dying. I asked Amy if she had met the patient before. Without any sense of worry she answered yes and said that she was always like this and sometimes she talked a little... I still wasn't convinced and double-checked with nursing auxiliary Gloria that this was how Emily normally was. It was only after double-checking that we started washing her and changing her nightdress."

Field notes 30.5.01

Initially I was shocked and horrified by working with the non-responsive residents. It is striking that my field notes from my early participant observations have descriptions of residents where I made comparisons with

fictitious imagery that are associated with the space between life and death or living death. Words such as deathly, zombie and "like a horror film" are often in my descriptions at this time. After a while of being involved in the unit this tended to disappear and like Amy in the data above I became unphased by the appearance and work with non-responsive residents. It was easy to ignore these residents after they had had their basic needs taken care of. These residents were rarely discussed in care plan meetings or the Reflective Work Groups. The residents tended to remain in their rooms and care was given as a matter of routine or when a relative requested it.

Working with self-doubt and guilt

The staff found working with residents who were shocked and traumatised emotionally demanding. Earlier I described how they became frustrated at not able to solve the practical dilemmas of providing care to residents when the care seemed intrusive and frightening for residents. I came across the same dilemmas in the participant observation, and also became frustrated. In addition, I felt feelings of guilt and doubted my own motivations and abilities. The next data extract is from a participant observation and involved delivery of intimate care to a resident with learning difficulties. Until his admission a couple of months before, he had been cared for by his sister at home. During an acute hospital admission he developed an infection and was transferred to Willow Ward. The Charge Nurse and psychologist were concerned that he had become increasingly depressed and confused. In the extract, I provided care for the resident with a more junior nurse. The levels of anxiety made the interaction difficult and it seemed the resident was very disturbed.

“(There was a strong smell of urine in the room) As we arrived Harry was lying flat out in his bed. He was wearing a nightshirt. He was trying to take it off. He was ripping his clothes. He had a scarf around his neck, a glasses case by his side and he was holding a ladybird book over his penis. It was difficult to get him to respond. He seemed anxious. Soon he started to say he was cold so we covered him with a blanket. We helped him wash. He was unable to participate at all... We could not get him to follow any directions. I took a lead because the patient was very complex. I was able to get him to straighten his legs a little. I did this by talking to him and physically easing his legs...

Agency nurse Sarah took swabs from his nose, groin, throat and catheter. We explained the procedure but Harry was resistant as Sarah put the swab in the intimate parts of his body. I held his hands so she could do this. We spoke gently with him and I tried to respond in a non-threatening way. If his swabs were clear he would be able to come out of barrier nursing and sit in the sitting room with the other residents... I felt very frustrated when trying to get Harry washed. Now writing this I feel guilty about holding his hands in order to allow his swabs to be taken. Although I did this as gently as I could, I did restrain him and it is in the same paragraph that I wrote I found it frustrating to look after him.”

Field notes 29.5.01

On completion of helping the resident wash and change his bed clothes, I wrote that I felt pleased that he didn't smell any more, but sad that I had not really been able to help him. Although I had been able to complete the practical tasks

I was left with feeling that the care we delivered had not comforted him or eased his disturbance. The sense of not being able to help was made worse because we needed to carry out procedures that the resident did not comprehend or want. Providing intimate practical care for this traumatised residents raised conflicting feelings in me. Whilst carrying out the care I felt frustrated and disturbed by the resident's anxiety. Afterwards I felt guilty about my inability to comfort the resident and the anger I had towards him. These feelings of self-doubt and guilt were not present in the staff's accounts of this type of work.

I also found myself experiencing self-doubt when talking with relatives about issues related to loss and grief. Like the staff I was often aware of a pressure of expectation from the relatives. I had a sense that they wanted me to say things were all right even when they weren't. The care staff were sometimes sympathetic about relatives and often made good relationships with them. In the Reflective Work Group though, they seemed more disturbed by a perception that relatives blamed them for the resident's state of health, deterioration and eventual death, and this made them angry. I did feel a sense of responsibility, but I was aware of the terrible pain relatives seemed to be going through and was always left with a feeling of doubt about whether I had said or done the right thing.

The resident in the next data extract was very dependent and unresponsive. She was Bengali and had had a profound stroke some months before. She was fed through a tube and remained on a special pressure-relieving bed for most of the time. I was involved in her care when her daughter came to visit. Her son and grown up grand-children were regular visitors, but I had not met her daughter

before. I tried to ask her if she knew where the resident's hijab (head scarf) was. She did not understand me, but became upset:

"In broken English and with painful silences, the woman said she was the eldest of four daughters and that the others were in Bangladesh. I got the impression she had to cope on her own. She said her father was unwell too. I responded in English with things like "that must be difficult" but obviously I made no real impact. At one point she became tearful. I tentatively went to touch her arm but she withdrew it. She spoke a bit more but I couldn't really understand what she was saying, so I just nodded and tried to sound reassuring."

Field notes 28.5.01

In my notes I recorded that I knew the resident's daughter was upset about her mother, but I felt terrible at not being able to communicate with her. I was concerned that my interactions had worried her and that my response to her upset was culturally inappropriate. Although the language and cultural differences between me and the relative meant this interaction was complex, the feelings of self-doubt about doing or saying the right thing to relatives who were distressed or upset were a common feature in my notes about the participant observation. The care staff articulated the practical problems of helping shocked and traumatised residents and relatives but they did not express the same sense of doubt and guilt about the adequacy of the emotional aspects of care delivery as I had felt.

Working with hurtful residents

Earlier I described how staff reported that crossing the usual boundaries in human relationships involved in caring for extremely confused and dependent people was emotionally demanding. Their accounts however minimised the emotional impact this had on them. In the participant observation I was aware of the complex relationships between residents and their carers.

Understandably, residents sometimes appeared frustrated by their dependent position. They may have been angry and envious of their younger, fitter caregivers. When residents reacted in an angry or resentful way at my attempts to help them I often became embarrassed and hurt. This was in contrast to staff who tended to laugh off or minimize the effects of residents' behaviour on how they felt. In the next data extract a resident with dementia asked me for help in the communal sitting room:

“Betty [resident] said she felt uncomfortable. I tried to help adjust her position in the chair but it didn't make any difference. She said she felt cold too, so I went and got her a blanket. When my help didn't seem to be working she started swearing at me, telling me to fuck off. I was aware of being in a public place and was embarrassed at not being able to get it right. She accused me of deliberately not helping her, she said: “You know you could help me if you wanted to”. I felt terrible. She is so hard to be with and I find it difficult to find anything about her I like.”

Participant observation 22.3.02

The resident in the extract had volatile moods and often swore and shouted at staff and fellow residents. The staff expressed affection for the resident and said they didn't mind when she swore. Sometimes I too warmed to the resident, but, as is demonstrated by the data extract, I was hurt by her rejection of my attempts at helping her and often found I did not like her. Some residents seemed to resent care staff and may have envied their independence. Although the care staff did not articulate this view, insulting behaviour often related to issues pertinent to dependence. In the next example the nursing auxiliary explained how she responded to a resident who cursed her:

“Nursing auxiliary Maria: *Yes Molly curses you she says “May God punish you and your children. May you end up in a wheelchair and your children die. [laughing]*

Researcher Cheryl: *That’s dreadful, how does that make you feel?*

Nursing auxiliary Maria: *Oh it’s nothing, she’s confused and doesn’t know what she’s saying. I just laugh it off and go home and don’t think about it.”*

Reflective Work Group 19.11.03

Although nursing auxiliary Maria was protecting herself from the resident’s anger and possible envy, by denying her capacity to make an impact and walking away she also emphasised the resident’s dependent position and powerlessness by not letting her curse have an impact.

Another aspect of some resident’s abusive behaviour was racism. Ethnicity was an important aspect of the relationship between residents and the staff. As

described earlier (Chapter Two) the majority of the residents were white and had grown up in East London. In contrast all of the staff, except for the Charge Nurse, psychologist, occupational therapist and one of the consultant doctors, had African, Caribbean, Asian or East Asian heritage. As a white person, I am not aware of ever having been racially abused, and I was shocked when I observed it or heard the staff's accounts of offensive language. The care staff's account of some of the residents' racism towards them was recounted in a matter of fact way:

"Nursing auxilliary Rita: *That's nothing, they call us all sorts; blackie, black bastards, paki, whores, monkey.*

Nursing auxilliary Gloria: *Even little Lucy [resident] called me blackie.*

Researcher Cheryl: *That made me feel terrible as you said that, the hairs on my arms stood up, it's so awful and hurtful.*

Nursing auxilliary Joyce: *Yes, it hurts.*

Nursing auxilliary Celia: *No, it's not hurtful, it's just one of those things. We have to go to work every day. So we get used to it and laugh about it."*

Reflective Work Group 18.11.03

I sometimes found residents' abusive language and hurtful comments influenced the way I felt about them. I was sometimes offended or angered. Even though in the data extract one nursing auxiliary does say racist abuse can be hurtful, the general response to this type of interaction with the residents was

to laugh it off or say it didn't affect them because they were used to it and that the residents are too ill to know what they're saying.

Working in isolation

Another feature of my participant observation was the sense that the ward was isolated from the rest of the hospital and other members of the multidisciplinary team. Although medical care was given to the residents it seemed separate from the nursing systems. I rarely encountered doctors unless I targeted my observation periods to coordinate with the weekly doctors' rounds and on a few occasions these were cancelled. The two participants in the research who were not from a nursing discipline were the occupational therapy assistant and the psychologist both of whom left during the data collection period and were not replaced. I found the lack of support from other disciplines frustrating. The staff however seemed resigned to this position:

“Researcher Cheryl: *My frustration is that either you are upstairs [referring to the rehabilitation wards] for rehab or downstairs [referring to Willow Ward] and you're not. I can think of quite a few residents who would benefit from a physio or speech therapist. ...*

Later in the discussion

Nursing auxiliary Geeta: *After that the doctor said he need physio. He made referral and nobody got back.*

Occupational therapy assistant June: *Are you sure it's [the referral form] gone over there.*

Nursing auxiliary Geeta: *Yes, yes it's definitely gone. It's the same as when Constance Williams [resident] needed the speech therapist for a*

swallow assessment it took a long time and so much chasing up. And every time you saw Constance she would say: "when is the speech and language therapist coming, can I eat and drink yet?"

Reflective Work Group 15.5.02

In the data extract the occupational therapy assistant and myself were angry about the lack of involvement in the residents' care by the other disciplines. We were also frustrated by the passivity of the staff who seemed to accept the futility of trying to make referrals. After a time I noticed that my anger about this issue waned. I came to realise I was finding the work and lack of appreciation of it tiring and depressing.

THE TRAJECTORY OF LIVING BEREAVEMENT: DEVELOPING UNDERSTANDING THROUGH SOCIAL RESEARCH

I have discussed themes that emerged from the care staff's perception of the emotional demand of their work with the complex losses involved in continuing care for older people. Through my participant observation I noted there were aspects of this demand that I experienced and they omitted to speak about or glossed over. These aspects of the emotional demand were explored further in the Reflective Work Groups and provided the key to uncovering the issues and obstacles that were relevant to developing the care staff's capacity for working with emotions. In the next section I will discuss the care staff's perceptions of their role in relation to the literature about loss and grief in continuing care.

The care staff's experience of living bereavement could be chaotic. In one Reflective Work Group several themes could emerge at the same time. Shift work patterns also meant that some care staff missed out on experiences and some people were not be present when the residents died or were admitted. The individual care staff member has a disordered and fragmented experience of the living bereavement trajectory. In one shift, they may move from their own anticipation of someone dying to a relative's anxiety about a newly admitted resident. This movement can occur in a relatively short space of time. The sense of disorder and fragmentation was mirrored in the body of knowledge (Chapter Four) and reported omissions and disjointed approaches to care. Care staff coped with the disorder of their experience by organising their work and focussing on certain aspects of it. In Willow Ward, when direct communication about emotions was needed it tended to be deferred to more senior staff and therapists. This was particularly evident during the admission process.

Disorder from the start

The admission period is a monumental experience for the resident and their family (Nolan *et al* 1996; Dellasega and Nolan 1997). The residents' feelings of separation (Reed and Morgan 1999) and the relatives' guilt and emotional turmoil (Dellasaega and Nolan 1997) make the experience painful and difficult. As I have explained, the care staff at this time were primarily involved with learning about the care for the new resident. They have to cope with the residents' shock and often find relatives' needs difficult to manage.

The literature reflects the disappointment the residents and their families have about staff at this time (Sandberg *et al* 2001; Davies and Nolan 2004), but no

intervention studies specifically focused on this area of loss and few mentioned it in the context of other issues (Drysdale *et al* 1993). The literature reports the admission period as being an emotional time. Research that explored the residents' perspective often reported that residents were angry with their relatives (Kelly 1991; Laufer 2001). There was little reference to this in studies of the relatives' perspective (Sandberg *et al* 2001; Davies and Nolan 2004). Moyle *et al* (2002) support the observations made by Willow Ward care staff in pointing out that relatives often present as being content with continuing care provision but under the surface they are seething with rage and often have a tendency to compensate for the loss of their loved one by shifting the blame for their relative's condition onto the staff and organisation. Ashburner *et al* (2004) imply that care staff have a tendency to displace angry feelings about residents onto relatives and colleagues.

I propose that living in a continuing care environment is an intense emotional experience. The admission period requires staff to contain a complex set of emotions in which anger is a significant but infrequently recognised factor. It is an area of care where the emotion and practical work become intermingled. It requires some counselling type skills related to the adaptation to institutionalised care and emotional sensitivity in the provision of the practical care. There is a lack of focus in the literature on how to manage feelings during admission and often the nursing auxiliary grade, who provide a lot of the practical care, bear the brunt of hostile feelings. I suggest that when research and care staff report a lack of priority given to careful and thoughtful admission or that there is an incoherent approach to transfer of care from one setting to another, there is a need to address the containment of feelings such as anger

that are provoked by admission. This is important because it sets up the start of what can be a long relationship and marks out a pattern for how conflicts in the relationship can be resolved.

Unbounded bodies and emotions

There was a focus in the care staff's accounts on the practicalities of their work. Even when there was an obvious emotional component they often concentrated on practical responses. Costello (2001) recognised this in the care of dying patients and Martindale (1989) described how he became preoccupied with the physical aspects of old age when providing psychotherapy for older clients. He suggested it is important for therapists not to be drawn away from the emotional experience. This is particularly difficult in Willow Ward because of the severe dependence of the residents and the high levels of physical need. I suggest that it is impossible to separate emotional and body care in this context and the integration of the two components is vital for the resident's quality of life.

Lupton (1998) provides a useful explanation about the relationship between the mind and the body. She describes the embodiment of emotions and argues for bringing back the body into the emotional sphere. With this in mind, the care staff were providing emotional care when providing practical care. I suggest this type of emotional care for patients and residents is less valued than talking approaches to emotional care and there is a tendency to denigrate the important skills in providing physically safe and emotionally therapeutic practical care. I propose that this relates to the attitudes related to unbounded bodies that Lupton (1998) describes.

She suggests modern societies view the relationship between mind and body in a particular way. She suggests keeping one's body boundaries controlled and distinct from other bodies has become an essential feature of contemporary life. Breaking down of the boundaries between inside and outside bodies is viewed as disgusting. She explains that in modern times there has been more emphasis on closed body/self and this by association relates to emotions. Bodies and emotions have come to be seen as more private and tightly regulated. On one hand this can be viewed as evidence of a progression in humanity, and on the other it can be seen negatively as being emotional can be viewed as a lack of control (ibid).

In Willow Ward the residents' degenerative conditions meant their bodies and emotions were unbounded. Lawton (1998) describes how people in hospices underwent a form of what she called dirty dying when wounds, incontinence and vomiting left their bodies unbounded. She argues this is particularly difficult for modern communities to cope with. It could be argued that residents with dementia lose the internal mechanisms for holding their own thoughts and emotions (Waddell 2002) and their mind becomes unbounded. I have described how a significant part of the care staff's role was to work with people whose bodies and minds seemed out of control. I suggest there is an emotional demand in the provision of care in this aspect of this work. I agree with Martindale (1989) that we should not focus on the physical as an avoidance of the emotional, but it should be recognised that there is a complex emotional component to practical care which receives less attention in the literature and practice setting.

The certainty and uncertainty of death

The end of a resident's stay in continuing care was usually death. The nature and anticipation of death in old age has been marked out as a unique feature of continuing care environments (Hockey 1990: Froggatt 2001) and this reflected the experiences described in Willow Ward. The research in residential care suggests that older people's health seemed to deteriorate over comparatively long periods of time resulting inevitably in death. Death was sometimes preceded by a period of ill health, warning that death was coming, but on other occasions residents made recoveries and lived on. This was frequently described as residents bouncing back from near death illness (Froggatt 2001). The literature reflected a contradiction about death in the continuing care environment. There was uncertainty about the death of older people that seemed to run alongside its inevitable certainty. This seemed consistent with the findings in this study. Hockey (1990) and Froggatt (2001) refer to it as a tension between living and dying in long-term care institutions, and Laufer (2000) articulated it as a feature of her therapeutic relationship with a 90 year old woman:

"As the therapist, our short time together evoked a wealth of deeply personal feelings in me. Until the last day of her life I probably retained fantasies of her continuing to live."

(Laufer 2000, p713)

In Willow Ward, despite the undeniable fact that residents were likely to die sooner rather than later, care staff seemed to demonstrate an attitude that they were trying to keep residents going. Much of their care was aimed at prolonging life and there was little consideration for palliative care principles.

They seemed to “turn a blind eye” to the inevitability and certainty of death and often expressed a sense of failure when someone died. I suggest the bouncing back experience that occurred when residents recovered after an acute period of illness gave care staff a sense of satisfaction that was often not available in their work. This makes it difficult to implement care practices underpinned by palliative care principles, even though they seem logical.

The thematic findings recognise the trajectory of living bereavement in continuing care. It is also important to notice that the actual experience is disordered, unbounded and uncertain. Some of the emotional demand was also missing or glossed over in the care staff’s accounts. It is suggested that care staff socially organise their work in order to regulate and separate dying (Hockey 1990; Froggatt 2001) and unbounded bodies (Lawton 1998). Lee Treweek (1996) described how residential care staff ordered and regulated residents’ emotions because they were perceived as dangerous. Using Lawton’s (1998) understanding of embodied emotions, the ordering of death and body care are inextricably linked with emotion work. In my observations of the work with loss and grief in continuing care I noted how care staff glossed over residents’ hurtful remarks and behaviour that might be considered socially unacceptable. I also noticed that specific groups tended not to mix with other residents. The non-responsive residents spent their time in their own rooms and so did residents with greater cognitive abilities. It is my suggestion that these social practices reflect the emotional demands in the care. In the next three chapters I will discuss how the emotional demand shaped the social practices related to care for dependent older people in the continuing care setting.

SUMMARY

I have articulated the themes that arose from the care staff's perceptions about loss and grief in Willow Ward. They expressed a trajectory of loss that began with the shock and trauma of admission to the ward. They described the grief that relatives endured and were able to identify issues of anxiety particularly related to separation from loved ones and home. There was also a strong emotional demand in providing care for such dependent residents whose bodies and minds were degenerating as a result of the chronic illnesses they suffered. Finally, the care staff recognised that anticipating death, caring for dying residents and the bereavement experience were all significant parts of the emotional demands of their work.

In my participant observation I noted aspects of the emotional demand that the care staff omitted or glossed over. This included caring for a group of residents who were profoundly dependent and had minimal communication skills. I referred to these residents as non-responsive. I observed how I felt doubt and guilt about the levels of care I provided whereas the care staff seemed sure and certain about their work. I was aware that I found some residents' behaviour unkind or unpleasant whereas the care staff seemed to suggest that this sort of behaviour didn't matter because the residents were too ill to know what they were saying. Finally, I missed contact with other professional groups and felt isolated in Willow Ward.

The care staff's experience was not sequential or organised. This meant some issues seemed to slip by unnoticed. The lack of direct communication and the

emphasis on practical issues at the start of a resident's admission affected the relationship between care staff, residents and their families. This style of helping someone settle in to the ward meant important feelings were not addressed and unhealthy patterns of relating were established. The dependent and degenerating conditions of residents' health meant care staff were expected to provide high levels of emotion work through the medium of practical care. The emotional work contained in practical care is less valued in contemporary society and there seemed to be a lack of recognition of its importance. Finally, death and dying were complex issues. Despite the certainty of death and dying care staff sustained a sense of keeping things going. The rewards of success when a resident bounced back from illness mitigated against a palliative care approach. Other authors have explained care staff's response to these issues in terms of their social practices. In the next chapter I propose psychological factors that shaped the social practices and customs in Willow Ward.

Aspects of the emotional demand that were not usually discussed were analysed in the containing environment of the Reflective Work Groups. Over time the care staff brought important and difficult issues to the group which were discussed in depth. I, in turn, took the discussions to the Tavistock Supervision Group where we analysed the content and processes of the work. Through this process it was possible to identify when psychological defences were alive in the work and to formulate suggestions about the source of any anxiety. In the next chapter I discuss one Reflective Work Group that illustrates the psychological defences care staff used to protect themselves from the most disturbing aspects of the emotional demand. I have selected a particular Reflective Work Group that illustrates the psychological defences that have

been identified as significant over time. In the second half of the chapter, I suggest that there are certain emotions that are unacceptable and unbearable that necessitate the use of psychological defences in continuing care. I discuss the formulations about these disturbing feelings in the light of relevant literature.

CHAPTER 8- PSYCHOLOGICAL DEFENCES AGAINST LIVING BEREAVEMENT: AVOIDING AND GLOSSING OVER THE UNBEARABLE AND UNACCEPTABLE EMOTIONAL DEMAND

This chapter illustrates the psychological defences that I suggest care staff used to protect themselves from unbearable and generally unacceptable feelings such as anger, hatred, guilt, envy and despair. In Chapter Seven I identified aspects of the emotional demand that remained hidden and were not spoken about. In this chapter I describe the way the care staff avoided or glossed over distressing emotions and I will demonstrate how new meanings were uncovered using the containing mechanisms of the Reflective Work Groups. In the final part of this chapter, I will discuss relevant psychoanalytic theory applied to the findings. This will strengthen my claims and place them in an appropriate theoretical context.

The links of containment in the research were designed to allow participants (including me) to come closer to the unbearable and unacceptable parts of the emotional demand. As described earlier, emotions cannot be identified in isolation as part of a stage by stage version of grief. More likely people pass between states of mind reflective of thoughts and feelings both dependent on and produced by the social context they are in. In this chapter, I present a fine grain version of findings using an example of one Reflective Work Group. Details of the data are given to provide the texture of the group's interaction and the emotional experience. The presentation of these textured findings allows the reader to make judgements about the validity of my interpretations at

the time of the group and to evaluate the conclusions I have extrapolated following input from the Tavistock Supervision Group and making links with theory.

The purpose of presenting findings in this way is both to give a texture to the care staff's emotional experience so that the complexity can be more fully understood and to ensure the methods I have used to understand it are clearly visible. These textured findings authenticate the claim that the research is psychoanalytically informed and give an account of how psychoanalytic concepts such as psychological defences and internal conflicts are understood in the research. They also show how the data produced by paying attention to the researcher's feelings (*counter-transference*) have informed a more in-depth understanding of the emotional demand.

It is not my intention to pin down the care staff's feelings in order to display a static and lifeless version of them. I want to show how the repetitious nature of the long term Reflective Work Group meant it was possible to test out ideas with participants about the possible nature of the distressing feelings connected to their work. In order to do this it was crucial to identify psychological defences which avoided or glossed over significant issues and to formulate suggestions about what was being avoided or glossed over. I have selected a particular Reflective Work Group for this chapter because it contains formulations that I have identified over time as significant to the research aims and it provides an extreme case that enables clear illustration of emotional issues that are central to this thesis.

My formulations were arrived at through the repeated links in a chain of containment. This included discussing experience in the Reflective Work Groups with the care staff, discussing and trying out new ideas about the research in the Tavistock Supervision Group and taking fresh formulations back to the Reflective Work Group for the participants to consider. Sometimes when formulations were fed back to participants they were rejected. It was difficult to know whether this was because the formulation was wrong or because the staff were psychologically resistant. Similarly, when formulations were readily accepted it was hard to know whether they were accurate or whether they were more comfortable and supportive of psychological defences. It was only possible to unravel this through examining my counter-transference feelings. This meant over time, it was possible to get a sense when nods or silences were a thoughtful taking in of a suggestion or a concrete resistance. I have tried to account for my interpretations by giving details about the care staff's response especially when it was felt in the counter-transference. This should enable the reader to evaluate the effectiveness of my ability to interpret.

The most significant indicator of the usefulness of an interpretation was when it produced a shift in the way issues were thought about or discussed, particularly if it led to a development in practice which will be discussed in Chapter Nine. I have made claims that are true to my own understanding and authenticated through the processes of containment and supervision within the psychoanalytically informed action orientated approach.

The next section relates to a complete Reflective Work Group which has been transcribed in Appendix Five. This is an illustrative case of the suggestion that

the emotional demand of working with complex loss in continuing care for dependent older people involves internal conflicts that provoke feelings that are generally unacceptable and are kept below the surface of experience by unconscious processes. I will use this case to demonstrate how the Reflective Work Groups explored the internal conflicts and psychological defences by allowing these unacceptable feelings to be aired and experienced. The practices I identified as psychological defences that are significant to the aims of this research are:

1. Keeping out strangers
2. Being on the offensive all the time
3. Denying residents' capacity
4. Valuing feistiness and ignoring non-responsiveness
5. Believing in Willow Magic
6. Being like a family

The Reflective Work Group I am going to discuss was about Betty (a resident). She was a woman in her eighties with a long history of mental health problems. She was mentally and physically frail and required help with walking and basic skills such as dressing. She was regularly rude and verbally abusive towards staff and other residents. In her working life she had been a landlady in a pub. She had a large collection of photos of her and her sisters when they were in their twenties and thirties and a photograph of her two children when they were small. She spoke of a partner who the staff assumed had died. She was admitted from a residential care home when her behaviour became too difficult to manage. She was estranged from her now adult children. When she did

eventually die, her son was informed but declined to attend the funeral. She had no visitors during her stay on Willow Ward. In previous discussions, the care staff had spoken about her with affection even though she was often racially abusive towards them. They said they liked her because she was feisty and kept the place going.

The care staff described how Betty had made a complaint about them to a senior doctor. She had suggested they were abusive because they were rough when moving her, for example, helping her in and out of bed using the manual handling equipment. It was unusual for residents and relatives to make complaints, but when they did it had a big impact and staff used the Reflective Work Group to discuss what happened. The care staff's response to this complaint was not to protest their innocence, but to suggest that they needed someone to witness the abuse that they endured. The following data extract was told in an agitated way to me. What was said suggested the staff felt they had been misjudged but the way the account was delivered, the contradictions and what was left out suggested the staff were anxious and self-doubting about the incident:

48. **"Nursing auxilliary Hortense:** *If they could see, just half an hour just to see what we do. One afternoon or one evening. When we are getting someone up or taking someone to the bathroom or just one evening when we are putting them back to bed.*

49. **Nursing auxilliary Gloria:** *Like you do [lots of agreement]*

50. **Nursing auxilliary Cella:** *Just to come and feed them. Then someone like resident Betty. The insults we have from that woman.*

51. Nursing auxiliary Hortense: *Just for half an hour, not a whole hour because they won't be able to cope.*
52. Nursing auxiliary Gloria: *See you, you heard Betty, what Betty calls us.*
53. Nursing auxiliary Meena: *Ah yeah*
54. Nursing auxiliary Gloria: *Betty went to the doctor to complain that the nurses had been bad to her. She herself told me this [said with laughter] that she had told the doctor that we were roughing her out. But you know if you just pass and Betty will call you a name. Because the doctor didn't know what she was like. The first report from Betty, they believe it, I know they believe it. Because the following day that young Doctor Emma. She was talking to Betty in her room and Betty said she wanted the toilet. That doctor was with me and Betty in the toilet she wanted to help me and Betty so I said I am going to get my nurse. I called nursing auxiliary Maria. I know she believed that Betty was telling her we roughed her up. So she wanted to see for herself what happens.*
55. Nursing auxiliary Hortense: *So she did stay and watch.*
56. Nursing auxiliary Gloria: *A little bit, then I said because the room was too crowded with the hoist and that so she had to leave.*
57. Nursing auxiliary Celia: *Was she calling and all that*
58. Nursing auxiliary Gloria: *She wasn't too bad, she just said she was in pain, don't use the hoist things like that. Before these big insults started. She wasn't there long enough to hear the name calling.*
59. Nursing auxiliary Angela: *Isn't there another side to this a psychological side to this. As people get older umm, in life [pause] they change and because we are not of that age group we should have more understanding umm.*

60. **Nursing auxilliary Gloria:** *Yes, but they will believe Betty and they will think we are doing something to Betty, that's what I'm saying.*
61. **Nursing auxilliary Angela:** *There is a for and against here. The doctor in her own self has been practicing for so long and I am sure this is not the first hospital she has been to or whatever. And she should have understanding this is what you get from certain people. That's if it should be understood, as a doctor well I'm sure she has experienced verbal abuse as well. [Yes lots of agreement] If they make a complaint it shouldn't really stand unless how can I say?*
62. **Nursing auxilliary Gloria:** *A bruise or something*
63. **Researcher Cheryl:** *So you feel very vulnerable*
64. **Nursing auxilliary Hortense:** *We are always vulnerable*
65. **Researcher Cheryl:** *Well you are vulnerable because you are working with people with dementia who could say anything about you.*
66. **Nursing auxilliary Cella:** *According to Doctor Ricci [discussion about which doctor he is] he said he has known this woman a long time and she has made accusations before.*
67. **Nursing auxilliary Hortense:** *Oh he knows*
68. **Nursing auxilliary Angela:** *Yes, yes*
69. **Nursing auxilliary Gloria:** *But this new man hasn't. [Lots of excited agreement]*
70. **Nursing auxilliary Angela:** *Betty is not the first patient he has come across.*
71. **Nursing auxilliary Cella:** *She's a difficult patient when she used to be at home and wouldn't let the nurses come and look after her. [More excited talk]*

72. *She fell down 5 times a day before she let them come in. Her doctor knows her.*

73. Nursing auxiliary Meena: *He's a junior doctor and he doesn't know her.*

74. Researcher Cheryl: *It's quite important you know I believe you.*

75. All: *Yes*

76. Researcher Cheryl: *I'll tell you a story about Doctor Emma, I was looking after Mrs Begum, giving her suction and mouth care one morning. In the ward round later that day, she came into the room with the other doctors for the ward round. Mrs Begum had horrible fluid coming out her mouth and nose and that doctor went and wiped her mouth. I wanted to say look we've been looking after her all morning, honestly. I felt guilty, but the doctor was just trying to be nice.*

77. *Agreement, yes, yes. [General]*

78. Nursing auxiliary Gloria: *I had been after you and changed her little towel.*

79. Researcher Cheryl: *yeah but you can't stop her nose dribbling when you are not there. The doctor was just acting kindly but I was suspicious, because I felt guilty. I think it's the nature of your work and your clients – whoever it is – whether it's me, Charge Nurse Steven, agency nurse or you we feel very guilty, because we can't make it better.*

80. Nursing auxiliary Hortense: *You always have to be on the offensive all the time.*

81. *Silence*"

Reflective Work Group 3.4.02 (Appendix Five, paragraphs 48-81)

In the next section I will discuss the psychological defences identified in this part of the session.

Keeping out strangers

It is my suggestion that the care staff are reluctant to let in strangers (that is, people who are not regularly involved in the day-to-day care), because it threatens their sense of certainty about the adequacy of the care they provide. In the example, a response from the care staff to the accusation of abuse by a resident was to express their desire for people outside Willow Ward to share in their work and witness their side of things. In particular they wanted people to see the emotional demand in the personal care they provided such as taking people to the bathroom or helping them back to bed. However, when Doctor Emma did offer to engage with their work by witnessing and joining in with care, the offer of help was resisted. Nursing auxiliary Gloria declined practical help and summoned someone who was "her nurse". In fact she only let the doctor stay for a short time before she asked her to leave because the bathroom was too crowded. On the one hand the care staff expressed the desire to share the responsibility for care with managers and other members of the multi disciplinary team, on the other they mistrusted any offers of help and seemed afraid to let anyone in (paragraphs 48-56).

In the session I acknowledged how vulnerable the care staff felt and suggested that their suspicion of people's motives was related to guilt and a fear of being criticised (paragraphs 63, 76, 79). There was agreement about feeling vulnerable (paragraph 64) and they did not reject my suggestion that caring for the residents can stir up feelings of guilt. Although they seemed to relate to my example of how I felt guilty when someone from another discipline helped with nursing work they were not as comfortable with this part of the formulation. On other occasions when I made this type of interpretation the care staff responded

similarly.

The care staff usually agreed that they were vulnerable to accusation because some residents were confused about the care provided. They accepted less readily that they might have guilty feelings or uncertainties about the adequacies of the care provided. I am not suggesting the care staff *are* abusive, I am suggesting that it is very difficult for them to acknowledge that there might be any deficiencies in the care they provide and that offers of help were often experienced as criticism. This is counter-intuitive, as it is not possible to provide perfect care all the time in such challenging environments. I suggest care staff's ambivalence about allowing other multidisciplinary team members in to provide help and offer expertise relates to feelings of vulnerability of being accused of being inadequate mixed with feelings of guilt about the inevitable imperfections in their under resourced, frequently ignored (see Chapter Two) and difficult work. Care staff were resistant to letting people in to the internal workings of the ward because their ideas were likely to introduce a sense of doubt and challenge the certainty they adopted about the care they delivered. Nursing auxiliary Hortense captured this when she said: "*You always have to be on the offensive...*" (paragraph 81). Although she did not explain this at the time, I recognised this from my observations when I first came to the ward. The care staff seemed suspicious of newcomers and kept themselves to themselves. This initially felt like they were unfriendly or even hostile.

Being on the offensive all the time

The care staff sustained a psychological defence that prevented different and new perspectives being allowed in with outsiders. I have argued that this was

because alternative views and suggestions were felt as criticisms and stirred up intolerable guilty feelings. Part of the defence was to insist that outsiders could not or would not share the responsibility by witnessing or joining in residents' intimate care. This manifested in an attitude that assumed help would be inadequate before it was even offered. Earlier, nursing auxiliary Hortense had suggested that people outside Willow Ward would not be able to cope with their work for longer than half an hour (paragraph 51). When Doctor Emma did want to share the responsibility it was the care staff who could only tolerate it for a short time. It was true that very few multidisciplinary team members were allotted clinical working hours to the continuing care ward, but the care staff also played a role in keeping themselves cut off from outside influences. The psychologist, occupational therapist and I had all received strong resistance about becoming involved with the care staff at the initial stages of the research. At first we experienced the care staff as unhelpful and even hostile. It seemed new ideas and approaches were only welcome as we became honorary insiders. The complex work of using manual handling equipment with residents who have dementia is very difficult and Doctor Emma's perspective may have been helpful in trying to find new ways informed by her medical knowledge. Perhaps equally importantly, Doctor Emma may have been offering an empathic understanding of the challenges of trying to maintain a sympathetic attitude towards a resident who says hateful and hurtful things. This could have been emotionally supportive for the care staff.

Denying residents' capacity

In my experience of Betty's insults and abusive behaviour I had found it difficult to like her and had been hurt and embarrassed by her comments (see

Chapter Seven). In previous Reflective Work Groups, care staff's discussion about Betty had been full of affection and good humour. The potency of the residents' feelings of hatred and anger was numbed by denying their capacity to know their own minds. This also served to avoid any reciprocal feelings of anger and hatred in the care staff. Phrases such as "She doesn't mean it" "I just laugh, he doesn't know what he's saying" and "She's harmless really" were common. At one level this strategy keeps feelings of anger and hatred at bay. These comments can also be used in a punitive way or as put-downs. The expressions take the sting out of residents' abusive comments by claiming they do not have the capacity to be insulting. This reinforces the care staff's position of power and the residents' position of dependence. I suggest that it is very difficult for care staff to acknowledge that residents have feelings of anger, hatred and envy about them. This may be because it is too painful to accept these feelings or it may relate to the unbearable and unacceptable feelings it provokes in return.

Valuing feistiness and ignoring the non-responsiveness

Previously, even Betty's most hurtful insults had been laughed off and forgiven. Another strategy used to numb abusive comments was to say that care staff didn't mind rudeness or insults because the resident was feisty. It was common for the care staff to categorise residents in terms of their liveliness. Some residents were seen as feisty or lively whilst others were spoken of as nice and quiet and the least active were hardly spoken of at all.

Feisty people like Betty were seen as contributing to keeping the place going by adding to a lively energy. The nice and quiet residents did not contribute to a

sense of liveliness by speaking out or being loud, but they participated in a less obvious way. For example, they might have been part of the group of residents who sat in the sitting room or ate in the dining room or who had interactive relatives. The least active residents were those whose physical condition had left them in a very dependent state requiring nursing care in order to survive. I described these residents in Chapter Seven as non-responsive residents. These residents seemed to exemplify the care staff's dilemma. They needed the care staff to provide care in order to keep going (stay alive) but they made little response to any of their interventions. These residents did not usually go in the day room and spent most of their time in their own rooms. On the rare occasions this type of resident was discussed in the Reflective Work Group, it was hard to sustain the discussion. There was often a sense of futility in the group and sometimes participants asked what was the point of talking about such a resident when nothing changes for them. It is my suggestion that focusing on feistiness and ignoring non-responsiveness allowed the care staff to avoid and deny the feelings of frustration, hatred and despair associated with the profound levels of dependence and their own powerlessness to make any difference.

As the discussion progressed it became evident that Betty's behaviour was related to a spate of deaths that had occurred. Six residents had died in the preceding two weeks, which is an unusually high number of deaths for Willow Ward. This stirred up anxieties for both residents and staff. Betty had voiced her anxieties by accusing the staff of murdering residents. The care staff in the group described how Betty's roommate Razia had died whilst she was present:

93. **"Nursing auxiliary Hortense:** *She was in with Betty.*
94. **Nursing auxiliary Gloria:** *Yes, Betty was making so much noise She was making noise. Then resident Razia was making so much noise. So I was saying to Staff nurse Maureen, maybe Razia is not that deaf, she can hear a little bit because Betty was making her usual and Razia was making it back. Razia was doing that talking she do and holding on to her cover. Then in the morning, we were in and out of there because of Betty, and she [Razia] was all right. In the morning we started in the two MRSA rooms then Staff nurse Rebecca and her nurse did Betty and then they went to change Razia. All of a sudden you hear Razia cough and then I came out the MRSA room and washed my hands and she had gone. Just like that.*
95. **Researcher Cheryl:** *Very sudden*
96. **Nursing auxiliary Gloria:** *Very sudden*
97. **Nursing auxiliary Meena:** *Betty was there when she died.*
98. **Nursing auxiliary Gloria:** *Yeah*
99. **Nursing auxiliary Meena:** *Because Betty was complaining that they killed a woman. She's scared we are going to kill her*
100. *[Laughter].*
101. **Researcher Cheryl:** *So Betty's frightened*
102. *[Lots of general talk] Yeah, yes*
103. **Nursing auxiliary Meena:** *She's frightened because they killed the woman you know?*
104. **Nursing auxiliary Gloria:** *Remember with Miriam. It's the same thing she says we murdered Miriam*
105. **Researcher Cheryl:** *So she is aware of Miriam as well.*

106. **Nursing auxilliary Gloria:** *She says we murdered that poor woman.*
107. *[Lots of talking over each other and some laughter]*
108. **Nursing auxilliary Hortense:** *Oh no*
109. **Nursing auxilliary Gloria:** *She sits next to [another resident] and she says "Oh they think I'm stupid I know".*
110. **Researcher Cheryl:** *Betty is never going to say, "Oh isn't it a terrible thing that so and so has died"*
111. **All:** *No, no [lots of talking over each other, Researcher Cheryl trying to make a point but losing it a bit]*
112. **Researcher Cheryl:** *She doesn't talk in that way, but it is her way of expressing what has happened.*
113. **Nursing auxilliary Hortense:** *She makes it that you are the culprit*
114. **Researcher Cheryl:** *Remember I was talking about the guilt thing. I noticed when Gloria and Hortense told me about Miriam dying. And when you do tell the story of somebody who has had a sudden death you go into quite a lot of detail like you did with Razia's death. It almost sounds like you are trying to justify it to me ... well I don't think you've murdered them.*
115. *[Lots of laughter]*
116. **Researcher Cheryl:** *I think they've just died. It's like you are trying to persuade me. It is human to feel guilty when someone dies. Someone like Betty is not helping.*
117. **General:** *Yeah"*

Reflective Work Group 3.4.02 (Appendix Five, paragraphs 93-117)

Resident Betty was an elderly woman at the end stage of her life. On one level she was confused but on another she was fully aware. She had a good grasp of

relationships amongst staff, could articulate her own opinions and feelings and interacted with other residents. In the last six months she had witnessed two of her roommates die and was probably aware of the deaths of other residents who she usually sat with in the communal sitting room. In the extract, the care staff told me that a resident had died suddenly and Betty had witnessed her death. They said she had accused them of murdering the residents. This was told in an excited way and there was laughter especially when the accusation was described. I heard the excitement and laughter as an avoidance of the seriousness of so many deaths and the disturbing feelings this had provoked. I adopted a serious tone and repeated back what was said without laughing (paragraphs 95, 101, 105, 112).

I felt overwhelmed by the amount of distressing material that was coming out in such an excited way and it was difficult to keep a hold of the group (paragraph 112). I understood the excitement and the attempts at laughing off Betty's accusations as psychological defence preventing thoughts and discussion about her fear of dependence and dying. Perhaps this also avoided the care staff's angry and maybe even murderous feelings towards Betty. It is my suggestion that this was an extreme case that touched on the anxious feeling the care staff have about the responsibility they feel for residents' lives and the guilt associated with their deaths. In order to avoid these feelings they invest all their energy into a life sustaining attitude in what is sometimes referred to as Willow Magic.

Believing in Willow Magic

The care staff had to bear the difficulties of being with residents for long

periods of time as their health deteriorated and when they eventually died. Rather than engaging with the inevitable deterioration of a person, the care staff tended to focus on providing good personal care of the body. The care staff took a lot of pride in the healing qualities of their personal care. Sometimes when a resident overcame an acute illness or showed signs of making physical progress the care staff would proudly declare that it was a result of Willow Magic. Sustaining life in such dependent residents was tiring and difficult for both the care staff and the residents, but care staff rejected thoughts that some residents wanted to be rid of their responsibility for living. In fact they took up a counter position, insisting they wanted residents to live as long as possible. There also seemed to be an unrealistic expectation of the care staff's ability to prolong life.

“Nursing auxilliary Meena: Yes. We don't like it when they die. We want to keep them alive until they are 100 or 101 like the Queen Mother [who had recently died].”

Reflective group 3.4.02 (Appendix Five, paragraph 182)

I understood the care staff's attitude about wanting to keep the residents going as a reaction formation and their investment in Willow Magic as a denial of their powerlessness to prevent inevitable deterioration and death. The reaction formation meant the care staff were adamant that they held one position in order to avoid any contemplation of their unconscious anxieties about the opposite. Perhaps they were sometimes tired of the burden of responsibility for life and death and at an unconscious level had a desire to be rid of their burden. This staff group usually kept any thoughts like this far from their minds.

Occasionally they gave an account of a resident giving up or wanting to die, but staff rarely spoke of relief when someone died or questioned the ethics of active care for a person who had a poor quality of life.

The event of six deaths may have stirred up anxieties attached to deeply held unconscious fantasies of wanting to give up on the residents or be rid of them. In the light of this, I acknowledged with the staff that Betty's accusation of murder was disturbing and did not help them cope with their guilt (paragraph 116). There was also a sense of despair in the session. At the start of the session they had asked what's the point?, referring to the function of the Reflective Work Group. As the session progressed it seemed they were questioning the point of their work when no matter how hard they try to keep them going, the residents will die anyway. Tolerating the knowledge that death was not far away, whilst trying to sustain liveliness, was tiring and difficult. The care staff seemed stuck in a position where they continued to try to keep things going and when anyone appeared to walk away they seemed resentful. This led to a sense of failure when a resident died and hindered their ability to adopt a palliative care approach (Chapter Seven). The underlying sense of being left with a burden that could not be escaped also seemed to cause resentment towards some relatives.

As the session progressed the discussion moved away from Betty and to one of the residents who had died. In this account staff described an idealised trajectory of care. This involved tolerating and understanding relatives' initial difficulties in accepting institutional care and making a good relationship with the resident and her family. They admired her husband for his dedication and

his appreciation of their work and they seemed to share his desire to keep the resident going for as long as possible. They nursed the resident through an acute period of illness so that she could live on a little longer until her death after another period of illness. They had received a thank you card from the family when the resident died and three staff members attended her funeral (Appendix Five, paragraphs 143-168). There were many stories of good examples of care in the data where staff seemed rewarded and satisfied. After someone died care staff often reminisced about the good times spent with the resident and their family.

Being like a family

In the care staff's examples of when things went well, care staff, residents and relatives struggled to keep going until the absolute end leaving the bereaved feeling sad but with a sense that they had done everything they possibly could to maximise the length of a person's life. Their example of when things went badly related to relatives who did not struggle to visit but gave up or seemed estranged from the resident. The care staff became angry when relatives displayed the opposite behaviour. In the Reflective Work Group where Betty's complaint had been discussed, the care staff asked an illogical but telling question:

Researcher's notes: *"They asked why we didn't tell the relatives to go and sit with the residents [when they were dying]? They said we are asked to sit with the residents but they don't have to."*

Reflective Work Group 3.4.02 (appendix four, paragraph 177)

The staff were describing and denigrating some relatives for avoiding the arduous task of being with residents as they endured an often prolonged and unpredictable ending. They were angry when relatives opted out of what nursing auxiliary Hortense had described as "waiting your turn" (paragraph 119). By this she meant enduring the sense of waiting when death was close but not imminent. The care staff divided relatives into categories, those who stayed and helped and those who abandoned the residents and the task of keeping things going. This avoided acknowledging that most carers, including the care staff, at some time want to be rid of the burden of caring for such dependent and dying residents. Once this division was created, the care staff aligned themselves with the residents and the relatives who stayed, as if they were one family.

I suggest the anger and denigration of relatives for abandoning residents and the integration of residents and regular visitors into the Willow ward family can be viewed as another form of the psychological defence of splitting. The unbearable feelings about wanting to be rid of the burden of the residents could be projected in to the bad relatives and disowned by the care staff. The care staff also expressed feelings of being dumped on that seemed personal as if they had been abandoned and not the residents. This could be interpreted as a projective identification with the residents. This meant the residents feelings got mixed up with the care staff's own feelings. This splitting and projective identification meant the care staff denied any of their own desire to be of the rid of the burden of care for residents but resulted in an envious anger towards anyone who could walk away from their burden.

PSYCHOLOGICAL DEFENCES AGAINST LIVING BEREAVEMENT: DEVELOPING UNDERSTANDING THROUGH COUNTER- TRANSFERENCE

It is not my intention to imply that the care staff were inadequate or poorly motivated but to suggest the emotional demand meant that it was inevitable that individuals developed psychological defences to protect themselves from the high levels of anxiety and disturbance that the work provoked in them and that was projected into them by the other people involved. Throughout this chapter I have used examples of counter-transference within the Reflective Work Group to support my suggestions. In the next section I show how the Tavistock Supervision Group helped me identify when I had become swept up in defensive thinking and *over identified* with the care staff. Through the supervision process I distinguished my own feelings from those of the research participants. I include this as an example of the analytic process and how counter-transference feelings contributed to a qualitative understanding of the texture of the care staff's emotional experience.

In the Tavistock Supervision Group I presented some work from one of the Reflective Work Groups. As we got into the discussion, it seemed to me that the supervision group members were more and more sleepy. This had a very strong effect on me. When they asked me questions and gave me ideas about how to proceed with the group I felt criticised and found myself saying things like "Well I've tried that and it doesn't work". I seemed unable to respond with any authority or conviction about what had gone on. I thought the supervision group seemed to be saying "So what?" and questioning the point of the

Reflective Work Groups. A couple of group members seemed to be trying to help out, but eventually they gave up and so did I. By the end of the session, the majority of the group members were silent or sleepy and I seemed unable to string a coherent sentence together. On leaving the Tavistock Supervision Group I felt very low and angry. The following is an extract from my research diary:

"Why was it so awful last Tuesday? I came away feeling tearful and hopeless, I just lost the plot. I had no confidence in what I was saying and I ended up not knowing what I was talking about. There was a lack of drive and purpose in what I was saying and I started to feel defensive and guilty. I was defensive about anything the others said and I started to feel guilty about my research. I thought the others thought I lacked the skills and that I was taking advantage of the staff. I couldn't ask the [supervision] group for help because I didn't believe they wanted to help me, they just left me to it. They all fell asleep and didn't seem to get the point of my work at all. I kept trying to wake them up, but they just kept dropping off. I felt like a tent peg and every interaction knocked me into the ground a bit further."

Research diary 29.1.03

Following further discussion of the incident within my psychoanalytic supervision, I recognised my feelings in the context of the research process and my over identification with the care staff. I came to understand my emotional response in terms of projective identification. The intolerable feelings related to the experiences on Willow Ward had been projected into me and they had been

called out as if they were my own. My emotional responses had started to get mixed up with the care staff's. I was unable to take in the suggestions of my colleagues in the supervision group. I was unable to think of some of the negative aspects of the care staff's work and I was struggling to keep them interested and awake. As I failed to keep the session going I resented the supervision group members who could just walk away from the work at the end of the session.

It was pointed out that the tent-peg analogy was a useful metaphor for the position of the staff working in continuing care. The feelings I experienced whilst trying to keep the supervision session going were experienced as if I was a member of the care staff trying to keep Willow Ward and the residents in it going. I felt the weight of the pressure to keep going, but inevitably my words just put people to sleep. I felt failure when my words did not make an impact and I became depressed about the inadequacies of my work. I felt I was letting the care staff down by not representing them properly. By the end of the supervision group I was tired and hopeless. The sense of powerlessness provoked in me was parallel to the care staff's experience of providing care for residents who, no matter how hard the care staff tried, inevitably died. The analysis of my unconscious defences gave me some insight into what might lie below the surface of the care staff's experience.

An understanding of my *counter-transference* feelings suggests the unconscious elements of the emotional demand of working with dependent and dying older people were powerful, upsetting and impacted on the capacity to think clearly. The containing links of the research process including experience,

reflection and supervision were designed to contain emotion and to identify when psychological defences were alive in the work. The selected Reflective Work Group and the example of my counter-transference in the Tavistock Supervision Group illustrated my formulations of how psychological defences were used to protect care staff from the unbearable and unacceptable aspects of the emotional demand that lay below the surface of the conscious experience. These formulations were made via the repetitious processes of the research. In the next section I discuss my claims and place them in the context of relevant psychoanalytic theory.

PSYCHOLOGICAL DEFENCES AGAINST LIVING BEREAVEMENT: DEVELOPING UNDERSTANDING THROUGH PSYCHOANALYTIC THEORY

Part of the Tavistock approach to understanding emotions is to make comparisons between data and established psychoanalytic theories. I suggest that the feelings and associated psychological defences attached to the hidden and less conscious aspects of the emotional demand provide the key to helping care staff develop their capacity for working with emotions in this area. I have explained how the care staff used psychological defences to protect themselves from disturbing and anxiety provoking feelings. In the next section I argue that the source of the disturbing feelings lie in the unique nature of their work. I argue that there are three particular components of the emotional demand that are significant. I will explain how three particular issues trigger the psychological defences already described.

1. Dealing with the residents' profound dependent states caused by mental and physical degeneration
2. Being denied the sense of reward and satisfaction when a person being cared for gets better
3. Having sustained contact with a sense of lifeless void.

I use psychoanalytic theory to support my suggestion that these are the aspects of care that provoke the unbearable and unacceptable feelings that are associated with the psychological defences

Dealing with the residents' profound dependent states caused by mental and physical degeneration

In Winnicott's (1949) classic paper on hate in the counter-transference, he suggested that what some might describe as negative feelings is normal between psychotherapist and client. He referred especially to feelings of hate, suggesting that no matter how much a person loves those in their care, there will also be hatred. He argued that the more the hatred is known and understood, the less likely it is to be acted out. Dartington (1994), in her observation of nurses and nurse teachers, suggested hospitals are bursting with intense primitive anxieties. She claimed that staff have deep fears about the harm they might do to patients and that the anxiety about care staff's potential for a sadistic abuse of their power over patients is not talked about or acknowledged. A central aim of this study has been to uncover disturbing areas of emotional demand such as feelings of hatred, which are not usually spoken about.

Martindale (1989) discussed working with a group of psychotherapists who were providing therapy for older people. He described how the therapists expressed a dread at the length of the relationship that they might develop and a sense of being trapped. He attributed this to the transference demands of the patients. He explained how the older patients' profound neediness seemed to overwhelm the therapists and left them worrying about their own dependability. He suggested that in the therapeutic situation the contact with the therapist stirred up the patient's longings for missed caretakers such as spouses, partners, sons, daughters and also the hate, resentment and envy of the younger person. He claims that older patients become threatening to the therapist because they feel burdened by unbearable guilt from the feeling that they themselves should be providing care for the patient all the time. It is my suggestion that similar transference demands are made on the care staff in Willow Ward because they have sustained contact with the residents and inevitably form relationships with them. This demand is more difficult to deal with if the resident has lost their capacity to process any of their own internal anxieties.

Waddell (2000) proposes that some older people, especially those with dementia, can return to more infantile states of mind. Earlier I described how for small babies experiences can be felt as immediate, dangerous and chaotic and are sorted by the infant into crude good or bad categories in order to prevent conflict (Chapter Three). For a person with dementia this mind state is not the building block for future development but the foundations they depend on for processing their current, often confused reality. Davenhill (1998) suggests that in this state of mind unresolved psychic issues can be replayed and, as a person's internal defences and coping strategies become less adaptive,

they can be subject to a raw or even abject sense of dependency. In this state, anxiety, guilt, rage etc are felt as catastrophic.

She argues that when a person's internal psychic structures of containment melt away the person is reliant on the external environment as a container. The older person's loved ones are left holding their function in memory and there is a return to what she describes as instinctive rhythms associated with voice, touch and touch. The older person's raw experience is projected into those who have close contact with them. In the continuing care situation the ability of the care staff to provide sensitive care relies on a capacity to tolerate and understand these projections. The next extract illustrates the extreme emotional demand in the moment of providing personal care. I have included it because it is a piece of everyday interaction where a carer is required to bear the resident's projections about dependence (Martindale 1998) and the raw experience of dementia that can feel catastrophic (Davenhill 1998). The resident involved asked if she could use the toilet whilst I was carrying out nursing care in the participant observation.

"Eventually nursing auxiliary Gloria came to help me. She said we needed to help Sarah [resident] on to the toilet using the hoist, and then I could change her underwear and clean her bottom. She went and got the hoist. I was not sure how to use this hoist with Sarah as it seemed rather alarming looking. Gloria said to sit Sarah on the edge of the bed. Gloria went and got Sarah's wheel chair. We stood Sarah and swivelled her on to the chair without using the hoist! [Later, I recorded in my notes that this was against the moving and handling regulations,

but it was a relief as using the hoist would have been so distressing]. We wheeled her to the bathroom and helped her onto the toilet. She shouted that she didn't want to sit on the toilet but Gloria said if we put her onto the chair she would want to go back onto the toilet straight away. As soon as she left Sarah started screaming loudly saying she was falling. I made sure she was safe and she had something secure to hold onto.

She continued to scream. I changed her pants as quickly as I could. She seemed to calm for a fraction of a second if I held both her hands and tried to get her to look at me. Gloria came back, she helped me stand Sarah and I cleaned her bottom. Gloria left again and I got Sarah's things together. I asked Sarah if she would like to brush her hair, she shouted and cried no as if I had said I were going to torture her. Soon she calmed down and asked me to brush her hair. She was still uncomfortable in her chair. I put her footplates down, so she could move herself back, but she was unable to understand what to do. In the end, against manual handling regulations, I stood behind her and [as gently as I could] pulled her up the chair. She seemed a little more comfortable. I took her into the sitting room." Field notes 2.6.01

My counter-transference feelings in this example were explored in the Tavistock Supervision Group. I reflected that like Gloria, I wanted to leave the room. The pressure coming from the resident in her shouts and screams felt unbearable and although contrary to regulations, I was relieved not to have to go through the torture of using the manual handling equipment with the

resident. It is my suggestion that I was receiving the projections of the raw terror of the resident in her fragmented state of mind. I also felt frustrated, inadequate and powerless to help. I suggest these counter-transference feelings relate to the resident's anger and fear about her dependence and powerlessness.

This sort of interaction is an everyday occurrence on Willow Ward. Care staff avoided the residents' unbearable projections by carrying out tasks quickly and not engaging with the emotional aspect of the practical work (Chapter Seven). The emphasis on the practical at the expense of the emotional supported the psychological defences described earlier in this chapter. Practical work sometimes had rewarding feelings attached to them that were often missing if a more holistic approach was assumed.

Being denied the sense of reward and satisfaction when a person being cared for gets better

The care staff in Willow Ward provided care for residents who would inevitably deteriorate and die. Main (1957) described how, in psychiatric services, patients who failed to respond to treatment were passed around from doctor to doctor. In the older adult services in this study a similar situation arose. In other wards, patients who got better were transferred home or perhaps to a care home. Those who didn't respond to acute care or rehabilitation, or could not manage at home were transferred to Willow Ward. Nearly all the residents in this study fitted a category of residents who did not respond to treatment and did not get better.

Main (1957) suggested that when patients do get better, they satisfy a need in their carers for a sense of reparation. When people fail to get better they provoke a strong response in their carers which can involve aggression, anger, guilt, depression and ultimately despair. He described the situation in relation to doctors, suggesting they can adopt an omnipotent scorn of illness and death. He claimed that they can become detached from difficult issues such as a poor prognosis so that they can continue their work without too much personal distress. Another side to this is a refusal to accept therapeutic defeat. He suggested this can lead to an over-enthusiasm for surgical and medical treatments that are not necessarily in the patients' best interest. It is my suggestion that the care staff in Willow Ward deny their feelings of frustration and hopeless despair about the lack of impact they have on the residents' conditions by focusing on the power of their practical care. When practical care achieves results, for example when a resident recovers from an acute illness, this supports the care staff's omnipotent desire to triumph over death like the doctors Main described. In the following extract a resident was admitted to the ward following the decision made by her son (who lived in America), the medical team, and senior nurses not to amputate her gangrenous foot.

Staff nurse Elizabeth "Ah yes, Constance [resident], she came in about a year ago. She was almost dead. Her foot was gangrenous and her son didn't consent to an operation. The doctors wouldn't do anything, so the woman got worse. She was in pain, unable to speak or eat. And then I say the Willow Magic, she comes back from the dead. The foot drops off bit by bit and she is nursed back to health."

Reflective Work Group 13.11.02

In this case, the good nursing care combined with artificial feeding seemed to save the resident from death. In order for the resident's physical recovery to be felt as a success however the emotional impact of her survival had to be glossed over. Even though she had not died, her quality of life remained very poor and she lived the rest of her life in Willow Ward, fully dependent on the care staff and on the artificial feeding. She was also separated from her friends and family which made her deeply sad. I am not suggesting the care staff should not provide good practical care, but I am highlighting that by focusing on the achievable practical aspects of their work they can feel a sense of satisfaction. If they were to adopt a more holistic perspective they might be denied this. It is impossible for care staff to provide care that will compensate for all that the residents' have lost or prevent their degeneration and eventual death. In order to avoid the despair of this situation they focus on the satisfying achievable tasks in practical care and place faith in Willow Magic to gain some control of the relentless threat of death they are faced with every day.

Having sustained contact with a sense of lifeless void

Finally, I suggest the residents who are in a non-responsive state or who are approaching this sort of degenerative condition produce in their carers a dreadful fear of non-existence. Bick (1968) described the very early forms of unintegrated personality as being in a passive state of helplessness with no sense of being bound together. Perhaps more modern language might describe this state as out of control, with no chance of keeping it together. Emanuel (2001) describes how this is akin to a fear of non-existence, or a fear of falling to pieces or disintegrating. He draws on Bion (1962) to describe the terror of a

space or nowhere place that becomes filled with a nameless dread. He goes on to discuss various defences he claims are universally employed against contact with the non-existent domain. I propose residents who were in non-responsive passive states where they seemed to be neither actively living nor actively dying not only provoked feelings related to not getting better but also stirred up deep feelings reminiscent of primal unintegrated mind states (Bick 1968; Davenhill 1998) that induce terror of a nameless dread (Bion 1962).

Emanuel (2001) suggests we have all had experiences of being terrified by some supremely non-existent object or void. He says that in its less intense form it can be equated to a child's boredom. This is similar to student nurses who often say they find the care for older people boring and the care staff in the study sometimes questioned the function of the Reflective Work Group by saying things like what's the point and nothing changes. Emanuel (2001) argues that if you scratch the surface of this type of boredom you will find the catastrophic anxieties experienced in the primitive mind states of small babies (Bick 1968) as well as older people at the end stages of chronic illness such as dementia (Davenhill 1998; Waddell 2000).

The next extract relates to a care interaction with a resident who was approaching the non-responsive state. I suggest it demonstrates his catastrophic fears and how carers responded to his disturbing transference demands.

“Nursing auxiliary Rita said I could feed Bill [resident]. I like Rita she always joins in the groups and has asked about nurse training before. Bill was laid out flat. Rita said he liked to eat lying down and she

laughed at my scepticism about this. His room had no pictures and his cot sides were up. I got a chair and sat by him. He soon started shouting "Help me, help me" in a very loud powerful voice. I made a reassuring response like "I am here" or "I am here to help you with your lunch". I started to feed him. I gave it to him on a spoon in reasonable size mouthfuls. After a while he shouted "I'm not dead, I'm not dead". Again I responded with "You're OK" and "I'm here" type responses. Looking back he was laid out flat a bit like he was dead. He had tattoos on his arms which accentuated his wrinkly skin. He was wearing a night shirt and I didn't think his eyes were following me. I'm back to my horror film analogies again - a kind of Frankenstein's monster. I felt he was cross with me and my responses were not what he wanted. This was confirmed when he said "You'll be all day. You'll be all day!" I got the impression he wanted me to give him his food more quickly. I was feeding him at a reasonable speed and it was my fantasy that he wanted me to be faster and less gentle. I remember a couple of students telling me they were shocked that the staff always "shovelled" the food into a certain patient here and I wondered if it was him. I found myself loading the spoon more. I had to leave before I could finish feeding Bill and Rita took over from me. As I left I noticed that Rita was standing over Bill and loading the spoon. She was not sitting next to him in the chair I left."

Field notes 29.5.01

In this example I sensed the resident's dread in the counter-transference feelings. I felt a sense of urgency which made me want to go faster and take

less care. I associated his state with an in between life and death existence – like Frankenstein's monster. It is my suggestion that this association was linked with the nameless dread or lifeless void that is felt so terrifyingly in primitive mind states. It is my belief that the care staff had responded to their similar counter-transference feelings by resorting to feeding him quickly, in a standing position and not taking care. I believe unconsciously they responded to his urgent anxiety and perhaps aggressively stimulated his senses to remind him he was alive. This defensive response is similar to the mother in one of Bick's (1968) case examples. The mother, unable to bear closeness with her baby's disturbance, resorted to feeding the baby whilst watching television or in the dark without holding the baby. I suggest that the practice of placing food into dependent older people's mouths, in an urgent fashion with limited intimate contact, is an example of acting out a defence that symbolically fills a frightening void.

SUMMARY

In this chapter I have provided a detailed discussion of a Reflective Work Group that illustrated the significant aspects of the emotional demand that lay below the surface. Using the example I suggested that the care staff protected themselves from the unbearable and unacceptable aspects of the emotional demand by adopting psychological defences. These included resisting the help of other disciplines and adopting a "being on the offensive" attitude to keep out any ideas that might shake their sense of certainty about the good work they carried out. In order to avoid the despair of looking after residents who inevitably failed to get better the care staff placed a lot of value on feistiness

and ignored non-responsiveness. They also tended to assume the residents did not know what they were saying in order to take the sting out of their hateful and envious insults. Lastly, the care staff tried to overcome their feelings of despair about the lack of impact their work had on the residents' well being by focusing on the satisfaction of practical care and placing faith in an omnipotent sense of power over death in what I have termed Willow Magic. In order to avoid feelings of wanting to abandon the residents, the care staff created a tight knit family atmosphere where thoughts of being rid of the burden of care were not tolerated.

I have supported my claims with an example of my own counter-transference feelings where I was made to experience the quality of the emotional demand on staff. I have also used psychoanalytic theory to support my suggestion that the psychological defences I observed were rooted in the very real and profoundly disturbing feelings associated with working with residents who were extremely dependent and experienced a slow degeneration of mind and body. I argued the volume and sustained work with residents who did not get better coupled with the close proximity to residents who lived their lives in a passive state between life and death stirred up terrifying anxieties that are universally defended against.

In the next chapter I will demonstrate the importance of the unbearable and unacceptable feelings and their associated psychological defences. The action orientation of this research was aimed at developing the care staff's understanding and creative response to working with emotions. Through the containing links inherent in the research it was possible over time to see shifts

in the way participants (including myself) viewed and worked with emotions. In Chapter Nine I will describe an illustrative case that demonstrates development in care staff's capacity for understanding and working with emotions. These new ways of working did not however become part of the culture of care on Willow Ward. In the concluding part of Chapter Nine, I will argue that this was because social systems throughout the whole institution supported the psychological defences described in this chapter in order to allow most people in the organisation to avoid contact with the most disturbing elements of the emotional demand in continuing care that provoked the unbearable and unacceptable feelings.

CHAPTER 9 - TUNING IN: DEVELOPING THE CARE STAFF'S CAPACITY FOR EMOTION WORK

I have discussed the emotional demand of working with complex loss and grief in a continuing care ward for older people in Chapter Seven. I have suggested that elements of the emotional demand are so difficult to tolerate that people use psychological defences to protect themselves from the conflicting and anxious feelings they provoke. In the previous chapter I discussed suggestions about the nature and source of these conflicting and anxious feelings. I illustrated how the Reflective Work Groups and the Tavistock Supervision Groups were used to generate these understandings. In this chapter I will show how the participants used the research to develop their capacity for working with emotions.

Structures in the research were designed to provide containing links (Chapter Four). These links provided a holding space so emotions could be taken in and digested. The cycle was completed as new understandings were fed back and applied in the practical experience. The links formed a containing chain that stretched from the practical experience of living, visiting and working in Willow Ward to the Psychodynamic Approaches to Old Age course at the Tavistock. This allowed the participants to develop and try out new ways of working with the emotional demand.

The findings I discuss in this chapter demonstrate how the research methods intrinsically provided containment. The results of the research are not only the product of the researcher's analytic processes but also a synthesis of work in

the Reflective Work Group, Tavistock Supervision Group and the researcher's self-reflection. Sometimes this took place over a long period of time or it could happen very suddenly. The feedback part of the research process meant findings were continually given back to participants where they could be used, modified or sometimes ignored.

I will use an example of an ongoing case to illustrate the process of containment within the research. In the example, the feelings associated with hatred, wanting to be rid of the burden of responsibility for a resident's life and the conflicts in accepting help from outsiders are evident. The emotional demand involves the difficult feelings, projections and defences of the resident, his relative and the care staff. The complexity of loss and its impact on the dynamics of relationships are central to the care staff's work in this example.

I describe the living bereavement experience of the resident and his wife and discuss the elements of the emotional demand, including the formulation of suggestions about the elements of emotional demand that lie below the surface. I will show how the care staff have a capacity for taking in difficult feelings, thinking about them and feeding them back in a more manageable form. The example demonstrates how the changes that are implemented can be very small, but may indicate substantial shifts in how working with emotions are conceptualised by participants. The account articulates the stages of the developmental process and is broken down into the following sections:

1. An account of a resident and his wife's living bereavement

2. Uncovering the emotional demand
3. Elements of the emotional demand that lie below the surface
4. Taking in the unbearable and unacceptable emotional demand
5. Giving back painful and distressing emotions in a more manageable form

An account of a resident and his wife's living bereavement

Resident Cyril and his wife Phyllis had lived in east London all their lives and had been married for over fifty years. Cyril had vascular dementia and was dependent on others for all personal care. He was admitted to the hospital following an acute infection, which caused deterioration in his already profound stroke symptoms. These included profound cognitive impairment and immobility. Before admission he had been living with his wife in their third floor flat. She had been his full-time carer. The decision to admit Cyril to continuing care was taken when Cyril made no signs of improvement and it seemed Phyllis would not be able to get out of their home because of the unreliability of the lift servicing her flat. Phyllis always seemed ambivalent about this decision.

The care staff discussed the couple's emotional state and drew conclusions about the best way to support them. The data extracts are taken from staff Reflective Work Groups during Cyril's admission period and again at a time when his health had deteriorated and it seemed he was dying. On arrival to the ward the staff seemed to get on well with Cyril and Phyllis and it was striking that separating this couple was disturbing for them both. When Cyril was left alone he seemed unable to settle and he frequently moved around his chair or

bed at night in an agitated way. This behaviour stopped in the presence of his wife.

"I'm not sure how or when but the talk turned to Cyril [resident] and his chair. June [occupational therapy assistant] had mentioned that she had heard him calling out and she didn't realise he could communicate verbally. Everyone started discussing Cyril's chair and how when he is left alone he wriggles into a very uncomfortable position. June was saying – "Can't we get him a better chair? Couldn't he be assessed for his own chair?" The nursing auxiliaries replied that he had already been assessed and this was meant to be the best chair for him, "He's happy like that". They said it was very heavy and he got himself into very awkward positions where he seemed he might fall but he didn't. Gloria [nursing auxiliary] told a story of when she was on nights and how he wriggles about. She said she had to go in and out of his room all the time and you get no rest. She said sometimes she lined chairs up against his bed in case he falls. She said you couldn't put cot sides up because that would be dangerous as he wriggles into strange positions between the bars."

Reflective Work Group notes 1.5.02

Here, the care staff described their own response to Cyril's behaviour. When viewed as counter-transference it gave clues to Cyril's feelings and the emotion work required of the staff. Although there was an attempt at denying any significance in the resident's behaviour by stating he was happy, the tone in which the account was told contradicted this. It is also worth pointing out that the behaviour was perceived as a cause for worry in my own participant

observation data and the issue was raised in another two staff Reflective Work Groups.

There was a sense of urgency in the account and a need to do something indicated by occupational therapy assistant June's suggestion about getting a new chair. There was a feeling of impending danger and that Cyril might fall. This was evident in nursing auxiliary Gloria's actions. The discussion produced a tense atmosphere in the group. From these data, one could hypothesise that Cyril's behaviour was indicative of his anxiety, which had an urgent and dangerous quality, like a fear of falling. His behaviour was an emotional communication (projection), which staff received but in this example tended to act out, rather than contain. For example, rather than allowing themselves to experience the urgent feelings and to consider what they meant, they were compelled to act: nursing auxiliary Gloria into making Cyril's bed safe and occupational therapy assistant June into making his chair safe. I do not think care staff should ignore practical solutions to the residents' risks, but being mindful of the emotional quality driving the action gave us clues as to what might lie below the surface of such experiences.

Acting as emotional containers in the practical experience would have involved the very difficult work of taking in Cyril's anxiety, holding it and their own worries about what could happen, thinking about it and expressing it back to Cyril in a more manageable form. This could be achieved through words, touch or the way caring procedures such as moving him around the bed were carried out. The difficulties and poor capacity for containment were acknowledged and described by the psychologist in the group:

"Hayley [psychologist] pointed out what a poor container the chair was. She tried to describe the idea of containment to the group. She used the analogy of holding a baby and feeling its distress as a means of comfort."

Reflective Work Group notes 1.5.02

The Reflective Work Group was used to contain the urgent feelings that provoked physical action so that the participants could engage in emotional activity. It was evident that Cyril's wife was also deeply affected by their separation. She had cared for her husband for a long time and had reluctantly given in to the suggestion that Cyril should be admitted for continuing care. She visited every day despite having to travel considerable distances. Initially staff viewed Phyllis' behaviour as evidence of her love and the strength of their relationship.

Researcher Cheryl: *"The discussion moved to Cyril's wife Phyllis. Gloria [nursing auxiliary] said what a wonderful woman she was. She got up very early in the morning and came on a difficult journey involving public transport and several interchanges. She then stayed with Cyril until 1pm. She then went all the way back home. She then always phoned at 7pm to see how he is."*

Reflective Work Group notes 1.5.02

The care staff were able to use the group to analyse their experience and observation of Cyril and Phyllis's relationship and to try out new ways of thinking about behaviour and interaction. The initial discussion about Cyril and

Phyllis gave us a preliminary understanding of their emotional state. Cyril's shock and the couple's anxiety were typical of the kind of emotional demand described by the care staff in Chapter Seven. It was evident that Cyril was reassured by being with his wife and anxious at being separated from her. The care staff also noticed that Phyllis needed reassurance when she was on her own and had observed her frequent and regular phone calls from home as a way of containing her own feelings. The intensity of this couple's anxiety was one of the components of the emotion work required of the staff.

Phyllis developed a routine that helped her manage Cyril's stay in Willow Ward. This routine was strictly adhered to. Phyllis requested that Cyril would get up, dressed and into his wheel chair by a certain time. After breakfast she took him out of the ward to walk circuits around the hospital and the surrounding grounds. They only returned at meal times and at the end of the day. They had their regular sitting and resting places that always involved contact with other people. Cyril was unable to talk coherently and Phyllis was very chatty. She had a way of including him in conversation through gestures of touch, eye contact and a sort of rhetorical questioning. They became a feature of the wider hospital and recognised by staff and regular visitors. Phyllis had in effect created herself some holding structures external to the ward: routine, walking and conversation. By creating a strict routine Phyllis was able to regain some control over her situation. Initially this seemed appropriate, but after a while care staff expressed concern that Phyllis' behaviour was detrimental to Cyril and her own well being.

At one level Phyllis spoke highly of the care staff and they seemed to get on well. On an occasion when Cyril contracted a chest infection and his health deteriorated, conflicts and hostilities emerged. The conflicts seemed to centre on issues related to who knows best about Cyril's care and for control over the decisions made about it. This was an example of the type of dynamic when a relative is initially anxious about the levels of care provided in Willow Ward and the care staff experience their behaviour as scrutiny and criticism (Chapter Seven). Phyllis seemed to be desperately clinging to her role and status as Cyril's wife and the staff experienced this as resistant, rejecting and critical. The next data extract is taken from a staff Reflective Work Group a year on from the previous extract:

"Staff nurse Susan: You know sometimes, while coming into the hospital you find her [Phyllis] sitting out there in the cold, you know your own natural way of taking care of patients; you know you have to [gestures adjusting clothing]. She doesn't feel it - the cold, but for someone as fragile as Cyril..."

Researcher Cheryl: Why do you think she does that? Let's pretend that she's our patient for a minute, not Cyril, she's our patient, she could be, she's an old lady, Why is she behaving like this?

Nursing auxiliary Theresa: Maybe she don't think we look after him properly, maybe she don't want to lose him, because it is only him that she has.

Sometimes I find him and his hands and face are all red. She takes him to the other side because the sun is in it and you see his red face."

Reflective Work Group 9.4.03

Here, the care staff expressed their concerns and frustrations about Phyllis' desire to take Cyril outside everyday. They thought this was inappropriate on cold days and detrimental to both of their health. The description of the behaviour did seem to suggest there was a compulsive element to Phyllis' motivations. She counted how many circuits of the hospital they had completed; always telephoned and visited at exactly the same time and the care staff reported that she seemed unable to "take anything in". Any discussion of these issues became very emotional and the atmosphere was tense and angry. As the group facilitator it was hard not to get swept up in the experience at the expense of thinking. This quality of interaction was indicative of the intensity of feelings and high levels of emotion work required of the staff.

Much of Phyllis' anxiety seemed related to being separated from her husband and the loss of her role as a wife and carer. These were typical of the themes in the emotional demand described by the care staff (Chapter Seven). The subjects of the personal care issues that were provoking the anxiety indicated that significant aspects of the emotional demand lay below the experience. Two particular issues in Cyril's personal care were picked out by care staff. Firstly it was important for Phyllis that the staff got Cyril up early in the morning, but the staff felt he seemed to want to sleep in sometimes. Secondly, the care staff were concerned about the way Phyllis fed Cyril his meals. A deeper analysis of these points of tension directed us to some complex and conflicting issues that lay below the surface of the experiences.

Uncovering the emotional demand

Staff talked of their concerns about Phyllis' compulsion to feed Cyril. This had become more evident when Cyril developed an acute chest infection. Earlier in the discussion a care staff member had described Phyllis' attempts at feeding her husband hot water and honey. The care staff gave the impression that Phyllis was desperate to feed some life into Cyril. The next extract reveals another aspect of this urgent feeling. Staff were again concerned that Phyllis' behaviour was harmful, particularly to Cyril.

“Nursing auxiliary Patience: *It must be hard for her [Phyllis] coming in doing all these things for him and going home. If she come and look after her husband and go home she can sleep. I think she just want to do things, she comes, she feed him hot, you have to tell her let it cool. Burning the inside of his mouth.*

Nursing auxiliary Meena: *All the time we got to remind her please the food is hot.*

Researcher Cheryl: *She probably feels: “how dare you tell me what to do with my husband”*

General: *Yeah*

Nursing auxiliary Patience: *But after now, the gravy it comes in a flask and it is boiling hot, and the food is hot and she puts on a whole heap of gravy and she starts ... all the food. Even you feeding the other patients, it is steaming for them. And some times you start feeding your patient before she does and she finish feeding him before you. And she's putting hot gravy and all his mouth goes burn up.*

Nursing auxiliary Meena: *All lips burnt and bleeding all the time.”*

The care staff expressed concerns that Phyllis' anxiety was causing her to be careless and to forget to be mindful of Cyril's needs. The care staff's own experience of Cyril was that he was resistant to being cared for. In particular he did not like getting out of bed and would fight any attempts to get him up before he was ready. Phyllis seemed determined he should get up early as a way of keeping him going. The tone and content of various incidents seemed indicative of more disturbing unconscious conflicts around the motivations being acted out in the delivery of personal care:

"Nursing auxilliary Theresa: *Sometimes we are meant to do what the patient requires and other times we need to do what the relatives say*

Researcher Cheryl: *Mmm*

Occupational therapy assistant June: *That's the hard part, because who do we take into consideration? Is it Cyril that he should be allowed to sleep in or do you take into consideration Phyllis who is going to get upset because he's not out of his bed by a certain time and dressed for her to take out.*

Nursing auxilliary Patience: *And even like sometimes you're feeding him he's eating and he's snoring you just to want to let him sleep.*

Nursing auxilliary Meena: *And then she goes like that and she shakes him*

Nursing auxilliary Patience: *And if she comes you say he's sleeping*

Researcher Cheryl: *What's that both of you demonstrated "shaking, shaking" what's that about?*

(A lot of loud talking and demonstrating the (quite violent) shaking.)

Staff nurse Susan: (jokes) *Do you want me to demonstrate on you?*

Laughter"

Reflective Work Group 9.4.03

In this extract, the care staff elaborated on Cyril's passive resistance and what could be interpreted as Phyllis' aggressiveness towards him. It could have been that Cyril was less motivated to fight for his life than Phyllis. He often did not want to get out of bed in the morning and even fell asleep whilst eating. In contrast staff articulated Phyllis' determination, which was emotionally intense. The nature of Phyllis' feelings were identified as aggressive in the staff's loud talk and demonstration of Phyllis "shaking Cyril awake". I noted that this felt "quite violent". The ferocity of these feelings was confirmed in the comment "Do you want me to demonstrate on you?" This comment was directed at me. I propose that by not reacting defensively, I was taking in some of the aggressive emotional demand. I heard the laughter and general sense of relief as confirmation of this.

Taking in the unbearable and unacceptable emotional demand

Initially my response was to view the staff as lacking sympathy for Phyllis' situation and I found myself trying to persuade them to view Phyllis more kindly. I used all sorts of tactics. I drew comparisons between Phyllis and someone who might go on daytime television with problems to discuss. None of these seemed to work and the staff group seemed fixed on trying to modify Phyllis' troublesome behaviour. In the group session it occurred to me that I was experiencing the same frustration the staff were telling me about. No

matter what I suggested nothing went in. This realisation was helpful as it allowed me to think about the nature of interactions between the care staff, Phyllis and Cyril. Phyllis seemed to find her emotional experience intolerable so it was projected into the staff via Phyllis' obsessional talk and behaviour. The care staff were overwhelmed by its intensity and were unable to hold it, so it got pushed back at her in the form of their persuasions to stop the compulsive behaviour. The same process was enacted in the staff Reflective Work Group. The intolerable feelings were being batted backwards and forwards like a ping-pong ball. The more I could allow feelings to go in the more the discussion was freed up and thinking became clearer.

Cyril and Phyllis were under extreme pressure. Cyril's dementia meant he was unable to process his own emotional states and his wriggling behaviour (described earlier) and resistance to care could be interpreted as anxiety or perhaps as time went by as giving up. This interpretation is supported if we view the care staff's feelings as counter-transference. Firstly they responded to his urgent feelings as if there was a fear of falling and now they felt they didn't want to have to make him keep going. The quality of Cyril's feelings seemed to reflect the catastrophic dread described in Chapter Eight. In addition, the couple's lifetime of being together and their mechanisms for coping had been severed by Cyril's admission to continuing care and they were facing permanent separation through death.

The complexity of the feelings this stirred up related to their personal histories as well as the current issues of care. I suggest feelings such as rage and despair provoked a situation where associated guilt and anxiety mediated most

interactions between the couple and the care staff. For example, I understood Phyllis to have feelings of anger and hatred that were intolerable for her. These feelings and the guilt and anxiety connected to them were projected into the staff. This sheds light on an incident that occurred and was often referred to when Cyril and Phyllis were mentioned.

"Nursing auxiliary Meena: And he [Cyril] fights and he fights. One day she [Phyllis] came, Gloria [nursing auxiliary] and myself tried, but he was fighting so we thought we'll leave him to sleep. When she come, I tell her he was fighting and wants to sleep. Oh my gosh, this woman get on with me. "Why do you hate my husband, why, oh my god, you hate Cyril, you're always doing things?" Oh my god. I said "Oh Phyllis please, I don't hate your husband it's just that he wants to sleep. He don't want us to wake him up." Oh gosh, she was going on, she cried and cried."

Reflective Work Group 9.4.03

The level of Phyllis' distress was clear in this extract, but her accusation that the nursing auxiliary hated her husband does not make sense. The nursing auxiliary did not want to get Cyril out of bed because he did not want to get up, which was not really a sign she hated him. An interpretation of this interaction, considering the other instances of conflict, is that Phyllis projected feelings of hatred into the nursing auxiliary. We hypothesized in the group that at an unconscious level Phyllis was angry and hated her husband. This may have related to his passivity or that he had seemed to give up. She may have been angry at him for leaving her to cope alone because he had dementia or because

he was likely to die soon. She may even have been envious of all the care and attention given to him. Whatever the cause, these angry feelings stirred up guilt and it was unbearable for her. By projecting her feelings into the care staff, she was relieved of them. In this interpretation, nursing auxiliary Meena's comment that was supposed to be reassuring ("I don't hate your husband it's just that he wants to sleep. He don't want us to wake him up,") challenged Phyllis' defences causing her to connect with her feelings and to "cry and cry". Taking this interpretation to another level, it might also be a feature of Phyllis' personality that she hated the dependent and vulnerable aspects of herself. This could then give us a working hypothesis about her brittle and fragile responses to the staff. For her to be able to take in care, gestures would have to be gentler than the persuasions being offered. For Phyllis these persuasions may have felt intrusive and hostile.

Giving back painful and distressing emotions in a more manageable form

I fed back my formulations in the group as part of the Reflective Work Group interaction. Formulations became stronger when discussion of similar issues repeatedly produced a particular emotional quality or when they had been developed or validated in the Tavistock Supervision Group. Agreement or disagreement between the care staff and me had to be thought about carefully. Disagreement, could indicate that we were working through an important and challenging issue. Agreement on the other hand might signify that the idea being discussed supported both the care staff's psychological defences and my own. In the case study, the main indicator that the feedback had been helpful was that the care staff brought up the situation in the group on several occasions over a prolonged period of time and that some of the participants

(including me) shifted in the way they worked with the emotional demand of the situation.

Much of the discussion was related to the guilt residents' relatives experienced when their loved ones were admitted to Willow Ward. Staff talked about their interactions with Phyllis in a less emotionally charged way and allowed a more empathic view. One group member compared Phyllis' experience of being separated from Cyril with going back to work having had a baby. The group aired the many aspects of care that provoked guilt related to separation such as resenting having to be there for someone or feeling inadequate for not being able to be there for someone, particularly in death. It was also possible to acknowledge the parallels with their experience as carers. In this Reflective Work Group the staff became more able to take in profound issues of guilt, think about them and return to their work, hopefully with a greater capacity for the emotion work required of them.

The emotion work in the case of Cyril and Phyllis was being with the couple and tolerating their difficult feelings, holding them and not batting them back, but thinking about them and then giving them back in a more manageable form. The discussion of guilt and associated anxieties gave the care staff the opportunity to take in some of the feelings involved and try out new ways of thinking about them so that when they returned to the practical experience, the feelings had been processed and any feedback was given in a more bearable form. In practice this is not broken down into separate components like this discussion, but is part of the way the staff spoke and behaved in the course of

their ordinary work. An example of this was given in the following Reflective Work Group:

"Staff nurse Susan: She's quite friendly with me I would say. And she like taking some action to my chipping in some advice. Before she would come in without any coat on and one day she came and as she was going I said about it. She said "Don't worry, I'll be all right." I said "Why don't you bring your coat?" She said "Oh it was sunny this morning so I didn't think I would need it, but now it's bad it's this and that." I said, "So what can you do now?" She laughed and then set her thinking. She said, "You know what, I'll go back to Cyril's room and I'll get one of his jackets because he doesn't need it now." Which is what she did. So the second day, I didn't see her... so I think it was the next night on the phone I said don't forget to bring back Cyril's jacket."

Reflective Work Group 23.4.03

In this piece of ordinary interaction the staff nurse was able to resist trying to persuade Phyllis to look after herself. She had learnt that Phyllis could not take in her persuasions. Instead she understood Phyllis' usual rejection of help as a sign of her feelings. The staff nurse was able to adopt an open and friendly manner. She expressed concern about Phyllis by asking whether she would be warm enough. Phyllis was able to accept this care and concern. The staff nurse then reminded Phyllis of the incident a couple of days later over the phone. This demonstrated the staff nurse's ability to hold Phyllis in mind even when she was not there. The staff nurse's calm and soothing tone as she recounted the

incident made me think she had been able to provide a secure sense of containment.

It is my understanding that conflicting feelings about love and hate, anger and compassion and fear of living as well as fear of dying were part of this case. Such intense emotions were connected to the high levels of anxiety and guilt that seemed pervasive. Sometimes care staff were defensive when these feelings were projected into them, batting them back to where they came from. This may have been because they were overburdened themselves or because the ferocity of the emotion made it so difficult to bear. I have demonstrated how the containing links of the research allowed these issues to be aired, taken in and thought about. This supported the care staff's capacity to creatively manage the emotional demand of their work. Although the change outcome may appear small, the capacity for participants to shift in their understanding and experience of the emotional demand is important. The practical aspects of change are seen as less relevant and the development of capacity for emotional engagement and new ways of working with the emotional demand are identified as significant emotional action.

THE CREATIVE FUNCTION OF THE RESEARCH: DEVELOPING UNDERSTANDING THROUGH PSYCHOANALYTIC THEORY

The thematic and textured findings demonstrate the complexity and intensity of the emotional demand related to loss in continuing care. Residents, their relatives and the care staff's experiences included issues related to shock, grief, anxiety, degeneration and death. Through a psychoanalytic lens, it was possible

to achieve a view of aspects of the emotional demand not usually spoken about. These included issues such as trying to cope with the complex mix of feelings about residents. These feelings were associated with a caring and loving attitude and inevitably feelings such as anger, envy, hatred and despair, which could be linked to a deep down desire to be rid of the burden of sustaining the lives of such dependent and non-responsive people. Although these issues remained below the surface it was possible to observe how they were sometimes acted out or repressed through psychological defences. This perspective was achieved by designing research methods that were emotionally containing. In this way psychological defences could be acknowledged and worked through so that a more complete picture could be seen.

The research model was not only observational (Hinshelwood and Skogstad 2000) but also had a creative function. The links between the clinical experience, the Reflective Work Groups and the Tavistock Supervision Group developed a capacity for containment in participants and allowed access to a different quality of data. In this research, expressing the experience of what might be understood as negative feelings is viewed as a positive part of the research. Winnicott (1949) suggests the more feelings like hate and anger are acknowledged, the less likely they are to be enacted. Having these feelings understood by another is both therapeutic to the individual and can prevent them acting in a non-therapeutic way towards others. The research methods modelled a way for participants to bear their disturbing feelings in order to try to understand them. They offer opportunities for growth in the individual and creativity in practice because it has the potential to promote a culture in continuing care that is invested in:

1. Resisting doing and encouraging being with emotions
2. Preventing non-therapeutic action
3. Improving the quality of relationships by acknowledging a full range of emotions including those considered to be negative.

Resisting doing and encouraging being with emotions

Fabricius (1995) suggests that there is a tendency in nurses (and care workers) to feel that there are only two choices in relation to the emotions provoked in their work. The choice being either to suppress feelings or act them out. She argues that conscious action is usually out of the question so nurses and carers are left with suppressing their feelings. However she points out that these often resurface with the “unconscious turning into action” p24. Much of the work of the Reflective Work Group was concerned with providing the opportunity for an alternative way. This was to experience feelings in a safe environment so that they could be thought about and taken in. It was important to try to resist acting out uncomfortable feelings in the group and to recognise and discuss defensiveness (Chapter Eight). The Reflective Work Group became a place where people could practice having feelings without suppressing them or acting on them.

I have suggested the emotions provoked by the work carried out in Willow Ward are psychologically disturbing and they are therefore difficult to be with in this way. It is usually assumed feelings such as hatred and anger towards vulnerable groups like frail older people are unacceptable. This adds social pressure to the psychic conflict. If the care staff are expected to provide care

that aims to be dignified and promote a person-centred approach to care (Department of Health 2006), it is essential that the realities of what this entails are acknowledged and not denied. I suggest that it is important to recognise that there are limitations to what can be done in order to allow care staff to be more in tune with the way a person feels. For example, in Chapter Eight, I described how I helped an elderly female resident on and off the toilet. It seemed impossible to make this experience dignified. I believe a more achievable, but still very difficult aim, might be to be sensitive to the resident's feelings and respond appropriately. This might involve very little change in the activities involved but it would be important to improve the capacity for containing the disturbing feelings that this sort of work provokes. The Reflective Work Group offered care staff a space to explore such instances.

In the group it was possible to try to understand how the resident might be feeling and explore the care staff's responses. Dartington (1994) argues that people are often drawn into care work by a desire to "put things right". As I have described earlier, the obstacles that stand in the way of care staff's needs for satisfaction and reparation through their work produce frustration and eventual despair (Main 1957). I suggest that those involved in policy making and service planning need to engage with the real difficulties of becoming dependent in old age as well as the need to improve the provision of care. Policies that are blind to negative feelings, concentrating only on doing things to create positive outcomes, are in danger of splitting off the needs of older people who fail to respond to treatment and get better. There is then a temptation to ignore those residents and denigrate the people who provide care for them.

I suggest that in long-term care for dependent older people much of the emotion work involves being with residents in an ordinary way. This is not easy, as it requires tolerating the extraordinary and unbearable feelings that are provoked in dependent and degenerative old age. The aim of the Reflective Work Groups was to facilitate this by modelling how to be with difficult feelings and developing participants' capacity to bear difficult feelings through repetition of containment. This was accompanied by a raised awareness of emotionality achieved through timely and sensitive feedback. In the illustrative case in this chapter this way of working seemed helpful, particularly when I was able to acknowledge that the care staff were shouldering the emotional experience for another person. It is important to validate this aspect of the care staff's role as it often raises a lot of resentment in care staff, especially related to relatives. I propose this is an essential skill in the specialist role for continuing care nurses and should take a higher priority in service planning and education (Chapter Eleven). It follows that there should be more emphasis on the care staff's difficult work of being with dependent residents and a recognition that although the practical tasks involved in the work can seem straight-forward they usually involve a complex emotional demand (Chapter Seven and Eight).

Preventing non-therapeutic action

I will return to Fabricius' (1995) point that nurses and carers suppressed feelings often resurface with the unconscious turning into action. Given the nature of the feelings that I have suggested remain below the surface in Willow Ward, this has important implications. It was a crucial function of the Reflective Work Group to acknowledge feelings such as hatred, anger, envy and despair in order to identify where the anxiety about them provoked non-

therapeutic action and, if possible, to prevent them being acted out in abusive behaviour. Dartington (1994) suggests that ordinary nurses caring for disturbed, frightened, dependent and angry patients are likely to feel mistreated, taken advantage of and like a slave. I have articulated the overwhelming burden of caring for residents who experienced the losses in life and death in a continuing care ward (Chapter Seven) and I have indicated that it produced a range of feelings in the care staff (Chapters Seven and Eight). The Reflective Work Group provided a space where the care staff's needs were considered important. It was important for its own sake that care staff under such extreme pressure should have a place in their working environment where their needs are allowed to be expressed and prioritised. This was an important therapeutic feature of the work.

There were specific issues related to the continuing care setting that exacerbated the feelings of resentment that Dartington (1994) describes as a normal feature of care work. I have identified these as the residents' profound dependence, the lack of satisfaction provided by residents who did not get better and a sustained contact with a sense of lifelessness and emptiness (Chapter Eight). In addition there were particular aspects of Willow Ward that also stirred up angry feelings. Care staff did sometimes complain that they felt like slaves or unpaid servants, which has a particular resonance when the residents were predominantly white and the care staff were predominantly Black people with African and Caribbean heritage. The sense of injustice may have been added to by the racial inequalities in the health care system amongst the staff (Ward 1993). The care staff expressed a feeling of not being properly recognised in the Care for Older People's Unit and that they occupied a low

status. The Reflective Work Group was a place where these feelings could be expressed, explored and digested. It was particularly important for me to recognise that I was often the only white person in the group. It was important to identify the institutional power imbalances whilst not colluding with any defensive thinking. For example, it was important not to go along with an assumption that nursing auxiliaries did not have any power or authority. It was clear that several individuals had a significant influence on the organisation of care. On the other hand the nursing auxiliaries were bound by the parameters of their role, their wage and the status that went with it. I was able to use the micro-environment of the group to illustrate this. Although I seemed to have a lot of power as the facilitator of the group, certain participants were often very outspoken, confident and very strong in ensuring the discussion was fair.

Dartington (1994) suggests that nurses' power over patients provokes a lot of anxiety. She describes a situation where nurses worry about their potential for sadistic abuse. The vulnerable nature of the residents and the invasive physical procedures required to care for them stirred up similar anxious feelings in the care staff on Willow Ward (Chapter Eight). It was an important function of the Reflective Work Group to deal with these anxieties in an honest way. The care staff felt vulnerable to being accused of mistreatment in relation to care such as the way residents are fed, spoken to or the nature of physical interaction. This was probably due to the high level of nursing auxiliary involvement in the group. It was important to recognise that the potential for mistreatment and abuse was in everyone involved in close contact with such dependent and dying older people. Residents' relatives (Chapter Eight) and senior members of staff (Chapter Ten) have anxieties about the adequacy of their own care for these

residents. When these anxieties are not recognised and attended to, they can result in non-therapeutic interaction, inadequate care and neglectful strategic planning that fails to recognise the emotions of those involved. The containing functions of the research allowed the participants the opportunities to air some of these anxieties and have them understood (Chapter Eight). The activities of the research and the feedback to the Trust Lead and Charge Nurse related to its progress also encouraged planning and policy that was more sensitive to the emotional needs in continuing care.

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Improving the quality of relationships by acknowledging a full range of emotions including those considered to be negative

Craib (2001) discussed the links between symbols, thinking and creativity. He suggested that thinking about something is not only a logical process but it involves all levels of the psyche. He describes psychoanalysis as a spiral of science and art in the production of new knowledge and argues the more able we are to engage with the symbolic world the more human we are. Transferring this notion to the research, the more we are able to engage with actions and interactions as symbols of the emotional world related to dependent old age and related care practices, the more likely we are to empathise with the human qualities of the people involved. This is difficult because it stirs up our own unacceptable and unbearable feelings related to older people and those who are closely connected to them.

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I suggest the containing mechanisms of the research were important to humanising continuing care in Willow Ward in two ways. Firstly, it encouraged the care staff to think about the residents and their relatives' behaviour as

symbols of their emotions and to try to understand their meaning. This is especially important when some of the residents lack the capacity to articulate speech and responses. The residents' profound dependence and non-responsiveness make them vulnerable to the hostile projections of others and stir up primitive anxieties in those who have close contact with them (Terry 1998). For example it is tempting to dismiss a person's mental capacity in order to protect yourself from their anger and envy (Chapters Seven and Eight). Secondly, in the Reflective Work Group the care staff's behaviour was treated as symbolic of their emotions, which the Tavistock Supervision Group and I tried to understand. An example of this was when I understood their resistance to come to the Reflective Work Group as ambivalence (Chapter Four). It was important not to treat the care staff as "cogs in a care machine" or as they sometimes said they felt, like work horses.

Ashburner *et al* (2004) argue that for staff to be able to provide person centred care, it is important for them to feel valued. Referring to Nolan *et al's* (2002) concept of relationship-centred-care they suggest there should be a focus on relationships that form the context of care. Ashburner *et al* (2004) refer to the need for a psychodynamic understanding and advocate the use of clinical supervision and action learning. I would like to develop these points in the light of this research.

The containing function of the research methods were helpful because they encouraged participants to resist the urge to do more and concentrate on feeling more. This facilitated a greater psychodynamic understanding through experiential learning. The methods also fulfilled the function of validating the

care staff's role as receptacles for other people's projections. It was evident that all levels of care staff had a strong sense that this was important but it was poorly articulated and rarely recognised formally. It is important to recognise this role because it confirms the importance of a hidden aspect of the care staff's work and more explicit than this it separates their feelings from those of the residents and their families. In Chapter Eleven I propose valuing the roles and relationships between of the Staff nurses and nursing auxiliaries in relation to these valuable aspects of emotion work is key to developing the specialist role of the continuing care nurse.

I have suggested that the attention paid to the emotional aspects of loss and grief in Willow Ward aimed to encourage the recognition of feelings such as hatred, anger, envy and despair. This had the potential to reduce the possibility of them resurfacing as unconscious non-therapeutic or abusive action. Later I will go on to suggest that it is important to develop clearer links between strategic planners and continuing care staff's work, so that the emotional component of all aspects of care delivery are recognised as important.

Finally, I have argued that paying closer attention to the emotional symbols in behaviour and interaction is key to humanising roles and relationships in continuing care for older people. The research developed ways of interpreting the psychological meaning in symbols and behaviour. This promoted careful thought about a range of emotions which enabled a more holistic view of residents and their relatives. This is consistent with a person centred approach to continuing care discussed by Nolan *et al* (2002). The containing links in the research methods also encouraged the participants to examine their own

thoughts and feelings about their responses to the residents and their families. This meant there was also an emphasis on relationship-centred-care, which follows the direction of Nolan *et al's* (2002) development of person centred approaches. My contribution to this line of progression is to argue for the recognition that feelings that are often considered negative are important to a holistic view of human existence. In Chapter Eleven I argue that research methods that deny their existence are in danger of colluding with psychological defences that can avoid aspects of older people's experience and result in non-therapeutic action. It is important to be mindful of the emotional symbolism in behaviour and interaction in order to sustain the human qualities of the very dependent older people in continuing care and the people in close contact with them.

SUMMARY

I have discussed how containing structures in the research helped promote care staff's capacity for working with emotions. Using an extended example I have demonstrated how working in the Reflective Work Group and the Tavistock Supervision Group enabled unacceptable and unbearable feelings to be processed and understood. I argued that it is important to recognise the role of the care staff in being receptacles for the projections of other people. This validates their work with emotions and, importantly, separates their needs from those of the residents and their families.

The research demonstrated that care staff did have a capacity for working with emotions. In the next chapter I will argue that emotionally sensitive care for

residents and their families was not only dependent on the care staff's motivations and abilities but also on environmental factors. I will argue that environmental factors and how the emotional demand was managed in the organisation affected the way the care staff applied the knowledge and skills they developed in the research. I suggest that the developments in the care staff's capacity could not flourish in the customs and practices of care because social systems in the organisation supported the care staff's psychological defences. This led to a situation where the whole organisation was unconsciously invested in maintaining the status quo. This prevented the care staff, residents and relatives on Willow Ward meeting their full potential.

CHAPTER 10 - SWITCHING OFF: THE FUNCTION OF SOCIAL SYSTEMS AS A DEFENCE AGAINST ANXIETY IN THE CARE FOR OLDER PEOPLE UNIT

In Chapter three I described how psychoanalytic theory explains how individuals' psychological defences can shape the culture of an organisation. It has been suggested that patterns of behaviour that support psychological defences can develop and become custom and practice in an organisation. These are referred to as social systems and can be unconscious aspects of a routine or influence strategic planning.

So far I have argued that the care staff employed psychological defences in order to protect themselves from the intolerable and unacceptable feelings stirred up by their work. I have identified the emotional demand connected to loss in a continuing care setting and demonstrated in Chapter Nine that care staff have some capacity to process emotions and to work through psychological defences. Although the care staff had the capacity to work in this way, it was not the custom and practice within the ward environment. In this chapter I argue that the social systems in operation in Willow Ward and the Care For Older People Unit supported psychological defences and prevented the knowledge and skills developed in the Reflective Work Groups influencing the culture of care.

I argue specifically that social systems within Willow Ward protected all individuals from the dread of a lifeless void connected with profound dependence and not getting better. The systems did this by splitting up the

residents and the care staff's emotional roles and responsibilities and locating them in a hierarchy. Residents who were furthest from the lifeless void, for example feisty residents and cognitively able residents received more individualised and personal emotional contact. The residents most closely associated with lifelessness and emptiness, especially the non-responsive residents received the most practical and least personal contact. The most primitive fears and anxieties related to all the residents could be projected into the non-responsive residents and emotional contact with them avoided.

I will argue that this process was replicated in a social system that operated throughout the whole Care for Older People Unit. The patients in the other wards and the roles and responsibilities of nurses, doctors and therapists were also in a hierarchy. The social system that functioned inside the continuing care ward was replicated throughout the whole organisation. In this system Willow Ward, which was the area most closely associated with the primitive fears of residents in continuing care, occupied the non-responsive status and psychic identity and therefore received the least contact and was ignored and rarely thought about (Chapter Two). I have articulated this process under the following headings:

1. Splitting up the residents
2. Splitting up emotional roles and responsibilities
3. The upstairs-downstairs effect

Each heading is discussed further below.

Splitting up the residents

In the participant observation I noticed how certain residents spent more time in the communal areas than others and that some people received a different type

of interpersonal contact with the care staff. I suggest that residents were split up and placed in a hierarchy with the most able and lively residents occupying the position with the most status and receiving the most personalised care. This was a similar process to social sequestration when people who are dying or have unbounded bodies are separated from the rest of a society (Chapter Seven). I understood the process as a social system created by individuals who were motivated by the need to avoid unbearable and unacceptable feelings connected to the emotional demand (Chapter Eight). It is my suggestion that the system functioned by splitting up the emotional demand of caring for residents who were either living, degenerating or dying in continuing care. By keeping the people in these various states away from each other the care staff and the residents avoided the conflicting feelings of love and hate, compassion and anger, envy and gratitude and the hope and despair related to sustaining the lives of people who were non-responsive or in a state of degenerative health and facing the possibility of becoming non-responsive. In this formulation, I suggest the non-responsive residents were an ideal receptacle for the hostile projections of other people such as care staff and relatives. They also stirred up primitive anxieties related to fear of emptiness and non-existence in the people who had close contact with them. Consequently these residents were most likely to be avoided.

In Chapter Two I described Willow Ward. I explained the way the ward was arranged and the routines were organised. I noted that residents tended to spend their time in certain places according to their level of independence and cognitive ability. The least able, non-responsive residents spent all of their time in their own rooms, the feisty residents and those who were often referred to as

“nice and quiet” spent a lot of time in communal areas such as the sitting room. The most able residents spent their time in their own rooms and received the most personalised care. This was also evident in their physical surroundings as their environments reflected more of their individual personality. For example, in the photographs on the walls or personal items such radios, cigarettes and religious symbols. The feisty and nice and quiet residents had some personal items in their rooms but tended to spend much of their time in the communal areas and were therefore often addressed as a group unless they were receiving personal care. Finally the contact received by the non-responsive residents was centred on care delivery and their environments were more clinical than homely.

The non-responsive residents often lay on large clinical beds designed to prevent pressure sores and were fed via a tube into the stomach. They spent their time in their rooms and some of them could sit for short periods in an armchair. It was unusual for these residents to get dressed in day clothes and the environment where they spent their time therefore tended to be more clinical. There were fewer reminders of their identity and personal histories such as photographs and cards from family and friends.

I suggest the choices residents and care staff made about where the residents spent their time and the levels of interaction with them was not only about the residents' practical problems but also related to a need to avoid distressing and anxiety provoking feelings such as those described earlier (Chapter Eight). When a non-responsive resident's daughter wanted to decorate her Mother's room, it caused the care staff some anxieties:

“Researcher Cheryl: Rita [nursing auxiliary] had told me about a new resident’s daughter who had decorated her mother’s room. She was incensed about it, saying she had cluttered the room up and it was preventing them doing their job. She asked me to come and meet the daughter. I went in and said hello and introduced myself. We had a short chat. The daughter had brought in matching duvet covers and curtains and the room seemed very soft. Her mother seemed to be peaceful and comfortable. She was asleep but stirred when her daughter stroked her face. There were soft toys and cushions on the bed and the resident’s daughter explained she had brought in a big television so her mother could see it more clearly and it felt like she had company. As we left the room nursing auxiliary Rita said “Do you see what I mean?” but I didn’t.”

Field notes 19.11.03

Later in a Reflective Work Group, nursing auxiliary Rita explained that she felt the resident’s daughter was treating the resident as if she had more capacity to think and feel than she really had. It was true that the resident was very dependent but it was impossible to know the extent of her capacity for thought and feelings as her communication skills were so poor. I suggest the denial of the non-responsive residents’ capacity for any feelings helped care staff avoid emotional contact with the nameless dread associated with what might be thought of as a void or empty state (Chapter Eight) and allowed them to distance themselves from the residents and the dreadful fears they might provoke.

The feisty and nice and quiet residents often sat in their own armchairs or wheelchairs and they got dressed in their own clothes. The sitting room did have a more homely decoration, but it was not individualised. Photographs and pictures were bought by the institution and the central focus was the television. This meant everyone in the sitting room was engaged in similar activities at any one time. For example throughout the data collection period there was a series of entertainers who visited the ward to sing to the residents. They delivered a standard set of songs that were assumed to be relevant for older people. Although many of the residents originated from the East End, the increasing cultural diversity in the residents illustrated how this group of individuals were being treated as a homogenous group regardless of individual preferences or levels of health:

Researcher Cheryl: *"I was shocked at how unwell Sarah [resident] looked. The singer was going on but Sarah had her head down and her tongue was hanging out. It looked swollen and dry. Amina the new resident from Somalia looked puzzled. She was watching the singing and I wondered what she made of it. Her advocate arrived and I felt embarrassed. She called him over and spoke to him. I thought she was going to ask him to take her to her room, but to my surprise the singer stopped the music and the staff called for the social worker to sing something in Amina's language. The young man looking a little embarrassed did a song and a dance that looked and sounded to be in an African tradition and the care staff clapped and cheered and Amina and the care staff from African heritage did the whooping call which equates to Westerners' applause."*

In the example the resident who looked unwell and the resident with a specific cultural background were expected to adapt and be part of the group and enjoy the East End sing-along. The interactions in the sitting room were kept at a superficial level due to the lack of privacy and a tendency to address the residents as a group. Sometimes care staff sat down with individuals and engaged on a one-to-one basis, for example, watching the television together or reading a newspaper. More frequently any interpersonal interaction was related to care needs such as helping someone with their drink or to eat a meal.

Despite the tendency to treat these residents as a group, they maintained more of an individual identity than the non-responsive residents. Their rooms often reflected some aspects of their personality and they participated in art classes or quizzes where they exercised their individual talents and preferences.

The final group of residents were the most cognitively able and they tended to choose to stay in their own rooms rather than mix with the sitting room residents. These residents had more control over what clothes they wore, which television programme they watched and generally had more personal items in their rooms.

“Researcher Cheryl: Robert [resident] had asked Geeta [nursing auxiliary] for something but she hadn't really understood. She thought he wanted to speak with June [occupational therapy assistant]. She used his communication board to confirm this. She found out that June

had agreed to get Robert's lottery ticket and he wanted Geeta to get him chicken and chips from the canteen. This involved accessing his money from the office and paying for the meal."

Reflective Work Group notes 27.9.01

The most able residents usually chose to remain in their own rooms. They had individual relationships with members of staff and the routines and external environments reflected their personalities and preferences, for example, a radio playing their choice of music or as in the example taking part in external activities like the lottery.

This custom of splitting up the residents was not imposed on residents by the staff and the more able residents in particular colluded with this practice. The splitting up process prevented residents from a different category of liveliness coming into contact with each other. Residents could therefore avoid the feelings of envy related to residents who were more able and lively and avoid fears about their own futures reflected in the residents who were less able and less lively:

"Later in the discussion, June [occupational therapy assistant] talked about Robert [resident]. She said he had an assessment for an electric wheelchair. She had helped him practice. When the assessment came he kept knocking the chair on the end of the bed. The assessor gave him lots of chances and he kept trying, but he just couldn't do it. June wondered why, because he had been fine during the practice times. We speculated about how hard it would be for him to come out of his room

and be with the others who are older and more confused. I wondered also about whether he might have thought he would get less one-to-one attention from June."

Reflective Work Group notes 13.9.01

When residents of different abilities mixed with each other it could provoke fear and anxiety as well as envy and rivalry. Residents with higher cognitive levels were more likely to receive one-to-one communication from people in specialist roles such as the occupational therapy assistant and psychologist. These residents were also more likely to receive individual attention from the care staff. In contrast, residents in the sitting room were more likely to be treated as a group and less likely to receive individual attention. When giving individuals attention in the communal areas it often provoked rivalry and stirred up distressing feelings.

"Researcher Cheryl: *I tried to be a reassuring presence and at one point I did put my arm round her [resident Muriel who had become upset] and I thought she might cry on my shoulder but she didn't. I was aware of feeling silly and I'm sure I was inhibited. Irene [resident], who tends to pinch and grab at people, is a very likeable resident. She put her thumb up. At one point she was asleep with her thumb up in an "I'm OK" way.*

June was moving between Betty [resident] and Sarah [resident]. Both of these residents are also difficult to help. Sarah was becoming quite restless and agitated. Betty was also calling for our attention when we

were focused on other residents. When Betty went to call me over I said no, because I was with Muriel. Betty started shouting and swearing. Muriel did seem to respond to Betty's noise. Sometimes she became agitated and shouted back. Trying to explain what the noise was seemed not to achieve any thing...Muriel could not respond in a meaningful way and I could feel myself giving up."

Field notes 28.2.02

The extract demonstrates the difficulties of interacting with cognitively impaired residents who have profound emotional needs. These difficulties can be exacerbated in a large group. The interaction in the sitting room tended to be group orientated or structured to avoid rivalry and competition for attention. For example, care staff often avoided interaction in the sitting room unless it was related to a task such as helping people at meal times. A resident whose behaviour became distressing for other residents was often removed from the sitting room and taken to their own room. In this way, engagement was kept at a surface level and distressing emotions such as anger, hatred, envy and despair were avoided. This meant the care staff were protected from the disturbing projections of the residents and their own emotional response.

The seating arrangements and hierarchy of attention paid to the residents was part of the culture of care in Willow Ward. It can be viewed as a system of psychological defence that prevented residents coming into contact with the unbearable feelings about their envy of more able people and dread of their possible futures. For care staff it prevented intimate contact that might stir up

the dreadful feelings associated with profound dependence, powerlessness to make things better and the deep void in non-responsiveness (Chapter Eight).

Splitting up emotional roles and responsibilities

Not only were the residents split up according to their abilities and liveliness but so were the roles and responsibilities of the care staff. There was a hierarchy related to the expectation of care staff's work with emotions and the type of contact it involved. The work with the most obvious and direct emotional component was carried out by senior nurses and clinicians from other disciplines, for example, psychological assessment of residents or meeting with relatives to discuss a resident's prognosis. The staff nurses sometimes engaged in work with an obvious and direct emotional component such as breaking bad news and they were also involved in personal care that had a less obvious but intrinsic emotional demand (Chapters Seven and Eight). The nursing auxiliaries rarely engaged in communication that had an obvious and direct emotional component. The majority of the emotional demand of their work was inherent in the personal care delivery such as helping a resident wash and dress (Chapters Seven and Eight). I suggest this was not only a practical organisation of roles and responsibilities, but also split up the emotional demand of the work. This supported the staff's psychological defences which were unconsciously motivated by a desire to avoid the conflicts and anxieties provoked by the unbearable and unacceptable feelings provoked by the work.

The Charge Nurse and members of the multidisciplinary team such as medics and psychologists dealt with the type of emotion work that usually involved talking to people about emotionally charged subjects. Consequently they tended

to be involved with speaking to relatives and residents about ongoing issues such as plans about treatment, non-treatment, conflicts or challenging behaviours. The psychologist and occupational therapy assistant were also involved in providing emotionally therapeutic interventions for the residents. The emotion work provided by the Charge Nurse and multidisciplinary team members often took place in a meeting or clinical encounter. Usually, the sole purpose of such an interaction was to deal with a specific problem. Except for the Charge Nurse, these practitioners were involved in personal care rarely if ever. The sort of emotional engagement undertaken by these people usually occurred with relatives or the most cognitively able residents and occurred in more controlled environments where communication was the focus of the interaction:

“Psychologist report: Sarah [resident] described the days as “long”. She told me how she enjoyed talking to me and how she always felt very lonely when I left. She said that she could not talk to the other residents in the sitting room. “I like talking to people”. At the end of the last session she told me how she enjoyed talking about her life and then started singing “Those were the days my friend, I thought they’d never end”...this felt sad thinking back.”

Clinical psychology assessment 12.7.01

The more senior nurses and clinicians from other disciplines worked with emotions in a more focused way. The communication was mostly verbal and they had relatively little contact with residents who were profoundly dependent

or non-responsive. Consequently their interactions that involved working with emotions were largely focused on the more able residents.

The staff nurses' role also involved direct and focused communication about emotional issues. These interactions tended to be less planned and more integrated into the day to day work. They included informing relatives that a resident's health had deteriorated, meeting relatives when a resident had died and speaking to cognitively able residents about emotional issues. This sort of communication was less likely to take place on a regular basis and was more likely to occur in a public space rather than in an office or meeting room.

“Researcher Cheryl: Rosie's [resident] sister arrived. She had rushed to get here following staff nurse's phone call to tell her Rosie had become very unwell. Staff nurse Paula came out of Rosie's room to meet her. They knew each other and Paula put her arm around Rosie's sister and started talking to her about Rosie's condition as she took her behind the curtains to see her.”

Field notes 7.8.02

The staff nurses sometimes stood in for the more senior nurses and clinicians, but they were less likely to engage in the planned types of interactions with residents and relatives that often took place in offices or away from the ward environment. Staff nurses and the Charge Nurse had responsibilities for personal care. They therefore had more sustained emotional contact with the profoundly dependent and non-responsive residents than doctors and therapists but less than the nursing auxiliaries. I suggest the more senior the nurse, the

more they are able to choose the type of residents and interactions they get involved with. Those who choose to be engaged with both types of residents have to tolerate the emotional conflicts that the splitting effect avoids.

This freedom to choose was also reflected in the levels of participation in the Reflective Work Group. The more senior nurses attended the group less frequently than the nursing auxiliaries. It was suggested that this was due to the specific time restraints put on staff nurses. An alternative explanation was that the staff nurses were in a particularly difficult position because they were expected to provide direct, verbal emotional care to the more able residents and relatives and perform the practical care for the most profoundly dependent and non-responsive residents. Discussion in the Reflective Work Group may have been most threatening to the staff nurses because they were least protected by the defensive splitting.

The nursing auxiliaries, who had the lowest status, had the most sustained contact with the residents with the most profound dependence and non-responsiveness. They found the Reflective Work Group helpful because it allowed them to air their feelings about the practical work they provided. The lack of staff nurses contributions however did mean it was hard to explore the potential of the nursing auxiliaries' role in providing direct verbal emotional care. Although the nursing auxiliaries were clearly capable of meaningful interaction that was not based on practical care, they tended to avoid it:

"I popped my head into the day room. There was a man [resident] in a reclining chair muttering loudly to himself. There were about twelve

residents all sitting in different types of chairs facing the television. I noticed the news was on the TV. I said hello to the residents and about three people responded. About three care assistants were sat in the sitting room as well but they were sat behind the residents and it almost looked as if they were hiding. I asked them what was going on and they replied that they were waiting for the lunch trolley to arrive."

Field notes 6.2.02

The nursing auxiliaries engaged in the practical care and the emotional demand inherent in it (Chapters Seven and Eight) but were not usually involved in direct communication about emotional issues avoiding the emotional conflicts this entailed. I have described how the work related to emotions was split up and organised in a hierarchy. The most senior nurses and clinicians were involved in the most direct form of emotional care, which tended to be via the spoken communication and therefore involved the most cognitively able residents. The nursing auxiliaries had the lowest status and tended to be exclusively involved in emotion work related to practical care. They were the group who had the most sustained contact with the profoundly dependent and non-responsive residents. The staff nurses had a role that involved the most integration although it was possible for them to avoid personal care for some residents if they chose.

The splitting up of the emotional roles and responsibilities supported the psychological defences I have already described (Chapter Eight). It kept the sort of emotional contact the senior nurses and clinicians had with residents and their families separate from the types of emotional demands inherent in the

practical care delivery. I suggest this helped all the groups of staff avoid unbearable conflicts and anxieties. More senior nurses and clinicians were able to engage with residents in a more intimate way and could adopt a more holistic approach, but they could avoid the sustained type of contact with the residents who provoked such deep anxieties related to profound dependence, not getting better and especially the fear of a lifeless void represented by the non-responsive residents. In contrast, the nursing auxiliaries had sustained contact of this kind, but avoided adopting a holistic view of residents that acknowledged their personal and intimate feelings by focussing on the practical aspects of care, denying residents' capacity and generally avoiding the direct form of communication about emotions. I suggest that whilst these systems were in operation it was hard to integrate work with emotions and promote a more holistic view of all residents.

Any attempts to integrate work with emotions into the practical care for example would be met with resistance. The next extract is from an assessment by the psychologist. She was very involved in the work led by the Charge Nurse and supported by this research. She completed psychological assessments of residents who were discussed in the Reflective Work Groups and made suggestions about how care staff could integrate her recommendations into their practical care. She found her detailed reports were rarely read by the care staff involved in the day-to-day work.

“Psychologist report: *For those around resident Sarah, it might feel as if she is constantly wanting attention and staff might feel defeated in how to deal with this seemingly insatiable demand. What we must*

remember is that these are universal feelings and that we have to try and understand her fears of separation, her shouts for contact and intimacy and help her feel contained, lessening the panic and anxiety of the unknown"

Clinical psychology assessment 12.7.01

It was unlikely that care staff would take up the psychologist's suggestions when the culture of practical care demanded a denial of residents' capacity for feelings, distress and conflict. Attempts to join up the different emotional understandings located in each group of practitioners were resisted. For example, the psychologist often complained that her assessments were not read by the care staff or incorporated into the nursing care plans and the medical team declined any invitation to join in the Reflective Work Groups.

Trying to change the shape of the culture involved trying to adopt more integrated approaches to care. For example although the group members increased their awareness of the importance of personal and biographical information about the residents, low levels of this type of information were recorded in the care plans. In order to address this, we decided that the Charge Nurse would run a care plan group on alternate weeks to the Reflective Work Group. The intention was to integrate the type of work carried out in the Reflective Work Groups into the care plans and day-to-day work. This created a more integrated approach to the emotional care for residents:

Charge Nurse Steven: *"When I assessed Ruby [resident], she was quite clear that although she has gone off her food, she did not want us*

to put in a feeding tube of any sort. I met with her a couple of times before she came onto the ward and only agreed to come here if I could assure her we wouldn't put down a tube.

Silence

Researcher Cheryl: *Steven this is one of the issues that does come up quite regularly in the group.*

Nursing auxiliary Cella: *Yes it's not fair, we can't not try with her.*

Staff nurse Elizabeth: *We can't just watch her starve to death.*

Charge Nurse Steven: *I'm not saying you can't give her food she fancies, maybe ice cream or something or sips of water. But when she gets more poorly she doesn't want a PEG feed [tube feeding into the stomach]*

Staff nurse Elizabeth: *Well you better make sure the doctor has it written in the notes, because some of these locum doctors won't listen to anything we say and just go ahead with what they think."*

Care plan group 20.12.02

In this example it is possible to see the importance of emotion work at every level of clinical practice and although the medical team were still not involved, the need for their involvement is evident. This type of integrated thinking was possible but again the custom and practice in the organisation mitigated against it becoming a sustained approach. External pressures meant that under times of stress, when a key member of staff left, for example, structures such as the care plan group just disappeared and the forces of psychological defences could not be held back.

All levels of practitioners colluded with the fragmentation of emotion work. The splitting up of the understanding of the emotions located in each role avoided the real emotional difficulties and distress the residents experienced on a day to day basis. The more senior levels of staff could limit themselves to speaking with the most cognitively able people such as relatives and to avoid emotional contact with the most profoundly dependent residents. The care staff limited themselves to the practical issues of the residents and minimised or glossed over the residents' capacity for feelings (Chapters Seven and Eight).

In the hierarchy of roles and responsibilities the care staff and especially the nursing auxiliaries were most closely associated with the very dependent residents who tended not to respond to the treatments and care offered. They seemed to be identified with carrying the burden of non-responsiveness. This had an effect on the way they saw themselves and how others perceived them. When people crossed these boundaries, for example, the psychologist's and Charge Nurse's efforts to integrate different ways of thinking about the residents' emotional worlds, and the occupational therapist assistant and care staff's participation in the Reflective Work Group, it increased anxieties. The level of support to sustain different ways of working with residents' feelings required careful thought and planning at all levels of practice (Chapter Eleven).

To summarise, I have argued that within Willow Ward, social systems were in place that supported the psychological defences described in Chapter Eight. The way the social systems worked was to split up the residents, roles and responsibilities in a hierarchy based on cognitive ability. The most able residents received more personalised and verbal emotional interaction from

more senior members of staff. Feelings such as anger, hatred and a desire to give up are projected into the people and activities most closely associated with death and non-responsiveness. It is then possible to ignore the people and activities that represent these unbearable feelings. The people who have more contact with the residents who represent high levels of this type of emotional anxiety use strategies to minimise the emotional impact that result in a less holistic view of the residents.

The system is very difficult to challenge because it is unconscious and changes provoke more anxiety. It is also noticeable that people with more power the cognitively able and senior practitioners, are more able to distance themselves from associating with degeneration, non-responsiveness and death. It is my thesis that this system is replicated throughout the whole organisation in the upstairs-downstairs effect.

The upstairs-downstairs effect

I have described how the social systems within Willow Ward support psychological defences. I suggest the social systems throughout the whole institution replicate this process. In Chapters Seven and Eight, I argued that Willow Ward tended to work in isolation and that the care staff found it difficult to let people in from other disciplines and therefore had a different attitude about their work. I outlined a situation where the ward functioned like a family on the inside and were separated from outside influences. This was not a one-way process. This social system supported the psychological defences of all the individuals and groups in the organisation. This included patients, residents, nurses, doctors, managers and so on.

I have described how Willow Ward was often ignored and out of the strategic mind. The sense of separation and being forgotten was particularly marked in the location of the ward (Chapter Two). All the rehabilitation wards, administration, management and doctors' office were upstairs and the continuing care was downstairs. The rationale for this was that people in continuing care could use the garden facilities but I propose this also served as an organisational defence, which separated the people who could get better and all their nurses, doctors and therapists from residents and care staff associated with not getting better and non-responsiveness. This meant they were vulnerable to the hostile projections of others and they stirred up primitive anxieties in people who had close contact with them.

Although occupational therapists, physiotherapists, speech and language therapists and social workers had regular funding to work in the rehabilitation wards they only worked in the continuing care ward on a case by case basis. This was rare and referrals often seem to go missing (Chapter Seven). In the early data collection period a closed continuing care ward that had adjoined Willow Ward was reopened as an intermediate care ward where older patients who were quite well came for day care. The shared dining and sitting areas between the two wards offered the opportunity for much fitter patients to mix with the continuing care residents. This presented a dilemma for everyone.

Psychologist Hayley: *Sorry we were just talking about the new ward and its impact on everyone here.*

Nursing auxiliary Gloria: *I think it's lovely to see the patients alive and talking.*

Researcher Cheryl: *Except they're not your patients*

Nursing auxilliary Gloria: *[laughter] but still.*

Nursing auxilliary Meena: *I saw everyone there sitting around the table it was so nice [general agreement]*

Occupational therapy assistant June: *They're a lot more up on the criteria than they used to be; they're not letting anybody in now.*

Nursing auxilliary Meena: *No you can't have a conversation with hardly anyone, just Betty [laughter] and Biddy*

OT assistant June: *and Sarah*

Nursing auxilliary Meena: *Well no not Sarah any more*

Nursing auxilliary Gloria: *The sister on the other ward has asked for the shutters to be drawn across the glass divided between the two ward sitting and dining rooms. They are not even allowed to see them*

Psychologist Hayley: *What do you think, it's up to us to think about it*

Nursing auxilliary Meena: *I think they should leave that part open, the dining room bit, then our patients can see somebody*

Nursing auxilliary Gloria: *She sees that all the time, that it will have an effect on her residents [patients] that she has coming in. Maybe she didn't like that, I wouldn't like it. I work there so I have to be with Betty, but ordinary people, I wouldn't like my Mum or somebody ... and these are people who are all right. You see them talking and that.*

Psychologist Hayley: *It may distress some people.*

Nursing auxilliary Gloria: *Yeah*

Staff nurse Joan: *Yes I think that is right because Betty swears a lot and I think those people wouldn't like it. Sitting around the table with their relatives and then she starts swearing. Also psychologically the*

other patients wouldn't benefit from being with our residents because they can only mumble and that."

Reflective Work Group 17.4.02

This is an example of how the people within Willow Ward and those external to it replicated the splitting process that occurred within it. I suggest that Willow Ward occupied a similar position in the hospital to the non-responsive residents in the ward. Like the non-responsive residents within it, Willow Ward was kept separate, out of sight and out of mind (Chapter Two). All the thinking, planning and rehabilitation went on upstairs whilst downstairs in Willow Ward they were charged with looking after residents who were no longer responding to treatment and therapy. The non-responsive residents represented the most disturbing feelings related to dependency, not getting better and a dreadful fear of a lifeless void (Chapter Eight). They were segregated and received little attention or thoughtful consideration. I suggest that this system was replicated throughout the whole organisation, with Willow Ward being identified as the non-responsive resident of the hospital.

This meant the most disturbing feelings related to dependence, not getting better and a dreadful fear of a lifeless void were located in Willow Ward and separated from the rest of the unit. The strategic planners then paid little attention to the continuing care service and avoided any thoughtful consideration of it. My suggestion leads me to conclude that the defensive splitting off of the continuing care needs from the rest of the service may have unconsciously caused the situation where resource allocation and strategic planning was almost non-existent for this aspect of the locality's health care

needs (Chapter Two). The implications of my suggestions are that to sustain any change in ways of working within Willow Ward all those involved in the organisation need to engage with the emotional demand of providing care for residents who live dependent and degenerating lives for relatively long periods of time with the most likely outcome being their death rather than getting better and going home.

THE FUNCTION OF SOCIAL SYSTEMS AS A DEFENCE AGAINST ANXIETY IN THE CARE FOR OLDER PEOPLE UNIT: DEVELOPING UNDERSTANDING THROUGH PSYCHOANALYTIC THEORY

Davenhill (1998) argues that the care staff's capacity to contain emotional distress is central to the quality of care that can be given. Referring to Bion (1962), she suggests carers need to take in and detoxify emotional distress so it can be fed back in a more tolerable form. Davenhill (1998) suggests the primitive processes that occur when care staff work with severe psychological disturbance make this very difficult. In this research, the residents were living through the end stages of chronic illnesses and consequently their bodies and minds were degenerating, causing them to live in profound dependent states. The fragmented states of mind in residents with dementia (Balfour 2006) and the emptiness of working with non-responsive residents (Terry 1998) placed a particular emotional demand in the care work.

I have explained that the quality of care was not only influenced by the care staff's capacity to work with emotions but is also related to the organisation of care in the wider context. In a similar way to Menzies Lyth's (1959/1988)

observations of hospital nurses, the anxieties provoked by the care staff's work caused them to protect themselves by adopting defences that enabled them to avoid or gloss over elements of the emotional demands of their work. These were often concealed under the surface of their experiences (Chapter Seven). There was a quality to the anxieties in Willow Ward that was distinct from the hospital experience articulated by Menzies Lyth (1959/1988). I suggest this was related to the specific nature of providing care for profoundly dependent residents whose minds and bodies were degenerating, the lack of satisfaction in the work that is usually provided when a person gets better and the sustained contact with people who stir up feelings related to deep fears about emptiness and not existing (Chapter Eight).

In Chapter Nine I have argued the care staff were able to use the containing function of the research to learn about emotions (Rustin 2003). I suggest the care staff were already aware of the projections of others and they seemed to recognise that they held the emotions for others. The research has helped them articulate this aspect of their role (Chapter Seven). This had the added bonus of treating their feelings as separate entities to the residents' and relatives' emotional states. I think this is what they were trying to express when they suggested they want someone to hear their side of things rather than always having their perspective heard in the context of the needs of residents and their relatives.

They demonstrated an increased capacity to digest and detoxify the emotional experiences of the residents and families in their care. I argued that this was important because it promoted the idea of being with emotions rather acting on

them. This also involved thinking about the emotional symbolism in interaction which offers the opportunity to prevent non-therapeutic behaviour (Dartington 1994; Fabricius 1995) and sustain the human qualities of those living, working and visiting Willow Ward (Craib 2001). Despite this potential, it did not become the custom and practice of the ward because social systems supported psychological defences. These were evident in the overall organisation of the unit and distribution of resources.

Rationing resources for making things better

I have suggested the whole organisation was fragmented in a similar way to how Roberts (1994b) understood a long-stay hospital for older people. She described a situation where the nursing staff were split from the doctors and therapists. The Care for Older People Unit in my research ran in similar lines to her description of Miller and Gwynne's (1972) horticultural model and the warehousing model but they were enacted in a different social system. The horticultural model defines the aims of care in terms of growth of abilities, whilst denying disability and the limitations of care. In contrast, the warehouse model is focused on prolonging life, but tends to encourage dependence and depersonalise the people being cared for. In the Care for Older People Unit, the rehabilitation wards upstairs were invested in the horticultural model where it was assumed that the outcome of rehabilitation would be that people got better. Resources and planning related to therapies like speech and language therapy and physiotherapy were prioritised and invested in this area of the Care for Older People Unit. Those downstairs were deprived of rehabilitation resources and encouraged to be dependent and give up any thoughts of getting better. The care staff become identified with the residents and assumed to share these traits.

This is why it was important that the Reflective Work Group was a separate space for the care staff's needs and feelings.

In Willow Ward there was a focus on practical care and a lack of engagement in what might make the residents lives qualitatively better (Chapters Seven and Eight). Roberts (1994) argues that although the horticultural model appears adequate it also involves denial of the limitations of health care. Following this suggestion, it may be that in the upstairs thinking related to rehabilitation, patients and care staff were prevented from contemplating any acceptance of dependence and avoided a confrontation with the end point to what can be done for a patient. This can stir up feelings of hatred and rage related to the reality that there are limits to our existence and therefore limits to our therapeutic endeavours (Davenhill 1998). The avoidance of these feelings has the potential to manifest itself in non-therapeutic behaviours such as interactions that deny patients' autonomy and enforce attitudes and therapies without contemplating the heavy burden of keeping going in semi-dependent old age.

I came to understand the lack of planning and allocation of resources in Willow Ward as hostile projections connected to profound dependence, the limits of therapeutic endeavours and the fear and dread of emptiness and non-existence. Willow Ward was cut off from the rest of the unit so that the people outside the ward felt safe from the deep psychological disturbance they had projected into it. Inside Willow Ward people were swept up in the emotional demand and connected psychological defences.

Many of the residents in Willow Ward were in the final stages of chronic illnesses which produced a state of dementia and sometimes a complete state of non-responsiveness. It is suggested, that in old age, people's ability to cope with loss and increased dependence will be determined by the legacy of earlier developmental difficulties (Balfour 2006). People with extreme degeneration of the mind may lack the mental capacity to contain their own emotions and can be terrified by a sense of returning to a state of complete helplessness (Balfour 2006). With no verbal or symbolic communication skills the person communicates through primitive projections and the person's external environment acts as a receptacle for their distressing feelings (Davenhill 1998). Willow Ward had the potential to become an external container for the residents' blurred and fragmented state of minds. With little conscious support and direction for the formation of the external containment structures, it was instead shaped by the unconscious forces motivated by avoidance of the painful and distressing feelings (Chapter Eight).

Willow Ward – a peculiar sort of refuge

Roberts' (1994b) analysis of social systems was focused on the division in roles between different disciplines. She argued that this was motivated by the anxieties associated with the residents' lack of capacity to respond to care and treatment. I suggest this research's observation and articulation of the qualitative experience related to the fear of a terrifying void stirred up by working with such profoundly dependent residents is a useful development of this concept. Overwhelmed by the intense emotional demand of their work and disabled by the projective identification with the residents, the care staff took refuge inside Willow Ward. In his exploration of defences against sensing

nothingness, Emanuel (2001) discusses the internal mechanisms of individuals for avoiding the deep dread of emptiness or non-existence. I have used this model to understand the care staff's response to their close contact with residents who stir up these dreadful feelings and their position as the repository for projection of others' such feelings. I have adapted Emanuel's (2001) description of individualised internal defences against the void to explain below, the organisational defences in Willow Ward.

It's a dumping ground

The care staff in Willow Ward retreated to a place inside and disconnected from the rest of the Care for Older People Unit outside. This place was full of feelings of persecution and resentment because it contained all the dreadful fears related to not getting better in old age, but nonetheless it felt safe and familiar. The care staff frequently complained of being treated like a dumping ground and resented the sense that they had to deal with everybody else's rubbish. There are all sorts of psychoanalytic associations in these statements, for example the care staff's recognition that the others projected their hostile feelings into Willow Ward, the denigration of residents (and over-identified staff) who fail to get better and the personal care that often involved body products such as faeces, urine and vomit. Emanuel (2001) argues that no matter how persecutory life inside can be at least it provides a sense of identity that wins over the lifeless void.

Fixed ways of thinking

Emanuel (2001) further argues that the formation of a kind of boundary around the inside space can allow a holding place that is akin to containment. There is

however investment in fixing the inside identity which prevents growth which is part of a truly containing relationship. Fixed ways of thinking avoid stirring up anxieties about change or confronting depression connected with how things have operated in the past. He suggests that this is at a cost of "isolation, stagnation and withdrawal." In Willow Ward this meant it was threatening to let in others who may not share the fixed ways of thinking. This meant practices such as low referral rates for external consultations from therapists became routine. This prevented those inside Willow Ward receiving help and often stifled creativity and growth.

A false sense of power over non-existence

The insiders are invested in their identity and ideas to such a point that they seem grandiose and arrogant. In Willow Ward, this was evident in Willow Magic where the care staff felt they were able to defy death and keep the residents going through the efforts of their care.

Emanuel (2001) suggests this can be seen as a consequence of living inside but argues that it is a particular form of delusional grandiosity used as a defence against utter emptiness. It was also hard for care staff to psychologically step outside as they would lose the protection of inside thinking and have to face the realities such as the limits of their care and ultimately the inevitability of death.

SUMMARY

In this chapter I have argued that the new ways of working and thinking about emotions developed in the Reflective Work Group did not become part of the

customs and practice of Willow Ward because social systems within the organisation supported the care staff's psychological defences. In the ward, these systems divided up the residents in terms of their levels of activity and separated the emotional roles and responsibilities of the nurses and clinicians. Senior nurses and clinicians and the most cognitively able residents tended to engage in the most direct, verbal communication. Staff nurses occupied a particularly difficult position in that they had responsibilities for verbal emotional care and practical care. The more senior the nurse the more choice they had about what roles they would fulfil. Nursing auxiliaries had the lowest status and least choice about their involvement in practical care. This meant they shouldered much of the burden of the emotional demand attached to the delivery of personal care.

The more able the resident, the more personalised and intimate the emotional contact they received. The most dependent and non-responsive residents received very little contact other than practical care. They were paid little attention and rarely thought about. These systems prevented envy and fear in the residents and located the most disturbing feelings in the non-responsive residents which could then be avoided. I have argued this system was replicated through an organisational defence where Willow Ward occupied the non-responsive position.

The social systems in the Care for Older People Unit resulted in a situation where Willow Ward acted as a repository for the hostile projections of others *and* stirred up feelings related to severe dependence, the limitations of care and treatment and a fear of emptiness and non-existence. The upstairs-downstairs

effect resulted in a situation where Willow Ward became identified with these traits and missed out on resources that might make things better. The care staff in Willow Ward seemed cut off from outsiders and developed an insider way of thinking and being. This provided them a sort of comfort for all the distress but prevented them developing to their full potential.

CHAPTER 11 - DISCUSSION AND CONCLUSIONS: THE UNIQUE CONTRIBUTION OF CONTINUING CARE STAFF

In the previous chapters I have discussed the findings in the context of appropriate literature. In this chapter I draw on the findings to assimilate the thesis and the discussion focuses on the conclusions and recommendations. I recap on the strengths and limitations of the study before making conclusions about living bereavement in Willow Ward by addressing the aims and objectives of the study. I have discussed the links between the data and theory in each of the findings chapters. The main points are summarised here as they relate to the overall conclusions. Finally, I make recommendations for a way forward for Willow Ward and the Care for Older People Unit and draw out principles that, within the limitations of this single case study, can be applied to other continuing care organisations.

Strengths and limitations of the study

A strength of this study has been the blending of social and psychological methods to produce a thesis that addresses the emotional and cultural issues of care work in a given context. In the literature review I found that the body of literature was fragmented and that studies tended to focus on either the cultural or emotional world. It is an important feature of this thesis that it explored the boundary where culture and emotions meet.

The literature review also suggested that perspective of different groups, for example, staff, residents and relatives tends to be researched separately. In this research there was a focus on the care staff's views. This can be justified

because there is a lack of qualitative research in relation to the care staff's perspective, but future studies should consider the importance of the relationship between the views of care staff, residents and their families.

In order to gain insights into the care staff's emotional responses and the psychological defences alive in the work, I adopted a psychoanalytic approach to the data. The psychoanalytic framework is a well established method of understanding unconscious processes, but sociological orientated qualitative researchers adopting a more pluralistic approach might find it limiting. These researchers would argue against viewing the world through a specific lens preferring to understand truths in a given context.

Some individuals in the research setting may also have found the psychoanalytically informed methods off-putting and so participated less in the research. This means the findings and the growth stimulated by the research is biased towards those who are comfortable with the methodology.

Understanding how unconscious processes motivate and influence the provision of care for this vulnerable client group is important and helpful, future research should be directed at exploring similar environments using a range of psychological methodologies in order to demonstrate the range of psychic truths that may exist.

Some may question issues of transferability from a single case study such as this. Sharp (1998) argues that in depth case single studies offer transferability through recognition. I have included rich description of the cultural context and

data generated through the containing methods of the research so that the reader is able to assess the relevance and fittingness of the findings to other continuing care settings. Sharp (1998) also suggests that intensive data collection and analysis has the potential for theoretical transferability. In this study there has been a systematic approach to data collection and analysis within an appropriate theoretical framework. Related studies are needed to confirm or refute the explanatory theories developed to address the research aims in this thesis.

Exploring the care staff's view of living bereavement

An objective of the research was to explore the views of care staff on Willow Ward and emotional response to loss in the continuing care setting. Exploring the care staff's perspective is considered a valid focus as few researchers in the literature review had tried to capture their experience for its own sake (Chapter Four). In Chapter Seven I described the themes that emerged from their accounts about their work. These related to a trajectory of living bereavement. The care staff described an emotional demand in their work that included their own feelings and a sense that they were on the receiving end of other people's feelings. This aspect of their role was rarely recognised and they seemed to find it burdensome.

Unlike previous studies which had concentrated on single aspects of loss in continuing care such as admission (Dellasega and Nolan 1997) or death (Froggatt 2001), the care staff articulated a trajectory of loss that was complex and included multiple losses. It started with the resident's shock on admission and was often accompanied by their relatives' grief. The loss experience

continued whilst the residents were living in Willow Ward and because they were separated from their families and homes. This separation often provoked deep anxieties. The residents were at the end stage of chronic illnesses and suffered losses incurred by degeneration of their minds and bodies. The final aspect of the living bereavement trajectory related to the anticipation of death, the process of dying and bereavement.

In my fieldwork I noticed that the care staff tended to omit or gloss over some aspects of the emotional demand of their work. This included their work with a group of residents who tended to stay in their own rooms and were rarely spoken about. I described these residents as non-responsive because they were in positions of profound dependence and had little capacity for spoken or symbolic communication. When I worked with these residents I noticed that I felt a lot of self-doubt about the adequacy of my care delivery for such needy residents. I felt guilty when I became frustrated and sometimes despondent about my lack of capacity to make any real difference to the residents' quality of life. I also felt angry and hurt when residents were abusive or rude. I also found it was an isolating experience working on Willow Ward and I missed contact with other disciplines. Initially, I didn't feel part of the family atmosphere that the care staff referred to. The care staff seemed much more certain about their work and laughed off any insulting behaviour, even when it was racist or cruel.

Uncovering the care staff's emotional responses

Previously, participant observation in continuing care environments has adopted a sociological perspective, for example Starck (1992) ethnographic

study and not attempted to record an emotional experience in the data. In contrast, psychoanalytic organisational consultants such as Roberts (1994b) have focused on emotional experience but have not included an in depth practical experience of the field. My research supports Roberts (1994b) findings that social systems in continuing care settings support care staff's psychological defence against the difficult feelings associated with looking after dependent older people who fail to get better. I suggest I have added to the body of knowledge by articulating the emotional experience related to the non-responsive residents who stayed in their rooms and were rarely spoken of and therefore not identified as significant in previous studies.

In Chapter Eight I used a detailed discussion of a Reflective Work Group to demonstrate how the care staff avoided elements of the emotional demand that were connected to feelings that were generally unacceptable or felt unbearable. I suggested these included anger, hatred, guilt, envy and despair. I proposed that care staff used psychological defences to protect themselves from these feelings. The particular Reflective Work Group that was discussed was selected because it contained the protective techniques I identified as significant through the repetitious containing processes in the research (Chapter Five).

The protective processes included keeping out strangers. The care staff often said they wanted people to witness their work, but when people with different perspectives wanted to get close to the issues of personal care they were discouraged. The care staff also seemed to adopt an attitude where they were suspicious and sometimes quite hostile towards outsiders. This was described by one participant as being on the offensive all the time. In order to take the

sting out of residents' abusive behaviour the care staff frequently denied the residents' capacity for feelings such as envy and anger. The care staff would often respond with things like "Oh she doesn't know what she is saying" which denied the potency of the feeling and reinforced the residents' position of powerlessness.

I argued that the care staff avoided contact with primitive feelings of lifelessness and emptiness associated with contact with very dependent people by distancing themselves from certain groups and paying more attention to others. I suggested the care staff valued feistiness and ignored non-responsiveness. Any one who was considered to bring the place to life was held in affection whereas those with minimal capacity to speak or interact were rarely discussed or thought about. In order to deal with the frequency and inevitability of death, the care staff seemed to place their faith in Willow Magic. I explained this as a sense that the staff felt their practical care was powerful enough to prevent the residents from dying. This helped them cope with despair associated with their frustrated desire to keep the residents alive for ever.

Finally, the care staff created an exclusive environment where relatives who helped keep things going and kept visiting the residents were integrated into the Willow Ward family. Residents who stopped visiting or rarely visited were viewed as abandoning the residents. All feelings about a desire to be relieved of the burden of care for such disturbing and dependent residents could be projected into the relatives who didn't visit and were disowned by the Willow Ward family.

Developing the participants' capacity for working with emotions

Another objective of the research was to support and develop the participants' (including my own) capacity for working with the emotions attached to loss and grief. In Chapter Four I explained how I incorporated the Tavistock method of learning about emotions (Rustin 2003) into the research methods. This provided education, supervision and a chain of containment that stretched from the experience of caring for the resident in Willow Ward to the Tavistock Supervision Group. In Chapter Nine I discussed the care staff's work with a resident and his wife. This was an illustrative case that continued over eighteen months. I argued that the care staff and I developed our capacity to take in feelings, think about them and feed them back in a more tolerable form. I developed this capacity in my role as the facilitator of the Reflective Work Group and the care staff improved their capacity to do this in the ordinary activities of their work. I suggest that this way of working did not become custom and practice on the ward because there were social systems inherent in the organisation that supported the psychological defences.

The impact of the emotional responses on the social organisation of care

In Chapter Ten I discussed how emotional responses impacted upon the overall social organisation of care which was another objective for the research. Previous studies have identified how social systems support care staff's psychological defences (Menzies Lyth 1959/1988). I have added to the understanding of social systems in continuing care settings and demonstrated how the social system in Willow Ward was repeated throughout the organisation.

I described a social system within Willow Ward, which split up the residents in terms of their liveliness. This splitting process was hierarchical with the most cognitively able residents at the top and the most dependent and least responsive at the bottom. The residents with higher levels of cognition received more personal and individualised interactions whereas the non-responsive residents tended to be given attention based on personal care delivery. Running along side the splitting up of the residents was the fragmentation of the emotional roles and responsibilities for all staff providing care and treatment. At the top of this hierarchy was the direct communication about emotional issues such as a resident's prognosis or a therapeutic intervention. This sort of interaction was often carried out in private and within a timed framework. At the other end of the hierarchy was the emotional work contained in the practical care. This was difficult work and it required sophisticated skills for emotional containment, but it tended to be less valued.

Members of staff with the highest social status such as doctors, therapists and senior nurses carried out the talk-based emotion work. The nursing auxiliary grade with the lowest status tended to provide the emotion work contained in the practical care for the most dependent and least responsive residents. Staff nurses and the Charge Nurse were involved in both types of emotion work, although they tended to have more choice than the nursing auxiliaries.

It is important to stress that this system was protective for everyone as it prevented them from being in contact with the unacceptable and unbearable feelings provoked by working with profoundly dependent residents who failed to get better and provoked feelings to do with a sense of lifelessness. The care

staff and multidisciplinary team members at the top of the hierarchy were able to adopt a more holistic and emotionally sensitive view of the residents as they were not confronted by the enormity of the dependence and need related to emotional demand of providing personal care. Care staff at the bottom end of the scale dealt with the difficulties of the emotional demand in providing care for such dependent older people by using the psychological defences I have described. This meant they adopted a less holistic and less emotionally sensitive view of the resident by focussing on the practical care and denying residents' capacity.

I argued that this system was replicated throughout the whole Care for Older People Unit, with Willow Ward being the repository for the hostile projections of those upstairs in the rehabilitation wards and the antagonist of primitive anxieties for those who came close to the fear of emptiness stirred up by working with people in very dependent old age. The care staff on Willow Ward had become over identified with the most disturbing aspects of old age and formed an alliance with residents and some families. I argued that to deal with their position in the organisations and cope with their own anxious feelings the care staff took refuge in the activities and identity that shaped the culture downstairs.

DISCUSSION AND CONCLUSIONS: DEVELOPING UNDERSTANDING THROUGH THEORY

The findings are relevant in the light of social and psychoanalytic theory. I have argued that although sociologically based research has offered explanations for

practices that are similar to those in Willow Ward, the psychoanalytic theory enabled an understanding of the potential for emotions and their connected psychological defences to shape cultural practices.

The complexity of loss in continuing care

Previous studies have suggested how caring for unbounded bodies and dying residents present problems for modern society (Hockey 1990; Lawton 1998; Froggatt 2001). It has been suggested that in contemporary society boundaries between the inside and the outside of bodies and the living and dying are highly regulated (Lupton 1998; Seale 1998). The experience of working with loss and grief in the continuing care setting was disordered, unbounded and the margins between life and death were uncertain. Research located in a sociological domain has suggested that care staff cope with these issues by separating out residents who challenge societal norms. Froggatt (2001) described how dying residents were nursed separately in care homes and Lawton (1998) explained how residents whose deaths were dirty tended to be separated from others. The social process of separating out in this way was referred to as sequestration.

This study has been located in psychoanalytic theory and although similar sociological processes have been described, in this study they were given emotional rather than social meaning. The central tenet to the thesis is that unconscious motivations, often related to avoiding painful or anxious feelings, shape the cultural practices in an environment (Hinshelwood and Skogstad 2000). Applying this understanding to the findings I propose that there are three issues that are central to the emotion work with loss and grief in continuing care environments.

The first is the profound dependence and degeneration experienced by residents. This not only gives the work a social stigma (Lawton 1998; Froggatt 2001) but it also has a profound impact on the psychodynamics between residents and carers. Residents can be envious and hateful of their younger fitter caregivers and the care staff can be resentful and hating of the residents who place such difficult demands on them. Winnicott (1949) describes the hatred stirred up in therapists providing psychotherapy for psychologically disturbed patients. He argued that hatred was inevitable in such relationships and that the more it was acknowledged the less likely it was to be acted out.

The second issue is that the care staff were denied the satisfaction and reward of seeing the people in their care get better and go home. Main (1957) observed that those in caring professions have the opportunity for personal reparation in helping other people and seeing them get better. He suggests the constant frustration of this opportunity can provoke anger and eventually despair. The residents in Willow Ward suffered prolonged and difficult endings and rarely got better. Unconsciously, the care staff fought against this, but inevitably were faced by repeated failure as the residents inevitably died.

Finally the sustained contact with such dependent and non-responsive people stirred up primitive feelings of dread about lifelessness and non-existence. This was evident in the care for such dependent old people but had a particular resonance in the non-responsive residents. These people not only stirred up dreadful feelings about non-existence but they were also an ideal repository for hostile projections of everybody's primitive anxieties about feelings of emptiness and void (Emanuel 2001). I suggest that the feelings and associated

psychological defences associated with these hidden and often unconscious aspects of the emotional demand provide the key to helping care staff develop their capacity for working with emotions in continuing care environments.

The creative potential of methods of containment

I have suggested that the research methods modelled a chain of containment and that this enabled the participants to explore the work so that they might get closer to a more complete picture of the emotional experience. I propose that the chain effect enabled them to develop some capacity for containment of the profound emotional experience of residents and their families when they carried out the ordinary activities of their work. I suggested this way of learning and developing was beneficial because it models resisting doing and encourages being with emotions. In other words the containing methods within the research did not require the care staff to do more in fact more often the development involved doing less. The learning focused on encouraging the participants to be more emotionally engaged with the everyday work practices. It encouraged thoughtful consideration and sensitivity to the emotional experience. This is helpful because it promoted understanding of people's emotional state which is therapeutic for its own sake and it allowed space for considering the possible unconscious motivations behind actions (Fabricius 1995).

Care staff are often full of aggressive and destructive feelings about patients and residents and having these anxieties understood and detoxified has the potential to prevent non-therapeutic action or abusive action (Dartington 1994). An ethos of understanding emotions and careful thinking can contribute to a person centred care and a better quality of relationships. Craib (2001) suggested

the careful consideration of symbolic meaning is humanising. In continuing care environments the behaviours of residents and customs in the care staff's working practices connect to the close contact with multiple and disturbing loss. These can stir up deep fears and anxieties, which make it difficult not to be propelled into infantile and primitive states of mind. These circumstances make a verbal articulation of the emotional state very difficult. I suggest the interpretation of symbolic behaviour is particularly important in sustaining the human qualities of all those associated with continuing care.

Social systems that support psychological defences

The social systems that were in operation in The Care for Older People Unit fragmented emotion work and placed it in a hierarchy. The system supported psychological defences by allowing those most closely associated with non-responsiveness to be a repository for hostile projections about hatred and anger about dependence, the limits of care and treatment and facing the inevitability of non-existence and death. At the various levels of the hierarchy, those who were identified with non-responsiveness could be split off, disengaged from emotionally and paid little thoughtful attention.

Menzies Lyth (1959/1988) observed a similar process of distancing techniques in hospital nursing and Roberts (1994b) suggested nurses were identified with the problems of not getting better compared to therapists and doctors who were associated with competence. The most prominent defensive splitting I observed in the Care For Older People Unit was the upstairs-downstairs effect which is consistent with the principles described by Menzies Lyth (1959/1988) and Roberts (1994b). This lends substantial evidence to the suggestion that the

fragmentation and splitting processes so prevalent in the body of literature (Holman *et al* 2004) and the social practices in care for dependent and dying people (Hockey 1990; Lawton 1998; Froggatt 2001) are connected to the world of emotions. This thesis makes a unique contribution by articulating the juncture between the social and psychological domain in a continuing care setting and placing the conflict between the desire for liveliness and contempt for lifelessness centre stage. I suggest that it is essential for those who are responsible for leading developments in continuing care to consider this conflict and how to respond to it.

The lack of integrated thinking and feeling about the profound issues of continuing care had led to a situation in Willow Ward where the care staff took refuge inside Willow Ward. As I have explained Willow Ward was closely associated with the disturbing issues of dependent old age and was an ideal repository for the hostile projections of other people as well as being a place for its own difficult feelings to exist. However taking refuge in Willow Ward was often full of persecution and resentment. Emanuel (2001) argues that, despite this, at least it structures an identity that overcomes the internal and universal dread of lifelessness. The Willow Ward care staff were clearly invested in keeping a separate identity from the rest of the Care for Older People Unit. This was related to a fear of stepping outside. This fear was associated with looking back in at Willow Ward and facing the reality of their work and also being confronted by the hostilities of the outsiders.

Emanuel (2001) argues that insider thinking is protective but costly as it can result in a state of isolation, stagnation and withdrawal because development

and growth inevitably involves closer contact with the most dreaded aspects of emotional experience. He also suggests that people develop an inflated sense of their own power. He describes this as a particular form of delusional grandiosity. I likened this to Willow Magic where the care staff sometimes seemed to believe they have the power to save the residents' lives by providing good practical care.

The care staff were often seen as fixed thinkers by people outside the ward, and it was often difficult to introduce new ideas. For example it was hard to introduce the practice of taking residents' life histories or developing a more palliative approach to care. Bringing in new ideas from outside like this would be very challenging to the insider defence because it stirred up all the fantasies and feelings that had been suppressed. Valuing life histories suggests residents have a capacity for feeling and thought and palliative care approaches prioritise quality of life over prolonging life. Both of these concepts directly confront the psychological defences used to defend against anxiety in Willow Ward. It is important that the continuing care speciality is encouraged to flourish and grow so that the realities of a dependent old age can be faced and appropriate care be provided but this can only be achieved if change agents consider the unconscious anxieties and related psychological defences inherent in the work.

RECOMMENDATIONS FOR HOW THE ORGANISATION COULD IMPROVE THE CAPACITY OF ITS STAFF TO WORK WITH THE EMOTIONS LINKED TO LOSS IN CONTINUING CARE

I have argued that a key reason for the care staff on Willow Ward being unable to meet their full potential in providing emotionally sensitive work relates to the social systems employed across the whole organisation. For the development of care practices in continuing care settings to progress it is important that all those associated with the speciality consider their own motivations and practices.

Recommendations for designated leaders in continuing care organisations

My recommendations for the leadership of the Care for Older People Unit are designed to encourage a more integrated approach to continuing care. This involves examining and challenging the customary ways of working. It requires rethinking the philosophy of care throughout the unit and prioritising resources accordingly. I suggest:

- The leaders of the Care for Older People Unit examine the philosophy and direction of the whole unit. This needs to include the development and support of strategies that join up the rehabilitation and continuing care process.
- Appropriate resources are allocated to the rehabilitation and continuing care settings that include the emotional aspects of the work.
- That there is a focus on developing practice of all care staff at the juncture between rehabilitation and continuing care. In other words, the preparation of residents and their families for continuing care and the

settling in period in continuing care. It would be important to be aware of all staff's role in talking directly about the emotional issues involved and the emotional issues contained in the practical care.

It is important that these recommendations are understood in the spirit of the overall thesis. I therefore suggest learning and development should be encouraged through the airing, taking in, digestion and feeding back of feelings in a tolerable form. This could be similar to organisational consultancy or psychoanalytically informed action research (Menzies Lyth 1959/1988; Roberts 1994b). Methods of containment such as reflective work groups should be located within a chain of containment that is secured to an appropriate structure. Although preferable, it may not be possible to use an external body such as the Tavistock, so an internal steering group with a clear commitment to integration and self-examination could be linked to an appropriate institution such as the local education provider.

This has implications for the provision of education and training in this speciality. The containment methods would be designed to help participants come closer to the realities of the work and interpret symbolic communication. Fabricius (1995) and Dartington (1994) describe how nurse educators are keen to work with student nurses in this form of learning, but a more systematic approach to this type of education provision maybe a useful way forward. It has the advantage of being interdisciplinary and directly linked to practice. I suggest the benefits of such an approach would be to sustain the human qualities of those associated with the care for older people and to prevent non-therapeutic action and abuse.

Recommendations for facilitators of Reflective Work Groups

I suggest the Reflective Work Group has been useful in that it has provided a space for care staff to be understood and I propose that it is a valuable and therapeutic endeavour in its own right. The Reflective Work Group has also provided a model of containment through which care staff are able to develop their own capacity for working with emotions. The links with the Tavistock Supervision Group allowed me to develop my skills in working with emotions and my capacity for containment. I suggest the capacity for containment is central to any development intervention because change inevitably requires loss of old ideas and customs, which may stir up anxieties. I recommend that facilitators of such groups in continuing care environments should:

- Ensure there are secure links of containment, which enable a continuous assessment of when psychological defences are alive in the work.
- Be aware of insider identity and thinking. This involves a heightened sensibility for having one foot in and one foot outside the setting. This can provoke disturbing and difficult feelings. The capacity to hold, identify and think about these feelings is key to understanding the emotional demand in the work.
- Provide careful and timely feedback about the emotional demand. This can be challenging but helpful in demonstrating the possibility of tolerating unacceptable and unbearable feelings without either suppressing or acting them out. The modelling of resisting action and promoting being with emotions is essential in coming to terms with the realities of what can and can't be done in the care for older people.

It is vital that facilitators of this type of work have adequate supervision. It is likely that people drawn to continuing care have personal histories that reflect the issues under examination and have a valency for the dominant psychological defences (Hinshelwood and Skogstad 2000). In my case, I became over identified with the care staff (Chapter Eight) and was often drawn into enacting feelings rather than tolerating them (Chapter Eight). The Tavistock Supervision Group and my personal reflections enabled me to identify these issues and develop my own facilitation style that was good enough to foster creativity in the research (Chapter Four).

Recommendations for care staff working in continuing care organisations

The care staff in Willow Ward became enthusiastic users of the containing functions of the research methods and demonstrated considerable courage in facing the realities of their difficult work. In the thesis I have inevitably focused on feelings such as hatred, anger, guilt and despair, as these are more likely to provoke anxiety and necessitate psychological defensiveness. It is worth noting that by attending the Reflective Work Groups and daring to explore their own feelings the care staff demonstrated their commitment and love for the residents. I suggest the way forward for the care staff in Willow Ward involves a clearer articulation of the specialist knowledge and skills in relation to being with patients rather than doing for them. I suggest this is inherently difficult as it relates to a profound shift in insider identity and thinking. I recommend that:

- Staff nurses become more confident in the value of their specialist continuing care knowledge and skills. This includes developing and modelling emotionally containing ordinary care work
- Nursing auxiliaries become more confident in their ability to engage in more talk based emotion work. This includes finding out biographical details from residents and speaking with relatives about important issues.
- The staff nurses and nursing auxiliaries share their specialist continuing care knowledge and skills with their rehabilitation colleagues.

The process of trying to understand care staff's emotional response to their work is therapeutic in its own right. It has the hidden benefit of separating the care staff's needs from those of the residents. This is especially important in continuing care settings which can become marginalised (Hockey and James 1993) and subject to an insider identity and way of thinking. Care staff can become identified with the residents (Roberts 1994b) and their needs get subsumed. It is important to validate the care staff's important role of being on the receiving end of other people's projections. Careful attention to this can free care staff from burdensome guilt and promote a freer more creative thought process. The purpose of this is to promote a relationship where care staff are viewed separately from residents but adopt an empathic approach. The less care staff over-identify with the dependent and dying residents the more likely they are able to be able to grow and develop in themselves.

Although the research failed to change the customs and practices on Willow Ward I suggest it has equipped all those involved to be able to adopt this

position and take opportunities for development. For example, since the completion of data collection, six nursing auxiliaries have gone on to study for their National Vocational Qualification in health and social care and have used the Reflective Group Work as learning material. This learning takes place outside Willow Ward and with members of staff from the rehabilitation wards. These are small steps but indicate a growing confidence in an identity based on the importance of continuing care work rather than insider thinking.

THE CONCLUSIONS IN A WIDER CONTEXT

As this is a study of one particular continuing care setting, I have made recommendations specific to this context. I have provided enough background and contextual detail so that readers can judge whether the findings and conclusions I have made apply in different continuing care environments such as care homes. I have also suggested that taking a view through a psychoanalytic lens is a helpful way of understanding continuing care but not the only way. I suggest there are some universal conclusions to be made about loss and grief in continuing care environments. These principles have broader implications that need to be considered in relation to education, policy and research strategies that are aimed at promoting quality care in continuing care settings.

Considerations for policy

I suggested that the Care for Older People Unit examine its philosophy of care as a whole. I suggested it was important to reassess the aims of acute care, rehabilitation and continuing care with a view to designing a strategy and

allocating resources that join up all aspects of care. I propose that this principle is particularly important in the care for older people as older patients who require acute and rehabilitation care inevitably have to engage with the limits and realities of their treatments. Similarly the needs and issues of older residents in continuing care are not solely concentrated on dying.

In the current National strategies for the care of older people there is an emphasis on maintaining independence in acute and rehabilitation services *or* end of life care (Department of Health 2006). I suggest that this policy can be seen as consistent with the defensive position of splitting older people into those who can respond to treatment and get better and those who fail to respond to treatment. The model being proposed for end of life care is based on the specific experience of dying from cancer (Department of Health 2006) which is unlikely to reflect the difficulties of the prolonged complexity of losses in life and death discussed in this thesis. The real difficulties of trying to sustain a creative and empathic approach to continuing care settings has been ignored, in the same way as non-responsiveness was in Willow Ward and the Care for Older People Unit in this research.

Nolan *et al's* (2004) work suggest that some elements of National policy that focus on person-centred approaches to care are in danger of ignoring the complexity of relationships and undervaluing interdependence. I propose that policy makers should consider focusing resources and planning at the juncture of such splits or fragments. This would encourage the examination of relationships between groups of people, time phases and social and emotional domains. For example it is important to improve communication between doctors, physiotherapists and other team members' about ending a person's

treatment and also link it with care staff's emotion work which is needed to help residents and their relatives adapt to a continuing care setting. This would involve a strategy that focused on relationships between carers, nurses, therapists and doctors across the services with a view to developing resources and strategies that were aimed at assessing the relationship between the patient's need for independence, enhancing quality of life and preparation for death. This is consistent with Nolan *et al*'s (2004) suggestion that relationship-centred care is a more integrated approach that is prepared to tackle the complexities faced by practitioners.

Considerations for research

In the research I identified the important role for care staff of containing the intense emotional demand of their work. I suggest that for care staff to achieve these roles and responsibilities researchers need to develop methodologies that explore the complex work with emotions required to carry out the ordinary work in continuing care. I do not think all researchers should adopt a psychoanalytic approach, but it is prudent for any researcher to ensure that there is enough of a secure framework to ensure they identify when they are being swept along with defensiveness. This may take the form of the usual indicators of good practice such as appropriate supervision or clarity in the researcher's roles and responsibilities. Following this study, those researchers who wish to be mindful of unconscious influences on their methods might also consider the impact of the potential for work closely associated to continuing care to be:

- Isolated from other agencies and disciplines

- Avoidant of negative feelings such as anger, hatred, envy, guilt and despair
- Focused on doing at the expense of being with feelings connected to not getting better
- Driven by an omnipotent desire to keep things going.

I recommend that it is particularly important for studies in this field to be linked with external agencies and to encourage integrated thinking within continuing care organisations. A view of the whole organisation is important and researchers are encouraged to be mindful of splitting defences such as the upstairs-downstairs effect.

When researchers explore continuing care environments where dependent older people endure multiple losses and eventual death, it is reasonable to expect a range of feelings or issues in all groups: staff, residents and relatives. An exclusively negative or positive view is unlikely to reflect the full picture. Researchers need to be prepared to engage with a range of issues in order to reflect the realities of the continuing care work. Denial or avoidance of unacceptable or unbearable feelings held by particular groups is not helpful. For example, ignoring residents' hostile and angry feelings is a denial of their full potential to feel and experience their lives.

It is also important that researchers engaged in action research or change initiatives do not collude with a tendency towards doing more rather than being with some of the difficult feelings associated with non-responsiveness and not getting better. I am not suggesting that researchers should avoid all action, but I

recommend that intervention studies assess carefully the motivations behind any aim to do more. It is important that researchers discover new ways of helping care staff engage emotionally with residents in continuing care settings in the ordinary activities of their work.

It is important that research explores the realities and difficulties of care staff's work. A more solid knowledge base related to ordinary working practices will validate the role of care staff in continuing care and enable more effective and appropriate interventions. Engaging with the more challenging emotional aspects of care can facilitate a more sustainable change in the quality of interactions and relationships that is fundamental to the role of nurses and carers in continuing care.

Although it is important to help staff "to feel good about what we do" (Nolan *et al* 2004) it is equally important that researchers identify non-therapeutic action or abusive practice. Methodologies that are aimed at improving practice should give feedback in a timely and careful way which ensures maximum therapeutic impact (Menzies Lyth 1969/1988). I suggest that it is essential for action research and developmental methodologies to model tolerating the most difficult feelings in order to acknowledge them and not act them out. For example, if research participants are locked into insider thinking, the researcher needs not only to note this as data but also to develop methods that contain the anxiety provoked by the presence of outsiders and the threat of change.

Following this research, I suggest researchers who wish to sustain change related to promoting dignity and person-centred approaches to continuing care for older people (Department of Health 2006) need to be able to tolerate

hearing care staff's feelings that seem unacceptable. Researchers need to engage with care staff's feelings that may seem to indicate a lack of respect for dignity and person-centeredness in order to understand the care staff's perspective and facilitate a more creative response to these negative feelings.

Considerations for education

I have argued that in continuing care working with emotions is intense and requires a skilled and therapeutic response. I have suggested containing processes can be useful for learning to develop the capacity for working with emotions and that providing containment is a therapeutic endeavour for its own sake. I suggest educationalists should consider adopting teaching methods that model and encourage learning about emotions (Rustin 2003). This will help validate and develop the specialist role of nurses in the continuing care for older people in the following areas:

- The care staff's role as recipients of the emotional projections of others (especially the residents and their families)
- The emotion work that is inherent in providing practical care
- Speaking about issues that are emotionally charged, for example a resident's personal biography.

In order to build on the findings of this research so that care staff can develop a greater capacity for working with emotions, it is important to provide education that facilitates the development of knowledge and skills required to provide containing environments and relationships. I suggest this is a central role for the continuing care nurse but has yet to be fully acknowledged or developed and

this is this is unique because of the particular quality and intensity of the emotional demand. I propose that education in the speciality should encourage a greater understanding of the importance of loss in old age. Failure to equip nurses to provide a creative response to the complex and multiple losses in dependent old age can result in a situation where *living bereavement* becomes enacted in the customs and practices of the organisation.

It is important that educationalists develop learning and teaching methodologies that examine the relationships between significant groups. Interdisciplinary learning that is work based can help learners to identify their own feelings and work with the projections of others (Rustin 2003).

The use of the Reflective Work Groups and similar experiential teaching methods can also model a creative containing response which is both educational and therapeutic. Education at all levels needs to acknowledge the complexity of practical care and education methods that teach practical skills in a vacuum deny the difficulties of the work involved. This is particularly important in continuing care environments where residents are often shocked and frequently suffer with dementia. Educationalists should consider whether their teaching methodologies explore or ignore problems inherent in continuing care.

I suggest those commissioning and providing education for continuing care staff should consider skills training in talking about emotional issues such as loss. The evidence from this study suggests this is particularly important in relation to the period of admission, losses incurred through degeneration and

separation whilst living in a continuing care environment and preparation for death. I suggest education related to direct communication is appropriate to all practitioners at every level. The roles of people such as doctors, nursing auxiliaries, physiotherapists and other staff should be clear but flexible and should acknowledge the kind of direct communication inherent in each role..

SUMMARY

In Chapter Eleven I have assimilated the findings in the thesis and the discussion that linked them to theoretical positions. I have made conclusions and recommendations about the findings as they can be applied to Willow Ward. Recommendations were made for to the role of leaders in the organisation, those who facilitate Reflective Work Groups and continuing care staff. I have also drawn out key principles that, although formulated in the context of a single case study and seen through a psychoanalytic lens, can be considered for application to other continuing care environments providing care for dependent older people who experience multiple and complex loss.

This thesis makes a unique contribution to the body of knowledge by developing psychoanalytically informed understanding and technique in the specific context of continuing care for older people. The issues of *living bereavement* have been articulated in a way that conveys the texture of the emotional experience. I have suggested that it is important to develop a capacity for emotional containment in all continuing care staff. In order for this to become a reality it is vital that careful consideration is paid to the care staff's needs and the way an organisation responds to the anxiety provoked by the care work. A strategy that can deal with a full range of experience rather than

avoiding unbearable and unacceptable feelings is more likely to produce creative and sensitive response to emotional difficulties.

APPENDIX 1 - GLOSSARY OF TERMS

Basic assumption mentality in groups: When a group's behaviour is driven by unconscious desires to avoid anxiety and internal conflicts.

Basic assumption dependency: When a group behaves as if the sole task of the group is to meet its own needs and that the group leader is supposed to protect group members and make them feel good. The leader is not expected to challenge group members with any of the demands of the real task.

Basic assumption fight or flight: When a group behaves as if there is a danger or enemy that they need to attack or escape from. The leader is expected to take action and the group members merely follow.

Basic assumption pairing: The group behaves as if a pair or couple will solve all its problems. This might be a couple of group members or the group leader and another, perhaps outside the group. There is a feeling that something in the future will make everything ok.

Containment: The process of taking in someone's feelings, thinking about the feelings and trying to understand them so they can be detoxified or modulated. This can make feelings more tolerable. The container can then give back the feelings in words or behaviours.

Counter-transference: The state of mind in which other people's feelings are experienced as one's own. This term is usually used in the context of a

therapeutic or caring relationship and relates to the therapist or carer's experience of the other person's inner world. This has a particular quality and can feel like someone is pushing their feelings onto you.

Denial: The unconscious avoidance or pushing out of awareness of feelings that are too painful or disturbing to acknowledge.

Depressive position: This is a state of mind described by Melanie Klein. It refers to a state of maturity when one is able to contemplate the world in a more balanced and multidimensional way and be able to accept "what we can have and what we can't have".

Emotional demand: The emotional experience associated with care provision including the care givers own feelings, the feelings projected into them by others and the psychological defences used to avoid or gloss over issues.

Free association: This is a term usually applied to the therapeutic situation when someone is encouraged to speak about anything that comes to mind, without censoring the content or trying to make it logical.

Negation: When an individual unconsciously draws attention to something repressed by suggesting it is irrelevant or referring to its opposite.

Holding: When the external environment is manipulated to provide an atmosphere that encourages feelings of security and trust.

Introjection: This is the taking in of the external emotional experience into the inner self. This is the term used to describe this process in early infancy and refers to the baby taking in feelings which are communicated by the primary carer (usually the mother) by the ordinary caring activities such as feeding.

Oedipus complex: A term used to describe an aspect of personality development that involves accepting the sexual relationship of one's parents. Each person does this in their own way, but essentially it entails acknowledging the difference between the relationship between one's parents and the parent-child relationship. Coming to terms with this equips a person to have healthier adult-to-adult relationships.

Paranoid-schizoid: This is a state of mind described by Melanie Klein. It refers to a primitive state of mind when one views the world in terms of good or bad and disowns any of our own bad qualities. In this state we lose the ability to see the other person's point of view and give ourselves an exaggerated sense of importance.

Projection: When parts of the self are attributed to another or parts of the other are attributed to the self. For example when a person aggressively accuses you of always being angry, you might suspect they are projecting their own anger onto you.

Projective identification: This is a step on from projection. The feelings of another are projected onto the self and unconsciously experienced as if they were one's own. This can of course happen the other way around. When

watching a scary movie with a friend for example, you might find your self frequently checking to see if your friend is alright. This could be your unconscious attempt at calling out their feelings of fear as a way of avoiding your own.

Rationalising: Avoiding contemplating the possibility of unconscious motivations for behaviour with practical or logical explanations

Reaction formation: When someone asserts the opposite of something they are trying to avoid. For example, when an idea or belief provokes painful or conflicting feelings the person might claim to hold the opposite opinion.

Reparation: This relates to both internal processing and external reality. It involves repairing the damage done by one's hate to one's loved ones.

Repression: This is a central defence where conflicting feelings that provoke pain and anxiety are unconsciously pushed from awareness.

Splitting: A psychological defence where anxiety provoking conflicting feelings are avoided by attributing them to individuals or groups of people (or ideas) and organising them into simplistic categories. This inevitably involves some form of projection as the associated feelings are located with a particular group or individual and often idealised or denigrated

Transference: When a patient or client uses the therapist or carer as a blank screen and projects their emotional experience onto them.

Definitions follow: Craib (2001); Halton (1994); Milton *et al* (2004); Roberts (1994a); Waddell (2002); Ward and Zarate (2000)

APPENDIX 2 – EXAMPLE OF HOW DATA WERE RECORDED IMMEDIATELY AFTER THE FIELD WORK AND AFTER THE TAVISTOCK SUPERVISION GROUP

An exploratory study to determine the nature and impact of loss and endings for older residents, their families and staff in a continuing care unit.

The proposed research study aim is to: develop an understanding of bereavement in the context of continuing care of older people and develop staff's roles and responsibilities in assisting residents and their families mourn their losses.

Reviewed research aims:

- To map out the multifaceted nature of loss in the continuing care unit.
- To identify ways that the losses are expressed
- To identify defenses and coping strategies used by the staff group that are supportive of good care practices
- To identify defenses and coping strategies used by the staff group that mitigate against good care practices
- Evaluate the effect of trying to understand these issues with the staff.

- Space: the physical place or places
- Actor: the people involved
- Activity: a set of related acts people do
- Object: the physical things that are present
- Act: single actions that people do
- Event: a set of related activities that people carry out
- Time: the sequencing that takes place over time
- Goal: the things people are trying to accomplish
- Feeling: the emotions felt and expressed.

First reactions from Tavistock Supervision Group:
Sad, miserable
Disenfranchised
Annoyed (id = stuff)
Annoyed at level of care
Improved
Sad, promise of grief.
Strong reaction - (alluded to but for unit when it goes)

Other side - support - to acknowledge
Dangers feelings
↓
The group remained split

Spradley 1980:78 in Hammersley & Atkinson (1995) Ethnography Principles in Practice 2nd

Ethos of coming and doing - when stopped how does it affect?

Participant observation: on Willow from 2-3pm Includes a group with Geeta, Meena, Wei-Kong, Theresa, Patience and Celia (SN Susan joined us later)

July 30th '03

What happened in the session	Supervision notes and my reflections
I arrived to find the room we usually use on Willow has been converted to another office for a team in the community.	It makes me so cross that the function of a room can change without any consultation or even a polite notification.
It seemed very slow to get going, but Geeta went round and got everybody to come to the room. I could hear her calling everyone.	I remarked that being on a room on the unit would mean they will be called

Staying with the 'living' (Hated of relatives)
End of the earth - lonely planet.

	away, but no one was called away
<p>We used the snoozlem room and Wei-Kong told us about snoozlem and we talked about whether any resident could use the room. Wei-Kong seems to doing well in his NVQ and refers often to this.</p> <p>There was mention of a new resident plus other names I did not recognize. I commented that there seemed to be a lot of new people on the ward. This comment was ignored and Geeta (who had been keen to have the group) said: there had been a lot of deaths and that Biddy Moon had died.</p> <p>I said which lady was Biddy Moon. They said the quiet little lady, very nice they liked her. I asked how long she had been on the unit and they thought about five years. I said that I had been coming to the ward for seven years and I think she was always here.</p> <p>I then wasn't sure whether I had the right resident. I confirmed by asking if she was the lady who liked the music sessions and was Mary's friend. They said that was her.</p> <p>There was a lengthy discussion about the circumstances of Biddy's death. She had seemed to "give up" in the last few weeks. She had stopped eating and when they went to feed her she could hold her mouth shut.</p> <p>L. & M. said they would have liked her to have had a peg feed - just to try it. There was quite a lot of silences. I asked them how Biddy's death had made them feel.</p> <p>-Supervisor comment - suicide + rejection</p> <p>Celia replied sad, she was a nice lady, quiet, she was no trouble.</p> <p>Theresa said she was a lovely lady and said she said to her are you still my aunty and she would reply (in Biddy's voice) yes.</p> <p>I asked them if they thought Biddy wanted a PEG feed. They did not answer. They said she had given up because she felt lonely and had nothing to live for. I asked them if they were Biddy would they have wanted a PEG feed - Patience and Meena said no.</p> <p>Theresa said it made her feel like she had failed.</p> <p>They then went on to talk about Biddy's daughter, granddaughter and grandson. They said that Biddy's daughter had refused to speak to her during the time she had been in the unit. The grand daughter visited regularly and then under pressure from Biddy's daughter she had stopped visiting. She had moved away and things had become difficult. More recently she had visited again. The grandson had also visited.</p> <p>I asked Theresa why she felt she had failed and she said because Biddy had died. I said she would have to be God or a</p>	<p>This is the second time he has mentioned his NVQ - the group is an opportunity to have someone pay attention to your good work.</p> <p>» Snoozlem room like residents - omnipresent - their control</p> <p>John + quiet + letting Biddy die alone x Biddy died on purpose or stuff presented</p> <p>Scary: Intense + how much had Theresa taken the woman inside. So intimately involved</p> <p>x Staff's refusal to accept and work on with daughter</p>
Biddy died on her own.	

<p>magician if she were going to succeed in keeping the residents alive forever. They all laughed. I said maybe if looked at like they had provided Biddy with good care and made good relationships and kept her comfortable all this time this was success.</p> <p>Wei-Kong agreed and gave an explanation of how providing comfort and quality of care was success.</p> <p>They said the granddaughter had asked her mother to visit and she kept on refusing. When she finally did, when Steven took her to see Biddy, Biddy had just died. I asked them how they thought Biddy's daughter must have felt and they replied guilty - they all laughed and it seemed people thought serves her right.</p> <p>We had a long discussion about whether Biddy had "planned" to die this way. Geeta said maybe that's how Biddy planned it. Yes said the others. Maybe Biddy didn't want to see her either. There was little sympathy for Biddy's daughter and they said they were angry with Biddy's daughter. They suggested that Biddy was lonely and sad and that was why she had given up. When I tried to suggest that Biddy was a frail old lady and maybe she had come to the end of her life, they did not agree.</p> <p>There were very long silences and a depressed feeling in the air. Patience and Meena kept laughing because they kept dropping off. <i>to sleep.</i></p> <p>Geeta introduced another resident who had been admitted to the ward and died just three days later. I said that must be very hard too. They said yes. They thought that he had come from the royal London. He had a black man and white woman visit him. But he did not have family. He was a big strong man but he died. They felt that when patients were going to die they shouldn't be moved from their ward.</p> <p>I said it must feel like people are just sent to their ward to die. They agreed. They then started talking about how fitter resident used to be (they were referring to recent past - 5 years ago). I questioned this and said well five years ago you used to say this. Wei-kong said that when they were in the other hospital they had many well resident. They went on trips to **** Park, SouthEnd and Even the Channel Islands. Some of the others asked if he had gone to the Channel Islands he said no but he could remember the resident.</p> <p>I said it seemed to me that now well residents go to nursing homes and they have to provide a lot of palliative care and deal with a lot of death. They started recounting all the resident who had died.</p> <p>There was some more discussion about Biddy's daughter. There was a sense of regret and sadness about Biddy's death, but no sense of real sadness for her daughter. They did recognize that her daughter must be feeling terrible.</p> <p>Susan came in and went over the last moments of Biddy's life again. The others asked her to because she had been on duty that day. She said she had been with Biddy. Someone had tried</p>	<p><i>Just... guilt</i></p> <p><i>Channel Islands... Hayley</i></p> <p><i>Here is me sensing their overidentification - trying to push them to see</i></p>
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to give her some ensure - was it Patience? No it was Hortense. So Susan had cleaned Biddy's mouth and made her comfortable. She then went to tell the relatives that Biddy was ready. They were talking with Steven. Then when they went into the room, they came out again and said she had died. Susan reiterated the point that Biddy had not wanted to see them.

They said they hadn't received any notification about the funeral so noone went. In fact they don't know whether she had been buried already - whether she had been buried or cremated. They mentioned that the daughter said as far as she was concerned Biddy had died 7 years ago. I asked if they thought that when people got old and frail and went into homes, some relatives mourned their death. I mentioned Mary (friend of Rebecca) and they agreed her daughter had done this too. When I talk about the residents as "frail and elderly" there is no real recognition that the resident is somehow "different" from us in the living world.

(outside)

And I said something like how important their job was because Biddy had been surrounded by people who cared for her. I said that they had become like her family substitutes. This meant they were suffering a bereavement and I pointed out that they had talked about being sad, angry, guilty, wishing things had been different. They agreed with this.

Me being down into his' and 'them'.

I then said that they were not her family though so it should feel different. Patience and Celia agreed, but Theresa said but it's not the case, she feels sad. When she looked after Biddy she would say (and she did an impression of Biddy)

I tried to point out that Biddy's care had been good because they had let her have what she wanted and not forced her to have the PEG feed. There was no response to this.

Sn Susan came in but had to go out again. She came back before the session had finished.

Susan had finished the session by saying how sad it was that no one was with her. Not like with Edward - when he was surrounded by his family. Biddy had died in a suffering way with - she had wasted away and had a pressure sore.

We finally got to the point of how awful this was, when this was a lady they all cared for.

that Biddy was too old to go on and that her relatives found it hard to visit her because she was no longer her former self - seemed alien. This would be a very contentious subject in elderly care scene.

- ?
them
pushing
the daughter

Theresa having the residents as her family - not as well as her family.

Levels:

1. Staff pushed out
2. This was a 'suicide' - lots of blame / rejection
3. Then - family professional
4. Death - special resident; What was it about?

- * Staff's experience - then experiences of death
- * Express rejection.
- * Then being second to family - hurtful

What about other side of keeping alive at all costs...
+ located in SMV + C/N

What residents represent to staff...

Painful or reparative wishes -
frustration we are stuck with.

How respect for
elders in culture
eyes for an eye
(Toward Biddy's family)

Things closing down. Being left on their own.

angry
to Biddy
discussed
how could be
as they feel.

APPENDIX 3 – CONFERENCE PRESENTATIONS RELATED TO THE THESIS

Holman C. (2005) *Living Bereavement: An exploratory study of a group of staff's experience of working with complex loss and grief in a continuing care unit for older people.* International Conference on Working with Emotions: Organizations, Occupation and Self. Emotion work network: Liverpool JMU, University of Surrey, Brunel University, UEL and Roehampton University. Oral presentation: London

Holman C. (2005) *Living Bereavement: An exploratory study of a group of staff's experience of working with complex loss and grief in a continuing care unit for older people.* RCN Conference Nursing Older People – Partners in Care. Oral presentation: Chester

Crowhurst K. and Holman C. (2005) *Promoting psychosocial aspects of care for older people – how a successful work based education project was informed by interdisciplinary supervision.* RCN Conference Nursing Older People – Partners in Care. Oral presentation: Chester

Holman C., Crowhurst K. (2004) *Exploring complex loss in a continuing care setting.* Reflecting Old Age. Tavistock and Portman Trust and City University Joint Conference. Oral presentation: London

Meyer J., Ashburner C., Cotter A., Holman C. (2003) *The voice of older people in continuing care: methodological implications for data collection,*

practice development and dissemination of findings. Symposium: British Society of Gerontology International Conference, Newcastle upon Tyne

Holman C. (2003) *Exploring complex loss in continuing care. Report on an extensive literature review.* RCN Conference Nursing Older People – Transformed through unity. Oral presentation: Torquay

Holman C. (2002) *Case presentation.* Tavistock Clinic. Later Life Conference – Organizational stress and team morale in working with older people. Seminar format: London

Holman C., Jackson S. (1998) *Living bereavement in a continuing care unit for older people. Findings from a pilot study.* Nurse Education Today Conference, Selected as a core paper. Oral presentation: Durham.

Holman C. (1999) *The role of the lecturer in clinical practice.* Oral paper presentation: at King's University 1999 (by invitation). London

Holman C. (1999) *Living bereavement in a continuing care unit for older people* RCN European Conference – nursing older people. Oral presentation: Eastbourne.

Holman C. (1998) *Using action research to change practice in continuing care for older people.* RCN Action research conference. Oral presentation: Manchester

APPENDIX 4 – AN EXAMPLE OF THE FORM USED TO REVIEW THE DATA

Tell it as it is data form:

Date of data collection: 28.2.02

Period of time spent collecting data: 1 hour

Participant observation: in the sitting room.

Space: the physical place or places

Actor: the people involved – Steven, June, Angela

Residents: Betty, Irene, Sarah, Molly

Activity: June doing Betty's hair, Me talking to Angela

Act: Sitting in the sitting room,

Psychosocial data analysis:

What do we notice...

About loss in the data?

The staff in the data?

The resident in the data?

The relationship between the staff and resident in the data?

Why do we notice what we notice?

Possible Interpretations

That Charge Nurse Steven has anger towards him when he tries to control the shifts through doing the off duty. Perhaps there is a loss of control for the staff when they have an effective leader.

Occupational therapy assistant June's loss of reward for her hard work in a traditional form – when resident Betty tells her to fuck off when she does her hair.

Resident Molly disturbed cries – "mummy" she reminds me of a lost child, yearning for her lost objects. I feel distressed. How hard it is when Molly can't be helped. Feelings of helplessness being projected into those around her.

Nursing auxiliary Angela thinking about her own mother and her fate and how they will be looked after. Angela has been ill herself recently and she is reminded of her own personal feelings. She makes a comment about – keeping the residents alive – not seeming to question whether this is right given their quality of life.

A lot of staff have illness – they are an older staff group and they have worked in the environment for ages and they come from disadvantaged groups.

Residents drifting in and out of sleep in the sitting room, it's hard to stay with them.

APPENDIX 5 – DATA FROM A REFLECTIVE WORK GROUP

Participant observation 03.04.02 from 11:00 – 16:00 includes a reflective work group

<p>Reflective group: With Meena, Angela, Gloria, Richard, Hortense, Celia, and Maria.</p> <p>1. Recorded consent. I was puzzled because neither psychologist Hayley nor OT assistant June turned up. This is unusual. The painters let us use their sitting room again. The issue of where the group will take place in the future will need to be resolved.</p> <p>2. Researcher Cheryl: <i>With your consent I would like to tape the group as part of my research. I have given everyone a leaflet. It is the same thing I have been doing about loss and bereavement. I am the only person who will listen to the tape. Nobody else. I read out these statements and if you agree to being taped if you could say yes. It is a requirement of the ethics committee. If you say no we can either remove your name or go back over the tape afterwards.</i></p> <p>3. I read the statements and they say yes.</p> <p>4. Researcher Cheryl: <i>There's no Hayley today.</i></p> <p>5. Researcher Cheryl: Some discussion about the fire exit being locked and the room being hot. <i>Is there any thing you would like to talk about today?</i></p> <p>6. <i>Long silence</i></p> <p>7. Nursing auxilliary Meena: <i>Can I ask you a question?</i></p> <p>8. Researcher Cheryl: <i>Yes of course</i></p> <p>9. Nursing auxilliary Meena: <i>What we getting out of this group?</i></p> <p>10. Researcher Cheryl: <i>Well, what do you think?</i></p> <p>11. Nursing auxilliary Meena: <i>I don't know. I just [laughter]</i></p> <p>12. Researcher Cheryl: <i>What are you supposed to be getting out of it, is that what you mean? Well.</i></p> <p>13. Nursing auxilliary Meena: <i>Mmm [silence]</i></p> <p>14. Nursing auxilliary Hortense: <i>Bereavement, people don't talk about it. They were discussing it on Radio 4 one day last week. On woman's hour, lot of people don't listen to it, but I always do. You get a lot of facts from it. They were talking about it. You don't know when it does happen and it does happen. You know relatives, strangers, neighbours, just don't talk about it. You can't discuss it.</i></p> <p><i>They will discuss everything else. They just can't bring themselves to talk about it.</i></p>	
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15. **Researcher Cheryl:** *I agree with you, but this group is the same group as we have been having with me and you and Hayley and June that we have been having since last August. The idea is that you can talk about anything it doesn't have to be about bereavement. But I will be listening to the tape for stuff about loss and bereavement. You don't have to talk about that you can talk about, like we talked about Betty last week, you can talk about any thing you want to.*

16. *Someone outside needs directions*

17. **Nursing auxilliary Richard:** *There's some interviews going on*

18. **Researcher Cheryl:** *The idea is that this is a place where you can come and talk about your work. It may not seem immediately obvious to you, but it supposed to supportive and helpful in that your work is stressful, sometimes depressing and difficult. The idea is that sharing what you say with other people on a regular basis is supposed to be helpful. If you like you can let off steam, but mainly what we are trying to do is understand the residents and their relationships with you and other people and how you work with them. You might say why, but why do we try to understand anything.*

19. **Nursing auxilliary Meena:** *I thought it was like a study group*

20. **Researcher Cheryl:** *It is it's about understanding. It isn't just a bereavement group. It is the same thing that we have been doing since August. It is trying to improve the way, it is supposed to be supportive of the way you think about and feel about your residents.*

21. *Silence*

22. **Nursing auxilliary Hortense:** *It's very hard work, not everybody can do it*

23. **Researcher Cheryl:** *No. I wonder if you are questioning whether this sort of group does work. Are you saying it's not obvious?*

24. **Nursing auxilliary Celia:** *I think what Annula is saying is that if we have some kind of problem, can you do something about it for us? What do we get from it? Yeah*

25. **Nursing auxilliary Meena:** *Yeah, Changing things or something like that*

26. **Researcher Cheryl:** *Well, silence, I suspect there are not many concrete things I can change. That is part of the broader project that I am involved with. There may be some things that I can help you change. But that isn't really the function of this group, although often change comes from a group like this. But err, it sounds a little*

bit like some of the discussions we have had before where all the focus comes on to me and it's "why aren't you changing things?" [Laughter]

27. **Researcher Cheryl:** *Maybe some of the frustration is that none of us can, some of the things we can't change. Silence What sort of things did you have in mind Celia?*

28. **Nursing auxilliary Celia:** *Laughter*

29. **Nursing auxilliary Richard:** *What you are doing is very good. Because I have seen an organization where they give counselling. Where*

Calling on Cheryl to "do something"

Anger towards C – nothing changes [perhaps, what's the point?]

<p><i>just to see what we do. One afternoon or one evening. When we are getting someone up or taking someone to the bathroom or just one evening when we are putting them back to bed.</i></p> <p>49. Nursing auxilliary Gloria: <i>Like you do [lots of agreement]</i></p> <p>50. Nursing auxilliary Cella: <i>Just to come and feed them. Then someone like resident Betty. The insults we have from that woman.</i></p> <p>51. Nursing auxilliary Hortense: <i>Just for half an hour, not a whole hour because they won't be able to cope.</i></p> <p>52. Nursing auxilliary Gloria: <i>See you, you heard Betty, what Betty calls us.</i></p> <p>53. Nursing auxilliary Meena: <i>Ah yeah</i></p> <p>54. Nursing auxilliary Gloria: <i>Betty went to the doctor to complain that the nurses had been bad to her. She herself told me this [said with laughter] that she had told the doctor that we were roughing her out. But you know if you just pass and Betty will call you a name. Because the doctor didn't know what she was like. The first report from Betty, they believe it, I know they believe it. Because the following day that young doctor Emma. She was talking to Betty in her room and Betty said she wanted toilet that doctor was with me and Betty in the toilet she wanted to help me and Betty so I said I am going to get my nurse. I called Nursing auxiliary Maria. I know she believed that Betty was telling her we roughed her up. So she wanted to see for herself what happens.</i></p> <p>55. Nursing auxilliary Hortense: <i>So she did stay and watch.</i></p> <p>56. Nursing auxilliary Gloria: <i>A little bit, then I said because the room was too crowded with the hoist and that so she had to leave.</i></p> <p>57. Nursing auxilliary Cella: <i>Was she calling and all that</i></p> <p>58. Nursing auxilliary Gloria: <i>She wasn't too bad, she just said she was in pain, don't use the hoist things like that. Before these big insults started. She wasn't there long enough to hear the name calling.</i></p> <p>59. Nursing auxilliary Angela: <i>Isn't there another side to this a psychological side to this. As people get older umm, in life [pause] they change and because we are not of that age group we should have more understanding umm.</i></p> <p>60. Nursing auxilliary Gloria: <i>Yes, but they will believe Betty and they will think we are doing something to Betty, that's what I'm saying.</i></p> <p>61. Nursing auxilliary Angela: <i>There is a for and against here. The doctor in her own self has been practicing for so long and I am sure this is not the first hospital she has been to or whatever. And she should have understanding this is what you get from certain people. That's if it should be understood, as a doctors well I'm sure she has experienced verbal abuse as well. [yes lots of agreement] If we make a complaint it shouldn't really stand unless how can I say?</i></p> <p>62. Nursing auxilliary Gloria: <i>A bruise or something</i></p> <p>63. Researcher Cheryl: <i>So you feel very vulnerable</i></p> <p>64. Nursing auxilliary Hortense: <i>We are always vulnerable</i></p>	<p><i>Me "good"</i></p> <p><i>Only they can cope with the reality of their work ... letting people in however uncovers what the reality of their work is.</i></p> <p><i>Disappointment in Betty. Sort of disloyalty</i></p> <p><i>The real difficulty of moving a resident who needs to move but is distressed/ uncomfortable etc.</i></p> <p><i>The frustration of not being trusted / not trusting the managers / not being able to self-analyse. The assumption that the care is just "fine".</i></p> <p><i>They seem</i></p>
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65. Researcher Cheryl: <i>Well you are vulnerable because you are working with people with dementia who could say anything about you.</i>	vulnerable like the residents Betty was supposed to be on their side.
66. Nursing auxilliary Cella: <i>According to Doctor Ricci [discussion about which doctor he is] he said he has known this woman a long time and she has made accusations before.</i>	Acknowledging how they feel
67. Nursing auxilliary Hortense: <i>Oh he knows</i>	
68. Nursing auxilliary Angela: <i>Yes, yes</i>	
69. Nursing auxilliary Gloria: <i>But this new man hasn't. [Lots of excited agreement]</i>	
70. Nursing auxilliary Angela: <i>Betty is not the first patient he has come across.</i>	Their guilt
71. Nursing auxilliary Cella: <i>She's a difficult patient when she used to be at home and wouldn't let the nurses come and look after her. [More excited talk]</i>	
72. <i>She fell down 5 times a day before she let them come in. Her doctor knows her.</i>	Justification
73. Nursing auxilliary Meena: <i>He's a junior doctor and he doesn't know her.</i>	
74. Researcher Cheryl: <i>It's quite important you know I believe you.</i>	
75. All: <i>Yes</i>	
76. Researcher Cheryl: <i>I'll tell you a story about the doctor Emma, I was looking after Mrs Begum, giving her suction and mouth care one morning. In the ward round later that day, she came into the room with the other doctors for the ward round. Mrs Begum had horrible fluid coming out her mouth and nose and that doctor went and wiped her mouth. I wanted to say look we've been looking after her all morning, honestly. I felt guilty, but the doctor was just trying to be nice.</i>	C trying to reassure
77. <i>Agreement, yes, yes. [general]</i>	
78. Nursing auxilliary Gloria: <i>I had been after you and changed her little towel.</i>	
79. Researcher Cheryl: <i>yeah but you can't stop her nose dribbling when you are not there. The doctor was just acting kindly but I was suspicious, because I felt guilty. I think it's the nature of your work and your clients – whoever it is – whether it's me, Charge Nurse Steven, agency nurse or you we feel very guilty, because we can't make it better.</i>	
80. Nursing auxilliary Hortense: <i>You always have to be on the offensive all the time.</i>	
81. <i>Silence"</i>	
82. Nursing auxilliary Gloria: <i>when you come against someone like Betty, you just ignore Betty, look at that student nurse. Initially she was so nice. We had that abuse session with Mary and them [on another ward]</i>	Hortense's description of their

83. Nursing auxiliary Angela: yes	defences
84. Nursing auxiliary Gloria: <i>If you stay in that session there were a lot of things that applied to our long stay and if you hear the student nurses what they are saying. If you are there 10 minutes, Betty is giving you all that. She says she's a whore and we are whore. Then she says she has money, but nobody will pay us for it. Because we are not good enough.</i>	Defence about abusive language – laugh it off / ignore it Referring to a teaching session on another ward.
85. Nursing auxiliary Angela: <i>Betty you just have to take her in your stride.</i>	
86. Nursing auxiliary Gloria: <i>She calls us all these heavy names and there's nobody from our side. I was embarrassed when Flossie West's son was there.</i>	Denying the impact of Betty
87. Nursing auxiliary Hortense: <i>I wonder if this is how she expresses her feelings.</i>	
88. Researcher Cheryl: <i>There are six people who have died here in two weeks</i>	
89. Nursing auxiliary Gloria: <i>And one, resident Razia was unexpected.</i>	
90. Nursing auxiliary Richard: <i>When was that again.</i>	
91. Nursing auxiliary Meena: <i>Last Friday</i>	
92. Nursing auxiliary Gloria: <i>Thursday night Friday morning.</i>	
93. Nursing auxiliary Hortense: <i>She was in with Betty.</i>	
94. Nursing auxiliary Gloria: <i>Yes, Betty was making so much noise then she was making noise. Then resident Razia was making so much noise. So I was saying to Staff nurse Maureen, maybe Razia is not that deaf, she can hear a little bit because Betty was making her usual and Razia was making it back. Razia was doing that talking she do and holding on to her cover. Then in the morning, we were in and out of there because of Betty, and she was all right. In the morning we started in the two MRSA room then Staff nurse Rebecca and her nurse did Betty and then they went to change Razia. All of a sudden you hear resident Razia cough and then I came out the MRSA room and washed my hands and she had gone. Just like that.</i>	Wonder how much they were aware of each others distress
95. Researcher Cheryl: <i>Very sudden</i>	
96. Nursing auxiliary Gloria: <i>Very sudden</i>	Uncontained / unbounded
97. Nursing auxiliary Meena: <i>Betty was there when she died.</i>	
98. Nursing auxiliary Gloria: <i>Yeah</i>	
99. Nursing auxiliary Meena: <i>Because Betty was complaining that they killed a woman. She's scared we are going to kill her</i>	
100. <i>[Laughter].</i>	
101. Researcher Cheryl: <i>So Betty's frightened</i>	
102. <i>[Lots of general talk] Yeah, yes</i>	Betty's fear

103. Nursing auxillary Meena: *She's frightened because they killed the woman you know?*

104. Nursing auxillary Gloria: *Remember with Mirlam. It's the same thing she says we murdered Miriam*

105. Researcher Cheryl: *So she is aware of Miriam as well.*

106. Nursing auxillary Gloria: *She says we murdered that poor woman.*

107. *[Lots of talking over each other and some laughter]*

108. Nursing auxillary Hortense: *Oh no*

109. Nursing auxillary Gloria: *She sits next to [another resident] and she says oh they think I'm stupid I know.*

110. Researcher Cheryl: *Betty is never going to say, "Oh isn't it a terrible thing that so and so has died"*

111. All: *No, no [lots of talking over each other, Researcher Cheryl trying to make a point but losing it a bit]*

112. Researcher Cheryl: *She doesn't talk in that way, but it is her way of expressing what has happened.*

113. Nursing auxillary Hortense: *She makes it that you are the culprit*

114. Researcher Cheryl: *Remember I was talking about the guilt thing. I noticed when Gloria and Hortense told me about Miriam dying. And when you do tell the story of somebody who has had a sudden death you go in to quite a lot of detail like you did with Razia's death. It almost sounds like you are trying to justify it to me ... well I don't think you've murdered them.*

115. *[lots of laughter]*

116. Researcher Cheryl: *I think they've just died. It's like you are trying to persuade me. It is human to fell guilty when someone dies. Someone like Betty is not helping.*

117. General: *Yeah*

118. Nursing auxillary Gloria: *I don't feel guilty. I do a good job.*

119. Nursing auxillary Hortense: *I'll give you an example, a few years ago I was on nights. We were working with a lady who I knew was in pain. I tidied her up and sit her right up, pulled out the backrest sat her up, she said Oh nurse I'm in pain. I said I know you're in pain I feel pain too cos a couple of days before I had been in hospital for an operation. I know what pain is like, she said oh nurse please help me to die, I said I can't, you've got to wait your turn like. I said it in a funny way and they all looked at me. She started laughing. What do you want me to say. She has to wait her turn I can't do anything. Sometimes you have to take things and laugh about it.*

120. Researcher Cheryl: *I don't think that was a funny thing to say. I think you were right we do have to wait our turn. Someone says they want to die doesn't want to wait because it is hard to wait. That's very hard for you, they can't wait for anything. I wanted to say something about Gloria saying she doesn't feel guilty, when you just told us the*

Miriam – Betty's distant companion

Central – staff feeling overburdened by blame and unable to examine their responsibilities

"We have to wait our turn" how difficult is

<p><i>story of Razia, you did the same, you said we had been in there a lot to see to Betty as if I would assume something else. I try and reassure that we don't assume anything different</i></p> <p>121. Nursing auxilliary Gloria: Yeah</p> <p>122. Yeah</p> <p>123. Nursing auxilliary Gloria: I don't know, maybe with the relatives. Their relatives never come. Razia's relatives only live locally. They called them and by the time they got there she had died. They refused to believe she died. No they wouldn't believe she died. Because of that, with that type of problems she's not going to release the body so the doctor had to come. Razia was a bit of a problem so they were hoping she might come back to life so they had to wait for one grand-son. It didn't take long for them to come in they only live round the corner. Then he came, then the doctor had to come and they come cry, cry, never seen her in months. Razia didn't even give them time to say good-bye, she ill and just die.</p> <p>124. [Very fast agitated talk]</p> <p>125. Nursing auxilliary Hortense: Maybe say good-bye</p> <p>126. Nursing auxilliary Gloria: They didn't have that. Then they couldn't bury her...there was the problem of the doctor who was a locum didn't know Razia. Then it was holiday time, bank holiday.</p> <p>127. [A lot of people speaking at once – agitated manner]</p> <p>128. Nursing auxilliary Hortense: you know the Muslim faith. Buried within three days. Buried within three days</p> <p>129. Nursing auxilliary Gloria: they need somebody to write a report that they know her that nursed her. Which Staff nurse Rebecca can't do that. So they had to bleep the doctor from his holidays.</p> <p>130. Researcher Cheryl: So staff nurse Rebecca couldn't do that.</p> <p>131. Nursing auxilliary Gloria: No it had to be the doctor. So in the end it was sorted, so Razia gave them a hard time. [Laughter].</p> <p>132. Nursing auxilliary Angela: They think everything can be done just like that but it can't.</p> <p>133. Nursing auxilliary Hortense: They want everything wrapped up and everything done in three days. And the Jewish faith.</p> <p>134. [A discussion of whether it is a two-day or three-day limit for Muslims. A lot of general discussion that is agitated and difficult to decipher.]</p> <p>135. Nursing auxilliary Gloria: They had to bury her by that Saturday</p> <p>136. Researcher Cheryl: Did they manage to?</p> <p>137. Nursing auxilliary Gloria: Yeah</p> <p>138. Nursing auxilliary Hortense: It's not like here, they don't like to bury them lying down, they like to prop them up like a mummy.</p> <p>139. Researcher Cheryl: I don't know, I don't know</p>	<p><i>this, when it takes so long</i></p> <p><i>From staff guilt to anger with relatives</i></p> <p><i>Angry with Razia for not letting them say good-bye</i></p> <p><i>Very "them and us"</i></p>
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140. <i>Silence</i>	
141. Nursing auxilliary Gloria: <i>We don't like to lose them because we don't know who is coming. Like that new patient who has diarrhoea. It is scary you don't know who is coming in. Because Freddie who died. We have known him a long time. He has been there for more than 4 years.</i>	
142. <i>[General agreement]</i>	
143. Nursing auxilliary Angela: <i>It's like Madge,</i>	<i>Multiple deaths and fear of what's next.</i>
144. Nursing auxilliary Hortense: <i>She came from upstairs.</i>	
145. Nursing auxilliary Gloria: <i>You find someone you get along with.</i>	
146. Nursing auxilliary Angela: <i>We had our ups and downs with Madge's daughters they used to be a lot of trouble always complaining. But now they get on well.</i>	
147. Nursing auxilliary Meena: <i>But the husband, he lovely</i>	
148. Nursing auxilliary Gloria: <i>The husband is lovely. [Yeah] Oh god he was in every day.</i>	
149. Researcher Cheryl: <i>He must be hurting</i>	<i>Anger at relatives</i>
150. <i>[General Ohhh.]</i>	
151. Nursing auxilliary Gloria: <i>He's lost, he's lost.</i>	
152. Nursing auxilliary Angela: <i>When he was well he used to come twice a day</i>	
153. Researcher Cheryl: <i>has he been back to the ward</i>	
154. <i>[General No]</i>	
155. Nursing auxilliary Celia: <i>I have never seen a man struggle to come in like him. No matter if you had just washed her, the husband would come and comb her hair.</i>	
156. Nursing auxilliary Hortense: <i>You could see he was from that old school like.</i>	
157. Nursing auxilliary Gloria: <i>When she died he came and said thank you. He knew she was dying.</i>	
158. Nursing auxilliary Angela: <i>There was a time before when in the other ward we thought she was dying. Every body had given up on her and thought she was dying.</i>	
159. <i>[Lots of general agreement]</i>	
160. Researcher Cheryl: <i>So she had a dip</i>	
161. <i>[Yes]</i>	
162. Researcher Cheryl: <i>and then she rallied round</i>	<i>The "bouncing back" phenomenon"</i>
163. <i>[Yes]</i>	
164. Nursing auxilliary Hortense: <i>They do some times</i>	

<p>165. Nursing auxilliary Angela: <i>Well she did have one year</i></p> <p>166. <i>[Yes]</i></p> <p>167. Nursing auxilliary Richard: <i>Yeah, they thought she was going they even called her husband, but all of a sudden she came back.</i></p> <p>168. Researcher Cheryl: <i>So she was a success. You knew her a long time, you got on well with her husband, you had difficulties getting to know her daughters but you overcame that.</i></p> <p>169. Nursing auxilliary Gloria: <i>See with the daughters, when they came on the ward I didn't recognise them, so I said can I help you, because I didn't know them. And they said they were Madge's daughters they were fine on Willow.</i></p> <p>170. Researcher Cheryl: <i>And the husband he got on well, he liked you</i></p> <p>171. ...Nursing auxilliary Gloria: <i>To the end the daughters were coming every weekend. When she was dying they were phoning twice a day.</i></p> <p>172. Nursing auxilliary Cella: <i>Some people are not like that - Flossie West, I didn't even know she had a grand daughter. When she died I said hello, who are you? I didn't know who she was. I didn't know.</i></p> <p>173. <i>Tape ended</i></p> <p>174. There was a long discussion about Flossie West's relatives. The group said that when her two sons visited they brought their wives with them and sat at the end of the bed and didn't talk to Flossie. They said they knew Flossie could talk. She used to talk to them, but the relatives didn't ever talk to her.</p> <p>175. They said they felt the relatives just came in to see Flossie for their own enjoyment and convenience.</p> <p>176. They were very angry a strong sense of "It's not fair" came across.</p> <p>177. They asked why we didn't tell the relatives to go and sit with the residents. They said we are asked to sit with the residents but they don't have to.</p> <p>178. We talked about how hard it is to sit with residents, particularly if they do not respond very much. I tried to acknowledge how hard their work is.</p> <p>179. Nursing auxilliary Richard said he thought Flossie's relatives were visiting because they should. I told them about my example of sitting with Mrs. Begum And asked the question was I sitting with her because it feels better to have someone with you in times of distress, was I doing it because it makes me feel better to do something or was I doing it because I should.</p> <p>180. I tried to point out the similarities between the paid carers and the relatives.</p> <p>181. I asked the group if they missed the residents when they died.</p> <p>182. Nursing auxilliary Meena: <i>Yes. We don't like it when they die. We want to keep them alive until they are 100 or 101 like the Queen Mother</i></p>	<p><i>Split "good" relatives and "bad" relatives. Those who struggle to keep visiting and those who abandon the resident [and the staff].</i></p> <p><i>They feel pressure to sit with residents</i></p> <p><i>The strain of death hanging over them [res, rels and staff] all the time.</i></p> <p><i>Want to keep residents going to avoid endings and new beginnings</i></p> <p><i>I was reminded of a previous conversation with Angela when she had talked about her own hospital experience and she had said she</i></p>
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[who had recently died].

183. They said this was because they didn't like to have new residents. They would have to get to know them they didn't know what problems they would present them – whether they would need feeding or whether they had diarrhea. Angela talked about how they get them clean.

184. They said they liked them to stay alive because when they die they feel bad

185. And finally and significantly they said they wanted to keep them alive because if they die their ward might close.

had asked her son to make sure if she were looked after in a home he had to make sure she had toiletries.

It also reminds me of a sense of tension between Steven and the Nas about enemas. He thinks they give too many enemas. I wondered if this was about having control of their uncleanness.

I wonder what they are cleaning away

All this refers to the changing nature of the clients – more able people go to nursing homes and the real possibility that the ward might close because it is difficult to fill the beds.

REFERENCES

Archives in London and the M25 area. Research Support Libraries Programme.
www.aim25.co.uk Local Hospital Archive Collection. Administration and
Biography. Hospital identity not given to protect anonymity. Retrieved 5 April
2005 from the World Wide Web

Almberg, B.E., Grafstrom, M., Winblad, B. (2000) Caregivers of relatives with
dementia: experiences encompassing social support and bereavement. *Ageing
and Mental Health*, 4(1):82-89

Ashburner, C., Meyer, J., Johnson, B., Smith, C. (2004) Using action research
to address loss of personhood in a continuing care setting. *Illness, Crisis and
Loss*, 12(1):23-37

Baer, W.M. and Hanson L.C. (2000) Families perception of the added value of
hospice in the nursing home. *Journal of American Geriatric Society*, 48(8):879-
882

Balfour, A. (2006) Facts, phenomenology and psychoanalytic contributions to
dementia care. In: Davenhill, R. (Ed) *Looking into Later Life: a Psychoanalytic
Approach to Depression, Dementia and Old Age*. 14.2.06. Unpublished

Barnes, B., Ernst S., & Hyde K. (1999) *An Introduction to Group work. A
Group-Analytic Perspective*. Macmillan: England

Batty, D. (2006) NHS sisters to protect older patients' rights. *The Guardian*, April 20th 2006

Beck, L. (1983) Psychotherapy of the elderly: case study #5: Psychotherapeutic treatment of an elderly widow with severe hypochondriacal and somatic symptomology. *Journal of Geriatric Psychiatry*, 16(1):67-71

Bell, I. (1984) Bereavement in continuing care wards. *Nursing Times*, 80(37):12-18

Bick, E. (1968) The experience of the skin in early object relations. *International Journal of Psycho-Analysis*, 49:484-486

Bickerstaff, K.A., Grasser, C.M. and McCabe, B. (2003) How elderly nursing home residents transcend their losses. *Holistic Nursing Practice*, 17(3):159-165

Bion, W.R. (1961) *Experiences in Groups and Other Papers*. Tavistock/Routledge publications: Bristol

Bion, W.R. (1962) *Learning from Experience*. Heinemann: London

Blakemore, K. and Boneham, M. (1994) *Age, Race and Ethnicity. A Comparative Approach*. Open University: Buckingham

Bond, J. and Bond, S. (1987) Developments in the provision and evaluation of long-term care for dependent old people. In Fielding, P. (Ed) *Research in the Nursing Care of Elderly People*. John Wiley & Sons: Great Britain

Bowlby, J. (1998) *Loss, Sadness and Depression*. (Volume 3 of Attachment and Loss). Pimlico: London

Britton, R. (1989) The missing link: parental sexuality in the Oedipus complex. In Britton, R., Feldman, M. and O'Shaughnessy E. (Eds) *The Oedipus Complex Today: Clinical Implications*. Karnac Books: London

Bryar, R. M. (1999) An examination of case study research. *Nurse Researcher*. 7(2):61-78

Burns, N. and Grove, S.K. (1997) *The Practice of Nursing Research. Conduct, Critique and Utilization*. 3rd Ed. W.B. Saunders Company: Philadelphia

Cadby, D. (1996) Counselling older people in residential care homes. *Professional Nurse*. 11(10):686-687

Carr, D., House, J.S., Wortman, C., Nesse, R. and Kessler, R.C. (2001) Psychological adjustment to sudden and anticipated spousal loss among older widowed persons. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences*, 56(4): S237-48

Charmaz, K (2005) Grounded Theory in 21st Century. Applications for Advancing Social Justice Studies. In N.K. Denzin and Y.S. Lincoln (Eds) *The Sage Handbook of Qualitative Research*. (3rd Edition). London: Sage.

Chichin, E.R., Ferster, L. and Gordon, N. (1994) Planning for the end of life with the home care client. *Journal of Gerontological Social Work*, 22(1/2):147-59

Coffey, A. and Atkinson, P. (1996) *Making Sense of Qualitative Data. Complementary Research Strategies*. Sage: California .

Coleman, P. (1990) Adjustment in later life. In Bond, J. and Coleman, P. (Eds) *Ageing in Society. An Introduction to Social Gerontology*. Sage: London .

Costello, J. (2001) Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards. *Journal of Advanced Nursing*, 35(1):59-68

Couve, C. (2006) The metapsychology of depression. In Davenhill, R. (Ed) *Looking into Later Life: A Psychoanalytic Approach to Depression, Dementia and Old Age*. 14.2.06. Unpublished

Cowles, K.V. and Rodgers, B.L. (1991) The concept of grief: A foundation for nursing research and practice. *Research in Nursing and Health*, 14:119-127

Craib, I. (2001) *Psychoanalysis. A Critical Introduction*. Polity: Oxford

Dartington, A. (1994) Where angels fear to tread: idealism, despondency and inhibition of thought in hospital nursing. In: Obholzer A., and Roberts, V.Z. (Eds) *The Unconscious at Work. Individual and Organizational Stress in the Human Services*. Routledge: London

Davenhill, R. (1998) No truce with the furies. *Journal of Social Work Practice*, 12(2):149-157

Davenhill, R. (2006) In the beginning. In Davenhill, R. (Ed) *Looking into Later Life: A Psychoanalytic Approach to Depression, Dementia and Old Age*. 14.2.06. Unpublished

Davidson, K., Tang, J.H. and Titler, M.G. (2003) Evidence-Based Protocol: Family Bereavement Support Before and After the Death of a Nursing Home Resident. *Journal of Gerontological Nursing*, 29(1):10-18

Davies, S. and Nolan, M. (2004) Making the move: relative's experiences of the transition to a care home. *Health and Social Care in the Community*, 12(6):517-526

Davies, S. and Seymour, J. (2002) Historical and policy contexts. In Hockley, J. and Clark, D. (Eds) *Palliative Care For Older People in Care Homes*. Open University Press: Buckingham

Dellasega, C. and Nolan, M. (1997) Admission to care: facilitating role transition amongst family carers. *Journal of Clinical Nursing*, 6(6):443-451

DePaola, S.J., Neimeyer, R.A. and Ross, S.K. (1992) Death concerns and attitudes toward the elderly in nursing home personnel as a function of training. *Omega: Journal of Death and Dying*, 29(3):231-48

Department of Health (2001a) *The National Service framework for Older People*. Department of Health: London

Department of Health (2001b) *The Care Standards Act 2000*. HMSO: London

Department of Health (2006) *A New Ambition for Old Age. Next Steps in Implementing the National Service framework for Older People*. Department of Health. London

Doka, K.J. (Ed) (2001) *Disenfranchised Grief*. (3rd Edition) Lexington: New York.

Drysdale, A.E., Nelson, C.F. and. Wineman, N.M. (1993) Families need help too: group treatment for families of nursing home residents. *Clinical Nurse Specialist*, 7(3):129 – 134

Emanuel, R. (2001) A-void – an exploration of defences against sensing nothingness. *International Journal of Psychoanalysis*, 82(6):1069-1084

Engel, V.F., Fox-Hill, E. and Graney, M.J. (1998) The experience of living-dying in a nursing home: Self reports of black and white older adults. *Journal of American Geriatric Society*, 46(9):1091-1096

Fabricius J. (1995) Psychoanalytic understanding and nursing: a supervisory workshop with nurse tutors. *Psychoanalytic Psychotherapy*, 9(1):17-29

Fagin, L. (1998) Occupational Loss. In Parkes, C.M. and Markus, A. (Eds) *Coping with Loss*. BMJ Publishing Group: London

Fielding, N. (2001) Ethnography. In Gilbert, N. (Ed) *Researching Social Life*. (2nd Edition) Sage Publications: London

Fineman, S. (2000) (Ed) *Emotion in Organizations*. (2nd Edition) Sage Publications: London

Fineman, S. (2005) Appreciating emotion at work: paradigm tensions. *International Journal of Work Organizations and Emotion*, 1(1): 4-19

Fitzgerald, R. and Parkes, C.M. (1998) Loss of sensory and cognitive functions. In Parkes, C.M. and Markus, A. (Eds) *Coping with Loss*. BMJ Publishing Group: London

Fonagy, P. (2003) The research agenda: the vital need for clinical research in child psychotherapy. *Journal of Child Psychotherapy: Special Edition on Clinical Research*, 29(2): 129-136

Freud, S. (1917) *Mourning and Melancholia*. *Standard Edition 14*. Hogarth: London

Froggatt, K. (2001) Life and death in English nursing homes: sequestration or transition? *Ageing and Society*, 21(3):319-32

Gladstone, J.W. (1995) Elderly married persons living in long term care institutions: A qualitative analysis of feelings. *Ageing and Society*, 15(4):493-513

Great Britain Royal Commission on Long Term Care. (1999) *With Respect to Old Age: Long Term Care – Rights and Responsibilities*. The Stationery Office: London

Halton, W. (1994) Some unconscious aspects of organizational life: contributions from psychoanalysis. In: Obholzer A. and Roberts, V.Z. (Eds) *The Unconscious at Work. Individual and Organizational Stress in the Human Services*. Routledge, London

Hammersley, M. and Atkinson, P. (1995) *Ethnography Principles in Practice*. (2nd Edition) Routledge: London.

Hanson, L.C., Danis, M. and Garrett. J. (1997) What is wrong with end of life care? Opinions of bereaved family members. *Journal of American Geriatrics Society*, 45(11):1339-44

Harper, H. and Thane, P. (1989) The consolidation of “Old Age” as a phase of life, 1945-1965. In Jeffreys, M. (Ed) *Growing Old in the Twentieth Century*. Routledge: London

Hart, C. (1998) *Doing a literature review. Releasing the social science imagination*. London: Sage

Heimann, P. (1950) On counter-transference. *International Journal of Psycho-Analysis*, 31:81-84

Herth, K. (1990) The relationship of hope, coping styles, concurrent losses and setting to grief resolution in the elderly widow(er). *Research in Nursing and Health*, 13(2):109 –117

Higgitt, A. and Fonagy, P. (2002) Clinical effectiveness. *The British Journal of Psychiatry*. 181(2)170-174

Hinshelwood R.D., Skogstad W (2000) *Observing Organizations. Anxiety, Defence and Culture in Health Care*. Routledge: London

Hinshelwood, R.D. and Skogstad, W. (2002) Irradiated by distress: observing psychic pain in health-care organizations. *Psychoanalytic Psychotherapy*, 16(2):110-124

Hochschild, A., R. (2003) *The Managed Heart. Commercialization of Human Feeling*. (2nd Edition) University of California Press: Berkeley

Hockey, J. (1990) *Experiences of death. An Anthropological Account*. Edinburgh University Press: Edinburgh

Hockey, J. and James, A. (1993) *Growing up and growing old. Ageing and dependency and the life course*. Sage: London

Hollway, W. and Jefferson, T. (2000) *Doing Qualitative Research Differently. Free Association Narrative and the Interview Method*. Sage Publications: London

Holman, C. and Jackson, S. (2001) A team education project: an evaluation of a collaborative education and practice development in a continuing care unit for older people. *Nurse Education Today*, 21(2): 97-103

Holman, C., Meyer, J. and Cotter, A. (2004) The complexity of loss in continuing care institutions for older people: a review of the literature. *Illness, Crisis and Loss*, 12(1):38-51

Hunt, J.C. (1989) *Psychoanalytic Aspects of Fieldwork*. Sage Publications: California

Jacob, S.R. (1993) An analysis of the concept of grief. *Journal of Advanced Nursing*, 18, 1787-1794

James, J. and Dewhurst, J. (1995) Death in service. *Health Service Journal*, 105, (5453):26

Kaplan, C.P. and Gallagher-Thompson, D. (1995) Treatment of clinical depression in caregivers of spouses with dementia. *Journal of Cognitive Psychotherapy: An International Quarterly*, 9(1):35-44

Kelly, B. (1991) Emily: a study of grief and bereavement. *Health Care for Women International*, 12(1):137-47

Klass, D. and Walter, T. (2001) Processes of grieving: How bonds are continued. In Stroebe, M.S., Stroebe, W. and Hanson, R.O. (Eds) *Handbook of Bereavement Research: Consequences, Coping and Care*, 431-448. American Psychological Association: New York

Klein, M. (1940) Mourning and its relation to manic depressive states. In *Love, Guilt and Reparation and Other Works. Vol. 1 of the Writings of Melanie Klein*. Hogarth: London

Laufer, E. (2000) The struggle between living and dying the analytic treatment of a 90 year old woman. *Psychoanalytic Review*, 87(5):699 – 715

Lawton, J. (1998) Contemporary hospice care: the sequestration of the unbounded body and “dirty dying”. *Sociology of Health and Illness*, 20(2):121-143

Lee Treweek, G. (1996) Emotion work, order and emotional power in care assistant work. In James, V. and Gabe, J. (Eds) *Health and the Sociology of Emotions*. Blackwell Publications Ltd: Oxford

- Leshner, E.L. and Bergey, K.J. (1988) Bereaved elderly mothers: Changes in health, functional activities, family cohesion and psychological well-being. *International Journal of Aging and Human Development*, 26(2):81-90
- Lewin, K. (1951) *Field theory in Social Science*. Harper: New York
- Lincoln, Y.S. and Guba, E. G. (1985) *Naturalistic Inquiry*. Sage: Newbury Park
- Lopez McCurdy, Y. (1999) Certified nursing assistants in skilled nursing facilities: perceived stress and strategies for coping with resident problem behaviours. *Dissertation Abstracts International: Section B: the Sciences and Engineering*, 60(5-B) 2350, Univ Microfilms International: US
- Lupton, D. (1998) *The Emotional Self*. Sage: London
- Maguire, P. and Parkes, C.M. (1998) Surgery and loss of body parts. In Parkes, C.M. and Markus, A. (Eds) *Coping with Loss*. BMJ Publishing Group: London
- Main, T.F. (1957) The ailment. *The British Journal of Medical Psychology*, 30(3):129-145
- Marquis, R., Freegard, H. and Hoogland, L. (2004) Influence on positive family involvement in aged care: an ethnographic view. *Contemporary Nurse*, 16(3):178-186
- Marris, P. (1986) *Loss and Change*. (2nd Edition) Routledge: London

Martindale, B. (1989) Becoming dependent again: The fears of some elderly persons and their younger therapists. *Psychoanalytic Psychotherapy*, 4(1):67-75

Matthiesen, V. (1989) Guilt and grief. When daughters place mothers in nursing homes. *Journal of Gerontological Nursing*, 15(7):11-5

Meyer, J., Spillsbury, K. and Prieto, J. (1999/2000) Comparison of findings from a single case in relation to those from a systematic review of action research. *Nurse Researcher*, 7(2):37-57

McKenzie-Smith, S. (1992) A psychoanalytic observational study of the elderly. *Free Associations*, 3, 3(27):355-90

Menzies Lyth, I. (1959/1988) The function of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. In Menzies Lyth, I. *Containing Anxiety in Institutions. Selected Essays, Vol 1*. Free Association Books: London

Menzies Lyth, I. (1969/1988) Some methodological notes on a hospital study. In Menzies Lyth, I. *Containing Anxiety in Institutions. Selected Essays, Vol 1*. Free Association Books: London

Menzies Lyth, I. (1987/1988) The psychological welfare of children making long stays in hospital: an experience in the art of the possible. (Revised from 1982) In Menzies Lyth, I. *Containing Anxiety in Institutions. Selected Essays, Vol 1*. Free Association Books: London

- Miller, E.J. and Gwynne, G.V. (1972) The tasks and functions of residential institutions. *Life Apart: A Pilot Study of Residential Institutions for the Physically Handicapped and the Young Chronic Sick*. Tavistock: London
- Miller, E. (1993) *From Dependency to Autonomy. Studies in Organization and Change*. Free Association Books: London
- Milton J., Polmear, C. and Fabricius, J. (2004) *A Short Introduction to Psychoanalysis*. Sage Publications: London
- Moss, M.S., Moss, S.Z., Rubenstein, R.L. and Resch, N. (1993) Impact of elderly mother's death on teenage daughters. *International Journal of Aging and Human Development*, 37(1):1-22
- Moss, S.Z., Moss M.S., Black H.K. and Rubinstein R.L. (2005) How family members respond to residents' wish to die. *Omega*, 51(4):301-321
- Moyle, W., Edwards, H. and Clinton, M. (2002) Living with loss: Dementia and the family care giver. *Australian Journal of Advanced Nursing*. 19(3):26-31
- Munhall, P. (1991) Institutional review of qualitative research proposals: A task of no small consequence. In Morse, J. (Ed) *Qualitative Nursing Research: A Contemporary Dialogue*. Sage: London
- Murphy, K., Hanrahan, P. and Luchins, D. (1998) A survey of grief and bereavement in nursing homes: the importance of hospice grief and

bereavement for the end-stage Alzheimer's disease patient and family. *Journal of American Geriatric Society*, 45(9):1104-7

Neumann, J. E. (2005) Kurt Lewin and the Tavistock Institute. *Educational Action Research*, 13(10):119-135

Newson P.R. (2003) Relocation to the care home: a peculiar form of loss. *Nursing and Residential Care*, 5(6):288-290

Nolan, M., Walker, G., Nolan, J., Williams, S., Poland, F., Curran, M. and Kent, B. (1996) Entry to care: positive choice or fait accompli? Developing a more proactive nursing response to the needs of older people and their carers. *Journal of Advanced Nursing*, 24(2):265-274

Nolan, M., Brown, J., Davies, S., Keady, J. and Nolan, J. (2004) Beyond "person-centred" care: a new vision for gerontological nursing. *International Journal of Older People in association with Journal of Clinical Nursing*. 13 (3a):45-53

Obholzer, A. (1994a) Freud, Klein and Bion. The Tavistock social systems model. *Tavistock Clinical Paper No. 150*. Tavistock Clinic: London

Obholzer, A. (1994b) Authority, power and leadership: contributions from group relations training. In: Obholzer A. and Roberts, V.Z. (Eds) *The Unconscious at Work: Individual and Organizational Stress in the Human Services*. Routledge, London

Palmer, A. (1989) *The East End. Four Centuries of London Life*. John Murray: London

Parkes, C.M. (1972) *Bereavement: Studies of grief in Adult Life*. Tavistock Publications: London

Parkes, C.M. (1998) Bereavement in adult life. In Parkes, C.M. and Markus, A. (Eds) *Coping with Loss*. BMJ Publishing Group: London

Peace, S., Kellaher, L. and Willcocks, D. (1997) *Re-evaluating residential care*. Buckingham: Open University Press

Pilkington, F.B. (2005) Grieving a loss: The lived experience for elders residing in an institution. *Nursing Science Quarterly*, 18(3): 233-242

Porter, L. (2000) The bifurcated gift: Love and intimacy in drama psychotherapy. *The Arts in Psychotherapy*, 27(5):309-320

Pruchno, R.A., Moss, M.S., Burant, C.J. and Schinfield, S. (1995) Death of an institutionalised parent: predictors of bereavement. *Omega, Journal of Death and Dying*, 31(2):99-119

Reed, J. and Morgan, D. (1999) Discharging older people from hospital to care homes: implications for nursing. *Journal of Advanced Nursing*, 29(4):819-825

Rickerson, E.M., Somers, C., Allen C.M., Lewis, B., Strumpf, N. and Casarett, D.J. (2005) How well are we caring for caregivers? Prevalence of grief-related symptoms and need for bereavement support among long-term care staff. *Journal of Pain and Symptom Management*, 30(3):227-233

Robbins, I., Lloyd, C., Carpenter, S. and Bender M.P. (1992) Staff anxieties about death in residential settings for elderly people. *Journal of Advanced Nursing*, 17(5):548-553

Roberts, V.Z. (1994a) The organization of work: contributions from open systems theory. In: Obholzer, A. and Roberts, V.Z. (Eds) *The Unconscious at Work. Individual and Organizational Stress in the Human Services*. Routledge, London

Roberts, V.Z. (1994b) Till death us do part: caring and uncaring in work with the elderly. In: Obholzer, A. and Roberts, V.Z. (Eds) *The Unconscious at Work. Individual and Organizational Stress in the Human Services*. Routledge, London

Robinson, D.S. and McKenna, H.P. (1998) Loss: an analysis of a concept of particular interest to nursing. *Journal of Advanced Nursing*, 27(4):779-784

Rudd, M.G., Viney, L.L. and Preston, C.A. (1999) The grief experienced by spousal caregivers of dementia patients: the role of place of care of patient and gender of caregiver. *Journal of Aging and Human Development*, 48(3):217-240

Running, A. (1997) Snapshots of experience: vignettes from a nursing home. *Journal of Advanced Nursing*, 25(1):117-122

Rustin, M. (2003) Learning about emotions: the Tavistock approach. *European Journal of Psychotherapy, Counselling and Health*, 6(3):187-208

Rustin, M. (2006) Infant observation research: What have we learned so far? *Infant Observation*, 9(1): 35-52

Sandberg, J., Lundh, U. and Nolan, M.R. (2001) Placing a spouse in a care home: the importance of keeping. *Journal of Clinical Nursing*, 10(3):406 – 416

Sapey, B. (2004) Impairment, disability, and loss: Reassessing the rejection of loss. *Illness, Crisis and Loss*, 12(1):90-101

Scrutton, S. (1995) *Bereavement and Grief. Supporting Older People Through Loss*. Edward Arnold: London

Scrutton, S. (1999) *Counselling Older People*. (2nd Edition) Edward Arnold: London

Seale, C. (1998) *Constructing Death: The Sociology of Dying and Bereavement*. Cambridge University Press: Cambridge

Segal, H. (1973) *Introduction to the Work of Melanie Klein*. Karnac Books: London

Sharp, K. (1998) The case for case studies in nursing research: the problem of generalization. *Journal of Advanced Nursing*, 27(4):785-789

Spradley, J.P. (1980) *Participant Observation*. Holt, Rinehart & Winston: New York

Starck, P.I. (1992) The management of suffering in a nursing home: an ethnographic study. In Starck, P.I. and McGovern, J.P. (Eds) *The hidden dimensions of illness: human suffering*. 127-53. National League for Nursing: New York

Stokes, J. (1994) The unconscious at work in groups and teams: contributions from the work of Wilfred Bion. In: Obholzer, A. and Roberts, V.Z. (Eds) *The Unconscious at Work. Individual and Organizational Stress in the Human Services*. Routledge, London

Sumaya-Smith, I. (1995) Caregiver/resident relationships: surrogate family bonds and surrogate grieving in a skilled nursing facility. *Journal of Advanced Nursing*, 21(3):447-451

Terry, P. (1998) Who will care for older people? A case study of working with destructiveness and despair in long-stay care. *Journal of Social Work Practice*, 12(2):209-216

Theodosius, C. (2006) Recovering emotion from emotion management. *Sociology*, 40(5): 893-910

Thompson, N. (2002) *Loss and Grief. A Guide for human Services Practitioners*. Palgrave: London

Titchen, A. (2000) *Professional Craft Knowledge in Patient-centred Nursing and the Facilitation of its Development*. Ashdale Press: Oxford

Tobin, G.A. and Begley, C.M. (2004) Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4):388-396

Tolle, S.W., Tilden, V.P., Rosenfeld, A.G. and S.E. Hickman. (2000) Family reports of barriers to optimal care of the dying. *Nursing Research*, 49(6):310-317

Townsend, P. (1963) *The Family Life of Old People*. Penguin Books: Great Britain.

Twemlow, S.W. (2001) Creating a peaceful school learning environment: A controlled study of an elementary school intervention to reduce violence. *American Journal of Psychiatry*, 158(5):808-810

Victor, C. R. (1997) *Community Care and Older People*. Stanley Thornes Publishers Ltd: UK

Waddell, M. (2000) Only connect: Developmental issues from early to late life. *Psychoanalytic Psychotherapy*, 14(3):239-252

Waddell M. (2002) *Inside Lives: Psychoanalysis and the Growth of the Personality*. Karnac: London

Wadenstent, B. and Carlsson, M. (2003) Theory-driven guidelines for practical care of older people, based on theory of gerontranscendence. *Journal of Advanced Nursing*, 41(5):462-470

Ward, I. and Zarate, O. (2000) *Introducing Psychoanalysis*. Icon Books: Cambridge

Ward, L. (1993) Race, equality and employment in the NHS. In Ahmad, W.I.U. (Ed) *Race and Health in Contemporary Britain*. Open University Press: Buckingham

Weiss, R.S. (1998) Separation and related problems of pair bond relationships. In Parkes, C.M. and Markus, A. (Eds) *Coping with Loss*. BMJ Publishing Group: London

Williams, S.J. and Bendelow, G. (1996) Emotions, health and illness: the “missing link” in medical sociology? In James, V. and Gabe, J. (Eds) *Health and The Sociology of Emotions*. Blackwell Publications: Oxford

Wilson, S.A. and Daley, B.J. (1999) Family perspectives in long-term care settings. *Journal of Gerontological Nursing*, 25(11):19-25

Winnicott, D.W. (1949) Hate in the counter-transference. *The International Journal of Psycho-Analysis*, 30(2):69-74

Worden, W.J. (1983) *Grief Counselling and Grief Therapy*. Tavistock Publications: London.

Yin, R.K. (2003) *Case Study Research. Design and Methods*. (3rd Edition) Sage Publications: Thousand Oaks

Young, M. and Wilmott, P. (1957) *Family and Kinship in East London*. Routledge and Keegan Paul: Great Britain

BIBLIOGRAPHY

James, N. (1989) 'Emotional Labour: Skill and Work in the Social Regulation of Human Feelings', *Sociological Review*, 37:15-42

James, N. (1992) 'Care = Organisation + Physical Labour + Emotional Labour' *Sociology of Health and Illness*, 14, (4):488-509

Smith, P. (1992) *The Emotional Labour of Nursing: how nurses care.* Basingstoke, Palgrave Macmillan