Becoming an effective practitioner through guided reflection

Thesis

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Title page

Becoming an effective practitioner through guided reflection

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Abstract

The study aimed to develop, monitor and explore the process and outcomes of guided reflection and its impact on enabling practitioners to achieve desirable and effective caring practice. A secondary focus of the study was to monitor and explore the process and outcomes of guided reflection as a form of critical action research which may generate theoretical insights regarding its use in clinical supervisory practices.

The process referred to as 'guided reflection' was developed and used to guide this study. Guided reflection represents a form of social action research which was framed within an ontology and process of critical and reflexive phenomenology of experience between practitioners and their supervisors over a period of four years.

Whilst each guided reflection relationship was written as a critical narrative to illuminate the reflexive development of effective practice, these narratives became a secondary level of analysis to construct meta-narratives of the nature of effective work and dynamics of guided reflection. Various frameworks were developed and tested within a reflexive process that was appropriately informed and juxtaposed with extant theory to adequately interpret and present the process and outcomes of the study.

The method and process of guided reflection generated two major empirical and theoretical insights.

- 'The 'Being available' framework to know effective caring practice, presented as one major exemplar of 'Pru'.
- Meta-reflection of methods and process of guided reflection. Three frameworks in particular are significant:
    - 'Being available' as a parallel framework for effective supervision practice. This parallel framework supports the coherence between developmental and research processes.

- The Model for Structured Reflection as an heuristic device for knowing reflection.
- 'Framing perspectives' as a series of integrated lenses to focus on discrete layers of learning within reflection.

The insights gained through the study have considerable significance for informing and guiding the future development of reflective practice within nursing curriculum, clinical supervision within practice, and the future development of nursing knowledge. The development of nursing knowledge is of particular significance in understanding the meaning and nuances of holistic nursing as a lived reality and have significantly contributed to the reflexive development of the Burford NDU Model: Caring in Practice. The study has become a springboard for research to gain further insight into the factors that facilitate or constrain the efficacy of guided reflection in enabling practitioners to know and realise desirable practice within everyday practice.

Christopher Johns

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Contents

Figures

Tables

page no.

Chapter 1

Beginnings

In January 1989, I was appointed as the clinical leader of Windrush Community Hospital. My understanding of my role as clinical leader is set out in figure 1.1. This understanding is based on my analysis of this role whilst implementing primary nursing in my previous role. Windrush hospital also utilised primary nursing as the system for organising nursing practice. As such, I used the clinical leadership template [Figure 1.1]to focus my new role.

Primary nursing

Primary nursing is characterised by the assignment of specific nurses, called primary nurses, to accept responsibility for managing an individual patient's total care whilst in hospital. At Windrush, this involved two primary nurses having responsibility for 9 in-patients. When the primary nurse is not available, responsibility for continued care is accepted by associate nurses. One consequence of primary nursing is, in theory, that responsibility for patient management shifts from the ward leader to the primary nurse, requiring a redefinition of authority and the relationship between the ward leader and the primary nurses. Essentially this requires a 'flattening' of the hierarchy and the development of collegial relationships (Manthey 1980). Collegial relationships acknowledge that each practitioner, including the clinical leader, has clearly defined responsibility for work within a mutually supportive team that shares common aims (Beyer and Marshall 1981). However, although collegial relationships are desirable, this does not mean they exist in practice. They are an ideal state, that needs to be actively worked

towards, because nurses have generally been socialised within bureaucratic-hierarchical relationships.

Figure 1.1

The clinical leadership role:

1. Facilitates the vision for practice.
2. Liberates staff from oppressive hierarchical- bound roles and facilitates the development of collegial relationships.
3. Maintains 'expert' clinical credibility.
4. Facilitates the development and support of staff responsibility in defined roles.
5. Facilitates the development of clinical practice.
6. Ensures the overall quality of care.
7. Manages the unit effectively:
   - selection of personnel
   - resource management
   - meeting and influencing organizational objectives
   - co-ordinating activity and ensuring effective communication systems.
8. Ensures self development and support.

The idea of liberating staff from oppressive hierarchical bound roles reflects the way nurses generally have an attitude of dependency within hierarchical systems that is not conducive for primary nurse responsibility. Collegial relationships require a mutuality, a perception of self on an equal footing with the clinical leader within an understanding of role. Instead of prescribing what needs to be done, as within overtly hierarchical systems, the clinical leadership role is a developmental role to enable others to succeed in their roles. This

requires the clinical leader to be available to support and develop staff whilst ensuring that quality of care is maintained.

My response to this challenge was to develop guided reflection as a way of working with nurses. In essence, guided reflection is a process of facilitating practitioners' learning through reflection-on their everyday work experiences to achieve effective work.

I established the Project in April 1989, with my appointment of Gill as a full time associate nurse. Her appointment was contracted on the condition she entered into a guided reflection developmental and collaborative research relationship with me. Our aims were to:

i] implement, develop and monitor the impact of guided reflection as the means to enable Gill to become an effective practitioner;

ii] to understand the nature of effective work and the conditions by which this could be achieved;

iii] to analyse the process and dynamics of 'guided reflection' necessary for effective guided reflection.

Facilitate the vision for practice - defining desirable work

These aims necessitated an understanding of 'effective work'. Prior to commencing guided reflection, I facilitated staff at Windrush to construct a valid philosophy to define 'desirable work' in order to give meaning to our nursing practice (Johns 1989a, 1990, 1991, 1994a) [figure 1.2]. Whilst Gill had not participated in the construction of this philosophy, she felt that the philosophy reflected her own beliefs about nursing. Indeed, it was for these reasons that she wished to work at Windrush. Hence, in principle we shared a vision of practice. This definition of 'desirable work' provided a background against which achieving effective work could be judged.

Figure 1.2
Windrush philosophy for practice

We believe .....

That care is centred around the needs of the patient. In this respect the nurse works with the patient from a basis of concern and mutual understanding where the patient's experience and need for control in their lives is recognised. In this way trust is developed between patient and nursing that enhances care. This extends to the patient's family, friends, and others that make up the patient's social and cultural world including their pets as desired.

That this approach is holistic in nature and for the benefit of the patient, whether towards recovery through rehabilitation, through respite care or towards adaptation with altered health states including death, or towards reducing the impact of stress for the individual and family. In this respect effective patient care and comfort is the first priority of this hospital.

That the hospital is an integral part of community care that aims to meet and develop the needs of the community it serves, whether in the person's own home or in the hospital itself as becomes necessary. As such it is responsive and sensitive to the community it serves.

That the essence of care is to support the patient as a person within the community. In this respect, assessment must focus on the patient as a member of the community and be carried out with sensitivity in a non-intrusive manner.

That through its status as a nursing development unit the hospital continually strives to improve care to patients, and by achieving and evaluating this, develops the social value of nursing. We have a responsibility to share our work with other nurses and health care workers to enable them to benefit from our expertise and development.

That care given by a community hospital is best given by those who care and have respect for each other, despite differences of opinions at times, and who can share their feelings at appropriate times openly, and mutually support others where needed. This is the foundation of a therapeutic environment that can only enhance patient care.

Research programme overview

My relationship with Gill spanned the period from May 1989 until September 1990. Subsequently five other primary or associate nurses at Windrush entered into guided reflection relationships within the study. This work bridged my own departure from Windrush in December 1991 and the appointment of a new manager in April 1992. The project was extended in the autumn of 1991 to involve nurses and nursing managers in six other nursing units. These managers had all expressed an interest in participating in this project and hence were self-selecting. Three of the units were district nursing practices, and three were hospital based [see chapter 3 for details]. All the units utilised primary nursing. The aim of extending the project was to enable a more diverse and reflexive understanding of the dynamics and conditions of guided reflection, as well as enabling these practitioners to utilise this method.

Structure of the thesis

The thesis unfolds the story of this work. Chapter 2 is an account of my methodological journey towards understanding the nature of guided reflection as a joint developmental and collaborative research method. In chapter 3, I outline the research programme and guided reflection as a developmental and collaborative research process in working with practitioners. This includes a discussion of how this work has been analysed and reported in narrative form. In chapter 4, I present Pru's narrative as an exemplar of guided reflection. This is representative of the 15 narratives constructed within the study, and is a contextualised account of the unique encounter between Pru and her supervisor Maud. This chapter is the soul of the thesis. Chapters 5 and 6 are an account of my analysis of the 15 narratives as a whole. This account is organised within the framework of the practitioner 'being available' to work with the patient and family, justified and supported by practitioners' reflected experiences. The template of 'being available' was

reflexively constructed through the developmental process. In Chapter 7, I develop my understanding of barriers that existed in practice, which limited the achievement of desirable work, and which practitioners therefore needed to confront. These 'barriers' are grounded in norms of power and gender embedded within the practice environment. This chapter is further developed to consider guided reflection as a process of empowerment towards overcoming these 'barriers'. In chapters 8, 9, 10, and 11, I unfold the parallel pattern of the supervisor 'being available' to work with the practitioner towards achieving desirable work within the guided reflection milieu. Chapter 12 closes the project. It is a reflective postscript on the project's major aims and discusses them within a wider contemporary framework, in order to reflect on the potential impact of this work within health care organisations in the light of the NHS Management Executive's promotion of clinical supervision.

Style of presentation

Use of tenses

The whole thesis is a looking back and making sense of what has taken place. As such it is written in the past tense. Extracts of dialogue taken from guided reflection sessions or as written within the individual narratives from the practitioners' narratives reflect the tenses actually used, even where this may be grammatically incorrect. At times I have edited the narratives, to make these extracts more coherent. However, practitioners and supervisors do not necessarily use the correct tense when speaking. All dialogue and practitioners' words taken from reviews and evaluations are shown in italics. The use of dots within dialogue indicate where parts of the dialogue have been edited out. The length of these dots is idiosyncratic and does not indicate any time measurement. Direct quotations from theoretical sources are presented with indented first line in 11 font.

Use of nurse/ practitioner, he/she

The use of 'nurse' and 'practitioner' are interchangeable. Both men and women took part in the project. As such, I have used she or he as appropriate. Where I have generalised I have used 'she' to acknowledge that the significant majority of participants were women.

Use of the terms 'supervision' and 'supervisor'

The term 'supervision' describes the meeting between the practitioner and supervisor within guided reflection. 'Supervisor' is the title I assumed for myself in my facilitative role within supervision. The use of these terms became more significant as the project progressed with the emergence of 'clinical supervision' within the NHS strategy for nursing.

Use of names

All names of practitioners and places within the thesis are synonyms. The names of the six supervisors; Pat, Jane, Brian, Melissa, Maud and Gay are underlined through-out the thesis to distinguish them from practitioners.

Referencing dialogue and quotes

Where dialogue is taken from a guided reflection session it is marked [S15] - meaning session 15. Other quotes marked [SEQ] are taken from the supervision evaluation questionnaires.

Use of extant theory within this study

All sources of knowledge referenced within the thesis have been viewed through the 'sceptical eye' within the context of practice, whether it concerns emerging issues within practice or'issues of methodology. All theory serves to inform and help the researcher/ supervisor/ practitioner to make sense of

practical issues rather than as a prescription of how things should be done. As Dewey (1933) noted

"reflective action entails active and persistent consideration of any belief or supposed form of knowledge in the light of grounds that support it and the consequences to which it leads" (cited in Tann 1993 p54).

Chapter 2
Guided reflection as collaborative research

Introduction

Guided reflection was developed as a joint developmental and collaborative research process. Within this approach, the nature of 'developmental' and 'collaborative' are congruent with each other within the 'whole' rather than as separate processes. The Windrush philosophy sets out an essentially humanistic view of working with patients towards realising health needs through their illness experience. As such, the developmental process to work with staff to achieve this work, required a parallel approach of working with staff towards realising personal need through the learning experience. This was made explicit through the intention to work towards 'collegial' ways of relating between all staff.

Collaborative research

By collaboration I mean two [or more] people *working with* each other on the basis of negotiated expectations within the principles of 'new paradigm research' (Reason and Rowan 1981a, Reason 1988). Reason refers to collaboration as a form of co-operative inquiry where all who participate are both researchers and co-subjects, and contribute to the design and management of the research. Being co-operative, it intends to be a mutual process of co-inquiry, negotiated social action and personal development.

'Background'

Within the project, collaboration is between the supervisor and the practitioner, with the clear intention of the supervisor enabling the practitioner

to achieve effective work. In the first stage of the research, the supervisor was myself. 'Who we are', and the ways we view and act in the world are constructed by the beliefs and prejudices we hold, and will determine how we respond to each other. Heidegger (1962) calls this 'background' - a pre-reflective state that leads people to respond to others in certain ways. Although accepting it is pre-reflective, this 'state' became visible within our dialogue and so amenable to reflection and change. Heidegger (1962) noted that the researcher's background will inevitably influence understanding simply because they exist in the world. In other words, I saw the practitioners' experiences through the lens of my own background, just as the practitioner's background was a significant factor in the way she saw and responded to the patient or family. Spence (1982) suggests the significance of this position in an effort to see the world as the practitioner sees it

" we try to imagine how the person is experiencing the world - we are then in a better position to understand her/his choice of words and to respond to his/her particular shades and colours." [p112]

The researcher/ facilitator needs to be conscious of the risk of listening through filters of his or her own concerns and interests, or established ways of seeing things. These may block sensitive listening, or lead the researcher/ facilitator to project a meaning prematurely, especially when what is being said 'fits' some scheme (Spence 1982). Hence, in contracting a guided reflection relationship it is helpful to explore mutual backgrounds and understandings of desirable work in order to begin a process of constructing a mutual background necessary to work *with* each other. The nature of each other's background is visible within dialogue through the patterns of communication. Because the practitioners and myself inhabited a similar social

world of clinical practice, our backgrounds would reflect commonalties. Street (1992) noted from her critical ethnography of nursing practice how:

> "nurses' backgrounds "shared common meanings concerning taken-for - granted knowledge about how things are understood and done. These meanings make up what it means to be a nurse and therefore powerfully and profoundly penetrate nursing culture." [p30]

However, peoples' shared backgrounds do not necessarily lend themselves to collaborative work within a prevailing culture of bureaucratic and hierarchical ways of relating to each other. This suggests that collaborative relationships need to be worked towards. As Greenwood et al (1993) noted

> "participation is a process that must be generated. It begins with participatory intent and continues by building participatory processes into the activity within the limits set by the participants and the conditions." [p175].

In contrast, Carr and Kemmis (1986) believe that action research should embody collaborative relationships rather than being a recipe to bring about collaborative forms of life. This is line with Freire's (1972) belief that empowerment should be a process of collaboration between groups rather than an outcome achieved by one powerful group for another less powerful group, or, in other words, where the powerful group retain control. Carr and Kemmis take a position grounded in emancipatory action research. Hart and Bond (1995) reviewed the development of action research. They note how this term has spanned different interests from the experimental, grounded in the early work of Kurt Lewin, to the emancipatory, as characterised by the educational action research of Carr and Kemmis. From this perspective, action research can be viewed as an umbrella term for many different interests and

intentions. Whilst I might view my own 'liberating' intention to 'free' nurses to respond effectively in primary nursing roles, this position still reflects a sense of imposing guided reflection as a technology to produce an outcome, albeit a more humanistic one congruent with the theory of primary nursing where collaborative relationships are considered essential (Manthey 1980). Webb (1990) is more conservative when she noted that 'action research' offered the *possibility* of *working with* people that was both non-hierarchical and non-exploitative. Hence a collaborative relationship always needed to be established within an understanding of the authority and *relationships* between roles. My relationship with practitioners at Windrush was hierarchical by virtue of our respective roles. Hence the issue was the *extent* to which hierarchy is emphasised.

Within a collaborative relationship the researcher cannot adopt a detached or objective position. Heidegger drew a distinction between the hermeneutic researcher's stance whereby the 'hermeneutic ontologist makes his theme precisely the shared background in which he dwells and from which he cannot detach himself' (In Dreyfus 1991 p82). Heidegger labels this as 'thematic consciousness'. He distinguishes this with a researcher stance, 'whereby the scientist is detached from and so is able to thematize and objectify his subject' (In Dreyfus 1991 p82/83). Heidegger labels this as 'objectifying thematizing'. From this position, the claim for 'researcher objectivity' is necessary to guard against bias and distort understanding. That the researcher can be objective is a self-distortion because of how people respond from a pre-reflective state. Hence, 'who I was' as a researcher could not be separated from 'who I was' as a manager and supervisor. This point has widespread acceptance within collaborative research theory (see Heron 1981a) and feminist theory (see Acker, Barry and Esseveld 1983, Paget 1983). Paget (1983) recognised how the similarity between her own and her interviewees' life experiences influenced

questions she asked and entered into her understanding and interpretation of the story being told. Paget points out her approach, which gave control of the interview process to the interviewee, establishing solidarity between them as they engaged in the shared task of trying to understand important life experiences. This highlights the intended collaboration of the supervision relationship- to understand and learn through work experiences towards shared goals .

'Open dialogue' and Fusion of horizons

Fundamental to an effective collaborative relationship was creating the conditions of 'open dialogue', whereby practitioners could be free to share their thoughts and feelings without feeling intimidated. Habermas (1984) noted, in his theory of communicative competence, the significance within an emancipatory social science, of establishing ideal speech situations where people could speak without fear of oppression; the outcome of debate being settled by weight of argument. As such, the perception of intimidation would be an indication of the extent to which collegial relationships had been established between supervisor and practitioner. Open dialogue is necessary for 'co-creating meaning', where meaning of events is jointly constructed between the supervisor and practitioner. In other words, the supervisor does not impose a meaning on the practitioner from his or her authoritative advantage.

'Horizon' is a metaphor to represent the person's normal vision and understanding. As practitioners learn through experience, their horizons are constantly shifting, as in a developmental process of moving forward. Hence new experience is viewed from a developed position of having learnt through previous experience. When practitioners look back, they can view their journey through the shifting accounts of their reflected experiences. They can see how

they have come to talk differently about themselves, reflecting their new understandings and changed actions. Gadamer highlights how people are always understanding and interpreting themselves in the context of their worlds and in light of their fore-knowledge, which, from the reflexive viewpoint, is always changing through experience. This looking back and seeing self as a changed person is the essential nature of reflexivity. It is not as some end-point, but is always open and anticipatory to future experiences. Gadamer (1975) notes

"every experience has implicit horizons before and after, and fuses finally with the continuum of experiences that are present before and after into the unity of the flow of experience." (cited in Weinsheimer 1985 p157).

Whilst I could help the practitioner see their background, this was not necessarily reciprocated because of the intention within the relationship of roles, i.e. my role was to facilitate learning in the other. Issues of clinical knowledge and status also apply despite collegial intent. In other words, the researcher and facilitator may struggle to see how their own pre-reflective state impact on the relationship. It is a significant question to ask who helped me to see beyond myself to pay attention to my own background and how this impacted on the dynamics of guided reflection? In fact it wasn't until two years into the project I realised the significance of this point. In defence I can only say that the process of guiding reflection led to a considerable insight of self. The overt focus of the project to understand the dynamics of guided reflection aided the development of my self-understanding. The subsequent development of the project to involve my supervision of other supervisors led to significant insights into the contradiction between the ideal of collaborative relationships and actual practice [see chapter 9].

Reflection-on-experience

Guiding the practitioner to learn through reflection-on their everyday experience is the focus of the developmental process. This involves one person [the facilitator] accepting a responsibility to guide another towards achieving desirable and effective work. But, the collaborative ideal of 'working with' also demands an 'active stance' by the practitioner. Fay (1987) notes that an 'active' stance is necessary within a critical social science that intends to enlighten people as to the nature of the crisis within their lives. On the basis of this enlightenment, people can take action to emancipate self, empowered by this new understanding, in order to alleviate the crisis. The appropriateness of drawing on Fay's understanding of critical social science, is evident within the way he conceptualises critical social science as, at once scientific, critical, and practical. Fay describes 'critical' as the 'sustained negative evaluation of the social order on the basis of explicit and rationally supported criteria' [p26]. By 'practical' Fay means how practitioners were stimulated to act on the basis of new understandings to transform the conditions under which they worked towards the realisation of their best interests. This is exactly what took place - within a 'scientific' process as represented by the total thesis. Whilst practitioners within this project did not necessarily present 'in crisis', the intention within reflection is always to problematize existing practice for its congruence with beliefs and values and the contradictions between beliefs and values and practice. Where no contradiction is apparent, the intention is to problematize held beliefs and/or practice, within a wider understanding about the desirable nature of nursing. In other words to understand what is desirable practice and what it means to be effective in achieving it. Fay (1987) identified that

'the idea of an active being can best be explicated in terms of four fundamental dispositions; intelligence, curiosity, reflectiveness, and wilfulness' [p48]

Fay's description of these 'dispositions' are shown in figure 2.1.

Figure 2.1

Fay's fundamental dispositions to being an 'active being'

Intelligence - 'The disposition to alter one's beliefs and ensuing behaviour on the basis of new information about the world.

Curiosity - The disposition to seek out information about one's environment in order to provide a fuller basis for one's assessments.

Reflectiveness -The disposition to evaluate one's own desires and beliefs on the basis of some such criterion as whether they are justified by the evidence, whether they are mutually consistent, whether they are in accord with some ideal, or whether they provide the greatest possible satisfaction, all in aid of answering the questions: what is the proper end of my life and thus what sort of person ought I to be.

Wilfulness - The disposition to be and to act on the basis of one's reflections.

[p48-50]

The extent to which the practitioner is inclined towards these four dispositions, determines the extent to which the practitioner can transform herself necessary to achieve desirable work. The 'evidence' is lived experience. 'Intelligence' and 'curiosity' are pre-requisite to reflection, whilst wilfulness is the commitment towards desirable work and to acquiring the sense of empowerment necessary to act towards achieving this.

Contradiction

Fay's description of reflectiveness acknowledges the centrality of contradiction between beliefs and desires and the evidence of a lived life. Through reflection, these contradictions become visible along with the factors, both embodied

within self, and embedded within the environment, that contribute to the maintenance of these contradictions (Cox, Hickson and Taylor 1991). These authors focus action towards contradiction resolution that explicitly means transforming self :

"As we come to expose these self- imposed limitations, then the focus of our reflection shifts towards new action, towards the ways in which we might begin to reconstruct and act differently within our worlds." [p387]

However exposing these 'self-imposed limitations' may not necessarily be easy or comfortable. It is difficult to see 'beyond self'. It may be difficult for practitioners to see beyond themselves because of 'habits of mind' that act as barriers (Margolis 1993). Margolis refers to the way paradigms are maintained and shifted. Where particular habits of mind need to be shifted for change to take place they constitute a barrier. However, practitioner's own best interests may be distorted because of competing dominant power discourses that she has internalised and taken for granted as normal. This is perhaps particularly significant for nurses whose own nursing discourse has been dominated within the discourses of medicine and managerialism. Practitioners may feel more comfortable adhering to false beliefs or 'false consciousness'. Lather (1986a) defined this as

"the denial of how our common-sense ways of looking at the world are permeated with meanings that sustain our disempowerment." [p264].

False consciousness may be an unhelpful concept because it suggests that there can be true consciousness, as if this is some end product. People only understand things in terms of their backgrounds. It is not possible to judge people in terms of what some outsider considers to be their best interests

except where somebody wishes to impose a different agenda. I interpreted 'false consciousness' on two levels:

- The validity of the practitioner's held beliefs and values that were either espoused or evident through reflection on experience.
- In the way practitioners rationalised the contradictions between beliefs and values and actual practice.

Mezirow (1981) viewed reflection as the means to enable practitioners to penetrate 'false consciousness' through perspective transformation. He defined this as

> "The emancipatory process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see ourselves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new understandings." [p6]

Psycho-cultural assumptions are those norms and prejudices embodied within individuals and embedded within practice settings that lead people to see and act in the world in certain ways. Mezirow sees reflection as the means to access and transform these norms and prejudices to enable them to fulfil their own best [emancipatory] interests.

Mezirow talks about "disorienting dilemmas" and how the "traumatic severity of the disorienting dilemma is clearly a factor in establishing the probability of a transformation" [p7]. It is this sense of disorientation or trauma that brings the person to pay attention to the experience, although a more deliberative stance can be developed as the practitioner becomes increasingly sensitive to themselves in the context of what they are trying to achieve. Mezirow' s concept of perspective transformation was strongly influenced by Habermas (1971). In particular he drew on the concepts of the idea of emancipatory

action which he equates with perspective transformation, one of three knowledge constitutive interests identified by Habermas, by which human interests generate knowledge. Mezirow's work is in a tradition of critical pedagogy that views education as a liberatory process (see also Kemmis 1985, Carr and Kemmis 1986, Smyth 1984, 1987). The learning opportunity within reflection-on-experience is therefore the attempt to resolve the contradictions between what the practitioner aimed to achieve and how they actually practised within the specific experience. What the practitioner aims to achieve is never taken at face value but is itself open to scrutiny for its appropriateness and consequences.

Argyris and Schön (1974) noted the distinction between theories-of-action and theories-in-use. Theories of action are the theories the nurse would espouse when asked how she/he would act in a certain situation. Theories-in-use reflect an understanding of how the nurse actually acted in that situation. Contradiction is apparent where theories-in-use do not match theories of action. Argyris and Schön (1974) assert that effective practitioners are those whose theories of action match their theories-in-use, or in other words they do what they say they would do. However this position assumes that the practitioner's theories of action are valid. Schutz (1962) makes a similar distinction between 'in order to motives' and 'because motives'. Schutz was a phenomenologist influenced by the philosophy of Husserl, who asserted that what the practitioner aims to achieve within any situation is

> "directed by virtue of some mental content that represents this situation and which gives intelligibility to the situation" (cited by Dreyfus 1991 p2).

In anticipating some action, practitioners almost certainly envisage the world in this way. However, this does not mean the practitioner views situations from some theoretical position. Heidegger (1962) believed that there was a

more basic form of 'Intentionality' that is integral to the person's being and which shapes how that person views the world but without mental representation (Dreyfus 1991). Heidegger would reject the idea that a person is able to look at a situation objectively from some preconceived theory, without reducing that situation [and those within it] to the status of an object to be manipulated. Indeed this was what was exactly done within guided reflection in contemplating other ways of responding to situations that had been reflected-on. However rarely did events turn out as anticipated. From Heidegger's perspective, 'Intentionality' cannot be discovered because of its pre-reflective nature yet it is manifest within all experience. Through reflection-on-experience, the pre-reflective world can be penetrated to see the prejudices, pre-judgements and norms that influence actions (Gadamer 1975). This penetration opens up the potential to consider new ways of acting and the consequences of acting in new ways that considers and confronts existing prejudices and norms, and the practitioner's existing repertoire of interventions. In this respect reflection-on-experience is a cumulative process of building on experience within the context of anticipating future experience [rather than specific situations]. Street (1992) drew the conclusion from her critical ethnography of nursing practice that:

"The confrontation with experience through reflection and of the meanings and assumptions which surround it, can form a foundation upon which to make choices about future actions based on chosen value systems and new ways of thinking about and understanding nursing practice." [p16]

Street reinforces Fay's concept of wilfulness, in considering how value systems guide the practitioner's actions. How strongly practitioners held values about the nature of their practice reflected the extent to which they were committed to living out these values in everyday practice, and the extent they were

committed to learning to become effective practitioners. This idea is given further substance by Gadamer's appropriation of Aristotle's idea of phronesis (Gadamer 1975). Gadamer shows how praxis is driven by phronesis - the notion of action being driven by an ethical commitment. It is values and beliefs that give a person this ethical commitment. Because beliefs and values matter to practitioners, failure to live these values in practice creates anxiety. Anxiety, because of it's discomfort, tends to make itself conscious and becomes a focus for reflection. It is the felt degree of conflict within contradiction that propels practitioners towards taking action to remedy the anxiety and, as a consequence, to resolve the contradiction (Kieffer 1984). Kieffer studied 15 people who were active in grassroots political and local leadership roles and who could self-acknowledge personal transformation. Kieffer chose these 'experts' to analyse and construct a model of empowerment as a developmental process. In considering the implication for practice Kieffer noted:

> "In becoming empowered individuals are not merely acquiring new practical skills; they are reconstructing and re-orienting deeply engrained personal systems of social relations. Moreover, they confront these tasks in an environment which historically has enforced their political repression, and which continues its active and implicit attempts at subversion of constructive change." [p27].

The word 'individuals' can be replaced by 'nurses', and 'political repression' with 'professional and organisational repression'. Kieffer emphasised how reflective experience was the irreducible source of empowerment and growth.

Acknowledging the significance of context and intuition

Learning through reflection is grounded in deconstructing the practitioner's response within the specific clinical situation that formed the core of the

experience. This learning opportunity is contextual and subjective. Schön (1983, 1987) recognised the complexity of professional practice, describing it as the "indeterminate swampy lowlands where confusing problems defy technical solution" [p3] . He challenged the dominance of technical knowledge or rationality [his word] as being both an inadequate and inappropriate knowledge base for the complexity of decision making within professional practice. On the contrary, the rationale for decision making is contextual and subjective, and largely based on previous experience. Available research doesn't easily fit the unique situations of human encounter because it has been de-contextualised according to the rules of the research methodology. It always needs to be interpreted within the specific situation. Dreyfus and Dreyfus (1986) suggest that practitioners, in the process of developing expertise, shift the basis of their decision making from a reliance on abstract formal models and logical linear processes towards a reliance on past concrete experience and intuition. The significance of intuition within decision making is widely acknowledged (Dreyfus and Dreyfus 1986, Tanner 1987, Rew 1988, Benner, Tanner, and Chesla 1992). Spence (1982) noted

" Each practitioner has their own private data base, immediate and persuasive, which informs them of the truth value of any particular concept... each practitioner develops their own narrative of the clinical theory by combining his clinical experience with their interpretation of theoretical concepts." (p212)

This 'private data base' is largely tacit. Learning through reflection is centred in the expression of this tacit knowing manifest within the practitioners' intuitive responses. Because most decisions and actions were intuitive, the focus of learning through experience is primarily to develop the intuitive response.

Limits to recall?

The efficacy of reflection-on-experience as an adequate learning milieu has been challenged by cognitive psychology theory with respect to whether people are able to recall events accurately (Newell 1993). This position questions whether the data made available through reflection can be a valid basis for learning. This viewpoint would suggest that practitioners relate what they believe to be a correlate of reality. The impact of limited recall on learning through reflection is not known and can only be speculated in the light of a psychological theory which suggests that people do not recall accurately. However, the issue is not one of accuracy of recall but on the meaning of events for people. If practitioners distort recall, then they do so for reasons which are part of their reality, or to deliberately create a false impression. Practitioners paid attention to the experience because it presented itself to consciousness, usually because of a strong affective component. The ability to reflect *in detail* was aided by the development of an heuristic model of structured reflection [see chapter 3].

Guiding reflection

Accounts of reflection-on-experience without guidance suggest this may be a struggle for practitioners (Gray and Forsstrom 1991, Cox, Hickson and Taylor 1991). As such, practitioners may require guidance to see how their best interests, notably defining and achieving desirable work, have been constrained. Practitioners may perceive themselves as relatively powerless to change self (Robinson 1995), and need guidance to see new ways of being and ways of taking action to achieve this and the courage to sustain such action. Even with understanding how factors have come to limit the achievement of desirable work, taking necessary action may prove to be too difficult. It may be easier just to accept the status quo (Smyth 1987). Menzies-Lyth (1988) noted how nurses tended to:

"Cling to the familiar even when the familiar has obviously ceased to be appropriate or relevant." [p 62]

Menzies-Lyth (1988) made this deduction within the context of understanding how nurses protected themselves against anxiety. The role of the supervisor is to mobilise forces to plant and water seeds *of doubt* in order to undermine and eventually overthrow the inappropriate dominant habits of mind that feed an accepted order of things (Margolis 1993). Menzies-Lyth also noted that change is made only at the point of crisis. Given the assumption that the focus of reflected experience is likely to be situations of 'breakdown' (Heidegger 1962) and subsequent anxiety [as indeed became evident within the project], reflection may be motivated as action towards rationalising anxiety and defending self rather than as a learning milieu. Guidance can help the practitioner to challenge the move to defend self, and offer the support to sustain this challenge. Guiding reflection can be viewed as the balance between high challenge and high support' (Blocher 1983). High challenge is necessary to help the practitioner to-

- Expose and confront contradictions.
- Fuel the sense of felt conflict necessary to take action to resolve the contradictions.
- Confront lack of commitment

High support is necessary to help the practitioner to -

- Minimise the risk of threat and defensiveness of high challenge
- Nurture commitment
- Gain courage and to feel empowered to take action
- Feel acknowledged and valued

Supervision

I named the collaborative space where I met with practitioners to guide their learning through reflection as 'supervision'. It wasn't until six months later that I read 'Supervision in the helping professions' by Hawkins and Shohet (1989) that opened the door to explore a vast literature on supervision within psychotherapy and counselling. I also discovered a tradition of supervision within social work (Kadushin 1985) yet there was no such tradition within nursing, despite its development through statute in midwifery since 1912 and its development in psychiatric nursing. An overview of the development of supervision within nursing became available in 1992, when Butterworth and Faugier published 'Clinical supervision and mentorship in nursing'. This work merely confirmed that no significant development of supervision within nursing had taken place. The congruence between guiding reflection and supervision was apparent within the psychotherapy literature. Loganbill, Hardy, and Delworth (1982) defined supervision as:

> "an intensive, interpersonally focused, one to one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" [p4]

This definition is congruent with the facilitation of staff development and support function within my clinical leadership role [figure 1.1]. An outcome-oriented approach was offered by Kadushin (1985). He identified three key tasks of supervision as supportive, educative, and managerial [figure 2.2].

Figure 2.2

Key tasks within supervision [adapted from Kadushin 1985]

Managerial task	Educational task	Supportive task
Provides the organisational structure and access to agency resources that facilitate the supervisee's work; Is concerned with organisational barriers to effective services; provides a model of an efficient worker	Provides the knowledge and skills required for work; Is concerned with ignorance barriers to effective services; Provides a model of the competent worker	Provides the psycho-logical and interpersonal resources that enable the worker to mobilise the emotional energy to work with patients and achieve effective job performance Is concerned with emotional barriers to effective services Provides a model of a compassionate, understanding and responsive worker.

The managerial and educational tasks are grounded in organisational perspective, whilst the supportive task reflects a more professional and philosophical perspective on how the practitioner should work and hence would need support. Its focus on outcomes suggests the focus of supervision is to produce a certain type of worker. It is not easy to glean from Kadushin's writing how this approach works in practice. Its value was to draw attention to the potential scope of supervision rather than as a prescription of what should take place. However, these tasks may require different supervision approaches, and, as such, may not be compatible with each other. The emergence of a clinical supervision definition for nursing (NHSME 1993) raises similar issues [see chapter 11].

Psychotherapy supervision models

The psychotherapist's approach to supervising trainees within psychotherapy and counselling training traditionally matches the psychotherapist's therapeutic approach to clients[1]. This is obvious in the sense that supervision is used to train the student in that approach. Reviews of research studies in the efficacy and processes of different supervision approaches (McNeill, Stoltenberg and Pierce 1985, Borders and Leddick, 1987, Hill, Charles and Reed, 1981) indicate the appropriateness of adopting the 'Developmental model' as a framework for envisaging the growth of practitioners through stages of development. Hill, Charles and Reed (1981) noted

"It is likely that students go forward and backward through the stages depending on personal issues and types of clients encountered - hence a continuum of relative growth. " [p435]

Loganbill, Hardy and Delworth (1982) emphasise that the individual's attributes, such as needs, motivations, and cognitive developmental level will influence the rate of growth through developmental stages. Developmental models are based on the logic that if the supervisor can match the developmental needs of the practitioner, then optimal growth and improvement of the practitioner would result (Hogan 1964, Worthington 1987). The Stoltenberg and Delworth (1987) developmental model has four developmental stages [figure 2.3].

[1] Approaches to supervision within psychotherapy tend to follow particular models depending on the orientation of the psychotherapist trainer. A literature exists that explores these different models used in different settings- see Hess A (1980) 'Psychotherapy supervision'; John Wiley & Sons, New York.; Bradley LJ (1990 second edition] 'Counselor Supervision: Principle, process and practice'. Accelerated development Inc., Muncie IN. More specialised literature deal with specific approaches, for example 'The Integration Model' that combines skill developmental model and personal growth model- Hart G (1982); The Process of Clinical Supervision, University Park Press, Philadelphia. These models were developed in the USA. Supervision models, which are derivatives of these earlier models have been constructed by Hawkins & Shohet (1989) - The Matrix model), and by Faugier (1992) -

Figure 2.3

Stoltenberg and Delworth Developmental model (1987)

Level 1	This stage is characterised by trainee dependence on the supervisor. 2 major difficulties are i] evaluation apprehension ii] objective self-awareness - "the practitioner can elicit negative evaluations of one's performance and concomitant feelings of anxiety" (p61)
Level 2	The supervisee has overcome their initial anxieties and begins to fluctuate between dependence and autonomy; and between over-confidence and being overwhelmed.
Level 3	The supervisee shows increased professional self-confidence with only conditional dependency on the supervisor. She has greater insight and shows more stable motivation. Supervision becomes more collegial, with sharing and exemplification augmented by professional and personal confrontation. The supervisee is also more able to adjust their approach to meet the individual needs of the patient (Hawkins and Shohet, 1989 , p51)
Level 4	The supervisee has reached 'master level' - characterised by personal autonomy, insightful awareness, personal security, stable motivation, and an awareness of the need to confront her own personal and professional problems. (p20)

I was attracted to this model because the developmental description in Level 4 portrayed an ideal practitioner. When I applied the model to analyse the practitioners development, I realised practitioners could not easily be pigeon holed within the levels. The practitioners generally met the description in level 1 and reflected behaviour within levels 2 and 3 within 12 months, although there was considerable overlap between these stages. In level 3, the concept of professional confidence should be linked to appropriate belief systems in order to be a credible measure, because the more experienced practitioners were confident within the extent of their existing beliefs about nursing. The model

was also limited because it's focus is on the process of supervision rather than the outcomes in terms of practice. As such it proved an inadequate guide of development. As the project progressed I continued to explore the supervision literature which led to my appropriation of Ralph's milestones model.

Ralph's 'developmental milestones' (1980)

This model proposed 4 milestones of development. In figure 2.4 I have interpreted Ralph's milestones to offer a developmental model for nurses congruent with the growth of responsibility within primary nursing roles. This model acknowledges how the self of the practitioner is the most significant dimension in the development of therapeutic work. Ralph's work was a moment of personal confrontation because I had always seen patient-centred care as the pinnacle of nursing development. Ralph's model reflected the primacy of knowing and monitoring self in effectively achieving desirable work. Yet it felt a culture shock to assert that nurses needed to be fundamentally self-centred to be effective. Yet the 'evidence' strongly supports this position. As Hall (1964) noted:

> "For the nurse to use herself therapeutically, she must.. learn who she is so that her own concerns will not interfere with the patient's exploration of *his* concerns." [p 152 - emphasis by Hall]

My interpretation plots a course of development from an a-theoretical orientation to work, through the adoption and reliance on formal models, to a primary focus on relationships with clients, and subsequently a primary focus of self-development. It was not until the practitioner did focus on therapeutic relationships with patients, that the self became recognised as significant.

Figure 2.4

Ralph's developmental milestones and Johns's nursing interpretation

Stage Ralph	Johns
Learning the role of the psycho-therapist as a non-directive expert.	Providing authoritative and definitive solution and advice to the patient - application of scientific knowledge in response to presenting signs and symptoms - reflects the practitioner who has reduced the patient to some object to be manipulated.
Adopting a patient-centred approach that is global, patient -centred, and concretely content-centred.	Adopts a theoretical approach in an undifferentiated and concrete fashion - reflects the practitioner struggling to assert a nursing model but in a prescriptive sense.
A relationship-centred approach that involves the discovery of psychotherapy as an inter-personal process.	Relationship-centred- the discovery of [nursing] as an interpersonal process - comes to view his/her own mastery and competence as a process of continual personal growth that extends beyond technical skill - reflects the practitioner who has become patient centred and can respond as such.
The development of a therapist-centred approach in which there is increasing awareness of the usefulness as well as the limitations that the therapist's own feelings impose.	Practitioner-centred - increasing awareness of both the utility and limitations of the practitioner's feelings - reflects the practitioner who is able to continuously monitor herself - recognising the centrality of herself to the effectiveness of care she has available.

Whilst interesting, I never formally used Ralph's model to determine the growth of practitioner development. As with other developmental perspectives it still proved to be too arbitrary and vague. However, the supervision literature was important because it offered a perception of supervision as a complementary developmental process in addition to merely being the space to guide reflection.

Summary

The *idea* of guided reflection certainly seemed an appropriate way to work with practitioners towards enabling them to realise desirable/ effective work, and to fulfil my self-perceived role expectations as a clinical leader. Guided reflection, as a joint collaborative and developmental process, is a reflexive methodology, a continuous process of juxtaposing knowing in practice through reflection-on using ideas in practice, informed by my critique and assimilation of theoretical approaches. This process continues to be evolving, for example with exploring the nature of guided reflection within Margaret Newman's theory of expanding consciousness (1994). How the *idea* became practical is the focus of chapter 3 within an account of the research programme and the methods used to collect, analyse and report these processes.

Chapter 3
Method

From methodology to method

In chapter 2, I set out the evolving framework for guided reflection as a joint collaborative research and developmental process grounded in a reflexive and critical phenomenology. In summary, the data was the dialogue that took place between the practitioner and researcher/ supervisor within guided reflection relationships grounded in the practitioners' reflected-on experiences. The methods used to collect the data the practitioners' lived experience were reflexively constructed within a continuous analysis of the guided reflection relationships. Each guided reflection relationship was constructed as a narrative structured through interpretative frameworks constructed from the analysis. These narratives were analysed to construct meta-analyses of understanding the nature of effective practice and the dynamics of becoming an effective practitioner through guided reflection. These two meta narratives form the substantive basis of the thesis.

The account of this process is organised through stages of method development within the overall research process.

- *Programme of research*
- *Contracting guided reflection and research relationships*
- *Data collection*
  - *model of structured reflection*
  - *structured reflective diaries*
- *Constructing supervision dialogue*
- *Constructing narratives*

- ***Coherence***
- ***Monitoring effectiveness***

Programme of research

The 'field work' spanned from April 1989 - April 1993. This involved 15 practitioners in guided reflection relationships with 7 [including myself] 'I' grade managers/ clinical leaders. A brief profile of each practitioner is set out in Appendix 3. No practitioner or supervisor had previous experience of either supervision or reflective practice although some had kept a personal journal. Each relationship was formally contracted and spanned between 10 -18 months. The initial guided reflection was contracted with Gill. I negotiated with her that she would work as an associate nurse for the first nine months; then work as 'protected' primary nurse for three months; and then work as a 'full blown' primary nurse for a further three months. In September 1990, Gill left to have a baby and we closed this relationship. The work with Gill was written as a case study[1]. At this time one of the other primary nurses left, enabling me to appoint two primary nurses, Jade and Myrna, who both agreed to enter into guided reflection relationships. Subsequently I continued working with practitioners at Windrush until April 1993 - even after I left Windrush in December 1991. A summary of this programme is shown in Table 3.1.

Between October and November 1991 I commenced supervising the six 'I' grade clinical leaders. The condition was that they each commenced supervising at least one practitioner accountable to them. The six units constituted three primary nursing units - two within other community hospitals and one within a general hospital; and three district nursing practices. A summary of this programme is shown in Table 3.2. These were line management relationships with the exception of Brian, who had a clinical specialist role. These managers were self selecting as a result of their interest in

[1] 'Becoming a primary nurse' - This was published in January 1991 as a hospital publication.

the Windrush work. Each relationship was contracted for 12 months. These managers and practitioners attended a half-study day to introduce them to the dynamics of guided reflection and to secure their involvement.

Table 3.1
Programme of guided reflection relationships at Windrush

Name	Date commenced	Date finished	Notes
Gill	May 1989	Sept. 1990	associate/ primary nurse - Guided by CJ
Jade	Sept. 1990	Nov. 1991	primary nurse Guided by CJ
Myrna	Sept. 1990	Sept. 1991	primary nurse Guided by CJ
Leslie	Sept. 1991	April 1993	primary nurse 2 week overlap with Myrna Guided by CJ in hospital manager role until December 1991 an then as an external supervisor
Karen	Oct. 1991	April 1993	associate nurse Guided by CJ in hospital manager role until December 1991 an then as an external supervisor
Gayle	Jan. 1992	April 1993	Commenced guided reflection relationship with CJ as an external supervisor - negotiated take over by Jane in April 1992

Notes:
Leslie, Karen, and Gayle were required to enter into guided reflection as a condition of contract. Gayle was appointed in January 1992. I met with her and offered her guided reflection as an external supervisor. This relationship continued until April 1992 when Jane commenced as manager. Jane was already in the project-as manager of Cairns Unit. These practitioners all continued to work at Windrush after April 1993.

Table 3.2
Programme of guided reflection relationships within the 6 units

I grade	Unit	Nurse	Comment
Jane	Cairns	Abbi Jeanne Liz	Unit within general hospital. Jane supervisor as manager between November 1991- April 1992. Continued as external supervisor until August 1992 [termination of relationships]
Brian	Omaha	Mary	Community hospital
Pat	Iowa	Rona Lucy	Community hospital ward
Gay	District nursing	Rachel	
Melissa	District nursing	Alice	
Maud	District nursing	Pru	

Contracting guided reflection/ Research relationships

I contracted with each supervisor to negotiate the conditions for working together. Proctor (1988) noted that:

" If supervision is to become and remain a co-operative experience which allows for real rather than token accountability, a clear, even tough agreement needs to be negotiated. The agreement needs to provide sufficient safety and clarity for the practitioner to know where she/he stands; and it needs sufficient teeth for the supervisor to feel free and responsible for making the challenges"

[cited in Hawkins and Shohet, 1989 p29]

I interpreted 'co-operative experience' to equate with collaboration, concerned with working together towards mutual outcomes. The notion of real accountability assumed a clear understanding of our expectations and responsibilities within the relationship. Contracting included a number of practical issues -

- Establishing when, where, how often to meet. [I eventually considered meeting for one hour every three weeks to be the optimum arrangement]
- The significance of note taking and data collection.
- Conditions for confidentiality.
- Keeping a reflective journal and preparation for sessions.

[The significance and practicalities of these issues is reflected on in chapters 8 and 9].

Data collection

The raw data for practitioners' development were their stories of everyday experience. The recall of lived experience enables a rich, contextualised account that illuminates the complexity of the practice situation. As Mishler (1986) noted

"Telling stories is a significant way for individuals to give meaning to and express their understanding of their experiences." [p75]

The ensuing dialogue between the practitioner sharing their experience with the supervisor was the raw data for analysis to determine the practitioner's development, and for understanding the dynamics of guided reflection that best facilitated this development.

An experience can be simply defined as the focus for reflection, centred on the self within a specific work-related situation. It may be a single situation or 'an experience' that spanned a number of related situations over several days or even weeks. Initially Gill and I did not adopt any theoretical approach to 'reflection-on-experience'. Gill was asked to reflect on her experience, as if this was some natural and known activity. I also asked her to write an account of her reflection in a journal to share with me in supervision. On listening to Gill's account, I asked questions to help her explore the significance of the experience towards enabling her to become a more effective practitioner.

The Model of Structured reflection

"While we cannot learn or be taught to think, we do have to learn how to think well, especially how to acquire the general habit of reflecting."
Dewey 1933 p35

Looking back over the first two years of supervision with Gill, Jade and Myrna, I became increasingly aware of a pattern of reflective questions within our supervision dialogue. I presented this pattern [figure 3.1] to Jade in our session 15 [approximately 2 years after commencement of the project], and suggested she use them as tool for guiding her reflection in preparation for sharing

experiences with me. I discovered a similar set of questions within one of the psychotherapy developmental models of supervision (Bernstein and Lecomte 1979). This had been based on what the authors felt were useful questions to ask.

Figure 3.1

Initial set of reflective questions presented to Jade

i] What was I trying to achieve?

ii] Why did I intervene as I did?

iii] What other choices did I have?

iv] What would be the consequences
of other interventions?

v] What was the consequence of my actions
- for the patient?
- for myself?

vi] How do I feel about the situation NOW?

vii] How does the patient feel about it?

viii] Could the situation have been better
dealt with?

I subsequently utilised Strauss and Corbin's (1990) 'paradigm' model as a heuristic framework to frame these questions. Strauss and Corbin constructed the 'paradigm' model to enable the 'grounded theory' researcher to think systematically about data in considering axial coding techniques. They note

"Use of this model will enable you to think systematically about data and to relate to them in very complex ways... unless you make use of this model, your grounded theory analyses will lack density and precision." [p99]

Strauss and Corbin's paradigm model has the following stages :

Causal conditions	-	What factors contributed to the event?
Phenomenon	-	What is the crux of this event?
Context	-	What are the specific circumstances in which this event occurred?
Intervening strategies	-	What are the broader significant conditions to this event?
Action/ interaction strategies	-	How was this event dealt with?
Consequences	-	What were the outcomes of this event for the people involved?

These cues would lead the practitioner to think systematically and to reach the level of density and precision necessary for insights and learning to be achieved. I felt this would answer Giorgi's (1985) question - " what makes an adequate description as opposed to an inadequate description? "[p3] The outcome was the 'Model of Structured Reflection' [MSR]. This has been reflexively developed through reflection on its use and value throughout the research. [Figure 3.2 illustrates the eighth edition of this model]. Whilst the MSR sets out a sequence of cues, it does not intend to prescribe the process of reflection. From a reflective perspective, the practitioner would internalise and transcend the model towards constructing their own model. Using the model offered an opportunity for self-reflection to encourage the practitioner to accept primary responsibility for learning. Self challenge is acknowledged as a therapeutic principle to accomplish therapeutic objectives (Hammond, Hepworth and Smith 1977). The reflective cue - 'What are the key processes for reflection in this experience?' is the bridge between description and reflection. This cue intends to focus practitioners to identify significant issues within the experience for specific attention. The need for this cue was a reflection of the

Figure 3.2

Model of Structured reflection [eighth edition][2]

Core question:

What information do I need access to in order to learn through this experience?

Cue questions:

1.0 Description of experience

.1 Phenomenon - Describe the 'here and now' experience

.2 Causal - What essential factors contributed to this experience?

.3 Context - What are the significant background factors to this experience?

.4 Clarifying - What are the key processes for reflection in this experience?

2.0 Reflection

.1 What was I trying to achieve?

.2 Why did I intervene as I did?

.3 What were the consequences of my actions for:

- myself?
- the patient/ family?
- for the people I work with?

.4 How did I feel about this experience when it was happening?

.5 How did the patient/ other feel about it?

.6 How do I know how the patient felt about it?

3.0 Influencing factors

.1 What internal factors influenced my decision making?

.2 What external factors influenced my decision making?

.3 What sources of knowledge did/ should have influenced my decision making?

4.0 Could I have dealt better with the situation

.1 What other choices did I have?

.2 What would be the consequences of these other choices?

5.0 Learning

.1 How do I NOW feel about this experience?

.2 How have I made sense of this experience in light of past experience and future practice?

.3 How has this experience changed my ways of knowing?

- empirics - ethics - aesthetics - personal [Carper 1978]

[2] The model of structured reflection has been revised twice since this eighth edition, reflecting the continued reflexivity of the model's construction through action-reflection-action cycles. [see Johns 1994 b, 1995 for outline of this development]. The eighth model is presented in the thesis because it's construction represents the closure of guided reflection relationships within the study.

general difficulty practitioners had in moving beyond description to reflection. The practitioners struggled with breaking down description into its phenomena/ causal/ context parts. This reduction distracted practitioners from telling their stories and interfered with the notion of naive description. Descriptive reconstruction intends a relatively 'naive' story telling, characteristic of phenomenological method (Merleau-Ponty 1962 cited in Giorgi 1985). Giorgi asserts that description should be as naive as possible "in order to reveal our spontaneous, pre-reflective ways of dealing with the world." [p43]. In a similar vein, Boud et al (1985) noted that

"the description of experience should be, as far as possible, clear of any judgements as these tend to cloud our recollections and may blind us to some of the features which we may need to re-assess." [p28]

When practitioners considered factors that had influenced them, they often repeated what they had previously identified as 'causal' and 'context'. This suggested that causal and contextual factors were better analysed as a stage of reflection rather than at the description phase.

Theoretical approaches to reflection

Boud, Keogh and Walker (1985) formulated their theoretical approach to reflection-on-experience based on their own experiences of teaching and the work of other authors. They define reflection as a:

"generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations." [p19]

They constructed a model comprising a number of discrete stages to explain how this is accomplished[figure 3.3]. They highlight that feelings influence the

way things are perceived and hence the significance of paying attention to feelings within relation to taking action. They note

"Of particular importance within description is the observation of the feeling evoked during the experience. On occasions our emotional reactions can override our rationality to such an extent that we react unawarely and with blurred perceptions. "[p28]

I don't agree that feelings blur perceptions. Perception is always within the context of feelings. Hence practitioners' accounts are always influenced by their feelings within their experiences and by their subsequent feelings on reflection. Boud et al suggest that it is necessary to remove obstructive or negative feelings as only positive feelings are conducive to learning. However, I feel they place too much emphasis on rationality as the basis for learning when clearly feelings are so influential. The expression of such feelings is always cathartic. The issue is not so much removing them but accepting them as valid. Removing such feelings gives a strong message that they are unacceptable. Boud et al's conceptualising may relate to how their work constantly refers to geology students, where working with emotions within an explicit humanistic milieu is not a recognised aspect of work, and where decisions tend to be generally based on rationality. During the project, the majority of experiences shared in the supervision sessions were related to feelings of anxiety. In no sense did these feelings appear as obstructive to learning. Indeed, the contrary appeared true, that the sense of conflict created by these feelings was a rich learning milieu.

Figure 3.3
Boud et al model of reflection-on-experience

Returning to the experience	
Attending to feelings	
Re-evaluating the experience:	
- Association:	Is the connecting of the ideas and feelings which are part of the original experience and those which have occurred during reflection with existing knowledge and attitudes.
- Integration:	Association brings together ideas and feelings in an almost indiscriminant manner; integration begins the process of discrimination - seeking the nature of relationships and drawing conclusions and arriving at insights
- Validation:	Testing for internal consistency between our new appreciations and our existing knowledge and belief, and trying out our new perceptions in new situations
- Appropriation:	Taking on this new knowledge in a personal way and making it our own

Boud et al acknowledged the significance of Dewey's (1933) influence although, ironically, they believed that Dewey did not pay enough attention to the significance of feelings within the learning experience. Dewey (1933) considered reflective activity to be a process of sustained and consecutive ordering of the perceptions and connections of parts within experience over time, towards a rational solving of problems that have become the focus for reflection.

Boud et al described how they constructed their model as something the student can do for themselves, even though they note that the "learning process can be considerably accelerated by appropriate support" [p36] and that attending to feelings "can be assisted by being encouraged" [p37]. Left to their own resources, nurses may defend against uncomfortable feelings, rather than use such feelings as a positive learning opportunity [see chapter 6]. Emden (1991) reflecting on her own reflective practice, considered that the stages within

Boud et al's model were relevant yet didn't help her to reflect. She suggests that adhering to this model may be unhelpful because it encouraged her to fit experience into arbitrary stages rather than using the model creatively. This highlights the potential risk of all models because of their prescriptive nature. Boud et al assert that reflection "has the objective of making us ready for new experience. The outcome of reflection may include a new way of doing something." [p34]. In line with their defintion of reflection, I take this to mean a new way of *perceiving* doing something. Boud et al's conceptualising of reflective practice fails to create a sense of experience over time- where learning through experience can only be appropriated or assimilated through reflection on new experiences. Boyd and Fales (1983) similarly restrict their definition of reflection to new understandings -

"The *process* [their italics] of creating and clarifying the meaning of experience [present or past] in terms of self [self in relation to self and self in relation to the world]. The outcome of the process is changed conceptual perspective." (p101)

Hence, 'does reflection takes place if no 'changed perspective' occurs? Boyd and Fales developed their description of the reflective process from a mixture of personal reflection [in much the same way as Boud et al] and with analysing questionnaire and interview data with various groups of adult educators and counsellors. They discerned six stages of the reflective process. I have set out these out in figure 3.4 together with my interpretative comments based on my reflection on these reflective processes within the study. Boyd and Fales's sixth stage - 'deciding whether to act on the outcome of the reflective process' suggests a rational, mechanical and linear process that denies the subliminal and reflexive nature of learning through reflection.

Figure 3.4

My reflection-on Boyd and Fales (1983) stages of the reflective process

Sense of inner discomfort.	- It was this sense that prompted the practitioner to pay attention to experience.
Identification or clarification of the concern.	- the model of SR encourages the practitioner to identify key issues of concern within the experience.
Openness to new information from internal and external sources, with ability to observe and to take in from a variety of perspectives.	- Without guidance, practitioners struggled to 'see' these influencing factors, although the model of SR identified the need for the practitioner to focus on all sources of information.
Resolution, expressed as "integration", "coming together", "acceptance of self-reality" , and "creative synthesis".	- This could only be demonstrated in reflexive sense through subsequent experiences.
Establishing continuity of self, with past, present and future through changed experiences.	- This was evident with viewing reflection as a process over time.
Deciding whether to act on the outcome of the reflective process.	- All reflection was action-oriented and reflexively applied to future experiences.

The way Boud et al, and Boyd and Fales conceptualised reflection fails to acknowledge explicitly that any intention of reflection is to expose and transform the conditions under which people practice. In other words they generally accept the workplace as normative. And yet, they both acknowledge the work of Mezirow (1981). Mezirow identified 'levels' of reflectivity [figure 3.5]. The description of each is my interpretation. Mezirow suggests the idea of a continuum of reflection from consciousness through critical consciousness towards perspective transformation. This can be re-conceptualised as a process of deconstruction; peeling off layers of influencing factors until the conditions of practice [what is embedded in practice] and who the self is [what is embodied] are exposed and made available to critique and understanding as a pre-requisite to taking action to change these conditions and one's self. In this sense reflection enables practitioners to know and work towards changing those factors that have limited their achievement of desirable work (Kemmis 1985).

Figure 3.5

Mezirow's levels of reflectivity

<u>Consciousness</u>		
affective reflectivity	-	becoming aware of how we feel about things.
discriminant reflectivity	-	perceiving the relationships between things.
judgmental reflectivity	-	becoming aware of how we make value judgements.
<u>Critical consciousness</u>		
conceptual reflectivity	-	questioning the adequacy and morality of concepts.
psychic reflectivity	-	recognising one's own prejudices and the impact of these in judgement and action.
theoretical reflectivity	-	understanding self in context of desirable action.

Powell (1989) used Mezirow's levels of reflectivity as benchmarks to monitor the depth of reflection undertaken by a group of 12 practitioners on a post-registration diploma of nursing programme. Her results indicated that practitioners failed to reflect at the level of critical consciousness- the level of cultural-political processes which determined the conditions of practice. Powell's study provides useful evidence with which to confront an attitude that reflection *is* a natural everyday experience and hence requires no skill development. van Manen (1977) conceptualised reflection within three levels. The first level is concerned with the techniques and practices to produce certain results. At this level reflection is primarily a problem solving technology, characterised by asking 'how' questions. At the second level, reflection is conceptualised as a means to consider practice against guiding principles and beliefs, thus exposing the contradictions between theory/ beliefs with practice. This level is characterised by 'why' questions. The third level is to expose and critique how cultural-political processes had determined the conditions under which practice takes place. As with Mezirow's levels of reflectivity, van Manen's levels indicate the broad range of activity that can be described as reflection. van Manen's levels reflect practical intent as opposed to internalised processes. These theoretical approaches were useful to inform and frame my reflexive understanding of reflection-on-experience although, as Emden (1991) highlighted, these theoretical models lack attention to processes of reflection. The breaking down of learning into stages resembled the approach of supervision developmental models within psychotherapy. From a practical perspective this was unhelpful. The identification of arbitrary stages is an attempt to explain a process that is not amenable to such simple configurations. Reflection is holistic- it considers the whole, where aspects within the experience can only be viewed within the context of the whole, they exist in dialectical tension, and cannot be reduced into parts or stages. This wholeness and fluidity is reflected by Dewey (1933).

Dewey noted that

"The successive portions of a reflective thought [sense] grow out of one another and support one another; they do not come and go in medley. Each phase is a step from something to something- technically speaking, it is a *term* of thought. Each term leaves a deposit that is utilized in the next term. The stream or flow becomes a train or chain. There are in any reflective thought definite units that are linked together so that there is sustained movement to a common end." [p4/5 his emphasis - I have suggested the word 'sense' rather than Dewey's more disembodied and limiting concept of thought]

Reflection within the situation

Schön (1983, 1987) makes the distinction between reflection-on-experience and reflection-in-action. He describes 'reflection-in-action' as reflecting

"in the midst of action without interrupting it. Our thinking serves to reshape what we are doing while we are doing it." [p26].

This is a response to a surprise within the smooth running of activity. However, I would argue that is more than this. That it, in fact, represents a deep sensitivity to even the smooth running of activity, a constant monitoring of Self within the situation that ripples along the surface of conscious thought. Schön developed 'reflection-in-action' as a technique to coach practitioners to learn within the practical situation, reframing and solving problems as they unfold. Schön's notion of 'problem' can be equated with Heidegger's concept of breakdown', when the smooth flow of spontaneous intuitive performance is interrupted for some reason.

Heidegger noted that many breakdowns are like blips that the practitioner can sub-consciously adjust to. However larger breakdowns create a crisis within the experience. Schön acknowledges the significance of coaching within a 'practicum' that partially protects the practitioner from the reality of the situation. However this may also limit the potential to learn from the situation because it cannot re-create the tension and complexity of real practice. It is notable that Schön's exemplars *within practice* (1987) were focused on music and architecture. His exemplar concerned with developing counselling skills was restricted to classroom learning without any evidence of the impact that reflection-in-action in these settings made on everyday practice.

Casement (1985), in the context of his psychoanalysis practice, describes a sense of having an 'internal supervisor'. This is a simultaneous monitoring of self whilst in the situation enabling a conscious reaction and response to the dynamics being played out. Boyd and Fales (1983) highlight this phenomenon,

"Once individuals became more aware of their spontaneous reflective activity and its importance to them, they expressed interest in whether they could control their own process. The majority indicated that they had, in some way, attempted to manipulate their own reflective processes as a result of becoming aware of it." [p113]

Whilst I did not explicitly use reflection-in-action as a developmental process, the development of self awareness as a consequence of reflection-on-experience did lead to greater sensitivity of the self within practice.

Maud noted : *"At one point I did find myself 'sitting back and reflecting on what was happening - but it didn't last long, I was too involved... it probably helped me in that the situation. I would have reacted defensively if I hadn't reflected - it helped me get on top of myself."*

Structured reflective diaries

I initially encouraged practitioners to write their reflections in a diary. This activity would enable them to reflect on experience as an everyday activity, and to prepare for sharing an experience within the supervision session. Holly (1989) highlights the potential benefits of this activity

"Keeping a journal makes possible new ways of theorizing, reflecting on and coming to know one's self and one's profession.. writing taps tacit knowledge; it brings into awareness that which we sense but could not explain." [p71/75]

Keeping a diary is not emphasised as an essential reflective activity by other writers. Boud, Keogh and Walker (1985) note the significance of allocating "specific time aside for keeping a diary." [p26] Walker (1985) developed the concept of a reflective portfolio. He observed how -

"participants found that by noting important learning experiences, and by recording their reflection on them, they were much more aware of the growth taking place." [p65]

A number of studies have monitored the impact of reflective diaries within nursing curriculum. Richardson and Maltby (1995) claim that "diaries assisted students in the skills of reflection and learning" [p240]. They judged the students' reflective ability within Mezirow's levels of reflectivity (Mezirow 1981, Powell 1989) from evidence in the students' reflective diaries. The results suggested that the student respondents failed to reflect on a critical consciousness level, replicating Powell's findings.

Landeen, Byrne, and Brown (1995) claim that "journals can be a useful educational tool" [p884]. Neither of these studies involved facilitation of reflection, although Landeen, Byrne and Brown gave written feedback, and offered students broad guidelines to aid reflection. Within both these studies, keeping a reflective diary was a requisite part of an educational course. It is difficult to draw conclusions from these studies, although they do contribute to an impression that keeping a journal is generally helpful to aid reflection, but perhaps not as helpful as facilitation. Practitioners' experiences with keeping a reflective diary is a focus for reflection within chapter 8.

Constructing supervision dialogue

Dialogue is the conversation that took place within the supervision session between the supervisor and the practitioner. It consists of descriptions of experiences and 'connective conversation' - the language used to facilitate learning, to maintain the flow of supervision, and for developing and sustaining the supervision relationship. The supervisor listened and responded by picking up cues and drawing the practitioner's attention to emerging issues. Listening to the practitioner's experience offers the supervisor a constant number of cues to respond to.

Recording dialogue

My intention was to take adequate notes that captured the extent and meaning of the dialogue, using as much 'verbatim' as possible. On average, a set of session notes consisted of about 1500 words. I often audio-taped the dialogue to check the adequacy of my note-taking. These notes were either written up as a 'fair copy' or word-processed and the practitioner given a copy within 48 hours. The 'I' grade supervisors commented that recording detailed verbatim notes generally made listening and responding to what the practitioner was disclosing initially difficult. This was a new skill that had to be learnt. Audio-

taping session was more arduous because of the time it took to transcribe the tapes [at least 6 hours to transcribe 1 hour dialogue]. Guided reflection, to become a reality in busy practitioners everyday lives needed to be a meaningful yet practical activity. The notes served a number of purposes:

- To enable the practitioner to agree the content and meaning of the dialogue [face validity].
- To enable continuity of dialogue through sessions by picking-up issues from the previous session's dialogue.
- To enable the practitioner to further reflect on issues.
- To confront the practitioner with the issues that might otherwise have been defended against within the oral mode.
- To provide a record to enable the practitioner to 'look back' and make reflexive sense of their experiences/ work in guided reflection over time.
- To created the opportunity for the supervisor to reflect-on what had been shared within the dialogue and to highlight issues that might be useful to raise next session.

[the dynamics of these purposes are explored in chapter 9]

Constructing narratives

I decided to construct a narrative to illustrate each practitioner's reflexive journey through guided reflection in becoming effective practitioners, and how this journey was facilitated through guided reflection. This approach would highlight and respect the contextual nature and complexity of practitioners' lived experiences and the uniqueness of each guided reflection relationship. However, the individual narrative required a structure to adequately represent this work and enable comparisons to be made across the narratives as a whole. Spence (1982) noted how the 'narrative fit' is significantly enhanced by the discovery of a pattern match. Pattern, as ways of understanding practitioners' experience as it emerged through my continual process of

analysis, came to influence how I listened to and interpreted subsequent shared experience. However, listening from a reflective stance is always intuitive informed by formal structures. Spence (1982) made the distinction between 'formal interpretation' and 'unwitting interpretation':

Formal interpretation	Unwitting interpretation
Owes much of its power to its linguistic structure - designed to be expressed in language in order that it can be made visible to the supervisee and produce a response; and in order that it can be eventually tested for narrative fit in the larger story of the supervisee's life.	Tends to operate in the margin of awareness, guiding the supervisor as he listens and helping him to make sense out of [and sometimes distort] the supervisee's utterances. He is only rarely aware of these interpretations in any explicit sense. [p138]

This unwitting or intuitive interpretation is the *art* of guided reflection, the creative response that grasps at some idea prompted by some cue, and bringing this into the formal interpretation mode that gives guided reflection its necessary yet reflexive structure.

Nursing phenomena

I analysed the first supervision dialogue [Gill's] using a methodical line by line coding, seeking and labelling phenomena. I then sought meaningful relationships between phenomena to construct a set of categories that offered an adequate construction of the whole experience. I labelled these categories as 'learning domains'. Giorgi (1985) writes of

> "a 'free imaginative variation' in order to discover what meanings must necessarily belong to the phenomenon in order for it to be a phenomenon of a certain type". [p47]

Being essentially a psychologist, Giorgi's concern was with 'psychological' phenomena which he distinguished from say 'anthropological' and 'sociological' phenomena. It challenged me to consider - 'what type of phenomena do I search for?' The answer was 'nursing phenomena' - where the psychological, the sociological, the anthropological, etc. are transcended through application to specific practice situations. The adequacy of the learning domains was constantly tested within the construction of subsequent individual narratives. The result was a reflexive growth of understanding through subsequent narrative constructions, as each subsequent narrative was built on the understanding of the previous narratives. I was concerned that constructing the individual narrative through learning domains would diminish the inter-subjective dynamics, and with it, its adequacy as an account (Spence 1982). My concern was unfounded because each narrative stood alone as a moment in time, although connected with previous and subsequent narratives. The imposed structure was merely a means of making sense of the complexity of practitioner's experiences that would help readers make sense of the work and enable comparison with their own practice. As Benner, Tanner and Chesla (1992) noted from their work in analysing narratives of expert practice that the

> "clinical world does have commonalties and patterns as a result of shared clinical wisdom and experience" [p27].

This was important in considering the purpose of the narratives to inform others' practice. Narrative is persuasive because it can accommodate contradictory experience and the complexity of experience. The more comprehensive, coherent, and self-consistent the narrative is constructed, the more adequate the explanation becomes both for the practitioner and the reader. Robinson and Hawpe (1986) note:

"In order to perceive order and recognize repetition and similarity we must go beyond the surface features in dealing with the world of concrete objects and human social interactions. A story provides the right balance between uniqueness and universality. Because stories are contextualised accounts they can convey the particularity of any episode. But because they are built upon a generic set of categories and relationships each story resembles other stories to varying degrees. A sense of familiarity is the result of this underlying similarity." [p113/4]

The extent of the similarity between practitioners' narratives became evident when Leslie thought I had used his and Karen's experiences in a journal paper. In fact this paper had been based on Jade and Myrna's work! The challenge was then not to de-contextualise and reduce experience into categories, but to construct a structure through which experience can be most meaningfully communicated, whereby the meaning of experience from the practitioners' viewpoints could be heard. The structure was not static or immutable, it was a reflexive structure, responding to new interpretations that emerged from the constant dialectical process of deconstructing shared experiences and constructing coherent narrative form whereby the practitioners' learning remained at the centre of the narrative (Giorgi 1985, van Manen 1990).

Time/space considerations

The dialogue within each learning domain was ordered through the progression of the sessions emphasising the connections between the past and the future to create a temporal flow through the constructed narrative. Smith (1987) noted how:

" narrative attempts to put actions into some sort of temporal sequence. To avoid seeing events as isolated situations "sectioned of" from other events - both past and future." [p118]

I identified two ways to organise the temporal flow. The first approach was to construct sub-narratives grounded in each learning domain. This approach was developed from Gill's initial narrative and was used to construct all the narratives except Abbi's. The alternative approach was to integrate the learning domains within a temporal unfolding of each session. In this second approach, the 'learning domains' became threads running through the narrative rather than separated as sub-narratives. This session by session approach gave a more visual picture of the practitioner's whole experience within guided reflection unfolding over time. Contrasting the two approaches, Jane preferred the sub-narrative approach [as used within Jeanne's narrative]. Jane felt the integrated approach fragmented the flow of development through each learning domain. The risk of the sub-narrative approach is that the learning domains would be seen as separate entities rather than as inter-related elements in dynamic tension within experience. This difficulty was apparent as I tried to use 'bits' of dialogue to support bits of learning domain. On reflection, I do not think the sub-narrative adequately portrayed the practitioner's experience as well as the integrated narrative. For this reason, I reconstructed Pru's narrative into this format for inclusion within the thesis [chapter 4]. Paget (1983) noted

"An exchange cannot be severed from the shared historical understanding which it pre-supposes without radically shattering its meanings. An exchange contains the meanings of what has already been said.... isolating an exchange from its antecedents, those exchanges which already occurred and are pre-supposed, shatters a discourse process and undermines the unfolding complex and multi- meaninged construction of experience." [p79]

Paget led me to recognise the need to use substantial dialogue to support 'proof' of practitioner development in order to portray the subtlety,

complexity, context and subjectivity of experience. As I constructed each subsequent narrative, I used more and more dialogue until approximately 60% of the narrative was actual supervision dialogue. The supervision dialogue best captured the spirit of the work rather than the language of interpretation "that flatten rather than deepen our understanding of human life" (van Manen 1990 p17). Because much of the supervision dialogue was led by the practitioner, it seemed 'natural' to use dialogue as the primary source of description (Agar and Hobbs 1982). Using supervision dialogue as central to the narrative construction inevitably incorporated the feelings, goals, needs, and values of the people who created it (Robinson and Hawpe 1986). These were always implicit within the supervision dialogue. The researcher makes explict the significant issues within the dialogue and fashions these fragments into a whole whose integrity is in its presentation in narrative form (Gergen and Gergen 1986). This is important to counter the domination of the researcher's interpretation and creation of the narrative form. This point is fundamental considering the empowering intent of guided reflection. Each individual narrative constituted between 10,000- 30,000 words.

'Patterns of knowing' meta-narrative

The purpose of constructing a meta-analysis of the individual narratives was to understand and illuminate the nature of desirable and effective work, structured through the 'being available' template. The 'being available' template was the last constructed reflexive framework to adequately represent the work. It consists of dimensions of knowing that influence the extent the practitioner is available to work with the patient and family [see chapter 4 for a discussion of this construction].

Dynamics of Guiding reflection meta-narrative

I constructed a second meta -narrative based on analysing the process of guided reflection within each guided reflection relationship. Whilst no individual narratives were constructed of these supervision relationships, the dialogue illuminated the process of guiding reflection. My intention was to understand those dynamics within guided reflection that enhanced or constrained the developmental process. I had recognised early on within the work how therapeutic work within guided reflection paralleled therapeutic work within clinical practice. Based on this insight, I utilised the 'being available' template to structure both the meta-analysis of desirable and effective work and the process of achieving this through guided reflection. In this way, the parallel nature of work within clinical practice and guided reflection was made explicit.

Coherence

"It is story and only story that conveys truth" (Krysl 1991)

It is important within any research project that the findings can be acknowledged as valid or coherent. Reason and Rowan (1981b) note the significance of *coherence* for validity in new paradigm research

"We are drawing from a number of sources to put together a coherent statement about the principles and practices which lead towards more valid inquiry within the new research paradigm." [p239].

The issues I have paid attention to lead to a coherent narrative. This is like the hermeneutic cycle, concerned with an ever increasing understanding of the text based on an oscillation between the parts and the whole. Hence coherence will always portray this understanding justified and supported by evidence. However, the unique experience of guided reflection means that the 'results'

from this type of study cannot be 'replicated' (Madison 1988, Packer and Addison 1989). Whilst reflective activity is widely espoused as essential to effective professional education, its process and efficacy are not well known. Smith and Hatton (1992) comment, from their literature review, that

"no research study has yet demonstrated either the effectiveness of strategies to produce reflection or that student professionals who engage in reflective activity during their professional education necessarily become more effective professional practitioners." [p 1]

I am not aware that this situation has altered since 1992. Perhaps one reason for this state of affairs is the failure to design research studies congruent with the processes and outcomes of learning through reflection. Yet, Smith and Hatton's challenge is not necessarily answered with a claim to reflexivity because it begs a further question as to what constitutes valid evidence. Within a collaborative research process where the research method was also the developmental method and the role of researcher was also the teacher, two levels of coherence are significant to pay attention to:

i] ***The coherence of collaboration*** - how coherence is reflected in the congruence between research methods and developmental methods.
ii] ***The coherence of process with outcome-*** - how coherence is reflected in the congruence between learning method and what is intended to be learnt.

The coherence of collaboration

For the research to be coherent as a whole, there needed to be congruence between the process of research and the process of development. In breaking down coherence into dialectical parts, Reason and Rowan expand a view of *truth* in terms of *perspectivee*, a dialectical concept that bridges the traditional

dichotomy between objective and subjective. Perspective is significant within a constructivist view of the world that knowledge and truth are created rather than discovered as a result of complicated discursive practices (Schwandt 1994). Schwandt noting this position assumes

"we invent concepts, models , and schemes to make sense of experience and , further, we continually test and modify these constructions in the light of new experience." [p125].

In other words, the truth is not 'out there' as some objective reality that the personal notion of truth must be judged against to qualify as the truth. Neither is it simply subjective, because people are not isolated. They exist in communities where some common understanding of what counts as truth is adhered to. The practitioner's perspective was personal, contextual and specific in time, always changing in light of new experience within the temporal framework of reflexivity. The supervisor represents the objective, always helping the practitioner to see self in context of the whole. The two reflexive perspectives of the supervisor and the practitioner were constantly being fused in co-creating meaning - the fundamental nature of dialogue (Gadamer 1975). Central to perspective is the meaning of 'working with'; how guided reflection was conducted in an interactive, dialogic manner, where meaning was negotiated through "free and open dialogue" (Elliott 1989), so that agreement as to what would count as a more truthful description of work-life can be reached (Kushner and Norris 1980-81, Lather 1986a). In practice this was achieved to the extent that practitioners felt empowered to feel involved in this process and the extent supervisors actually engaged them in this process.
I am conscious of a challenge that what practitioners say they do corresponds with what they actually do. Practitioners shared what they say they did with people who knew their practice well over a considerable period of time, within

a dialogue where understanding was co-created. The focus of the dialogue is contradiction, or put another way, exposing the tension between subjective and objective self.

The coherence of process with outcome

I assume that congruence between guided reflection as a developmental process with the practitioners' beliefs about the nature of desirable practice is significant. The congruence is stronger where the researcher's and practitioner's beliefs are made explicit and acknowledged to be compatible. Where the nature of 'desirable' is not agreed, it poses the problem of who's beliefs or personal interests set the agenda, and creates the potential dissonance of goals that ultimately interferes with collaboration. It follows that learning which intends to develop humanistic caring practices [as espoused within the Windrush philosophy for practice- see figure 1.1] is necessarily an humanistic process. This congruence is made explicit by analysing the outcomes of guided reflection and the process of guiding reflection within the same analytical framework. The congruence can be ascertained by reflecting on the intentions and processes of guided reflection within the characteristics of humanistic learning as established by Carl Rogers (1969). See Table 3.3.

Table 3.3

Humanistic characteristics [Rogers 1969]	Coherence with Guided Reflection
'Human beings have a natural potentiality for learning.'	Rogers notes how human beings are curious about their world unless this curiosity is blunted by their educational experiences. Fay (1987) noted the significance of curiosity as pre-requisite for reflection. Without curiosity the nurse has no need to pay attention to experience except perhaps to rationalise discomfort. And yet reflection, by its very nature, encourages curiosity. Rogers note how students are ambivalent about learning because significant learning involves a certain amount of pain, either pain connected with learning itself or distress connected with giving up certain previous learning. Rogers illustrates this ambivalence by the small child who is learning to walk. He stumbles, he falls, he hurts himself. It is a painful process. Yet, the satisfaction of developing his potential *far outweigh* the bumps and bruises. Reflection on experience by nurses was often on painful and distressing situations. Yet the realisation of caring within everyday practice was profoundly satisfying.

Rogers suggests that this ambivalence is managed positively through commitment and the achievement of satisfaction. This commitment is central to both nursing work and learning through reflection . A second type of ambivalence may reside in the challenge to the validity of the practitioner's held beliefs and values. Rogers notes: "Learning which involves a change in self- organisation in the perception of oneself is threatening and tends to be resisted." The practitioner will be ambivalent at the perceived threat to having one's sense of competence exposed, and the recognition that previous ways of coping are no longer congruent with desirable practice.

Significant learning takes place when the subject matter is perceived by the learner as having relevance for her/ his own purposes. '

Reflection enables practitioners to pay attention to those things that matter to them. This is given greater significance by adult learning theory (Knowles 1980) that adults are ready to learn material relevant to their life situation.

Those learnings which are threatening to the self are more easily perceived and assimilated when external threats are at a minimum.

This principle reflects how the supervisor needs to respond to the practitioner in ways that minimises threat. This includes the supervisor being aware of their own prejudices and not oppressing the practitioner into some conformity but recognising and valuing the practitioner's own viewpoints. This is a powerful parallel process for practitioners working with patients.

Much significant learning is acquired through doing.

Reflection is grounded in the practitioners' lived experiences whilst anticipating new experiences. It is this real world of practice that becomes the learning milieu whereby new insights and new ways of acting can applied and tested through future actions.

Learning is facilitated when the student participates responsibly in the learning process.

Rogers notes: "When he chooses his own directions, helps to discover his own learning resources, formulates his own problems, decides his own course of action, lives with the consequences of these choices, then significant learning is maximised."

The growth of the practitioner to accept responsibility is an explicit aim of guided reflection which includes the responsibility for self-development and monitoring their own performance.

Self-initiated learning which involves the whole person of the learner- feelings as well as intellect - is the most lasting and pervasive.

This acknowledges how learning through guided reflection is fundamentally holistic. The notion of involvement reflects how the practitioner is engaged within the learning experience because it is grounded in 'who they are' rather than in detached ways. Dreyfus and Dreyfus (1986) noted how the development of expert skill acquisition involved the : "Passage from detached observer, standing outside the situation, to one of a position of involvement, fully engaged in the situation" (cited in Benner, Tanner, and Chesla 1992)

The most socially useful learning in the modern world is the learning of the process of learning, a continuing openness to experience and incorporation into oneself of the process of change.

Reflection on experience is a process of learning that becomes embodied within self as a way of seeing and responding to the world. Reflection always anticipates future experiences with a reflexive process.

Guided reflection is a change method grounded in collaborative change theory. Indeed the study could be re-titled 'the management of change through guided reflection'.

'Validity' themes

Lather (1986a, b), in exploring issues of validity in open ideological research, re- conceptualised the criteria for validity acknowledged in traditional research [as outlined in Reason and Rowan 1981c]. She identified four key criteria:

- Face validity.
- Triangulation.
- Construct validity.
- Catalytic validity.

Lather doesn't claim these criteria in a prescriptive sense. Indeed in a later paper (1993) she distances herself from being seen as prescriptive. She tentatively offers them and measures them against comparative examples from feminist, neo-Marxist critical ethnography, and Freirian empowering research. Lather felt these criteria best 'fitted' empowering type research, "openly committed to a more just social order" [p66]. The explicit focus on shared vision, collegial working, working with patients and families, and creating and sustaining conditions where being available is possible, all point towards a more just social order - to liberate nurses from oppressive conditions to know and fulfil their therapeutic potential.

Catalytic validity

Catalytic validity is concerned with how the practitioners came to see themselves as changed people within an understanding of what they felt their concerns to be, recognised through the reflexive coherence of the narrative (Agar and Hobbs 1982). This requires the narrative to represent adequately what took place without textual distortion. As Steele (1986) notes :

"All narratives leave out people, events, or ideas which if included would cast doubt on the truth of the theory being expounded or the story being told. Textual distortion by omission of relevant data is difficult to see when reading a work because

there are only often obscure signs in the text that point to what is missing from it."

[p262]

As Steele notes, 'textual distortion' is difficult for the reader to perceive and perhaps can only be challenged through a reflective scepticism. Are the 'results' well founded in and consistent with the dialogue? Are the results systematically connected within a coherent sense of the whole ? Where research intends to be empowering, then clearly the construction of the narrative that represents the practitioners' experiences must have been negotiated as a continuous process, not just at the end, when the account has largely been formulated.

Face validity

One test of the truth of critical theory is the considered reaction by those for whom is it supposed to be emancipatory (Fay 1987). In practice, the practitioners confirmed the adequacy of supervision dialogue:

Gayle [S5] :*"The notes reflected very much what we talked through"*

Rona [S2] :*"I thought the notes were okay .."*

This confirmation by practitioners shouldn't be a surprise for them because of the reflexive nature of guided reflection. Within any experience there are many interpretations depending on where one is looking from. Hence the importance of negotiating meaning rather than imposing one particular interpretation. Points of discrepancy were discussed and mutually agreed. Only on a very few points was there failure to co-create meaning. Reason and Rowan (1981b) note

"Good research at the non-alienating end of the spectrum... goes back to the subject with the tentative results , and refines them in the light of the subjects' reactions." [p248]

The notion of working with practitioners in co-creating meaning forced me to examine my own values, assumptions, and motivations to monitor how they affect supervision dialogue and interpretation of findings *as a transparent process*. Beckett (1969) reinforced this point

"We can try to see that these transference feelings are examined within the context of the working alliance." [p177]

'Who I was' was visible within dialogue . However this is limited in comparison with the 'I' grade supervisors who became very visible within their supervision with me. Looking back it is remarkably difficult to be certain of one's own openness and authenticity even though I felt completely open and authentic. In advocating guided reflection as a research method, I would insist the research supervision paralleled guided reflection.

Being seen to be heard

Acker, Barry and Esseveld (1983) highlight how the conditions of 'adequacy' are met through the voices of the women participating in the research being actively heard within the text. Hall and Stevens (1991) note that the active voices of participants is enhanced

"by using their language to describe phenomenon and create theory, and by presenting their verbatim stories to illustrate analytical arguments." [p 26].

The use of dialogue within the narrative enabled the co-creation of meaning to be visible.

Replication and retrospection

Narratives are unique and obviously cannot be replicated under similar conditions (Robinson and Hawpe 1986). Retrospection can be viewed as a process of "testing the continued validity of life experience stories" (Robinson and Hawpe 1986 p124). This building on experience through sessions is central to reflexive development and is visible within changing descriptions that practitioners recognised as their own.

Reading the text - completing the narrative

The ultimate test of coherence lies with the reader - the extent to which the reader is able to relate to the text. The art of reading texts, or hermeneutics, is dialogue - the engagement between text and reader, other and self in coming to a mutual understanding or clarifying disagreement. The readers [as interpreters] will approach these narratives with their own horizons, and whilst they may not share my interpretations, they should be able to make sense of it. Gadamer (1975) expressed the hermeneutic belief that the reader projects, in advance, a sense of the whole as soon as an initial sense appears. This is because the reader brings to this text a viewpoint on what to expect from the text, i.e. his or her own meanings and experiences with the world. This position assumes

"the audience is not composed of isolated, passive consumers of social spectacle but is in a position to use this work as a resource, critically appropriating aspects of it to help them to clarify the basis of everyday life and the possibilities for its transformation." (Simon and Dippo, 1986 p 199).

This position reflects the perspective of the reflective practitioner, in that all extant knowledge, whatever its nature, needs to be interpreted for its value to apply within the specific situation. The text offers examples based on concrete

experience rather than rules to be followed. As Read (1983) has shown, people appear to relate more easily to examples, particularly within complex situations, than following a set of rules. It doesn't matter which characteristics are unique and which are general within the reflective perspective. Generalisation can never be an intention of empowering research.

Monitoring effectiveness

Becoming an effective practitioner can be monitored by the extent to which desirable work is achieved. The emphasis on *becoming* indicates that this is always a process rather than an end-point. Whilst the development of de-contextualised 'patterns of knowing' as representing the dimensions of desirable work gives the concept of *becoming effective* substance, being effective was always a judgement within the specific clinical experience. The individual narratives illustrate the reflexive development of the practitioners becoming effective over time together with the barriers that limited this achievement. This was the essential source of evidence to judge the efficacy of guided reflection to achieve its intention. Newell (1994) draws attention to the gap of perceptions between what practitioners perceive and clients' own perceptions, indicating that practitioner accounts are not a good measure of monitoring changed practice, and how this can only really be fathomed with studies that reflect client's perceptions. Newell asserts this is all the more important considering the claims being made for reflection in the absence of empirical support. It would have been difficult to respond to Newell's challenge within the scope of this study. However, Newell's did not substantiate his scepticism about the ability of practitioner accounts to accurately chart change in practice.

Reflective reviews

An alternative method of constructing individual narratives was to ask the practitioner to write their own narrative as a 'Reflective Review'. This offered a dynamic approach to performance review grounded in the practitioner's own reflective perceptions of their performance and development of effectiveness. This approach enabled the practitioner to identify key areas of work that have been the focus for reflection and to make a judgement, supported by empirical experience, of their development. The structure of Reflective Reviews was initially adapted from the Model of Structured Reflection. Subsequently this became structured through learning domains.

The reviews offer a practitioner perspective on the narratives that:

- Enabled the practitioner to 'look back' and analyse her/ his reflections over time to determine growth of effectiveness in specific areas of practice and factors that have limited this growth.
- Reinforced how reflection was a process over time, as opposed to being individual acts of reflection or isolated supervision sessions.
- Integrated guided reflection into the organisation - in ways that reinforce the practitioner's responsibility for monitoring effectiveness.
- Institutionalised the 'judgement' role of the supervisor but in ways that the practitioner is able to control.
- Created the opportunity to negotiate future expectations / other educational opportunities to develop strengths/ enhance weaknesses.
- Gave feedback as to the efficacy of guided reflection.

Development of monitoring tools

During the course of the study, I developed a number of monitoring tools as 'reflective windows' to enable practitioners to get feedback on discrete aspects of the developmental process. Lather (1986b) noted that different sources of data, multiple methods and convergence, and multiple theoretical schemes are

useful triangulation to enhance the validity of new paradigm research. However, triangulation within this study could only ever be an illusion, offering no more than ironic contrast to the narratives. However this understanding does not diminish the value of heuristic devices as the means to get feedback and to help make sense of emerging issues. These tools are outlined in chapter 9 within a discussion of 'framing the development of effectiveness'.

Supervision monitoring scales

I constructed a number of tools to enable the practitioner to get feedback on their supervision, and give feedback to the supervisor as to the efficacy of guided reflection in terms of both the process of supervision and the outcomes in terms of practice. The practitioners were asked to complete these tools on termination of their involvement within the study [although not necessarily their termination within guided reflection].

- Helping styles inventory [HSI].
- Hawkins & Shohet questionnaire.
- Supervision evaluation questionnaire [SEQ].
- Adapted Bernard Supervisor Rating Scale.

Helping styles inventory [HSI]

The learning style inventory developed by Cherniss and Egnatios (1978) [see Appendix 1] was adapted for practitioners to reflect on the extent their preferred learning style was matched by received supervision style.

Hawkins & Shohet questionnaire

This questionnaire was constructed from the set of questions offered by Hawkins and Shohet (1989 p 30) to help supervisees "consider ways of being more pro-active about their support and supervision" [p30]. I used it to help Gill

reflect-on and evaluate her supervision with me. Gill felt the questions helped her to think about her role within supervision. However, this tool was discontinued with the development of the SEQ. Gill's completed questionnaire is shown in Appendix 4.a.

Supervision evaluation questionnaire [SEQ]

This questionnaire was constructed from analysing the dynamics of Gill's guided reflection informed by the literature on supervision.[3] Its purpose was to help the practitioner reflect and evaluate her own supervision towards constructing more effective supervision. Based on this work with Gill, I developed a revised edition to use with the subsequent practitioners. Practitioners' comments and ratings have been used in the main text to illustrate and support key points [marked SEQ]. I felt the qualitative comments were more insightful than the actual ratings. These comments give a useful evaluative perspective in the practitioners' own words. Gayle's complete response to the SEQ is shown in Appendix 4b. I have also included a complete list of ratings in Table A4.1 to enable a comparison of practitioners' ratings. Table A4.2 shows practitioners' responses to SEQ questions related specifically to the supervision process.

Adapted Bernard Supervisor Rating Scale

This rating scale was adapted from Bernard (1981 revised) [cited in Borders and Leddick, 1987]. My adaptation was to extend the number of items to match emergent dynamics from the study and to change other items in terms of relevance and wording. As with the SEQ, it enabled the practitioner to reflect on her supervision by rating a number of key dynamics. Its intention was to give feedback to the supervisor. I have included Pru's completed scale [Appendix 4c]. The ratings [Table A4.3 - Appendix 4] quite accurately portray

[3] The SEQ was revised in January 1992 following the analysis of Jade's and Myrna's guided reflection. The revised SEQ was used for the remainder of the project.

the narrative impression of what constituted a good supervision experience for the practitioner. These ratings also correlate reasonably well with ratings using the SEQ [see Table A4.4- appendix 4]. As such, it may offer some indication of what constitutes inadequate, adequate, good and excellent supervision.

Summary

As the project unfolded, the method used to collect data, and the framework to understand process and outcomes, and adequate/ coherent means of reporting this data were reflexively developed through the juxtaposition of reflection-on the experience of these ideas in practice within a continuous search of an appropriate literature. This reflexive development is congruent with the principles of collaborative research, to actively involve the practitioner within the study design.

Chapter 4
Developing the individual narrative

The first part of this chapter is an outline of the reflexive development of the interpretative framework which is used to structure the individual narratives. This work culminated in the 'being available' framework. The second part is Pru's narrative. This is an example of the 15 individual narratives constructed during the course of the study.

Development of the 'Learning domains'

My analysis of the dialogue within Gill's supervision led to a construction of a learning domain framework to frame Gill's development towards becoming an effective practitioner [figure 4.1]. This framework was re-conceptualised through my relationships with Jade and Myrna [Figure 4.2]. The categories in figure 4.2 mark out more explicitly the developmental flow from knowing Self in becoming patient centred, to using Self in working with patient and families, to considering the context of practice responsibility and support.

The subsequent work with Karen, Leslie and Gayle led to new understandings which resulted in collapsing the learning domains into a framework consisting of three 'patterns of knowing' -

- Working with patients and families.
- Working with colleagues.
- Coping with work in congruent ways that sustain therapeutic work.

This framework integrated the learning domain of 'becoming patient centred' within each pattern of knowing and acknowledged the significance of the parallel caring process of working with patients and families, and working

Figure 4.1

Initial learning domains [Gill's narrative]

C1 Accepting responsibility for care
- .1 Becoming patient centred
- .2 Developing competence
- .3 Becoming involved
- .4 Accepting accountability for care

C2 Carrying out responsibility for work
- .1 Breaking free from hierarchy
- .2 Making good impressions
- .3 Giving feedback ["noses out of joint"]
- .4 Being assertive

C3 Relationships with primary nurses
- .1 Role models
- .2 Being 'pushed out'
- .3 Being acknowledged

C4 Coping with work
- .1 Dealing with stress
- .2 Getting support

Figure 4.2

Learning domains [Jade and Myrna's narrative]

1) Becoming patient centred

- Work that aims to liberate the practitioner from previous learnt norms that emerged as barriers to achieving effective work and moving towards new norms compatible with achieving effective work.

2) Therapeutic work with patients and families
   - Effective and ethical decision making;
   - Becoming involved with patients;
   - Nursing interventions.

3) Giving and receiving feedback

An essential element of the primary nurse's role is being able to give feedback to other workers as necessary to fulfil role responsibility in achieving desirable work and to actively seek and positively accept valid feedback to ensure the practitioners' actions are effective.

4) Coping with work in ways compatible with achieving desirable work.

with colleagues. These two processes intertwined and complimented each other.

Being available framework

The 'being available' framework reflected a conceptual shift in seeing the nature of effective practice. This framework is centred in the core therapeutic activity of the practitioner being available to work with patients and families towards meeting their health needs. This understanding places the individual practitioner firmly at the centre of events. This is not novel. Indeed, it has been widely accepted as central to nursing. For example, Benner and Wrubel (1989) note

"The ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the basis of nursing as a caring practice." [p13].

The dimensions of being available

I explicated a number of elements [Figure 4.3] that influenced the extent the practitioner was able to be available to work with patients and families to help them meet their health needs. Threaded through these elements is the practitioner's sense of 'knowing self'. Knowing self' acknowledges that 'who the practitioner is' was the fundamental irreducible source of therapeutic potential. In every experience the practitioner could only speak from the self. Hence the self was ever present, being exposed and confronted for the self's congruence with desirable work. 'Knowing self' included the beliefs, attitudes, feelings, commitment, as well as embodied ways of viewing, relating and organising how everyday practice is perceived. As Jade noted: *"Supervision helped me to understand myself, my insecurities. It has also enabled me to receive positive feedback and helped me to begin to increase my self-esteem. I believe these*

things had to happen before I could focus too closely on relationships with patients. Now - I feel strong enough to do this." [SEQ]

Figure 4.3

The elements that influenced the extent the practitioner was available

- Knowing what is desirable practice;
- Concern for the patient;
- Knowing the patient;
- Being able to respond to clinical situations with appropriate and skilled action;
- Managing the involvement of Self within relationships;
- Creating and sustaining an environment where being available was possible.

Pru 's narrative

Pru's narrative is an example of the work that took place within a guided reflection relationship. It provides a contextual illustration of the 'being available' framework which is used to interpret the supervision dialogue, and to gain a sense of the reflexive nature of development. It also illustrates the process of guiding reflection through the sessions. Pru is an experienced district nurse. Maud is her 'I' grade line manager. Their work within guided reflection spanned 15 sessions over 10 months. During this time Maud also had 11 supervision sessions with me. Although the narrative is edited, it is still presented in considerable detail in order to portray the richness and detail of dialogue that took place. The narrative was originally constructed chronologically through each of the [previously noted] levels of knowing -

- Working with patients and families.
- Working with colleagues.

- Coping with work in congruent ways that sustain therapeutic work.

I have re-constructed the narrative chronologically through each session, using the 'being available' framework to interpret Pru's reflexive growth in achieving effective practice and the factors that limited this. The primary focus is therefore on working with patients and families [to achieve desirable work]. Working with colleagues and coping with work become part of creating the conditions where being available is possible. Guided reflection itself becomes part of these conditions.

Session 1 [8 October, 1991]

Maud: *"Shall we work through the guidelines that CJ has drawn up in order to focus our thoughts on drawing up a contract?"*

Pru: *"Yes. I see the purpose of supervision as being a constructive way of reviewing my work. By discussing it with someone it will help me to work things through and look back on things I've done."*

Maud: *"Do you think that will help you?"*

Pru: *"Definitely. Particularly if someone bounces things back to me and says - 'why?' - you've got to give a clear answer then."*

Maud: *"Gosh, I'm finding it hard to write all this down whilst you are talking. I'm not use to note taking. Also I don't like not being able to look at you... I feel I'm not giving you my full attention."*

Pru: *"It doesn't worry me- its not putting me off."*

Maud: *"Maybe Ill try a tape recorder next session. How do you feel about that?"*

Pru: *"OK, but who will transcribe the tapes?"*

Maud: *"I will. "*

Pru: *"CJ was saying that the sessions should come from us - that I should actually control the input."*

Maud: *"Are you happy with that?"*

Pru: *"Yes, I think so. I feel its up to me what I should be reflecting on. The more I put into it, and if I'm honest with you, then I'll benefit. You'll benefit too."*

Maud: *"I must point out Pru that sometimes I can be very direct. I feel it fair to warn you because some people can see it as threatening. Once when I was on a counselling workshop we had to role play. After my attempt at feedback - several people commented on my direct approach. It was a real growth point for me."*

Pru: *"One of my patients once commented on the nurse that had visited before, who had asked a lot of questions. I know from what she said that it was you. CJ said that the supervisor's role was a lot of counselling- that's something we all do to a lesser or greater extent."*

Maud: *"Do you see that you will be keeping a reflective diary?"*

Pru: *"Yes, but I haven't thought about that yet. I think that using a diary is a good way of picking up topics. I keep a form of diary now. I sometimes write 'bad day' across a page! I might never look at it again but that's enough for me, I got rid of it."*

Maud: *"Going back to note taking. I'll try and write them up within 24 hours or otherwise I can see it'll be hopeless- I'll forget what my scribbles are! "*

Pru: *"Notes at the beginning of each session will help us. CJ talked about why he thought the manager was appropriate to supervise rather than a colleague. We talked about things being confidential between us."*

Maud: *"Yes, one thing I've thought about is how you might feel about sharing things with Leah, my job share?"*

Pru: *"I don't mind. Hopefully there will be nothing that I don't want shared, but are you still in your manager's role if you feel the need to share? "*

Maud: *"I'll tell you what - shall we agree that I won't discuss the content of our meetings with Leah - there probably is no need to anyway, unless there is mutual agreement?"*

Pru: *"Yes, then you won't be here as a manager."*

Maud: *"We must address the issue though of a situation arising whereby I need to put my manager's hat on and take a matter further - if you hit a patient or admitted stealing something. I couldn't just let it go. Do you understand that?"*

Pru: *"Yes, but it could be said that I told you in confidence?"*

Maud: *"I feel very uneasy though not being able to do something. How about if we use the professional code of conduct as our base line. If either one of us feels that the other has broken that code then we will discuss what action we need to take?"*

Pru: *"That sounds okay."*

Maud: *"What about having a responsibility about the time and length of the sessions? Shall we keep it to one hour every two weeks? Let's plan the next date now. Did CJ mention to you the length of time he saw supervision going on for?"*

Pru: *"Really as long as both people felt appropriate for. He felt one year was a minimum for his research purposes. We may feel the need of change of person - or we may get into a trap of enjoying the sessions and they end up as a chit-chat!"*

Maud: *"Yes. We will have to monitor that."*

Session 2 [14 October, 1991]

Pru commenced: *"I've got to be honest. Its been chaos and I haven't had time to think or breathe! Let me run through my diary to remind me of things... I know one good thing that's happened. Mrs Plate's leg ulcer has healed. Do you remember them?"*

Maud: *"Yes I do.. lets talk about them. How long have they been going on?"*

Mrs Plate

Pru: *"Two years or so. I picked it up last September. The nurse said - 'You'll never get them healed, you'll think your about to, when they break down again.' We visited daily for two months. I decided to change her treatment to 'granuflex' but she was very unhappy about that. It had been used before with disastrous results, everything got soaked, shoes, the lot, so she had a very negative attitude about 'granuflex' and didn't*

want it. I asked Eva [wound care specialist] to come in and advise me. I gave it as long as I could but I felt that she hated it and the cost was prohibitive. I went back to saline soak and 'jelonet'. We reduced the visits to alternative days, she didn't like that, but it was getting drier and smaller. She was taking 'co-proxamol' for pain - we mentioned how much she was taking and came to some arrangement that for it to heal she would have to put up with some pain. We noticed she was taking less pain killers as weeks went by."

Maud challenged Pru to look beyond the actual wound dressing regime to consider the whole person, in particular the patient's diet.

Pru: "*I got the GP to visit which was good because he considered that her diet maybe a problem and he started her on vitamin C."*

Maud challenged Pru's wound assessment: *"Did you consider taking photographs?"*

Pru: *"We didn't get around to taking any unfortunately - we did drawings and measurements of it... I promised the patient that we wouldn't let the centre of the wound break down, as it had in the past, and how it eventually did."*

Maud: *"How did it make you feel having promised again knowing you might not be able to prevent it? How would she have felt?"*

Pru: *"She'd have been disappointed but I think she now trusts us enough and our relationship is good - I wouldn't do it again though..."*

Maud helped Pru to see how promises or glib reassurances can be quite damaging to relationships if they fail. This was particular apposite for Mrs Plate as Pru needed to persuade her to accept 'granuflex' dressings again.

Maud also challenged Pru's continuing visits to Mrs Plate when they were no longer necessary in terms of doing the dressings.

Pru: *"I eventually cut our visits to three times weekly. When we stopped visiting at week-ends she was very fearful, so we would phone her to give her support. There's a*

big connection between Mrs Plate's physical condition and her psychological condition. I couldn't just treat the ulcers, I must take into account the whole person even if this necessitated extra visits."

However, responding to Mrs Plate in this holistic way had certain involvement consequences for Pru. Mrs Plate lived in a social services residential home which was being closed shortly.

Pru: *"She's refusing to go anywhere unless I am involved. We are the only positive thing she relates to in the past year - the fact we got her ulcers better means so much to her. On top of it all she's lost her carer - that's one of the reasons she holds onto us."*

Maud: *"Does that make it difficult for you? - the fact she is dependent on you?"*

Pru: *"I've got to explain to her that she can't base her decision around me. It' a real problem, the social worker is great. She's doing a lot to find her a new home."*

Maud: *"You have a difficult role here don't you? You are her advocate."*

Pru related her experience with Mrs Plate to another patient's leg ulcer treatment. She noted: "I've *come to the conclusion that it's not what you put on them but the amount of time and attention you give them, obviously using your knowledge of research and regular assessments. The other thing I have learnt is to be positive about ulcers and not give up. I've had another patient who has severe rheumatoid arthritis and ulcers for 2 years. She was a very independent lady, who couldn't raise her legs to rest them. She was very determined lady who manipulated the system - sort of patient that people don't like. Her home was damp. Her son lived a long way away.. she has a poor diet, she wouldn't conform., she lost letters. Eventually I realised that we would have to get her to comply, and rest was the only way of getting her legs healed. She did eventually agree to be admitted to hospital - I told her that I couldn't provide her with anymore care - what I was doing wasn't helping because she had to be put onto bed rest. I was honest with her. Her legs are healed now."*

Pru reflected how caring for this patient had exhausted her: *"I have to admit that part of me has switched off as far as that patient is concerned now, so I have asked*

Tilley to be her primary nurse - it will provide a change, someone fresh coming in can see things differently. I know I've got more to do with her but I've run out of energy."

Concern

Pru's concern for these women is evident within the way she talks about them. They matter to her.

Knowing the patient[s]

Pru has known these women for some time reflecting the nature of district nursing. Pru 's holistic values are evident. She paints a picture of social complexity that frame the boundaries of her response within these situations. Treating the ulcers are not merely technical decisions but social decisions that affect the lives of these women.

Responding with appropriate action

Treating the wound is viewed through this holistic lens. Pru describes how she involved Mrs Plate in decision making even though the decisions are difficult. This illustrates how holistic decisions always have an implicit ethical dimension- 'what is best in this situation?' Pru is challenged to know her role responsibility within the context of what holistic means and available resources, such as the cost of dressings and use of her time. She successfully confronted the patients' restricted behaviour against a background of trust and support.

Managing involvement of self

Pru does not stand outside these women in some object-object relationship. She has become involved within their worlds and the dilemmas this has created in terms of managing her boundaries of involvement. With the second patient, Pru reflects on her knowing self, recognising she is no longer available for

therapeutic work with this patient. It was not acceptable to her to cope with her anxiety by detaching herself from this level of involvement.

Creating the conditions

Pru was able to be open and honest and say 'I can't cope' - seeking appropriate help and support. Whilst supervision creates this space to receive feedback and support, this space had been lacking in the course of her everyday work. Perhaps with support she would have withdrawn from the patient.

Session 3 [30 October, 1991]

Maud: *"How has the week gone?"*

Pru: *"Really hectic, rushing all the time, what with the computer and everything. I'm tired, never mind though, I'm taking some time back."*

Creating the conditions

Pru's opening comments are similar to those she shared in session 2. She begins to paint a picture of a 'rushed' person. This reflects the growing tension of her time with patients being eroded by an increasing administrative task. However, Pru also noted the immense benefit that installing an answer phone had made. It was an example of improving the environment of practice for Pru and her patients who tried to contact her, and for the GP practice in terms of taking messages. And yet it had been a struggle to get the Health Authority to fund this.

Pru noted: *"A GP covering our practice visited a gentleman with senile dementia, who was cared for by his family. He had a catheter in-situ and was refusing to drink so he kept needing to be re-catheterised, The GP's had got really fed up with this.. they*

kept being called out. They told us we would have to do something about the catheter and asked us to do daily 'bladder wash-outs'."

Maud: *"Had you being doing bladder wash-outs prior to this?"*

Pru: *"Yes, but only once a week. I've worked on the neurology ward so I knew a lot about catheter care and knew the best course of treatment was to minimise the interference with his bladder. Grainne*[1] *and I told him this. We told then we wouldn't visit every day but we took it upon ourselves to visit alternative days. Physically it wasn't possible to visit every day. We kept it going for about a week longer, each time before it needed changing but this made a significant difference. We decided to change the washouts to 'subi-G' . We took all the literature into the GP's - but they refused to change the prescription - they said they were more money and they couldn't see the point. When they are like that there's no point in pushing them - we've learnt that. "*

Maud: *"How did you feel about that?"*

Pru: *"Grainne and I let go, we couldn't persuade them. But then I was devious. I waited till one of the GP's who responds better to us was on call and talked to him about it. I persuaded him to refer the patient to a Urologist. He agreed and said we could stop giving bladder wash-outs, but we decided to continue to go in on alternate days now that something was being done and it was a way of monitoring him. Then this week end there was a relief GP on. He was called out to re-catheterise the patient. When he phoned me, he asked me if we had ever thought of doing anything else other than bladder washouts. He thought that bladder washouts were a waste of time and perhaps we should reassess. I told him I agreed whole-heartedly with him and asked him if he'd like to have a word with our GPs when he spoke to them on Monday. I didn't get any feedback from that. Meanwhile the patient was admitted* [to hospital] *for respite care. The catheter blocked again, but this time we decided to leave the catheter out and pad him up because the staff were able to care for him and I knew he was having an Urology appointment soon. Unfortunately he died."*

Maud: *"That sudden? What did he die of?"*

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[1] Grainne was an E grade staff nurse within Pru's team.

Pru: *"Old age. In many ways it was expected but his daughter was away on holiday in America. I had warned her he may die whilst she was away but I did reassure her she couldn't do anymore than she had done. She called every day and was getting very tired and unwell. Hopefully she knows that she has done all she can. Ben - Mr Cash's son - he lived with his father and hated him going into respite care. He had put his life into caring for his father, He's going to feel so guilty. I've sent him a card but I'm not going to visit straight away. He needs time to grieve and come to terms. He's the sort of chap who finds it difficult to express himself. He walks out as we walk into a room. I think he finds relationships difficult, even his sister finds it difficult to talk with him. Since about last September I've been saying to him that he's got to start thinking about his own life. Joan, his daughter, was going in there every day- absolutely shattered. I think she realised she was coming to the end of her tether. I'm sure she'll felt very guilty though."*

Maud: *"There are two things that seem to emerge. Firstly, how you handled the situation with the GPs, and when you feel strongly about something and they don't agree with it, how you can learn to handle that. Secondly, how you are going to handle the situation now with the family. We've only got another 10 minutes or so.. which do you want to talk about?"*

Pru: *"The GP one."*

Maud: *"Why do you think they were difficult about the bladder wash-outs? Was it, do you think, because you caught them at the wrong time and they didn't want to be seen not to know as much as you do? Or do you think they had a genuine reason for not changing? What did it matter for someone who was so chronically sick?"*

Pru: *"There was no reason really. That was what so frustrating, especially to realise that one of the GPs, about a month later, actually agreed with us and wouldn't say so in front of his colleagues! I find that extremely irritating. They don't work with specific patients so you can't pin one GP down about a specific patient."*

Maud: *"How could you get round the situation another time? Is there anything you did that prevented them from co-operating?"*

Pru: *"Problem was I wasn't there when the situation blew up. Grainne had to deal with three very angry GPs - 3 against 1. She was able to go back to one of the GPs, who was particularly awkward, and tell him what she thought, and that she had sorted the problem out. The only way I coped with it was by insisting on getting the Urologist involved. It took 3 months. I got it in the end. If only he could have got there - the patient died before making this appointment - I could have had a lot more ammunition next time.*

Pru continued: *"Whilst he was in hospital for respite care a nurse suggested a supra-pubic catheter - I mentioned this to the GPs - they just laughed at me. They called me 'supra-pubic nurse'."*

Maud: *"How can you get over that?"*

Pru: *"I don't think you can - I've got to know them well enough and I think I know how to handle them now. For instance they asked me to visit daily but we said we'd only visit alternative days. Eventually, if it had gone on much longer, I'd have gone back to them and insisted something else was done."*

Maud: *" Looking back on it, is there anything you'd have done differently if you had the same situation again?'*

Pru: *"I think I'd have been a bit stronger and argued longer."*

Maud: *"Do you feel quite comfortable negotiating with the GPs or do you find it difficult?"*

Pru :*"No I don't because they make everything into a big joke, so it's hard to talk with them. Its frustrating. They are never resistant when I prescribe something, only when it affects them. It highlights their weaknesses. Sometimes they just ignore you and walk away, they don't listen."*

Maud: *"Literally?"*

Pru: *"Sometimes. If you're in the same room they'll turn it into a joke, so you can't talk."*

Maud: *"So how do you cope with that? You must find it difficult?"*

Pru: *"Yes I do. But I try seeing them on their own. I hate confrontation."*

Maud: *"How do you feel after it?"*

Pru: *"Afterwards I usually feel.. phew! Sometimes I question whether I should have said that, but usually if I feel strongly about it, no. Its funny though, because their perception of me is totally different. They told me once that when they see me coming they know they can say something to me and I go wallop back. I had never thought that about myself. They think I don't let them get away with things which obviously I do, but that's how I come across. They think they don't bother me either."*

Maud: *"That's interesting. Its amazing to have feedback."*

Pru: *"Yes, I'm often shaking like a leaf but they think I am very confident. "*

Maud: *"You do come across very assertively actually, not aggressively, but someone who has thought things through and feels strongly about things."*

Pru: *"Actually, they don't worry me. As such as they are not easy to deal with - they are alright really. I wish they had more of a set system though. We have a new practice manager who will improve things and will help us."*

Knowing the patient

Pru illustrates how knowing the patient involves knowing the whole family, being sensitive to their feelings. Responding to the technical problem of the catheter is set against this holistic background. Pru's talk is infused with her concern for the patient's family and how she anticipated and responded to the family's needs. She sought to support the daughter by being available to her.

Creating the conditions

Pru paints a picture whereby doctors don't listen easily to her advice. She resorted to 'game-playing' in order to respond appropriately to her perceptions of the patient's need. This creates an obvious dilemma for Pru - whether to be assertive and confront the GP's limited beliefs and behaviour towards herself and the patient - or resort to these tactics to achieve her own and the patient's needs. The difficulty with the non-assertive and

confrontational approach is that the status quo is maintained giving Pru constant feedback of her lack of effectiveness and reinforcing her sense of subordination and powerlessness. Yet the assertive route is also problematic as the GP's resort to humiliation techniques [Chapman 1983]. Pru's use of the word 'ammunition' reflects a feeling of battling against the doctors. Yet she rationalised the GP's behaviour as she struggled to cope with her anxiety within this situation. Talking through this situation helped Pru to understand the dynamics within this situation and affirm her holistic resolve. She cannot easily avoid this sense of conflict because her practice matters so much to her. This understanding gives meaning to the notion that concern sets up possibilities, but it also sets up what counts as vulnerable (Benner and Wrubel, 1989).

Session 4 [15 November, 1991]

Pru commenced by saying she had not recorded any specific event in her diary but had just jotted a few points :

"- No time to review care with colleagues

- GPs are difficult at present - difficult to accept this.

- I feel all district nursing teams are going under."

Maud: *"Which of these shall we focus on? Perhaps the third point would be useful?"*

Pru: *"I agree. One of the reasons for putting that point down was following on from last Wednesday's staff meeting when, once again, I felt that myself and others were being called on to take on more and more. Every time we have a staff meeting we are being asked - 'can you look at this', or bits of paper are sent to us asking us to do this and that. I feel everyone is saying don't give me anymore. We are all going down, all the groups are feeling the same. Then it was made worse when I walked into your office after the meeting and saw how stressed you obviously were. I recognised at that point, that it was not just the district nurse teams but the managers as well. In some*

ways it was reassuring, that the pressure was coming from all levels. District nurses want to take things forward and take district nursing somewhere but I feel everyone is losing energy."

Maud: *"Reflect back to your opening comment- that district nurse teams were going under. Could you give me specific examples?"*

Pru: *"Its a feeling rather than specific things.. the skill mix debate had made people feel threatened, under valued."* [discussed].

Maud: *"What do you feel we can do to improve things?"*

They discussed this. Pru admitted she had developed a 'closing system' - as a way of switching off when she felt overloaded with information at these meetings. She also admitted that she was passing some of this stress onto others at her own Tuesday team meetings. She also noted how she was forgetting things, for example, an Asian cultural session.

Maud's response was to focus on Pru organising herself and setting priorities. She suggested that the sessions could be useful to help Pru achieve this.

Creating the conditions

Pru and many of her colleagues felt an increasing pressure from management to take on board more 'organisational tasks', that were perceived as interfering with being with patients. Pru's frustration is evident. Supervision creates the space to share and work through these feelings with the person who hands down this pressure, rather than let them ferment. Pru felt unable to express these feelings openly at the meetings, reflecting the hierarchical nature of the work culture. The consequence is that both Maud and Pru understand the issue, Pru has been able to express her feelings, and together they can work towards a mutual solution, whilst recognising that this is the modern world of health care management.

Working with Tilley

Pru said she was feeling guilty at allowing Tilley to take on most of the new referrals and covering for messages in the afternoon whilst she was busy with prior commitments. She didn't want Tilley to think of her as lazy. Maud reminded Pru that it was still very new for her to have a colleague to share with. Maud challenged Pru as to whether she was perhaps feeling she should appear as over-worked and stressed as previously to justify doing a good job.

Maud urged Pru: *"You can let go half now and still be conscientious, committed, hard working, caring , effective and all the things you want to be. Let Tilley take some of the strain now. We know that this practice was one of the busiest, we have the statistics to prove it.. we know!"*

Maud advised Pru that she and Tilley: *"should come to an agreement that they can tell each other if they feel either of them are not 'pulling their weight'"*

Pru agreed it would take some getting used to having an equal colleague. Pru highlighted her need to control her workload, and how Tilley threatened this. Even though it was stressful to maintain control over a large case-load, it is also stressful to let go of it to someone else. Pru noted: *"Only today I was questioning myself about something Tilley had done, but I realised I mustn't go and tell her."*

This concerned the way Tilley had changed a dressing treatment for a patient. After discussing it with Maud, Pru agreed she should ask Tilley her reasoning for treating the dressing the ways she did. Pru envisaged that this would be difficult: *"I have to think about how to question what Tilley does without upsetting her."*

Creating the conditions

Prior to commencing supervision with Pru, Maud had recognised that Pru's case-load was high and that she lacked support. Maud had responded to this perceived need by attaching another 'G' grade district nurse, Tilley, to work

with Pru. She replaced an E grade staff nurse. In effect, this appointment had split Pru's case-load into two, although it gave her no more 'hands-on' support. Pru's response was a sense of threat at losing control. Talking through the issues helped Pru to focus positively on developing an effective working relationship with Tilley. Pru acknowledged her difficulty in giving Tilley feedback, reflecting her need to avoid conflict in order to maintain a sense of 'harmony'. In this culture conflict is brushed under the carpet or inadequately resolved. Issues are dealt with and left to fester (Johns 1992a).

At the end of the session, Maud asked Pru what she had liked most.
Pru: *"Letting it out, I can go home now and feel better! It's been helpful that you've questioned more what I have said. You've been more involved this time."*
Maud noted she liked best Pru being open and honest: *"I like least the stresses placed on you. However this has been positive for me - I can now reflect on how best to handle this differently in the future."*
Maud noted the mutuality of learning and how she is able to contemplate action to create better conditions for practice for both herself and Pru.

Session 5 [29 November, 1991]

Picking up her discussion with Tilley concerning the treatment of wounds, Pru felt Tilley had justified her use of this dressing. The envisaged 'upset' had not materialised.

Responding with appropriate action

Pru had given Tilley feedback that was uncomfortable for her. As a consequence the issue was resolved. Pru had been able to act on her resolve from the last session and discuss her concerns with Tilley.

Maud's role

Maud reflected on the previous session and noted how she had felt a tension between her managerial role and her supervision role and admitted she found this uncomfortable. This tension is a reflection of moving from an essentially hierarchical to a collegial relationship, necessary for effective supervision. This relationship begins to spill over into the practice relationship. It highlights the mutuality of learning within the relationship.

Pete

Pru shared how she felt caught between two conflicting opinions about a patient's care. The patient had been admitted to hospital, where his hospital primary nurse wanted to catheterise him, whilst the GP was refusing, because he believed the patient was only incontinent because he failed to comply with wearing a 'sheath' and using a commode because he was both lazy and difficult.

Pru :*"I didn't have strong views either way -I realise I was sitting on the fence - one minute I was agreeing with the hospital and next I was agreeing with the GP. I couldn't insist on one way or the other because I didn't have enough information. I was relying on the hospital to tell me, I didn't have my own facts."*

Pru noted that after the patient had gone home without being catheterised, things had deteriorated. She responded by instigating a case conference to be held during the patient's next planned respite care admission. Pru had encouraged the carer to log all the events that were happening at home so the patient could be challenged when he says all he does at home.

Pru :*"The hospital believe the patient and don't believe me when I tell them how worried I am about Pete, the carer. He is so angry."*

Pru recognised she was acting very much on the carer's behalf and felt the hospital were only looking at things from the patient's viewpoint exposing a

conflict of values and ownership. She organised a case conference to review this care and to come to agreement over catheterisation in the long term.

Pru :*"I was the carer's advocate. I could see that the patient was lying. I feel bad though because I think I pushed the patient into a corner. I haven't been the patient's advocate. I find this responsibility uncomfortable. I encouraged Pete to speak up at the case conference - which he did."*

Knowing the patient

Pru sees the patient within the context of the home care situation, most notably within her role to support Pete, the carer to support his father.

Responding with appropriate action

Pru' s recognises her dilemma of working within the conflicting needs of the patient and Pete, his carer, set against a background of 'knowing ' the disintegrating context of care at home. Her response was to help Pete have a 'voice' at the case conference and in doing so fulfil her self-perceived advocacy role [Gadow 1982]. Pru highlights the interpersonal conflict between herself and the hospital over different perceptions of 'what's best' and who has legitimate authority to make decisions. This conflict is also fuelled by Pru's concern for the 'right' outcome for Pete.

Session 6 [16 December, 1991]

Pru noted: *"I feel frustrated with continence assessments - I'm not clear in my mind how to go about it. I can see the point of re-assessing everybody - it stops abuse of the system and helps us look at how we are monitoring patients, but there seems to be a stumbling block at every step - for example the need for 6 monthly assessments and with people I don't know."*

Despite Pru agreeing the sense of this policy in terms of patient benefit and efficiency, she felt a lot of hassle could have been avoided if district nurses had been consulted before the policy was brought in. Without being part of this process she felt this was imposing an additional burden on her work life which she was powerless to control.

Working with the Continence adviser

Pru continued by sharing an experience that involved her working directly with the continence advisor: *"The continence advisor did not give me help when I most needed it. I wanted her to do a practical visit for me. She insisted on a joint visit so it took ages to arrange. It was a waste of district nurse time. I knew what the problem was but I wanted her to go in and sort it out for me, but she didn't do that. Instead, she did another assessment and decided what was needed but I had to chase around and get things."*

Maud: *"Did you pick up anything useful from the joint visit?"*

Pru: *"Well I suppose I did. I benefited from the teaching she gave. I had forgotten how to use the pads so that was useful. I still think a joint visit is a waste of time though."*

Maud explored with Pru why she felt this.

Maud: *"What did you expect from Hazel's visit?"*

Pru: *"I expected and wanted her to take the problem away. I was getting cross because it was taking up so much of my time. I didn't feel it was my problem. Hazel is the expert. I felt she should sort it out."*

Maud: *"How do you see the 'advisor's role?"*

After discussion, Maud challenged Pru: *"Do you still think Hazel should have dealt with the problem?"*

Pru: *"No, I realise now that what I thought was not my problem in fact was. I realise Hazel was there to help me, not to do it for me as I had hoped."*

At the end of the session Pru said she liked best: *I've clarified things in my mind. You have been quite challenging, it's been stimulating. I thought I had sorted things out but I realise I hadn't. And liked least? I realise I can't run away from the problem by using Hazel. I don't like the fact that I can't run away or being made to realise that!"*

Responding with appropriate action

Pru is confronted with her attitude regarding the role of the Continence Advisor and is helped to shift this perception.

Creating the conditions

This experience is set against a background of Pru's concern with being over-burdened with her work. Hence she initially saw Hazel as doing something for her, rather than working with her, in order to relieve some pressure.

Session 7 [10 January, 1992

Pru noted - *"At the staff meeting we were being asked to be wheelchair assessors. We had a piece of paper around about it - I read it but chose to ignore it because I resented it and felt annoyed. It made me think - 'where is the district nurse role going? We seem to be trying to grab at anything that comes along- if we all do these things where will the patient be? What will our role become? I don't mind ordering a wheelchair for someone who just needs propelling, but I've got a friend who is an O. T. and he tells me its a specialist role. I don't think we should be doing it!"*

Maud was uncertain about what the paper had said. She suggested Pru focused on her role.

Pru: *"Yes. I am getting to feel like everytime we sit in one of the staff meeting we come out thinking what else are we being asked to do or that our own accountability is being questioned."*

Maud asked Pru to clarify examples. Pru identified BM assessment and miscellaneous study days that all seemed concerned with legal issues. In summary Pru noted: *"These sort of feelings make me confused, and angry. I feel resentful."*

Maud: *"You have mentioned two or three times now in supervision, that you come out of staff meetings feeling angry, put upon. What do you think of the idea to use your diary to reflect some of your feelings after the next meeting? Jot down the things that you have to do as a result of the meeting. We could focus on that?"*

Pru: *"Umm.. maybe...we all come out feeling restless.."*

Pru and Maud discussed this in depth, and looked at Pru's isolation from other district nurse teams and possible ways to rectify some of these issues.

Creating the conditions

This experience further highlights Pru's concern at being over-burdened with organisational tasks and her resistance. She extends this to discuss other organisational issues that interfere with her sense of control of her work environment, notably how these additional tasks interfered with meeting the needs of patients. Working in the organisation meant that Pru had to solve the tension between her professional focus grounded in caring for families and the organisational demands made upon her. Pru was stressed, although sharing her frustration with Maud enabled her to work through this frustration positively. Supervision was cathartic, supportive, and problem solving. From a supervision perspective, this experience illustrates the benefit of Maud as Pru's manager, in being able to work together towards solving these problems.

Session 8 [30 January, 1992]

Pru began the session by stating she was feeling bad because she hadn't done what she had agreed - write her diary. Pru :*"You know what we agreed, I've been wanting to do it, but I've been working such long hours that I can't face it."*

Maud :*"How has that made you feel?"*

Pru :*"I'm very aware I haven't used it. I feel guilty because I wanted to see how it worked -I wanted to do it but I've had such long hard days. It's a busy time of the year."*

Creating the condition

Pru suggests that her sense of being busy interferes with the reflection process. This creates the sense of contradiction within her. Yet it also reflects how Pru had internalised a sense of self-regulation to conform to the expectations of supervision.

Pru shared: *" There is one thing I would like to focus on today- the way I handled a situation with one of the GPs. Dr. Gatton challenged me on something I had done. I'm sure what I did was right, but I'm not sure if how I handled it was right. We have a ten minute meeting with Dr Gatton on a Tuesday afternoon because she doesn't attend the other meeting we have with the other GPs on a Wednesday afternoon, as she is part-time. Over the week-end, one of Tilley's patients became unwell. She's a difficult lady anyway and Tilley and I rely on bits of information to communicate with each other as we do not have proper hand-over time. She's a lady with a package of care, and she has a son who gets angry. I went in on Saturday to find her unwell. She had had bad diarrhoea last Tuesday and hadn't been to the toilet since. She has a history of not telling us when she gets constipated . She's a lady of 86 - she said she hadn't passed urine for 3 days, she said she hadn't eaten and felt uncomfortable. She wasn't looking well, her abdomen was slightly distended. I wasn't sure what to do initially - the GP on call was not one of our practice so he did not know her. I checked her rectum and it*

had soft faeces in it so I decided to her give her a small ''microlax' enema - she had a commode by her bed.

After the enema I helped her out onto the commode and she became hypo - she passed urine by the way which I was pleased about. I got really worried about her and got her back into bed. I couldn't get a BP, her pulse was rapid. She told me she felt she was dying. She's a big lady -I got panicky. I phoned the GP on call."

Maud: *"How do you feel about what happened?"*

Pru :*"I felt it appropriate to have done the enema - she refuses to take oral aperients, there was nothing in the note from the GP to indicate I shouldn't have given her one. When I contacted the GP on call I asked him to check her and then leave message in the nursing notes of what I should do tomorrow."*

Maud: *"What did you do next?"*

Pru: *"I went back Saturday afternoon - the GP didn't visit until the evening, about 8pm., and then I went in again on Sunday. She was much better by then. I suggested she should stay in bed. I left a message for the family. The GP who visited said he would let the GP know - he said to do no more bowel care but to keep an eye on her. On Tuesday when I walked in to the meeting Dr Gatton said - 'Why did you give her that enema?"*

Maud: *"How did you respond?"*

Pru: *"I justified what I had done. Dr. Gatton said I shouldn't have given an enema but I told her there were faeces in the rectum."*

Maud :*"What did Dr. Gatton say then?"*

Pru: *"She didn't. I felt she was criticising me without having found out the facts first. I don't think I handled the situation satisfactorily."*

Maud: *"What didn't you achieve?"*

Pru: *"I didn't make her realise what my role is - in a sense she is condescending - she was telling me off - not treating me like an equal. She had made her judgement of me before finding out the facts. She had no back up from the notes."*

Maud recapped with Pru that in previous supervision sessions she had mentioned how doctors humiliated her: *"shall we look at how you intervened with the GP?"*

Pru: *"I don't let them bother me."*

Maud: *" Are you sure?"*

Pru :*" Well maybe they do, but I don't have time to deal with it.. we only have a ten minutes session each week."*

Maud: *"Shall we look at how you intervened with the GP?"*

Pru: *"I defended myself!"*

Maud :*"Could you perhaps have reacted differently - responded in a different way, that would have maybe achieved a different response from the GP?"*

Pru: *"Maybe.. but it is very stressful. There are so many other issues to discuss about patients that there is no time to talk about us."*

Maud: *"What do you think you need to do?"*

Pru: *"We need to sit down and sort out our feelings."*

Maud: *"Maybe you could suggest taking part as a team in the FHSA team building event- that would give you all plenty of opportunity to look at role clarification, attitude, etc.?"*

Pru: *"I showed them the information last year- they ignored it."*

Maud: *"Maybe you could discuss the situation with the two facilitators at the FHSA. They may be able to encourage your team to become involved?"*

Pru: *"Nurses to them are the doers, they can't cope with the fact that district nurses and health visitors have their own opinions and can say 'no'* [Pru shared recent experience involving a health visitor]... *They do care and I like them - if I hated them it would be easier, I could handle it better. They close ranks and are sarcastic - they manage to make a joke of things and this breakdown conversations to a non-professional level."*

Maud: *"What do you do when this happens?"*

Pru: *"I go along with them when they are flippant, it's the easier way out."*

Maud: *"Maybe consider a different approach - perhaps tell them you don't like it when they humiliate you like that? How do you think when it happens again would be the best way to handle it?"*

Pru : *"I need to go back to Tilley."*

Maud: *"That's interesting you say that - can you say why?"*

Pru: *"Yes - we need to be speaking the same language. We need to have agreed what we would like to achieve and then how to approach them."*

Maud: *" Could be that two of you are stronger than one?"*

Pru: *"Yes."*

Responding with appropriate action

Working in the community, Pru had to interpret and respond to situations as she finds them. Pru illustrated the unpredictable nature of much of her practice.

Creating the conditions

Supervision enabled Pru to review her rationale for her action, which is reasonable. With the benefit of hindsight, others can criticise and 'blame' her. This experience is again grounded in Pru's conflict with the GPs and her anger and distress at the GPs response to her, which she feels is unfair. The GP's response reflects the power relationship between the nurse and the doctor- a recurring focus of reflection. Maud's response is to help Pru focus on positive action towards establishing core effective communication patterns with the GP and with Tilley. However, her ability to achieve this presents as a significant barrier.

Session 9 [26 March, 1991]

Maud explained that she wished to structure this session slightly differently from previous sessions. She suggested spending half the time reflecting on issues that had arisen from session 8 and the remainder to focus on what Pru had to share. Pru agreed.

Maud began by asking Pru if the time span between sessions had made any difference [55 days]?

Pru: *"Not really. As things gave been just recently it would have been more of a stress to think I had to fit supervision in. Its either been the case of one of us not around or there's not been anything that's been an issue."*

Maud then helped Pru reflect further on issues of mutual support and reflection within her team. Maud confronted Pru's reluctance to share accountability for the work-load with Tilley : *"Do you consider it may be an issue of sharing accountability too?"*

Pru :*"Yes, I suppose so...well it's more of a back up.. someone else's presence."*

Maud :*"It must have been very hard for you when you first started here - you had no immediate colleague to share with - with Corinne [staff nurse] being new also."*

Pru :*"I find it more difficult now. Not having Tilley around is worse than when I was the primary nurse for all the patients - I knew what was going on then - now I'm not so aware. I do not feel in control. The communication is not the same. Don't get me wrong - I love it when Tilley is here, but we don't work so closely. We have no time together to discuss ways of working. Tilley doesn't necessarily leave things for me in the same way as I do for her - she doesn't always warn me of potential problems. We haven't met up to work things out and haven't shared these issues."*

Maud commented that lack of communication had been an issue raised in previous sessions and suggested that it may be a priority area for Pru and Tilley to address. She noted similarities in her work relationships with the person with whom she job-shared.

Maud also picked up the patient with diarrhoea and Pru's '10 minute meeting' with the doctor. This prompted Pru to reflect on the doctor's attitude: *"She still looks to us as the bath nurses. Sometimes she just doesn't turn up at the meeting. She always apologises when she next sees us, but in the meanwhile we've wasted our time."*

Creating the conditions

Maud creates the opportunity to look back and make sense of issues arising from the last session. In doing so, she reinforces the significance of the issues and maintaining the thread of experience through the sessions. The issues of creating positive relationships with Tilley and GP are tough for Pru to contemplate because she feels unable to confront the situation because of social norms that prohibit this. It highlights how things are not easily changed. Yet re-visiting such situations supports and challenges Pru to feel empowered to take new informed actions.

Archie

Pru: *"He goes to the community hospital for respite care one week in every six. He has a negative feelings about the place. I've tried to liaise closely with them by 'phone and letter but I get no feedback... there are two areas of concern - his wound care and how Archie is unhappy about his primary nurse - they do not get on together. I interfered as I did because of the increasing tension - the respite care is supposed to be there for relief but it is not working. I can see he'll refuse to go and then what!? I was pleased about the wound care -that they followed my care and the wound has healed. The primary nurse is avoiding the relationship issue - it's unfortunate because she is a colleague of mine. She has admitted she finds Archie 'difficult'. I'm annoyed I was not more assertive on the phone. I asked how she felt - I got definite negative vibes about her*

professional relationship with Archie. I asked about the possibility of changing as his primary nurse but her comment back to me was - 'it would come back to me anyway'.

Pru continued: *"How did I feel when it was happening? Awkward, I found it difficult challenging a colleague. I'm not sure what I feel should happen. It's a real problem not just Archie inventing it. It's been accepted by the primary nurse - she finds him difficult . Stella [his wife] also finds her difficult - she avoids Stella. How does the patient feel? - Pessimistic - he wants to be in charge of his care - not the wound care, he's indifferent about that, but his care generally.*

How do I know how he feels? - we discussed it before-hand and when he came home. I explained to him I was going to liaise with the primary nurse. The comment that came out from him was that the hospital would never change. Archie doesn't have an insight into his illness - I hate looking after people with multiple sclerosis."

Maud: *"That's a very powerful statement."*

Pru: *"Yes it was. You would never get me working on a neurology ward. Multiple sclerosis- I hate it. I find the mood swings difficult. I don't like what the illness does to people. I am frightened of it.. frightened it could be me."*

Maud: *"Do you think your feeling about the disease affect the way you care for patients suffering from the disease?"*

Pru : *"It could be. Mind you, looking after Archie forces the issue - which helps me. He can still monitor what he does in life. When Grainne was here we used to break the care up between us. Now with Tilley here, I go in to Archie every week."*

Maud: *"What would you feel if you had another patient admitted to your case-load with MS?"*

Pru: *"I'd run a mile. If I had more than two such patients I would find it exhausting, a challenge. I'm learning a lot but I'd still run a mile."*

Maud: *"What is it that you are learning?"*

Pru :*"Watching someone with such disability and following it through - I have not done that before - more so than with anyone else."*

Pru continued: *"Could I have dealt better with the situation? - more assertively on the phone. I could have been more challenging. I could have suggested meeting her again. I can't see the sense that the primary nurse is still his primary nurse. She books annual leave when he comes in to avoid him!"*

Maud: *" That's a bit desperate. It sounds as if she needs support- supervision!"*

Pru: *"He exposes our weaknesses. He is bitter about his illness. He's bitter we can't offer him what he wants 24 hours a day. People resent the way he expects the system to change just for him."*

Pru continued using the model of structured reflection: *Factors which affected my decision? - "I don't want to jeopardize respite care with the hospital."*

Maud :*"Why should you?"*

Pru :*"Well if I challenge the primary nurse's role, I've got to be careful how I handle it. I don't like to challenge a colleague and I don't like upsetting people. What have I learnt? - that it is a continuing problem. I need to approach the nurse again. It's going to be difficult but we need to meet up. Archie is good at manipulating situations and Rita doesn't challenge him."*

Maud :*"Have you thought of any other ways there may be of helping him?"*

Maud helped Pru explore her options and ability to resolve these issues.

Responding with appropriate action

Pru's concern for Archie prompted her to tentatively confront the primary nurse. Yet this was half-hearted within her greater concern to avoid conflict with the primary nurse, rather than act in her patient's best interests. There was a paradoxical twist because, as she recognises, confronting the primary nurse may not be in Archie's best interests. Pru rationalises her non-action in terms of possible sanctions against Archie. Yet, her tentative confrontation has enabled the primary nurse to express her concerns and opened a door for talking about feelings more openly. The consequence for Pru of her inability to

openly confront the primary nurse is her own distress at seeing Archie and his wife suffer.

Knowing self

Pru has some sympathy with the primary nurse, because she also finds Archie 'difficult' to nurse. Maud helps Pru explore her 'negative' feelings and helps her to see the situation from Archie's perspective through the label of a 'difficult' patient. This leads to an understanding of the situation, a renewal of energy, an affirmation of her caring beliefs and her responsibility to challenge the primary nurse.

Session 10 [6 April, 1992]

Maud asked Pru how things were progressing with Archie in hospital?

Pru: *"He has made a complaint in writing about the hoist- he wants it moved just for him. They never liaise with me though, which makes it difficult. I have asked them to liaise with me on Wednesday- I hope they will."*

Maud: *"Have you managed to get him referred to the neurologist yet?"*

Pru: *"The GP is very reluctant. He said there is nothing else we can do.. he's not interested. He doesn't want to know. There is no specific doctor allotted to him as he is a difficult patient. Archie thinks it is everyone else that is difficult, not him. "*

Maud helped Pru to identify and explore tactics to penetrate this doctor's indifference.

Maud continued: *"Have you approached the primary nurse yet?"*

Pru: *"No, because of the issue with the hoist, I need to sit down with her and have a chat."*

Responding with appropriate action

Maud reinforced Pru's need to take positive action with the GP and the primary nurse to develop effective communication and possibly confront negative attitudes that interfere with Archie's care management, to see Archie and his needs beyond the 'difficult' label that blurs seeing him and his wife. The contrast of values between the hospital nurse and Pru are stark and fuels the conflict between them.

Vera

Pru :*"I've been going into Vera, who is obese, she fell, and developed a leg ulcer as a result of trauma. However, her main problem is immobility and fear because she is obese - she only moves from chair to bed. Elaine, her daughter, is the main carer - she's an alcoholic - I've never broadcast that. Vera's leg has improved over the past few months but we now have a problem of pressure sores. For the past few months I felt she has needed to be in hospital for 2 hourly turns. I have had the O. T. and physio involved but they feel they can achieve no more with things as they are. She doesn't want to go in."*

Maud: *"I remember it took you a long time to persuade her to have her bed downstairs."*

Pru: *"Yes - it takes six months to achieve anything. The pressure sores we can't contain any longer. She has a sinus on her sacrum - she sits in the chair for most of the day. One of her heels has broken down. Indeed hospital admission is needed for nursing care and support for Elaine. However Vera is reluctant, or was until today, because she said -'If I go in I'll end up like my husband and die. She gets panic attacks when I mention hospital."*

Maud: *"What alternatives do you have?"*

Pru: *"I've considered going in everyday but I can't see the point. It won't improve the situation. She won't accept social services. What she needs is physically turning every two hours to change her position."*

Maud explored mattresses and beds etc. with Pru. She asked: *"What would you say is the main problem?"*

Pru: *"Trying to tell her about hospital. I don't want her to get bed bound - but the home situation is not conducive to mobility. Everytime I go into her I say I am controlling the pressure sores but I am not healing them. I keep mentioning hospital but part of me can't help thinking I am pushing her against her will. I wonder if it is because they, like me, that are coming round to accepting the possibility. Today they said they realise they can't carry on without the hospital admission - she feels uncomfortable and realises we are not going to heal it."*

Maud: *"Why do you feel bad?"*

Pru: *"Because I have pushed it."*

Maud: *"Does that matter?"*

Pru: *"A patient of Tilley's died on Saturday. He had been sent into hospital and was only in two days and died. Part of me thinks that will happen to her."*

Maud: *"Maybe the answer is to help Vera to see this admission as a positive thing - plan for her discharge on admission, set some goals, remain part of her care whilst she is in hospital - maybe someone from the hospital could visit her at home?"*

Pru: *"Yes - the main consequences [looking at the MSR.] of my actions for the patient was getting her to accept we were coming to a standstill."*

Maud: *"How does Elaine feel?"*

Pru :*"Tired, exhausted, she never said so but I think she'll crack up of we don't get Vera in."*

Maud: *"So what will be your main objectives from getting Vera admitted?"*

Pru: *"To reduce her sinus - its 2 cm. long x 5 cm. deep."*

Maud: *"She'll need to be nursed in bed?"*

Pru: *"Yes, but they've got the hoists and monkey poles. I want to avoid a crisis admission. I want the nursing care to be set up to provide security for her. She's scared of the outside world... 'this is disjointed- I can see the point of writing in a diary now!' "*

Maud: *"How are you talking things forward?"*

Pru: *"We need to see if the hospital can take her. It may take two to three weeks before she can go in."*

Maud: *"Is she likely to go back on the decision?"*

Pru: *"No, once she's made a decision its okay."*

Maud: *"What do you want to be different for when she comes home?"*

Pru: *"Aids to help them, for her to be able to change her position throughout the day and reduce her fear since she fell five months ago. She also needs to be mobilised."*

Maud: *"Is that realistic?"*

Pru: *"As long as we can get her back to how she used to be- using her frame and getting from bed, chair."*

Maud: *"Does she understand that?"*

Pru: *"Yes, Elaine is a big problem because of her drinking and she's big too. But we must try."*

Maud: *"What have you learned from all of this?"*

Pru: *"In the community you need the trust of the patient. You can't rush certain things."*

Maud: *"Looking back - would you have done anything differently to have got to this stage earlier?"*

Pru: *"Her heel- I was looking at it regularly but she was not moving it enough. Maybe an aid on her heel earlier may have prevented the breakdown."*

Maud: *"Do you think it would be appropriate for someone from the hospital[2] to visit them at home prior to admission so they can see first hand the situation?"*

Pru: *"Yes, if they accept her. It may help."*

Responding with appropriate action

Pru paints a picture of the complex nature of holistic caring. She highlights her understanding of the ethical dilemma in 'pushing' but without 'rushing' a

[2] This was a community hospital

patient to accept a certain course of treatment when the outcomes are unknown, especially in the traumatic circumstances of admitting the patient where her husband had died. As with her earlier experiences with Mrs Plate and with Pete, she has to balance confrontation- of what she perceives as best for the patient and carer, with the patient's own fears.

Managing involvement of self

Pru felt at risk of being overwhelmed in this situation. She is afraid of the worst consequences and appears to be accepting responsibility for these - her sense of 'feeling bad'. Supervision helps Pru to 'see' the situation, to work through her uncertainty and focus on positive action. Through this process she knows herself a little better.

Session 11 [6 May, 1992]

Maud: *"As we have been in supervision for seven months now and have had 10 sessions. I thought it may be useful to reflect on that today and see what we both feel about how things are going. What do you think?"*

Pru: *"Yes. I started off seeing supervision as more of a support system. I now see it is to try and improve my thinking mechanism.. I still see it as a support. "*

Maud: *"I went through all the notes last night and tried to draw out some common themes. Would you like me to share these with you?"*

Pru: *"Yes -I went through my notes too and can see the value of them now. I realised I still have to look at communication with Tilley."*

Maud then recapped each session by session:

"Session 1 - we drew up a contract. You said you saw the purpose of a reflective diary as a means of getting rid of things, closing the door on them. Do you still feel that?"

Pru: *"That's me. Its the way I've always been. I work on things fast. I don't always reflect enough to make the next step. It's a process I am having to learn."*

Maud: *"We also agreed to meet an hour every two weeks. We don't seem to be meeting that often now?"*

Pru: *"Time factor."*

Maud: *"Or is it perhaps you want to avoid having sessions?"*

Pru: *"No, I don't think so. It would have been more stressful trying to fit a session in with things as they are. I do need to stop and think though. I see the session as very much an hour to myself. I've moved on."*

Maud: *"Session 2 - we focused on Mrs Plate's leg ulcers. This was a positive experience for you. You felt you had achieved success even though you were working against the patient's wishes- you changed her dressing and cut her visits down."*

Session 3 - You said you hated confrontation and the need to avoid conflict."

Pru related this to her work with Archie, and how contemplating her visits to him churned her up because she anticipated that things would be difficult, although this had improved significantly. Maud fed in some theory regards confrontational skills [3]. Pru had read this paper and noted *"it raised so much."*

Maud: *"It maybe worth reflecting on a particular incident and looking specifically at your effectiveness in caring for Archie?"*

Pru: *"Yes, it's one of the problems with district nursing. There are some people you can't face seeing each day. I do take a lot on board but hopefully think I am able to take a step back and see what is. The trouble is that I take on board all the other professionals' views."*

Maud: *"What makes you do that?"*

Pru: *"I don't want to lose Archie's respite care."*

Maud: *"Do the other professionals recognise you feel like that?"*

Pru: *"I'm not sure- they pour out their problems to me but its never the other way round."*

Maud: *"Is that reasonable you absorb all the other peoples' feelings? Maybe you need to look at how you handle your own feelings when you take on board everyone else's?"*

[3] This was a paper I had written based on using Heron's Six Category Intervention Analysis.

Maud continued through the sessions: *"It seems that most of the issues focus on interpersonal relationships- with patients, GPs and nurses. You also seem to have difficulty coping with stress. How does this affect your work? Maybe this is something we can look at?"*

Pru: *"I like the similarity being brought up. Clinical work I discuss with colleagues. When stress gets involved I don't like it. I can handle what goes on most of the time. Only when it flares up I find it difficult."*

Managing involvement of self

The process of review helped Pru to look closely at the types of relationships she had with her patients and to reflect on her level of involvement. As her experiences have highlighted, Pru does become very involved in line with her holistic intent and her caring concern. She gives meaning to the phrase- 'the therapeutic use of self' which she believed was central to her belief system about her practice. Pru recognised how she tended to absorb the distress of her patients and carers, and often contradictory views which creates doubt and uncertainty for her. She also acknowledged how others off-load their concerns onto her- reflecting how her availability to her patients and families spilt over to other professionals. Yet when the actions of others are inappropriate she was unable to adequately confront these situations in her greater need to avoid conflict. She felt isolated and unsupportive. Perhaps she felt she should cope or that she did not want to burden others- the risks of becoming over-involved and becoming 'entangled' in others' feelings.

Vera

Pru picked up Vera's care: *"I've reflected on Vera's admission to hospital. I've reflected on the whole situation and tried to evaluate it. It's been useful. The hospital nurses did visit her at home as you suggested. It was helpful. I also sent my notes in. This may become a trend."*

Pru worked through the model of structured reflection to describe and reflect on how she was able to maintain a presence in caring for Vera, being able to assert the appropriate wound dressing which involved negotiating with and overcoming resistance from the hospital primary nurse.

Pru noted: *"Learning? - I feel good about it. We reviewed her care yesterday. Her leg ulcers are nearly healed. Her heel is only 1 cm., no necrotic area. The sinus isn't healed. That's quite good they have not been able to heal that. I suggested using normal saline soaks but the primary nurse wasn't very keen, but I told him that I had had good results in the past and were worth trying. He's going to try it. She's happy. She likes the staff and trusts them. Her CCF is improving. She hates to get off the bed now. I don't believe it - I couldn't get her on it at home! She's not mobilising yet. "*

Creating the conditions

This experience gives Pru feedback that she is now more able to be assertive with hospital staff whilst significantly improving liaison for the future, and was less concerned with avoiding conflict by putting Vera's care as primary focus for intervention rather than the conflicting interests of the nurses.

Session 12 [1 June, 1992]

Pru: *"What I have done is gone through this communication thing with Tilley. I've tried to use the model of structured reflection although I'm uncertain about using it properly. Since my new colleague has started I have felt the lines of communication have changed -I am no longer accountable for the whole case-load and, as a consequence, I am not aware of all the situations and secondly personalities of the two nurses are different."*

Maud: *"Can you give me specific examples?"*

Pru: *"Not really, but after two days off and annual leave I was coming back to work on my own and a problem - I can't remember what it was -except it was difficult to deal with. I didn't have the information I needed. I felt annoyed.*

Maud: *"Did Tilley have that information?"*

Pru: *"Yes, but she hadn't told me."*

Maud: *"Did you talk to her about it at the time?"*

Pru: *"Since then I have discussed it with her and we have agreed to leave 'good' notes or phone each other at home -we didn't like to disturb each other - now we have agreed to do it if it's necessary. I could see myself getting annoyed - I was annoyed that I haven't done it before. If I had spoken to her two months ago it wouldn't have been an issue. It was a busy time though and we didn't have time to share things."*

Maud: *"How do you think Tilley felt about it?"*

Pru: *"OK - she doesn't have the same problem. I leave her adequate notes. We have agreed to have a run down on the patients more often."*

Maud: *"Have you set regular time aside to achieve this?"*

Pru: *"I look a week ahead and see what may or may not 'blow up'."*

Maud: *"Have you considered what factors may cause these problems between you? Is it that you don't want to make decisions for each other in your absence?"*

Pru: *"Its not that.. it's not about treatments, its more about the social things. I can't remember the example. I just need that extra bit of feedback. There is a lot to get ready when you are going off-duty. Tilley was trying to protect my day off - not to disturb me."*

Maud: *"Are you sure? Maybe Tilley didn't see the need to pass certain information on?"*

Pru: *"No, she didn't."*

Maud: *"Do you phone her on her days off?"*

Pru: *"I used to leave written messages. I've asked her if there's anything I do that annoys her. She said - 'no'. I feel we've sorted it out now."*

Maud: *"That's good - what triggered you to sort it out when you did?"*

Pru: *"In my last supervision session I had put it down as a problem and I committed myself to it."*

Maud: *"So supervision perhaps helped raise your awareness of what was happening?"*

Pru: *"Yes, I suppose so."*

Maud: *"You mentioned writing your diary using the model of structured reflection was clumsy. Do you want to explore that?"*

Pru: *"Yes. I think I write quicker than I think."*

Maud: *"Don't worry about that. I find writing things difficult at times too. I'm not going to judge you in any way."*

They explored this difficulty.

Responding with appropriate action

Pru had taken action with Tilley to resolve this conflict. She realised that the unresolved conflict with Tilley would not go away. It merely broods and magnifies and ultimately became more difficult to deal with. Pru was annoyed at herself, at her lack of action. She felt the conflict and felt she could no longer rationalise it. The outcome is some mutual understanding about notes.

This was the last time that Pru mentioned Tilley, suggesting this new understanding was adequate. Pru noted in her 'reflective review[4]' -*'the whole team feels stronger. For Tilley I have come to realise how initially I had not fully accepted her as a replacement for Ann. By understanding this situation we now work as a team and communication has improved.'*

Pru also shared her experience of meeting the GP's with Tilley. She noted that this had been a positive experience, but felt it was unlikely to be repeated as it only occurred due to the absence of the senior partner who usually blocks

[4] See Appendix 6 for Pru's reflective review.

things. Despite this absence, this action illustrated Pru and Tilley's growing co-operation and assertiveness to challenge the GPs' unhelpful behaviour.

Session 13 [15 June, 1992]

Pru picked up on her concern with using the model of structured reflection 'properly'. She said he wanted to talk through the model using a situation that happened with a GP over the week-end."

Maud: *"If I read out the headings and then you talk your way through the model*[5] *.. phenomenon - describe the experience. Don't go into a lot of detail, summarise the main point."*

Pru: *"I got a message via the answering machine on Saturday to visit a patient. I'd met him before but didn't know him, therefore it was like a new visit. It was a direct referral from the patient himself."*

Maud: *"Causal - what essential factors contributed to this?"*

Pru: *"I came across a GP who was basically refusing to do his job. I got caught in a dilemma of accountability."*

Maud: *"And the context? - what are the significant background factors? Describe what happened?"*

Pru: *"I called to see this patient. He had had a painful eye since Tuesday. The GP visited but did not prescribe any treatment but referred him to the eye hospital. He went on Friday. They thought it was possibly an eye infection, and prescribed 'chloramphenicol' eye ointment. The eye was now swollen. I thought it was probably a reaction to the ointment. He wanted help to administer the ointment - he thought he had put it in incorrectly. I rang the GP on call, he was not one of ours, and asked for a*

[5] Based on the 5th edition

visit as I was unsure whether to continue treatment. He gave me a sarcastic answer - 'what do you expect me to do? Patients don't normally react to chloramphenicol'. He gave me the impression I was talking a load of rubbish. I persisted and said I still wasn't happy to administer the ointment. He told me there was no point in him coming out and told me to go and pick up a script from the chemist for some 'fucidin'. He arranged to phone the chemist."

Maud: *" Let's reflect in what you were trying to achieve?"*

Pru: *" I wanted the treatment changed and a reassessment of the patient's eye as the condition had changed since the previous day, otherwise I would have had to have left it until Monday. I picked up the prescription from the chemist and taught the patient how to administer the ointment correctly."*

Maud: *"Was it written down on a drug sheet?"*

Pru: *"No, but I decided that as I wasn't administering it, it would be okay. I recorded what I was doing. I told the GP I would write in the notes that he had refused to come out. I checked with the chemist that 'fucidin' was alright to use."*

Maud: *"Do you consider there is a difference between actually administering the drug and teaching a patient to give it himself?"*

Pru: *"I was feeling uncomfortable but thought it was okay. Straight away I knew I had to write it down. I knew I had to cover my back. "*

Maud and Pru discussed accountability.

Maud: *"How did the patient feel about it?"*

Pru: *"He was pleased I went and got a change of treatment. He didn't comment that the GP did not visit although I had indicated he would."*

Maud: *"How did it make you feel?"*

Pru: *"Annoyed - because I had made an appropriate referral and felt I was being totally diminished as a professional by my judgement not being taken into account. I was uncomfortable because of the decision, and because I didn't turn round and refuse to pick up the script. That's what I should have done!"*

Maud: *"The GP had manipulated you into a situation you didn't want to be in?"*

Pru: *"Yes. And I was embarrassed for the patient's sake as the GP wouldn't visit."*

Maud: *"Was that necessary to be embarrassed? Maybe you were taking on board the patient's feelings?"*

Pru: *"Yes - I was put into an awkward position, one that should never have occurred. I emphasised to the patient and his wife, that if the situation got worse to contact the GP. I felt confident they would although I had planned to go in next day to check the eye was responding to the treatment."*

Maud: *"Could you have dealt better with the situation?"*

Pru: *"I think I will refuse to go and pick up the script next time in a similar type situation. I don't care how much flack I get. I will say- 'No, I'm not happy, I'm not endangering the patient. If I make a referral to a GP then he should visit."*

Maud: *"Are you sure? Hindsight is a wonderful thing? Its easy to say that now - how may you react if the GP was to say- 'I'm not coming?"*

Pru: *"It's a principle - I should have had the guts to stand up to him. He obviously knew he should go in. In fact he went in an hour later. He walked in, said carry on with the 'fucidin', two minutes and he was gone. When I went in next day he had had a bad night- so much pain, the eye was swollen. There was no infection but his eye was closed and he had spots on his forehead."*

Maud: *"Shingles?"*

Pru: *"Yes. It never occurred to me. I informed the [different] GP, who visited and treated it."*

Maud: *"Did you have any other choices?"*

Pru: *"I could have called my manager."*

Maud: *"Did you consider contacting the eye hospital? "*

Pru: *"I never thought of that. I was so annoyed with the GP - that prevented me from thinking. I could also have got the patient to contact the GP directly rather than me responding, but he would not have responded so quickly."*

Maud guided Pru to consider the consequences of other options- contacting either her colleagues or her manager, and the need for support and advice when necessary.

At the end of the session Pru said: *"Its been a very positive session. It clarified what went on and the structure. It redefined my thinking."*

Responding with appropriate action

Pru's concern for this patient prompted her action and prompted her annoyance of the GP's action. She responded to help the patient although Maud helped her to identify and explore other options. Pru recognised her dilemma- that if she resisted the GP the outcome may not be in the patient's best interests. It was as if Pru had trapped herself in this moral black-hole by refusing to assert her own best interests. Yet, by responding with a written note that the GP had refused to go in- she put the ball back in his court, or in other words confronted him with his responsibility.

Creating the conditions

Another situation concerning an unco-operative GP. As Pru notes - *"I should have had the guts to stand up to him"*. This acknowledges her sense of frustration at herself. Yet the way the GP responded was 'normal' behaviour, an embodied response grounded in what constituted acceptable professional relationships between nurses and doctors. Pru's struggle to resist this response reflected her own embodied response to be accept this behaviour, even though Pru felt it to be unreasonable. It illustrates how changing culture against power gradients is not so easily achieved.

Session 14 [13 July, 1992]

When Maud arrived, Pru was surprised to see her. Pru had not written the date in her diary.

Maud suggested that Pru her forgotten to write the date in her diary might indicate that supervision was not a priority for her?

Pru: *"Perhaps. I've been wondering if I have been using it properly. I find it supportive but I'm not sure I m getting from it what I should be?"*

Maud reflected back to Pru the challenge made by CJ that supervision needed to be high challenge- high support.

Maud: *"Where do you feel most of our sessions sit on the chart?*[6]*"*

Pru: *"Low challenge - high support quadrant."*

Maud: *"I agree. I find it difficult to move into the high challenge quadrant."*

Pru: *"I want to continue supervision and move into the high challenge- high support quadrant."*

Pru continued: *"There is not enough time to do everything. I've just been talking with Tilley and Maggie*[7] *and they feel the same."*

Maud: *"Perhaps we can look at that today? You frequently say you are stressed and there is not enough time to do things and all your colleagues feel the same. Can you tell me what factors are making you feel like that? Be specific."*

Pru: *"How many visits I have to do. Its depressing the list.. some days I feel I can't take anymore."*

With Maud's probing Pru disclose a range of stresses within her personal life. It was as if Pru projected these stresses, into her work life. Pru became upset and Maud didn't take any further notes.

Knowing self

Pru was at a point of crisis. This prompted her to reject supervision as not being helpful enough, ironically for not being challenging enough. This then prompted her to disclose the difficulties in her personal life that impinge on

[6] See Appendix 2 - High challenge- high support chart.
[7] SEN in the team

work at this time. It was an emotional session, that illustrated Maud's being there to support and energise Pru.

Creating the conditions

This dialogue illustrated how being stressed gave Pru less energy to be available for her work. Pru had to use energy to balance her sense of stress, hence she was drained of energy. It highlights the essential need to create support mechanisms *within* everyday practice as drainage taps to drain the stress as it accumulates. Whilst supervision offered this tap, a session every 4 weeks meant that Pru had to carry this 'burden' around with her. As Pru has illustrated she did not feel supported well enough within everyday practice.

Session 15 [27 July, 1992]

Pru fed back her analysis of the past 8 sessions which she had scored using the high challenge-high support scoring chart[8]. Pru noted how useful it was to review the notes and affirm how she has moved forward in many aspects of her work. Pru and Maud confirmed their intention to work hard at increasing the challenge factor.

Alfred

Pru shared an experience concerning her *"extra visit"* to a patient -whom she described as *"heavy, heavy, and awkward"*. This patient had recently had emergency respite care in the local community hospital where a nursing home had been arranged in response to the family's plea that they couldn't care for him any more at home -

[8] This is inserted in chapter 10 within a broader discussion on the balance of challenge and support.

Pru: *"I walked in and found an abusive situation - the wife greeted me with - 'How dare you! Who organised it? How can you force an 80 year old man to go away from his home? She was really abusive. I felt angry - having done what they had wanted."*

Maud: *"What about Alfred? What was his view?"*

Pru: *"He is manipulative - he can walk the length of the ward when he is in the hospital but can't walk at all once he gets home. He said he was scared. He was frightened he would go in and couldn't come out again if he didn't like it. I said he should give it a try."*

Maud: *"Was that in front of the family?"*

Pru: *"No, just with Alfred - I went back to the family and said we had only set it up as a request from them - the family had wanted us to make the decision that Alfred is insane and needs to go into a home. When he was in hospital, one of the nurses sat down with him for two hours - he agreed to try a home. The social worker was there and his carer informed. The wife went hysterical, literally. She went blue! She has a psychological problem anyway, which she used on me. I phoned the nurse at the hospital. He was angry too."*

Maud: *"How did you react?"*

Pru: *"As calmly as possible - they said -'Why couldn't he have gone direct from the hospital? ' That made me angry."*

Maud: *"What were you angry about?"*

Pru: *"That they said I was lying and they had no control. We have done a lot of hard work - stopped other people getting care because he has had the maximum help possible within the limitations of the service."*

Maud: *"What were the consequences of your anger?"*

Pru: *"I was more angry when I came out. I normally shy away but I challenged them and went back over it - I put it into context. I explained that the hospital couldn't pick-up the pieces anymore - we had done all we could - it was down to them now."*

Maud: *"How did that make you feel?"*

Pru: *"Good. I talked forcefully - unlike me."*

Maud: *"And them? - how were they feeling?"*

Pru: *"Awkward - his son tried to cover it up, kept saying -'Let's leave it now'."*

Maud: *"What about after you left the house - how were you feeling then?"*

Pru: *"Worried that I was getting angry - concerned that maybe I was not being professional."*

Maud: *"Can you explain?"*

Pru: *"Concerned I wasn't going to be able to control myself because I felt so angry."*

Maud: *"What do you think might have happened?"*

Pru: *"I was frightened I might do something I'd regret."*

Maud: *"Such as?"*

Pru: *"By perhaps saying something in a raised voice - I might get tearful. I don't like abusing a situation."*

Maud: *"Were you afraid you might cry?"*

Pru: *"Yes - I might not have kept my cool."*

Maud related this experience with previous situations where Pru's emotions had possibly disabled her: "*Your feelings of anger are stressful for you - were you wanting to avoid conflict because this is too uncomfortable? - my role in supervision is to enable you to recognise when you are absorbing other people' feelings and how this then restricts your coping mechanisms and prevents you from working effectively. Why do you think the wife reacted like that?"*

Pru: *"The wife felt guilty."*

Maud: *"Could you talk to her about that?"*

Pru: *"No."*

Maud: *"Why?"*

Pru [pause]... *"Maybe at a later date."*

Maud: *"Would you?"*

Pru: *"Probably not!"*

Maud: *"Do you think it would help her? If she feel guilty - Alfred is making her feel guilty - maybe you owe it to her to allow her the chance to say what she really feels. It's a big decision to agree to someone going into a nursing home."*

Pru: *"She tells me one thing one week, one thing another week - she says that a nursing home is the best thing and says she can't cope with the situation anymore .. and then says -'what are you doing about it?'"*

Maud: *"How do you respond to that challenge?"*

Pru: *"I tell her that we've planned it once and they've turned it down - it's up to them now."*

Maud: *"Maybe its her way of dealing with this situation - she feels out of control - she tried to dump it on you. How can you handle that?"*

Pru: *"I don't know."*

Maud: *"Are you allowing yourself to absorb their feelings of guilt?"*

Pru: *"I realise they feel guilty."*

Maud: *"What have you agreed?"*

Pru: *"If he wants to go into the nursing home, they'll arrange it. The hospital are not going to pick-up anymore emergencies - they've made that clear."*

Maud: *"What have you learned from this situation?"*

Pru: *"He should have been admitted straight from hospital."*

Maud: *"Why would that make a difference?"*

Pru: *"The family wouldn't be black-mailed by him - they can't cope with seeing him cry. The big problem is that an assessment at home is very different from an assessment in hospital - he's incontinent of faeces at home but not in hospital. I recognise that I have got to learn to distance myself."*

Responding with appropriate action

This experience is centred in the inter-personal conflict within the family and between the family and practitioners. On one hand they struggled to cope with Alfred at home but on the other hand they could not cope with the idea of his

nursing home admission. The family were out of control and projected their feelings of guilt and anger onto Pru. Pru felt trapped within the complexity of this family's ambivalence and conflicting needs. Pru's appropriate response was blurred within the emotional entanglement.

Knowing self

Pru felt defensive and angry with the wife, and yet she also felt guilty because she wanted to help this family. In response she struggled to remain available whilst coming to understand the family dynamics. She feared her anger would be communicated as she struggled to be 'professional'. 'Professional' appeared as a facade to hide behind. Pru was defensive because she felt she and others had tried their best. These feelings blurred her seeing the situation for what it was. Hence she reacted to the presenting behaviour and not the underlying causes. Pru was left with a residual of mixed emotions, reflecting how arduous this experience had been for her.

Summary of Pru's 'being available'

Sharing these experiences with Maud made visible the extent Pru was available to work with her patients and families to help them meet their health needs [see figure 4.3]. Pru illustrated that she already practised in a congruent way with her holistic beliefs. Reflecting on this work with Maud enlightened her as to these practices which she had largely taken for granted. Over the 10 months of guided reflection, Pru illustrated her commitment to holistic care and her ability to work effectively with families from this perspective and to perceive her weaknesses and factors that contribute to this.

Creating and sustaining an environment where being available was possible

Sharing these experiences was also both self-affirming and affirmed by Maud. Maud was a significant other as Pru's manager, who acknowledged, valued

and cared for her. Maud contributed towards creating the conditions where Pru could be available to work with her patients and families in desirable ways. Conditions emerged in various ways as interfering with Pru's 'availability'. Even Maud emerged as barrier, in her managerial role as representing the organisation and passing down more and more organisational tasks for district nurses to do. Pru's sense of frustration was keenly felt. Her superficial response was to immediately resist new organisational demands being pushed down because she was very 'busy'. Pru noted [S2]:*"I have to be honest. It's been chaos and I haven't had time to think or breathe."*

She noted [S3] :*"It is really hectic, rushing all the time.. what with the computer and all that - I'm tired."*

This culture of busyness emerged as a coping mechanism to rationalise non-action of work that was perceived as peripheral to the primary task of working with patients. Almost every session contained an outburst related to this issue. In session 15 Pru acknowledged that time management was a key focus for future reflection. However this was merely the superficial problem. The deeper issue of coping and being in control had been constantly addressed through the dialogue. Pru had been able to give feedback of her feelings, have these feelings acknowledged as valid by Maud, and had discussed, explored and worked towards resolving the issues within Maud's collegial approach. Maud's organisational interests are visible within the dialogue, and are surfaced within the discussion. Yet they are never oppressive but help Pru frame her experiences and responsibility within real world contexts.

Pru's frustration was distracting and diverted her from her caring quest. She felt anger that was not easily expressed or resolved. She had learnt to live with this anxiety. Perhaps she felt this frustration keenly because she did care deeply about her practice. Sharing the experiences with Maud enabled Pru to make these frustrations visible and begin to work towards bringing these issues under control. Her later experiences suggests she succeeded in some

respects with the community hospital nurses and with her primary nurse colleague. Pru's working relationships with others was not always easy due to conflict over issues of control and values. This was most difficult with doctors because she perceived she lacked the power to do this, reflecting how she had been socialised into these relationships, and with her need to avoid conflict within the team. This was less a problem outside the team with others, but still a major resisting factor to taking appropriate action to confront the hospital primary nurse. Pru summed it up: *"Confrontation is an area I find difficult but I have challenged GPs more than before. There is still more to achieve.."*

Pru created an alliance with Maud, her manager where such frustrations can be expressed and worked towards mutual solution. In this sense Maud was empowered through the dialogue of Pru's experiences to see and respond to the world in more appropriate ways. Pru's shared experiences constantly confronted Maud with the meaning of district nurse practice and ways of realising caring in everyday practice. The development of the collegial relationship becomes increasingly stronger through the narrative. Pru was able to demonstrate her understanding of Maud's own problems and offered herself as support. Her understanding of Maud's difficulties helped put her own in perspective. Pru was visibly more relaxed, more in control, at the end of the narrative. She had gained a deep understanding of herself in context of her practice. She felt empowered and illustrated how she had taken action towards being more available in her everyday practice in her work with patients and families. Pru recognised the paucity of her support mechanisms at work. Supervision was a positive support mechanism for her [SEQ].

Their guided reflection relationship lasted 10 months. Whilst it reflected the learning that took place, perhaps more significantly it illustrated the process of learning over time. Both Maud and Pru were new to guided reflection. They were learning how best to use the techniques as time progressed. Perhaps their

best work was yet to come. Maud acknowledged that she was not challenging enough. Indeed Pru acknowledged her frustration that Maud was not challenging enough. Maud's lack of challenge highlighted a prevailing 'parental' culture of management, that Maud unwittingly subscribed to. Her own reflection with me enabled her to see and challenge herself with these issues. Maud could also acknowledge that she struggled to help Pru frame her knowing in practice within extant theory. The input of theory into the dialogue is starkly absent. This reflected how district nurses did not work from or have access to a *known* theoretical knowledge base for much of their practice.

Summary

In chapter 2 I drew attention to Smith and Hatton's (1993) concern that no research study has yet demonstrated that student professionals who engage in reflective activity become more effective practitioners. I am also mindful that this text does not prove that change in practice actually took place. However, by interpreting the significant dimensions of effective practice, and reflexively using these interpretative frameworks through the unfolding guided reflection sessions, Pru's development of effective practice, those factors that were significant in limiting her development of effective practice, and the process of development within guided reflection to facilitate development can be monitored. The next two chapters explore in depth the elements within the 'being available' framework in order to give a deeper insight into the nature and development of effective practice.

Chapter 5
Unfolding the pattern of being available

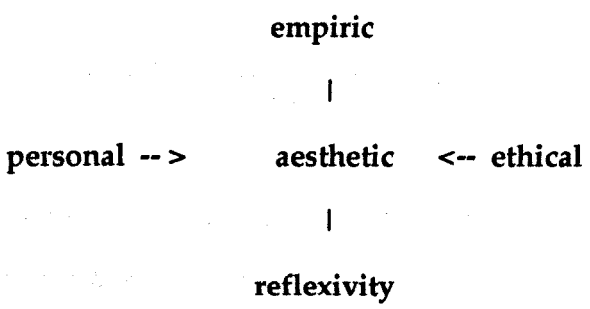
This chapter [with chapter 6] outlines and justifies the development of the 'being available' framework as an adequate way of understanding the nature of desirable and effective knowing in practice.

Knowing in practice

Pru's narrative was an account of her work with Maud in guided reflection. It illustrates the significance of Pru being available to work with her patients and families and the factors that influenced the extent that she was available within each particular situation. The 'being available' framework serves to frame knowing in practice and contributes to a reflexive understanding of what constitutes desirable and effective practice. This knowing in practice is subjective, unique, contextualised, and usually intuitive. The experiences Pru shared with Maud were stories of her responses within particular situations. Carper (1978) described this response as the 'aesthetic response'. By this she refers to how Pru grasped and interpreted what was taking place, how she decided what she needed to achieve, and the way she responded in order to achieve this. Pru then reflected-on the situation to judge the efficacy of her actions. Her 'aesthetic' response' was informed by the personal, the empirical, and the ethical ways of knowing that Carper identified as the fundamental ways of knowing in nursing. The relationship between these ways of knowing is shown in figure 5.1.

Figure 5.1

The relationship within Carper's fundamental ways of knowing within nursing



The Aesthetic - knowing how the clinical moment is grasped, interpreted, envisaged what is to be achieved, and responding with appropriate action.

The empiric - knowing how "knowledge that is systematically organised into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing." [p14]

The ethical - knowing what action should be taken within the context of the situation.

The personal - knowing self and impact of self within the situation.

Reflexivity - contextualised temporal knowing applied to new situations.

White (1995) considered that Carper had not paid attention to the contextual nature of knowing. In response to her critique she identified a 'cultural-historical' way of knowing that acknowledged how all experience, and hence all knowing, is developed from previous experiences towards anticipating future experiences. Within this study, the underlying conditions of practice were very influential with regard to practitioners being available within any situation. I have described this way of knowing as 'reflexivity'.

'Knowing in practice' stands in sharp contrast with a view of nursing knowledge as being 'objective', de-contextualised and claiming universal

application in the form of theory. This latter form of knowledge has been claimed as necessary for nursing's disciplinary knowledge base because it can be observed and verified (Kikuchi 1992). From a reflective world-view, 'objective' knowledge, or empirical way of knowing (Carper 1978), is merely one source of information to inform the practitioner's knowing in practice. Such knowledge must be critiqued for its relevance within the context of the specific situation. It can then be assimilated and transcended within the practitioner's knowing in practice. Nursing is a practice discipline and as such any claims for its knowledge base must be grounded in practice - in how nurses' practice and ways this knowledge can be developed. Frameworks, such as 'being available', can be constructed from analysing patterns of lived nursing experience, to understand this experience and to inform other practitioners.

The dimensions of being available

As I have stated, the extent the practitioner was available to work with the patient and family to help them meet their health needs was influenced by a pattern of elements [Figure 4.3]. This pattern is used to structure this account:

- ***Knowing what is desirable***
- ***Being concerned***
- ***Knowing the person***
- ***Responding with appropriate and skilled action***
- ***Managing involvement of self***

I have drawn on relevant extant theory to inform and frame this knowing in practice within a wider literature. Whilst this exploration of the literature is not comprehensive, it does illustrate the juxtaposition of knowing in practice with extant theory.

Knowing what is desirable

The practitioners within the study held certain beliefs about nursing. Pru's dialogue was infused with her beliefs, they rippled along the surface of the dialogue and set up contradiction. Resolving contradiction involved confronting Pru's beliefs for their adequacy and clarifying their meaning in practice [This process is explored in chapter 7 - philosophical framing]. Knowing what is desirable was necessary in order to understand the meaning of effective practice.

Being concerned

Each experience shared by practitioners was infused with their felt sense of concern towards their practice and their patients. This is evident within the experiences shared by Pru. Her concern for her work set up what mattered for her (Benner and Wrubel 1989 p86). It was not a stereotyped ideal stance she adopted or a particular intervention she could utilise (Jourard 1971). It was heart felt and set up the potential for involved relationships with patients and families. Carr and Kemmis (1986) draw on Aristotle to discuss the concept of phronesis, as the sense of commitment within praxis as "informed and committed action" [p46]. Commitment manifested itself through concern for others and with the practitioner's self-challenge and striving to be effective in her work. As a noun, commitment can mean 'a declared attachment to a doctrine or cause', although it can also mean - 'an obligation undertaken' (Chambers Twentieth Century dictionary 1972). From a sense of commitment, the practitioner acted from a set of firmly held beliefs and values about caring that implicitly led her to consider every situation on its merits prior to taking appropriate action (Cooper 1991, Packard and Ferrara 1988, Yarling and McElmurray 1986, Johns 1993b). van Hooft (1987) critiqued the nursing literature on caring and surfaced the tension between caring as unconditional giving of the self and as a conditioned professional response to situations. He

made the distinction between commitment and obligation. Obligation referred to carrying out an expected sense of duty. It represented the major ethical principle of deontology that a person acts from a perceived sense of duty with good intention (Seedhouse 1988) irrespective of the outcome of adhering to these duties. For example, the duty always to tell a patient the truth irrespective of the fact that it might be more compassionate to mask the truth, or that it might lead to conflict with the patient's family. Commitment was the resolve to act out of concern. For example, Pru's anxiety within situations was always a response to a threat to her beliefs being compromised. Her concern, whilst it sets up possibilities for caring, also sets up what counted as vulnerable for her, especially through the actions of others that threatened to interfere with achieving the patient and family's best interests. James (1989) noted in her research on nurses' emotional work with patients

"Emotional labour is hard work and can be sorrowful and difficult. It demands that the labourer gives personal attention which means that they must give something of themselves, not just a formulaic response." [p19].

This notion of "giving something of themselves" reflected the practitioner's commitment to act out her beliefs and values even in situations of personal stress. The contrast with a formulaic response highlights the distinction between involvement and detachment by the practitioner within her professional relationships. Forrest (1989), in her phenomenological study of nurses' lived experiences of caring, supported concern for patients as central to a concept of caring. She commented:

"For practising nurses, caring is first and foremost a mental and emotional presence that evolves from deep feelings for the patient's experience." [p818].

In general, the nurses struggled to express their concern for patients. The reasons for this seemed to lie more directly with the conditions under which they had been socialised, rather than any great loss of belief in caring. These conditions had not encouraged or supported them to value or become involved in therapeutic relationships with patients and families. This understanding fitted with Rawnsley's observation that

"The personal warmth and affection of friendship seems alien to the artificiality of the legal bonding that defines the association between professionals and clients." [1990, p46].

Rawnsley suggested that the word 'professional' needs careful interpretation and understanding when applied to nursing *if* nursing is defined within a caring philosophy. As such, *effective caring* will be enhanced by commitment and personal involvement in relationships with patients and families. However, the literature reflects a strong ambivalence to this personal involvement (Dunlop 1986, Jourard 1971, Menzies-Lyth 1988). For example Dunlop noted

"Nursing sought to teach me to maintain both separation and linkage in my practice - separation -'You must remember that the other is a stranger', and linkage -'You must think and act as if he were not'. Thus one achieves something like 'caring' .. a combination of closeness and distance, which always runs the risk of tipping either way." [p663]

I sensed a relationship between practitioners who were involved deeply with their work and their expressed satisfaction and commitment. It followed that creating the conditions where practitioners can become 'involved' with their work would lead to more satisfying and productive work. Once practitioners

work would lead to more satisfying and productive work. Once practitioners were able to recognise that they could effectively act out their beliefs and values of caring in day to day practice, the sense of satisfaction that resulted from this knowledge was inspirational. Satisfaction seemed essential to sustain commitment. The following text illustrates Jade's concern and the vulnerability of this concern in a difficult situation.

Jade with Molly

Jade [S3] shared how negative she had felt towards Molly when she was crying but had been unable to say what was upsetting her. Molly was crippled with arthritis and Parkinson's disease. Her failure to get Molly to respond to her interventions made Jade feel helpless. Despite Jade's impatience, Molly was eventually able to say she wanted help to get changed into her night dress before the night staff came on duty, which made Jade concerned with the night staffs' attitude towards Molly. They had said that Molly was a difficult patient to nurse because she was difficult to help and took so much time. Jade noted her residual feelings of guilt which she didn't know how to deal with, but which she could clearly recognise : *"I knew it was wrong to feel like that... I didn't like myself for feeling like it. I felt rotten about it."*

Jade acknowledged the contradiction between being concerned and these negative feelings. Rejecting 'difficult' patients had become unacceptable to her. She struggled to manage her negative feelings in order to avoid rejecting Molly. Jade noted that she was not skilled in this aspect of her work. As a consequence she absorbed this distress and became distressed herself. She could not easily rationalise her residual sense of guilt because of her commitment to caring. And yet, Jade's sense of concern energised and motivated her.

'Knowing' the person

The more concerned practitioners were, the more they paid attention to patients and their families. As a consequence, they got to know their patients better. The significance of knowing the person is captured by Hall (1964). She noted "You can only nurse what the patient allows you to see" [p15]. Practitioners at Windrush were aided to see the person within the context of the hospital's philosophy through the construction of a pattern of reflective cues that tuned the practitioner into the hospital philosophy within each clinical moment. This structured the viewing lens. The significance of 'knowing the patient' was vividly illustrated by Leslie's admission of Mrs Banning.

Leslie with Mrs Banning

Leslie [S15]: *"She was such a one off. You couldn't image anyone like her. Her GP said she was an obsessive, neurotic, and anxious lady. When she arrived here there was a look of sheer terror on her face. I had to respond. She said - 'Dr Pressley promised me a single room'. I responded - 'I might have one when its free [but] that might be a long time or never. I don't know. You can have some privacy by drawing the curtains around you.' She said that she couldn't possibly sleep on a bed, that she had to sleep upright in a chair with pillows to support her back. I arranged for this and told her that Dr Pressley had asked for her to elevate her legs. She accepted this and put them up on a stool. She also said she was in a lot of pain. I asked her where it was and when she last had pain killers. I offered her two co-proxamol at once and gave these with some cold water. She said she couldn't stand cold water and indicated to her flask of hot water."*

CJ: *"How did you feel when she said that?"*

Leslie: *"I momentarily felt put out but then I went along with the things she wanted in order to help relieve her anxiety. She also wanted a strong cup of coffee in her cup and saucer and some biscuits from her tin. I went to pour the coffee and she said -'I can do that I am not helpless'."*

CJ: *"Did that make you feel clumsy?"*

Leslie: *"Yes a bit - but I was happy to go along with whatever she wanted. I asked her what she knew about her illness, why she was here and what support she had. She said she didn't want to talk about it now, so I went away."*

CJ: *"You interpreted that as a dismissal?"*

Leslie: *"Yes - when I returned at 8.45 pm. with the night nurse- it was 8 pm. when she arrived - she was quiet, calm, and grateful. She called me matron - she called me that all the time she was here, never referred to me as Leslie except once when Jane was doing her dressing. She liked to be called Mrs Banning - she was very firm about that."*

CJ: *"Did anyone ever call her by her Christian name?"*

Leslie: *"I think one person did but she didn't respond... reflecting on the consequences of my actions, I felt I did help reduce her anxiety. She was comfortable in her chair and she was surrounded by familiar objects - her biscuits, clothes, dressings, etc. She had arranged these things around her bed, with all her crockery, cutlery, newspapers, and books on tables in front of her and at the side of her. The curtain was drawn to the right hand side of her bed to make a private space. What's interesting about the way she had arranged her bed-space was it was just like a nest - during the time she was here she pulled the curtains back until they were fully opened and she seemed happy to be seen."*

CJ: *"Why was that? Do you think she had become used to the environment or was it her trust in the staff?"*

Leslie: *"Both."*

CJ: *"Did you ask her what made her pull the curtains back?"*

Leslie: *"No but I checked out that she was happy here - I reflected on alternative actions - I could have ignored her and got on with the other patients, or got her to lie on the bed and to follow our instructions, or to respond with irritation to her anxiety, following the GP's advice not to show her any sympathy. However, the consequences of these interventions is that she would probably remain ultra anxious. How did I feel when it was happening? - I felt instinctively she was not unlikeable but her palpable tension made me feel concerned for her. I wanted badly to help her feel comfortable.*

How did the patient feel? - She seemed to feel more calm and at ease - my assumption was made from her appearance and non-verbal communication. How did I know how she felt? - she accepted my actions, she became quiet and noticeably unmasked her terror and pain, the way she arranged her bedside, her warmth towards me and Shelly [night associate nurse] on the handover walk-round, and how she became more openly warm in her responses to people, and her improved mobility - she could hardly walk or even stand on admission. Early one morning I noticed she had walked out to the single room to visit another patient. She didn't want to show the day staff she could walk.. What have I learnt? - That responding directly to an anxious person's agenda may lead to a significant reduction in anxiety and allow the commencement of a therapeutic relationship."

CJ: *"Which you achieved?"*

Leslie: *"To some extent."*

CJ: *"Did you feel you were rivals for control of the environment?"*

Leslie: *"In some ways - definitely, but I felt that it was more important she had control than I did. If I had tried to take control there as an even bigger risk that she would have discharged herself and no chance of a positive admission. When she came in I had the feeling she was going to go home and this wasn't going to work."*

CJ: *"Were you able to give the GP feedback about his briefing for her coming into hospital?"*

Leslie: *"Yes, but he was sceptical about how it would endure after she had gone home. He had a very laid back attitude towards her."*

CJ: *"Well he had written her off. I expect she knew that. How did your colleagues react to her?"*

Leslie: *"Umm - Gayle was her primary nurse yet in many ways I had established the groundrules for her, but Gayle and Karen found her difficult at times, and at other times had good relationships with her and responded warmly to her. Certain staff felt we indulged her far too much and we shouldn't allow patients to express and have their individual needs met to such an extent. These staff to some extent ignore the*

philosophy and the rationale of the [holistic] model."

CJ: *"Did that threaten to undo the trust you had established with Mrs Banning ?"*

Leslie: *"In fact Mrs Banning threatened to report one of the care assistants."*

Leslie illustrates how 'knowing Mrs Banning' enabled him to respond appropriately with sensitivity to her unfolding needs. Mrs Banning had already been labelled 'difficult', a label that threatened to cloud his perception. Leslie was able to shrug aside this threat to see Mrs Banning for 'who she was', her anxieties and her needs that are crucial to understand if they are to work together rather than in some adversarial way. It was 'knowing her' that countered the tendency to label her. When people are known as labels, nursing theory (Stockwell 1972, English and Morse 1988, Kelly and May 1982) suggests that practitioners are likely to respond to the label behaviour rather than the reasons that cause people to respond in ways that are perceived as 'difficult'. Jade illustrated how she confronted herself with her labelling of George.

Jade with George

Jade [S16]: *"I had a long chat with George. Myrna had been strict with him. He felt that he respected the nurses but that he felt he wasn't listened to or valued at Windrush. We discussed why he thought that was."*

CJ: *"What did you decide to do?"*

Jade: *"To do a deal with him. This included letting him go back onto his bed if he wished during the day as he did at home; letting him stay in his pyjamas if he chose to do as he would at home on occasions. I reflected this in his care plan. Everybody noticed an improvement in George's manner after that. The situation made me aware I wasn't being... I wasn't giving him time. The conversation with him was really honest. It made me feel guilty."*

CJ: *"Can you frame that within the hospital philosophy?"*

Jade: *"He made me feel I was blind but I'm glad that it happened, he opened my eyes. I*

think I had been avoiding him because of our unpleasant past experiences with him."

George was a patient who had been admitted on several previous occasions for respite care. Jade and Myrna had both shared experiences of nursing George that highlighted their struggle to respond positively towards him because he was so unpleasant at times. Because Jade was able to spend time to listen to him she came to understand why he behaved as he did, to confront his behaviour, and 'do a deal' based on knowing him. Jade felt this led to an improved relationship with him, more effective care for George, and greater mutual satisfaction.

Another significant barrier to knowing the patient was the tendency for practitioners, who worked in the hospital units, to see the person primarily as a 'patient' rather than as a person living within a community. Jade illustrated how she successfully challenged this de-personalisation of Philip.

Jade with Philip

In her next session [S17] she talked about Philip who had been re-admitted for respite care.

Jade: *"Philip, he actually seemed pleased to see me. He remembered, he recognised me, he couldn't actually remember who I was.. but he chatted quite openly with me which is something that doesn't often happen .. and then we lost him! We eventually found him in the staff toilet. I expressed my concern for him.. Mavis [the nursing auxiliary] was in mad panic running around the hospital saying - 'We've lost Philip' but I knew he hadn't wandered out of the hospital. I automatically walked down to physiotherapy where the door was open. I knocked on the toilet door and said - 'Philip.. are you in there?' He staggered out with his braces down and just laughed at me and he said - 'Why?' I said - 'You gave us a fright and I wondered what had happened to you'. He stumbled- 'Its alright, I just wanted to go the toilet'. I said - 'Okay, that's fine', and*

then walked back with him and we were chatting about why we were concerned. He just laughed and at the time I couldn't get any response out of him at all.. but it was strange because the whole of the next three days he was a lot warmer to me, whereas in the past he always seemed to have a masked face as if nothing was going on."

CJ: "Did that change the way you were towards him?"

Jade: "I don't think so... no. I like Philip, you know how you just like people and perhaps he was showing me he liked me to..."

CJ: *"You initially saw Philip as a 'dementia' rather than knowing him as a person. Because of that you underestimated his abilities and failed to interact with him?"*

Jade: *"Yes, the satisfaction came from interacting with him."*

Jade acknowledged she had seen Philip as a label rather than as a person. The revelation was profound. However, as Pru's experiences have illustrated, knowing the person within the context of his or her family was significant in order to respond appropriately to the family as a whole. This significance is illustrated in my continued dialogue with Jade.

CJ: *"Do you understand the relationship between Philip and his wife?"*

Jade: *"No, whenever I try to talk to her she'll talk about what she wants to talk about, then if it goes any further she has to go then. I've tried to contact her at home a few times to try and make an appointment for when it would be convenient for her to come and talk. She is always too busy."*

CJ: *"She's oppressive with him."*

Jade: *"Umm.."*

CJ: *"I discharged him."*

Jade: *"Did you?"*

CJ: *"When his wife was there.. the way she bullied him got him niggled. You could really see him smarting every time she did it. She said he is quite unpleasant to her and I'm not surprised. She laughs about it, laughs it off."*

Jade: *"Umm."*

CJ: *"I think she must be a tyrant towards him. It might actually be worth experiencing. You could just say - 'How are you coping?"*

Jade: *"Perhaps I could go and visit them at home or something?"*

CJ: *"She might have some trouble in dealing with that. She may feel guilty? Can we use my experience to focus on respite care about not being a baby sitting service but focusing on carers and their needs?"*

Jade: *"It's quite often the impression you get from the carer- 'Oh he's yours now, over to you'. Its interesting."*

CJ: *"I get the impression that she may need some help."*

Jade: *"I tell you what I do get concerned about and that's getting out of my depth."*

CJ: *"My response to that is to get out of your depth and then share it.. yeah, jump in the deep end and actually find it difficult and make sense of it. My impression is that you won't get too much out of your depth and by being very aware of yourself you can say to Mr Evans - 'I'm having trouble handling this' - I would feed that back to the person I was trying to help."*

We then explored 'jumping in and getting out of a jam techniques' to help Jade consider appropriate action.

Because Jade had felt intimidated by Mrs Evans she had avoided her, and hence did not know her. In a later session [S19] Jade said: *"Philip is back in. I have spoken to Mrs Evans. I saw this as an opportunity to run through things with her to enable her to open up with how she copes with Philip at home. She was always trying to get up and go as we spoke. She said she was going on holiday this week to the Lake District. When she comes back maybe I'll arrange to visit her at home."*

Jade enabled Mrs Evans to acknowledge that she was struggling to cope with Philip's care at home. Mrs Evans's reluctance to disclose this struggle told Jade that Mrs Evans needed to manage a facade of coping. The extent that Mrs Evans will open up and respond to Jade's availability remained to be seen. Jade

cannot help Mrs Evans without knowing her perspectives and that caring for Philip must be within this context. The dialogue illustrated how I confronted Jade's avoidance of Mrs Evans, which exposed her limited perceptions of what knowing a patient means, her own fears of 'getting in too deep', and the specific intervention skills Jade might require to respond appropriately. Jade was also empowered to take action to speak with Mrs Evans.

Opportunity for knowing the patient

Knowing the patient required opportunities for practitioners to be with patients. All practitioners had potential control over the day to day management of their work, and how they prioritised their time. Bathing patients emerged as a significant opportunity to be with the patient without interruption. Rhona notes [S8]: *"I made up my mind to restore the relationship and yet face him with some tough decisions. And I made time to offer him a bath so we could be alone and be able to talk. It was what he wanted and it seemed ideal."*

The opportunity to know patients required a 'space'. On the busy ward with a plethora of distractions it was easy to ignore this, with the result that relationships were often superficial and involved a reaction to request rather than a proactive intervention.

Leslie [S2] shared how he had got to know Agnes: *"I felt I got to know Agnes for the first time this morning since I've arrived."*

CJ: *"Was that easy?"*

Leslie: *"No .. but it was satisfying. I took her for a bath and she talked about her legs, the swelling and pain. We made frequent eye contact and she showed me she was enjoying the bath and was quite comfortable."*

Wolf (1986) suggested that nurses rationalised their adherence to bathing patients in various ways; as an opportunity to talk with the patient; that

families of loved ones expect their loved ones to be bathed; that bathing demonstrates that the nurse cared. Hall (1964) asserted that doing physical things does tell the patient that the nurses do care for them and through experiencing intimate physical tasks the patient is more likely to disclose herself. Bathing was a place where practitioners could focus and develop their involvement with patients. Yet this required confronting a prevailing attitude to get through the baths as part of the morning routine, which obscured bathing as a potential therapeutic opportunity.

Responding with appropriate and skilled action

The practitioner's response to any situation involved grasping and interpreting the situation, and envisaging the outcome (Carper 1978). Whilst the practitioner's response within any situation was always visible within shared experience, the rationale for action could not always be justified. Responses within situations were either habitual, intuitive or deliberative, depending on the situation. Few experiences paid attention to technical aspects of care that might have lent themselves to more deliberative action. It was as if technical aspects of practice were unproblematic in contrast with the complexity of the human encounter and the interactional skills that such situations demanded. Practitioners had to learn that caring responses were not techniques to be applied but rather a way of being within the situation that was not easily anticipated given the complexity and uniqueness of each encounter. For example, I helped Karen [S13] to plan how she could intervene with some relatives when they next visited. She felt very certain about her required intervention but, in the unfolding moment, this became inappropriate because the relatives did not respond as we had anticipated. However Karen felt the session had prepared her on an emotional level and with envisaging desirable outcomes.

Negotiation skills

Responding appropriately always needs to be negotiated wherever possible, with the patient. Negotiation skills are visible within Karen's experience with Mrs Kitchen.

Karen with Mrs Kitchen

Karen [S8] shared how she had spent time with a patient: *"To the point that I could challenge her behaviour - It didn't feel like that I had even done that before. It felt really good - she's a very independent 93 year old lady who wanted to go home but relied heavily on her zimmer frame but needs to use her sticks again. So I challenged her and said if she wanted to be as independent as she was prior to the accident why was she holding herself back? And it seemed funny because she hadn't thought about it at all."*

CJ: *"How did she respond?"*

Karen: *"A lot better than I thought. I thought she would withdraw or retaliate but she was thoughtful for a couple of minutes and then she agreed with me - she could see it."*

CJ: *"Did it change her behaviour?"*

Karen: *"She was more determined to try the sticks."*

CJ: *"But?"*

Karen: *"She till uses the zimmer frame... she says she's tired and that she has used them in the mornings."*

CJ: *"You accept that from her?"*

Karen: *"I have done. I came to work today thinking I'm going to get her going again tonight. She obviously wants to be independent again."*

CJ: *"Do you think she's giving you two messages?"*

Karen: *"She's saying she wants to be independent but she's a bit frightened and scared of it."*

CJ: *"Have you tried talking to her about that - exploring the accident? She may have repressed this and it is now affecting her confidence?"*

Karen contemplated confronting Mrs Kitchen's restricted behaviour. Her reluctance to confront Mrs Kitchen stemmed from anticipating a negative response and conflict. As a consequence, she felt uncomfortable with using confrontation. Karen had perceived the patient's desire to go home but not the factors that limited this. The risk was that in 'pushing the sticks' Karen would lose sight of the patient's fears. Mrs Kitchen, like many patients, had multiple and often conflicting needs that required Karen's understanding and appropriate intervention. Besides confronting Mrs Kitchen with her non-use of sticks in the context of envisioning the future, Karen could see she needed to help Mrs Kitchen explore her anxieties regarding the accident. I helped Karen to envisage using a 'cathartic' intervention to help Mrs Kitchen express her feelings about the accident and her fears for the future, and then a 'catalytic' intervention to help Mrs Kitchen talk through these issues. To be therapeutic, Karen could see she always needed to use these types of interventions within a supportive milieu, in particular showing Mrs Kitchen how concerned she was and acknowledging how tough it was for Mrs Kitchen to face the future.
Karen reflected on her confronting intervention in our next session: *"It was very empowering. I felt very positive about doing something, taking a risk and it came off."*
CJ: *"That situation came out of having time to be with people without feeling pressure."*
Karen: *"That's not so possible when we are busier."*

Karen, as were other practitioners, was clumsy or avoided using confrontational, cathartic and catalytic responses. This limited her ability to be available to the patient as appropriate. Burnard and Morrison (1991) noted how nurses rated themselves less skilled in using catalytic, cathartic and confronting skills, in contrast with giving advice, information and being supportive. They considered how catalytic, cathartic, and confronting

approaches involved an 'investment of self' which may be emotionally draining for the practitioner. Indeed this assertion was generally supported by practitioners' actions within the study. Consequently, I constructed a self-monitoring tool to enable practitioners to monitor their ability in using these particular responses. The feedback from using this tool confirmed the difficulty Jade and Myrna experienced with using these types of interventions [Appendix 5].

Responding appropriately required imagination and creativity to expand the practitioner's repertoire of interventions, to avoid being constrained by 'normal' ways of responding. The reflective cue within the model of structured reflection - 'What other choices did I have?' opened the opportunity to consider new ways of responding. For example, Jade's experience with Nancy opened up the potential of using distraction.

Jade with Nancy

Jade [S2] shared her experience in dressing Nancy's leg ulcers. These chronic ulcers were extensive on both legs. Jade noted how Nancy was generally perceived as a 'difficult person' by all who had dealings with her.

Jade noted: *"She started screaming.. 'the pain, the pain'. I felt awful - people will think I'm torturing her. I got annoyed with her. Nancy said that no-one understood her. I was frustrated because I didn't know what to do. I felt out of control."*

I had actually intervened within this situation to calm Nancy. Jade reflected on how I had responded to Nancy, how I had talked with Nancy about herself and about her lifetime experience. This hadn't taken away Nancy's discomfort but it had distracted her from thinking about it. This illustrated how asking people to talk about meaningful events in their past enabled the practitioner to imagine that person like that, as a proud and capable person. This facilitated respect and empathic understanding. I had given Nancy my undivided

attention which she valued. Jade said: *"Nancy told me she was a 'special case' and that we didn't know how to nurse her."* I suggested to Jade that she could show Nancy she both understood and was concerned for her. I said: *"Why not pop in to say hello after the session before you go home to make her feel she was special. This will help you to feel better about her ."*

Jade did this and shared with me later that it went well. Jade acknowledged she had emphasised the task rather than Nancy, whereas a more appropriate response would have been for Jade to respond to Nancy's anxiety. The dressing, whilst complex and time consuming, was itself not technically difficult. Paying attention to Nancy resulted in her becoming relaxed and co-operative. Responses such as distraction and imagery with Nancy are illustrative of creative ways of responding appropriately to the unfolding clinical moment.

Using Transactional Analysis

Jade's 'annoyance' with Nancy reflected the extent to which Jade did not know Nancy and the limited way in which she had interpreted the situation. I suggested that perhaps Nancy was acting like a hurt child and suggested that my response had been that of a nurturing mother in order to calm her. I framed my response to her within the theory of Transactional Analysis (Stewart and Joines 1987), in this instance responding to Nancy at her ego-state level of a frightened child. My response as a 'nurturing' parent was in contrast with Jade's 'critical' parent response which had limited Jade's perception of the situation and led to a breakdown in her relationship with Nancy because Nancy did not want to be treated as a 'naughty child'. She needed to be understood and comforted. Transactional analysis [TA] offered Jade a theory to underpin her understanding of communication patterns with others based on the theory that people communicate from the different ego-state levels of parent, adult and child. Effective communication, although not necessarily

therapeutic, is recognised within reciprocated ego-state levels. Where lines of communication become crossed then communication breaks down. Within a desirable 'working with' relationship, both the nurse and patient need to respond as adults. This is not to deny that at certain times patients, such as Nancy, needed to be in other ego-states in order to cope with what was happening to them. The issue was for practitioners to recognise this and respond appropriately, which may include responding from other ego states besides the adult.

Karen [S10] reflected back over her relationships with three different male patients whom she felt she had 'mothered' to varying extents. Sid had severe dementia, Troy was recovering from a severe depression- having been transferred from the local psychiatric hospital, whilst Liam was recovering from a severe stroke. Their common denominator was enforced dependence on nurses for support to manage everyday activities.

As Karen noted: *"I know I do it [mothering] but I still do it."*

CJ: *"Can you make sense of that? Troy acts like a little boy unable to do things and Sid responds well to affection. What about Liam?"*

Karen recognised her parental ego-state, which she had unwittingly adopted in responding to these patients. I challenged Karen to reflect on whether these ego-state communications were therapeutic? My challenge was based on the concept of symbiosis, which explained how communication can become stuck within a self-perpetuating pattern of ego-state communication. In Karen's relationships with these three men, this symbiosis was demonstrated by her moving between her parental and adult ego-states whilst firmly encouraging each patient to stay within his child ego-state. This symbiosis was both comfortable and satisfying for Karen, and she had assumed, albeit unwittingly, it was also comfortable for her patients. Maintaining parental ego-states was one way Karen could control her environment. However, except for Sid, its

therapeutic value could be challenged. As part of their rehabilitation, Liam and Troy needed to be helped to accept responsibility. Perhaps this helped to explain why Karen was so angry when patients reduced her to the child role. It illustrated how her own concerns threatened to mask grasping and interpreting the clinical situation in terms of the patient's needs and hence reducing her ability to 'be available'.

Ethical decision making and action

"Any discussion of ethic in nursing must begin with the lived experience of nursing practice." [Bishop and Scudder 1987 p36]

The way practitioners respond within clinical situations is always an act of moral reasoning (Carper 1978). How the practitioner *should* act is, in principle, determined by her nursing beliefs and values. However, for many reasons, it was often not possible for the practitioner to take congruent action within the real world of everyday practice. This often resulted in a sense of intrapersonal conflict within the practitioner. Failure to negotiate 'what was best' with the patient or family often resulted in inter-personal conflict between the practitioner and the patient. Often, conflict existed between family members that led the practitioner to take one side, rather than respond to the whole family. Often environmental factors, such as relationships within the organisation led to interpersonal conflict, in particular when other workers, such as nurse colleagues or doctors, interfered with the practitioner's effort to fulfil their responsibility to the patient.

These varying levels of ethical conflict can be summarised as

- situations of conflicting values within the practitioner;
- situations of conflicting values within the patient [family];

- situations of conflicting values between the practitioner and patient/ family;
- situations of conflicting values/ status between the practitioner and other workers/ organisation.

- **Situations of conflicting values within the practitioner:**

Jade with Geoffrey

Jade [S17] shared how she confronted Geoffrey, a man dying of bowel cancer. She had been informed by the night associate nurse that Geoffrey's bowels were 'loose and watery', but he had refused an offer of 'imodium' - saying his bowels were fine. This prompted Jade to confront Geoffrey with this contradictory information.

Jade: *"I felt quite strange - I didn't want him to think I was forcing him. He was trying to conceal things from us - maybe he was trying to be independent. That's fine - I sometimes feel as an associate nurse - how far do you go? I didn't know him very well although he did say when I challenged him that he was fed up with taking tablets. What did this mean?"*

Jade and I then explored her dilemma of 'pushing' the imodium and her options for responding appropriately within this situation.

Jade continued: *"The next day Geoffrey had left a mess in the bathroom . He had been incontinent of diarrhoea. I felt by his action that he didn't want his space invaded. He declined my help to run a bath for him. I understood how he felt - I didn't feel rejected. That's fine because it was what he wanted. I would have assaulted him if I had physically taken over."*

Jade intuitively 'knew' how to respond based on her chat with him yesterday. It was essential that Jade's empathy was right, because to leave a dying man covered in diarrhoea to cope by himself might leave her open to criticism. The previous day she had insisted on his taking the 'imodium'. Now she could accept his need for self-determination. She had made herself available to

Geoffrey and gracefully accepted his rejection of her availability *on this occasion.* In this way she remained available to Geoffrey for other occasions. If she had insisted on helping Geoffrey with his diarrhoea she risked conflict with him.

- **Situations of conflicting values between the practitioner and the patient / family**

The following experiences shared by Jade and Karen illustrate how differences of perception, attitude and control, lead to situations of inter-personal conflict between practitioners and patients/ relatives.

Jade with Hilda

Jade [S9] shared how Hilda [a patient] had told her she was horrid. Jade had asked her why. She said it was because Jade had made her stand and take a few steps. Jade reminded Hilda that she had agreed this action with the primary nurse and her husband the previous day - as recorded in the care plan. Jade noted: *"Hilda's response to this was - 'I didn't agree to anything no matter what anyone said!'. Hilda implied that 'we enjoyed bullying her', which upset me. I told her that -'if we wanted things to be easy we would just leave you' - which brought an almost predictable response from Hilda - 'Just leave me alone', which I then did. I felt pressured at this time with the needs of other patients. It made me feel uncomfortable all morning."*

CJ: *"Could you have acted differently?"*

Jade: *"No - it would be just the same. I had taken the right decision and made the right action based on the chat I had with the primary nurse yesterday."*

The ethical issue which Jade understood and which prompted her action was her dilemma of making Hilda act contrary to her own wishes. Whether Hilda had agreed one thing yesterday was history. She may have merely complied

yesterday and now faced with the reality of this decision she felt quite differently. Jade had to be certain that she was acting in Hilda's best interests rather than her own, which was to carry out planned care. Yet Jade, as an associate nurse within this situation, should not blindly follow planned care. She needed to make a judgement as to whether the planned care was still appropriate for the patient's needs. Jade noted that she had still felt awful about this experience some days later, which she rationalised as her being over-sensitive. She was unable to avoid these "awful" feelings because of her concern. She recognised her caring dilemma: *"We don't come to work dressed in a suit of armour to protect yourself from all this shit... you just feel you are a target for people to fire at."*

Jade noted that this experience had affected her relationship with Hilda: *"I went back later to do her dressing and she just pulled away, didn't communicate, closed her eyes to dismiss me."*

This rejection by Hilda had made Jade angry on top of feeling awful. One way of dealing with such awful mixed feelings is, of course, to blame the patient. However, Jade also noted that she now felt "horrid" for feeling angry at Hilda. It was as if Jade was on a merry-go-round of energy sapping emotions towards herself and Hilda. Jade lived the dilemma of knowing what was therapeutic for Hilda; on one hand Hilda hated being in hospital and wanted to go home to be with her husband, but on the other hand she wanted to be left alone because she felt so tired. Hence she was ambivalent about her rehabilitation and about her level of dependence on the nurses.

This situation highlights how the effective practitioner is someone who is sensitive and responsive to changing situations. Jade's experience also makes visible the ethical tension between prioritising different needs for different patients. For Jade to spend more time with Hilda limited her time to be with other patients. I asked Jade whether she had talked this over with her

colleagues. She said she hadn't because she didn't want to burden them with her problems. Neither had she written about this experience in Hilda's nursing notes. I discuss the significance of support and documentation in chapter 6.

Karen with Mrs Fenner

Karen [S16] talked through her conflict with Mrs Fenner, the wife of Jack who had suffered a stroke.

Karen: *"I think we all found him difficult to care for because he was physically heavy, but his wife was adamant she wanted him home and to be involved in his care. She was quite an abrupt lady, I don't think she meant it nastily - it was just her manner. I felt a huge respect for her when I knew she wanted to be involved because that's how I would want to be if Craig* [Karen's husband] *was ill. I felt really positive about the situation - I felt I could be of help in empowering her to care for Jack at home. One evening she asked me to help Jack before she went home."*

CJ: *"Is that a pattern - she had taken over that aspect of care?"*

Karen: *"We wash him in the morning and she came in every afternoon and evening and gives him a wash then. I went along to help her - I gave her the control of the situation but I could see there were places that I could help, and suggested to her different things but she wouldn't listen. I felt humiliated. I wanted to be of help to her but she wouldn't acknowledge my knowledge and skills."*

CJ: *"You felt rejected?"*

Karen: *"Definitely - and frustrated - I had such good intentions in helping with this family. In a small way I felt as if I was failing Jack. If I had been more assertive he could have things done more comfortably."*

CJ: *"Could Jack speak?"*

Karen: *"If he wanted to sometimes... and sometimes it was just nonsense. If he was upset he would say something. He made his feelings clear to us on several occasions that he didn't want us to do things in certain ways."*

CJ: *"So he was happy with what his wife was doing?"*

Karen: *"In that situation he was, but maybe he didn't know it could have been done more comfortably. It links with what you were saying* [1] *about how our feelings towards patients and relatives affect our availability to them - because after that I felt very very hard to be available to her."*

CJ: *"Do you want to share that?"*

Karen: *"My reaction was frustration! I needed to be more assertive with her, but to phrase my assertiveness differently with her."*

CJ: *"Could you have just thought 'this is no big deal' and just accept her position?"*

Karen: *"I noted that as a possibility, but my feelings were stronger than that and I knew I had to work out something different from that."*

CJ: *"Do you think your feelings clouded the issue?"*

Karen: *"I don't think so.. without those feelings I don't think I would have identified the issue at all."*

Karen struggled to accept and work with the relative's needs when they were in conflict with her own perceptions. She had reacted to Mrs Fenner not valuing or acknowledging her role. The consequence was that Karen felt rejected and withdrew from Jack's wife. Yet the wife needed considerable emotional and physical support. The skill was for Karen to recognise Mrs Fenner's needs and remain available to her whilst Karen dealt with her own feelings. The dialogue exposed how Karen tended to impose her own values into the care situation - respecting Mrs Fenner because she would have done that for her own husband yet - how would she feel if Mrs Fenner had wanted to reject her husband? Being available must involve a perception of self-feelings in order to understand and accept the patient's or relative's without prejudice. The reality is that Karen, as all nurses, have prejudices that impact on the care situation. The skill is to surface, and acknowledge these prejudices in order to work at limiting their constraint on helping potential. I explored

[1] This was a reference to a previous session

with Karen how she might sublimate her negative energy into positive energy through helping Mrs Fenner explore her feelings, including how she viewed the future. For example, perhaps Mrs Fenner has to manage the best way she can because of her need to be useful and her need to cope. Perhaps being told that there are better ways to manage Jack merely exposes her limitations. Instead of working with the relative Karen found herself in another 'win-lose' situation that was therapeutically destructive. Understanding experiences like this reflected the centrality of feelings for decision making, particularly within situations of human distress. Emotions energise the ethical quest (Callahan 1988), and yet, they also complicate it. As Carper (1978) noted:

> "Moral choices to be made must be considered in terms of specific actions to be taken in specific concrete situations." [p21]

Ethical principles are inadequate to guide the practitioner's response within the unique human encounter of the practice situation (Parker 1990, Noddings 1984). This response can only be situational based on a deep understanding of the situation. It was evident within practitioners' shared experiences, that once the patient became an object within decision making, then his or her humanness was diminished. The specific situation always presented limits to possibilities - but these merely fuel the negotiating process with the patient rather than dictate its outcome. Practitioners, like Jade and Karen, needed to recognise, understand, and ultimately transform the boundaries that impacted on taking appropriate ethical action.

Managing time/ Prioritising work

In a busy world, prioritising work was a significant ethical issue. When Karen shared her experience in exploring walking with Mrs Kitchen, I noted the significance of having time to be with people without feeling pressure. As

Karen responded: *"That's not possible when we are busier."*

CJ: *"When you say busier, do you mean this as physical work?"*

Karen: *"Yes, it helped having faith in the care assistant I was working with who could handle other patients whilst I spent time with Mrs. Kitchen."*

CJ: *"Faith? Do you mean she wouldn't judge you?"*

Karen: *"I did feel she wouldn't judge me."*

Karen suggested that in order to be available to work with Mrs Kitchen, no other work claimed a greater priority, and that she could rely on other staff to manage her other patients. However, as Karen noted: *"that was different with other care assistants"*. Karen acknowledged she had been socialised within units that had prioritised physical work, as if there existed a hierarchy of work priorities. Working with Mrs. Kitchen enabled Karen to realise that it was counter-productive to urge Mrs Kitchen to walk when psychologically she was afraid of doing this. The contradiction was starkly evident.

Managing involvement of self

We must first understand ourselves if we are to know and appreciate the world of others." (Boykin and Schoenhofer, 1991p 247)

"It is an art to know what one can offer in a situation without becoming over-extended or assuming more responsibility for the situation than necessary."

(Benner and Wrubel 1989 p375/6)

Pru's narrative illustrated her involvement with her patients. Her involvement was a reflection of her concern rather than a deliberate response to a situation. This involvement was an essential response in order for her to work with her families from the holistic perspective she espoused as desirable. This perspective involved responding to patients and carers on an emotional and spiritual level. Pru illustrated how this work was emotional and sometimes

distressing for her. Hence to be available to work with the patient required Pru, and the other practitioners, to manage this involvement. Leslie's experience with working with Alec, shared over several sessions exemplifies the nature of this work.

Leslie with Alec

Leslie [S7]: *"I've got a patient at the moment who is quite a puzzle to us all - Alec. He's quite elderly, 88 and has had major prostate surgery. He suffers from reduced mobility, chronic constipation, lethargy, low motivation - he sees no point in eating, drinking in fact doing anything. Gary [GP] says he can go home if he eats and drinks. Alec won't listen to people. If you persist he gets quite irritated. He also requires two nurses to help him from bed to chair and he grabs people and objects. When you insist he does stand better but he panics after a few minutes. I haven't had time to spend a long time with him but I feel I have got to get down to what he wants and how to achieve that."*

I fedback Leslie's last sentence to him and added: *"What about his family?"*

Leslie: *"His wife died last summer in the hospital!"*

CJ: *"Is he depressed because of that?"*

Leslie: *"Possibly."*

CJ: *"You haven't tried talking to him about that - his feelings?"*

Leslie: *" I asked his doctor to speak to him, to point out to him the nature of his serious illness and what he needs to do to regain health to get home again. He took to his bed 8 years ago, and spent most of his time in bed or in a wheelchair. There was no medical reason for that."*

CJ: *"How does he see the future?"*

Leslie: *"Karen asked him that. He replied - 'No pain' - he described how he was going to achieve that by lying still. That was a rare occasion he has given a direct answer. I know I need to make time to be with him... it's bothering me."*

In our next session, Leslie noted: *"I used the Model of Structured Reflection to reflect on Alec's care prompted by my continual feeling of frustration in caring for him culminating with his death. It's still unfinished - I needed to sit down, talk about it, write about it, to work it out and learn from it."*

Leslie continued: *"What was I trying to achieve with Alec? - I was trying to achieve what he wanted -for him to go home and to be pain free. Why did I intervene as I did? Because it was what he wanted within our limits to meet his true needs. It was difficult because he was ambiguous about these."*

CJ: *"These needs were difficult to unravel?"*

Leslie: *"Yes. What were the consequences of my actions? For him - starvation leading to heart failure and death. It was peaceful but proceeded by a lot of anger and distress that he couldn't go home again. He had shut himself off - kept us at a distance. He said 'my mind wants to live but my body doesn't... why can't you help me?' We challenged him -'We want to help you, tell us how, let us near you so we can work together at what we both want.' What were the consequences for me? That I didn't deliver most of the goods. I managed interventions with his consent at times."*

CJ: *"Physical interventions?"*

Leslie: *"Yes, but beyond that it was very limited. What alternative options did I have? - Discuss his care at length with my colleagues, the GP, the Reverend. I thought at times to contact Eloise - to draw on her expertise with complementary therapies. I did eventually call her but it was too late. I'm trying to widen my personal options of care and to give the impression that some of this was being done. How did I feel about this? I felt bad about his care because others look at you for some kind of direction."*

CJ: *"I get the impression of helplessness?"*

Leslie: *"I feel very sad about it now - I felt I didn't do all I could - I wish I had asked Eloise a lot earlier than I did - it was only a week before he died.. she came the day after."*

CJ: *"You haven't been able to rationalise his death?"*

Leslie: *"I have to a certain extent - although he said he wanted to live - all his other*

actions and extent of our relationship in terms of what he would agree to - in terms of his eating and drinking, led to his death. He knew that - we discussed that quite clearly. I feel powerless, at a loss. It made me feel like a bad nurse, not a primary nurse. I felt I should have been able to reach him , to find a therapeutic intervention to help him - to achieve something positive."

CJ: *"You say he died last Thursday, six days ago - how do you feel now?"*

Leslie: *"I've started to feel a bit better. I talked to his niece from Ireland - she understood we did all we could - she knew he shut himself off at times - he had begun this 'closing off' from people when he had the operation on his nose nine years ago because he felt disfigured."*

CJ: *"That was the GP's theory when we discussed this previously. We both felt that was rather dubious."*

Leslie: *"Other people have confirmed it."*

CJ: *"When did his wife die?"*

Leslie: *"Last summer - that has magnified all of this."*

I helped Leslie reflect on the apparent contradiction that Alec wanted to live and felt his body wanted to die, to try and help him make sense of Alec's feelings.

Leslie: *" How did he feel about it? When I confronted him with the consequences of his actions he either clamed up or talked about something else."*

CJ: *"What did you infer from that?"*

Leslie: *"The impression I got was that he was very afraid of what was happening to him - of losing control and dying. He couldn't admit it to me. I can only assume that what he said was what he felt. I challenged him with the contradiction but he didn't respond."*

CJ: *"Perhaps you were getting close?"*

Leslie: *"Yeah.. I still clutch onto Eloise - if I had only contacted her earlier - maybe there would have been some way?"*

CJ: *"Is that being reasonable on yourself?"*

Leslie: *"Perhaps it isn't - but it would have allayed my unhappiness and saying that I didn't know what to do, and I feel I ought to have known what to do."*

CJ: *"That sounds a bit like the medical model - needing some intervention to fix the problem?"*

Leslie smiled ruefully: *"It does in a way. I didn't see it that way at the time - I just wanted to help him - but I couldn't."*

CJ: *"Perhaps there was nothing more you could do.. Eloise is just a red herring. Are you blaming yourself for not being skilled enough?"*

Leslie: *"Maybe - but I also need to come to terms with the fact that I cannot help people as much as I or they would like me to in these problematic situations which are messy and indefinable. That was all in context of the model of structured reflection. That proved valuable.. this situation has been bugging me all this time."*

I acknowledged Leslie's sensitivity in his work with patients, but how this made him vulnerable, reflected in how distressed he felt because Alec resisted his involvement with him. Leslie felt he had failed himself, Alec and his colleagues. I confronted Leslie with this: *"Are you taking responsibility for the staff's anguish?"*

Leslie: *"In that we discussed it and I said I don't know what to do and they said we know you don't know what to do."*

CJ: *"And you blame yourself for their pain?"*

Leslie: *"It's that I am the primary nurse and therefore they had to project their pain and anger into me and I had to absorb this."*

I challenged Leslie that he had no right to accept this anger. His responsibility was to help his colleagues deal with their anger appropriately, not to carry it himself as some metaphoric cross as penance for guilt. Leslie indicated how absorbing this experience had been for him, complicated by his unresolved conflict with the district nurse after Alec's discharge, whose complaint had

triggered the re-admission.

Leslie: *"Alec has occupied my mind so much these past days. I've nothing else I wanted to pick up on. Its such an issue as you say in picking up this balance between sensitivity and coping."*

Leslie clearly expressed his feelings of guilt, anger and sorrow at Alec's death. He berated himself for failure to make interventions earlier. His need to involve Eloise was a last ditch effort to find the right intervention. It is the failure of the medical model to fix the problem. Leslie's own feelings had become entangled with Alec's. As such, he was unable to stand back and see himself within this situation. He 'stews in his own juices', unable to resolve these issues, distracted and less available to work with his patients.

In session 10 Leslie reflected: *"Your feedback from our last session regarding Alec - I felt at the time that I hadn't resolved anything. Next morning I woke up and felt a great weight lifted from me, that I hadn't mucked up, and had been hard on myself. It was like a delayed benefit from the session."*

CJ: *"That sounds as if this was a very powerful experience?"*

Leslie: *"It has raised so many important issues for me. "*

Leslie suggested that he had worked through his emotional response to Alec's death. Yet, even months later this experience continued to haunt him and effect his availability to work with patients. It illustrated how changed perspectives do not necessary lead to changed actions despite good intentions and struggle to move beyond self.

Personal concerns as a barrier to involvement

Leslie's experience is illustrative of how practitioners' own concerns interfered with 'seeing' and responding appropriately to the patient. These concerns were like a 'haze' that obscured the view. Two experiences shared by Karen illustrate

how her concerns interfered with therapeutic work.

Karen with Maud

Karen [S7] shared her feelings about Maud: *"I have this feeling she is manipulating me. I've been through the reasons for feeling like that - but it has left me feeling the same way [but] suddenly my feelings have gone past that. Reading the Morse paper (1991), I can see it as one of the steps in building up a relationship. I've not experienced that before - it really affected me at the time, although I don't feel I coped with it particularly well. I would like to cope better if I experienced it again."*

CJ: *"How did you cope before?"*

Karen: *"I've never got that close to a patient before."*

CJ: *"So how did you cope within this experience?"*

Karen: *"I tried to make sense of why she was doing it - but I didn't get anywhere, for example I gave her feedback that I didn't like the nicknames that they embarrassed me -'angel of delight', 'Karie'..."*

CJ: *"Do you think she was trying to mother you?"*

Karen :*" To some extent. I don't need mothering. I'm qualified now - they still see me as a 22 year old girl!"*

CJ: *"Can you see she may have need to mother you as a way of coping?"*

Karen: *"If she was like that then wouldn't she act like that with other staff?"*

CJ: *"She may just want to mother you?"*

Karen: *"It made it that I didn't want to go near her if she was going to be like this."*

We rehearsed interventions to move Karen and Maud into an adult mode.

Karen had recoiled from an unacceptable familiarity. I used Transactional Analysis to help her see and make sense of this pattern of communication between them, that limited Karen's availability to Maud. When Karen failed to move Maud from this 'parental script', Karen responded as a 'child'- hurt and sulking, which she recognised but which made her feel more resentful. Once

Karen could demonstrate to Maud her 'adult-hood', Maud may be able use her to explore her anxiety and cope differently which she is unlikely to do if she continued to respond to Karen in parental mode.

Rachel's love - accepting gratitude

Karen [S20] explored her reluctance to visit a respite care family at home because she felt: *"Smothered by love with everything I am doing. I'm reluctant to go and to feel closed in by them - stupid things like calling me sweetheart!"* [cringing]
CJ: *"It feels like a situation of 'involvement' - as if you want to take a step backwards and they want you to take a step forward."*
Karen: *"Yes - I'm [trying] to maintain a professional distance."*
CJ: *"Maybe you need to unwrap yourself from this dilemma - it is a product of how you have become involved with them - it has blurred your own boundaries. Your work is now to close this relationship and be gracious and accepting their need to love you?"*
Karen: *"Yes - I can accept that."*

Karen paradoxically resisted being involved within a mutual caring process. She feared losing control and consequently, retreated behind a defence of 'professional' distance that limited her availability to work with this family who needed to show their gratitude to Karen.

'Involvement'

The span between Karen's two experiences was six months. This highlights how managing involvement of self within relationships was not easy work for Karen, or indeed for any practitioner. Involvement can be contrasted with being 'detached' from patients. Practitioners often used the word 'professional' as an acceptable facade for retreat from patient involvement, for whatever reason. This 'professional' stereotype creates dissonance within nurses who believe they should care but are largely socialised to rationalise such beliefs in

the face of an unsustaining reality (Dunlop 1986). Spencer (1982) considered the nurse needed to perform some form of social ju-jitsu in managing simultaneously her engagement in intimate contacts with the patients or engage in some form of self-sacrifice whilst attempting to remain detached, for she is a stranger nursing a stranger (p413). Peterson (1988) draws on the literature to paint a typical background picture

> "Staff are expected to control their feelings. Shows of emotion are discouraged; personal and emotional involvement are feared. Clients' feelings tend to be ignored. Systems of control predominate over systems of caring." [p86]

Yet practitioners did become more involved with some patients than others. Whilst reluctant to admit this, the practitioners' varying concern for patients was evident, as were the factors that limited or complicated this concern and consequent involvement. One factor that mitigated against involvement was a fear of 'getting in too deep.' Often practitioners, like Leslie, experienced the sensation of being entangled in an emotional web woven by the patient and family.

Morse (1991) explored the nature and negotiation of nurse involvement with patients. She initially interviewed 44 nurses across a range of practice settings, and subsequently 'tested' her substantive theory with a further 59 informants. She distinguished between uni-lateral and mutual relationships and identified 4 types of mutual relationships; 'clinical', 'therapeutic', 'connected' and 'over-involved'. These types reflect a general movement from the practitioner seeing the person as a patient towards seeing the person as a person with a parallel sense of developing involvement. 'Over-involved' was reflected in the way the nurse's emotional engagement became out of control, resulting in a paradoxical therapeutic failure plus much anguish and distress for the practitioner. A similar typology was constructed by Ramos (1992) through

analysing clinician's perceptions of the involvement with patients and families. Within Morse's typology, Leslie strove towards achieving connected relationships in the belief that such relationships were desirable. Leslie's own concerns are reflected in his need for a reciprocated involvement but one resisted by Alec. As Alec resisted, Leslie pushed harder, absorbing Alec's angst.

When Leslie read Morse's work, he immediately identified with 'over-involvement' although I felt 'entanglement' was more descriptive of how he actually felt. My understanding of Leslie's and others' experiences suggested that the unilateral - mutual types of relationship was a false dichotomy. Within all relationships 'reciprocation' and 'resistance' exist in tension. In situations of either reciprocated or resisted involvement the web of entanglement awaits the unsuspecting and unskilled practitioner. Responding appropriately to patients and their families requires that practitioners know and respect the level of involvement desired from patients and relatives. The practitioner's concern says 'I am available', but an availability that is not conditional on reciprocation. The essence of reciprocated relationships is illustrated through two experiences Jade shared towards the end of her guided reflection relationship[2].

Jade with Dick

Jade [S20]: *"I spent some time talking to Dick. He was angry about what had happened to him [CVA], and anxious about his embarrassment, and tearful. It was difficult for him to talk the thing through. He had been arguing with his wife. I think he's grieving. I've written -'I don't know how to help him except helping him to talk'. I took him to the toilet and picked up his feelings that he didn't like that - that he would have preferred a man to help him."*

CJ: *"Did you feel rejected?"*

[2] **The growth of Jade's development in establishing effective involvement with patients and families was the focus of an International conference paper and published paper - 'On becoming effective in ethical action [see Publication Anthology- Appendix 7]**

Jade: *"No - I was pleased he was able to talk to me about it."*

CJ: *"Why?"*

Jade: *"Here was a man having problem accepting help for personal care and he shared it with me."*

CJ: *"Therefore you felt accepted. Did you create that opportunity?"*

Jade: *"I took him to the bathroom. He looked down and said - 'I am a silly old fool'. I responded - 'Do you want to talk?' He said - 'You don't have time - you girls are so busy. I said - 'I have time to talk with you'."*

CJ: *"How are you going to build on this?"*

Jade: *"Attending to his feelings, the man needs to feel in control, to know what's happening. He needs to know the truth. He also needs more time than we can give him. He was apologising for his anger, he just wanted things to be like how it was - he was crying a lot."*

CJ: *"How was that making you feel?"*

Jade: *"OK."*

Jade suggested that she was able to control her feelings whilst being sensitive and appropriately responsive to Dick's experience.

Jade with Pauline

Jade had 'counselled' a distressed relative who was unable to face the fact her husband had had a CVA. Jade: *"I like her. I have a good relationship with her. We had a long, long chat - she was crying, talking about the future. She wanted me to reject her, expected me to. I told her it was OK - what she was saying. She was so relieved - she cried and cried. I was all gooey-eyed as well. It was alright - it was good. We talked about a lot of things.. how things had changed for her, what it was like, what she was going through. It was one of the most rewarding experience I've had since I've been at the hospital."*

When Jade read this text she noted: *"I remember feeling very positive even though it was an emotional experience - I 'got the balance right'. I felt I had given her*

something - perhaps just relieved her guilt."

Jade had been available to grasp and respond appropriately to Pauline's distress, and in doing so, she acknowledged and managed her own feelings. Jade's satisfaction acknowledged that her response to Pauline was effective. Ramos (1992) noted similar findings within practitioners who were successful at managing their emotions whilst being involved. Ramos noted

> "They said it hurts but it's okay" [p504]

These words resonate with Jade's own words. Jade's experiences with Dick and Pauline indicate that she had developed her ability to be available with patients and families at this deep level of involvement. Practitioners lived out the tension of whether they should be involved or detached in their relationships with patients and families. This work was presented as a constant contradiction and struggle. As Morse (1991) noted:

> "Wise nurses, experienced nurses, learned painfully by trial and error how to find the right level of involvement in a relationship." [p465]

And, as Morse suggests, there was no prescription.

Summary

This chapter has unfolded the nature of 'being available' through elements that influenced the extent the practitioner can be available. This has been illuminated through the experiences of practitioners, which has also illustrated the process of guided reflection as a way of working with practitioners towards developing their ability to be available. As the account indicates, the work was both profound and complex. The next chapter is an account of the extent the practitioner could create and sustain the conditions necessary to be available.

This takes reflective practitioners into the realm of political action embedded within their own cultural- historical context to ask the question - 'why are things as they are? and 'what must I do to change these in order to achieve desirable work?'

Chapter 6
Creating and sustaining an environment where being available is possible.

Practitioners worked in practice environments, where factors such as conflicting values and interests, finite resources, lack of support, and power relationships constrained their ability to achieve desirable work. These factors could be grouped as two key factors that required managing as part of everyday practice:

- Managing interpersonal conflict between the practitioner and other workers/ organisation.
- Sustaining self.

Managing interpersonal conflict between the practitioner and other workers/ organisation

Pru's narrative illustrated her relationships with health care colleagues with whom she came into contact with. Within the course of her everyday practice, she interacted with social workers, physiotherapists, doctors, managers, nurses in other settings, and her colleagues within the workplace. Pru illustrated the way these people had a significant impact on her ability to achieve desirable work. Analysing the interactions of all practitioners within the study indicated that the appropriate management of conflict with others was necessary to achieve desirable work. This conflict was concerned with differences in status and power, legitimate authority to act, and differing values and concerns.

This interpersonal conflict is illustrated within Gayle's experience of conflict with Maggie, a hospital based social worker. Jane is the supervisor.

Gayle and Maggie Bryant

In session 6 Gayle blurted out her discomfort in working with Maggie, the hospital based social worker.

Gayle: *"I want to go out with Maggie and then she might talk to me properly! It was a couple of comments she said. I understood her to be coming to the hospital but I didn't confirm it. She was put out - patronising in the way she spoke to me. I think she doesn't respect my work. Perhaps I don't appreciate what she does. I think I'll go out with her and develop our relationship. She has so much information she doesn't tell me. She lets me know bits slowly."*

Jane : *"You feel you respect her work?"*

Gayle: *"Yes I do. She has expertise with benefits, peoples' different social situations, facilities available. I think I must come across as not having a clue. I do know some things but she uses it as a position of power."*

Jane : *"Knowledge can be powerful - perhaps she sees herself on a higher plane than you as a nurse - all the professions see themselves in a hierarchy?"*

Gayle: *"But today I won!"*

Jane : *"It was a case of winning?"*

Gayle: *"It was with Hector - I told them about how much worse he was becoming in here. He used to be able to hold his head up and fasten his buttons and now he can't. I don't want him to get worse. I said he should go home and she said No. Three times I said it -and then I brought Hector up and he told them definitely. I acted as his advocate. He doesn't want to be here. He doesn't identify with anyone. They didn't want to know. The three of them thought they knew him better. They talked amongst themselves until Hector came up."*

Jane: *"Perhaps they do know him better overall but not at this time and in this context and that makes the difference. Knowing him has caused an issue of ownership."*

Gayle: *"They are very involved but like relatives not as professionals."*

Jane: *"What do you see as the differences between personal and professional involvement?"*

Gayle: *"It's about allocation of time- I know this sounds quite cold but it's not meant to be. I hadn't thought about it until now. It's about accepting responsibility. At work you plan care - you are personally available - with personal involvement you are emotional about them all the time. Professional responsibility takes over from personal involvement at a level where you can rationalise your involvement. I can't find the right vocabulary but with Maggie, it's like she's talking about her dad - she really gets angry. You may get angry but you have to accept your limitations, you can stand back and look."*

Jane: *"Perhaps one of the limitations of standing back is becoming detached?"*

Gayle: *"I don't think so. You shouldn't take your work home. It's a fine line. There are times when you are more affected than others. They see Hector as a relative rather than acting as trained people."*

Jane: *"What does their behaviour say about their philosophy of care and the way they view people?"*

Gayle: *"They try to do their best but it's a shame if they don't like you."*

Jane: *"Is this compatible with our philosophy?"*

Gayle: *"They have a personal commitment."*

Jane: *"It could be - it seems very materialistic - they have the power, take no risks, the patients are helpless."*

Gayle: *"They make the decisions for the person rather than helping someone to make their own decisions and respecting their choices whatever they are."*

Jane: *"So there's a different philosophy?"*

Gayle: *"I think it's important that patients go to meetings. I know some say it is difficult and don't know what to do. But if they know there is a group of people who will decide for them, then they will decide, if you support them."*

Jane: *"So there is a role for the primary nurse in preparing patients for these meetings?"*

Gayle: *"Yes - they need to know what is going on and to identify with a person - to think about the problems and not to be brought in cold."*

Interpersonal conflict with Maggie

Gayle's experience was centred in the conflict of values and ownership between herself and Maggie that resembled a battle, exemplified by the concept of 'I won'. The dialogue is infused with a mixture of Gayle's emotions, elation at winning, yet frustration and anger at Maggie. These emotions are a reflection of her concern for Hector. Why else would she be so angry? Gayle's distress reflects the gulf of values that divides her and Maggie and the real threat this posed for achieving a working relationship congruent with therapeutic outcomes. Their conflict of values can be visualised as a tension between Maggie seeing and responding to Hector primarily as a disability and Gayle seeing and responding to Hector primarily as a person. Decisions about Hector's care were made in these terms. Gayle genuinely felt she was responding to Hector's real needs because she knew him. She felt confident that she was right. As she strove to fulfil her responsibility to Hector, Maggie emerged as a barrier to obstruct this achievement. The conflict polarised their respective values and roles over who had legitimate responsibility for making decisions about Hector. The competition for this legitimacy reduced the clinical situation to a win-lose game. Within such games someone had to lose, with the potential consequence of stoking the conflict between them, as no-one liked to lose and have their lesser status reinforced, and self-esteem squashed. Hector became a pawn in this game, and as such his needs became obscured. Gayle's direct action in the face of losing this game was to take Hector into the meeting and support him to make his case. In this respect Gayle's claim "I acted as his advocate" had substance. The conflict Gayle experienced empowered her to

take this direct action in order for Hector to get his voice heard above the din of 'we know what's best for you'. It was an effective response because it re-centred the issue once more as primarily a patient concern.

Gayle had interpreted the meaning of advocacy as enabling Hector to take self-determined action towards achieving what was best for him (Gadow 1980). However, whether this action was primarily empowering Hector to take control of his own life, or a tactical ploy by Gayle to win the game is open to interpretation. From Gayle's viewpoint, collaboration with Maggie could only [philosophically] be based on this premis. This interpretation does not reject the notion of advocacy as being concerned with asserting the patient's rights in the face of an inhumane health care as suggested by the UKCC code of professional practice clause 1 [1992]. However, interpreted in this way, advocacy is perhaps more concerned with nurse empowerment rather than patient empowerment, and the management of interpersonal conflict, although the UKCC emphasises that advocacy is not concerned with conflict for its own sake. The difficulty is that in asserting the rights of patients against the values of dominant others, it is likely to become an issue of interpersonal conflict and power relationships rather than an issue about what is best for the patient. Such action is more appropriately described as confrontation, the confrontation of restricted beliefs, attitudes or behaviour (Heron 1975).

Gayle attacked Maggie for a different and unacceptable 'maternal' type of professional involvement characterised by the patient being reduced to a child and the professional role to decide what's best. An accusation that Gayle could herself stand accused of. This was not the same as paternalism (Benjamin and Curtis 1986) because what's best was decided by Maggie's own values rather than in response to Hector's real needs. It was as if Maggie has not listened to Hector and responded as a protective 'mother'. Decisions based on this criteria are not necessarily best for the individual patient, as was evident within Hector's own response.

Gayle's intrapersonal conflict

Gayle's ability to act positively within her conflict with Maggie was limited by her ambivalence towards accepting the extent of her involvement with Hector ; what Gayle described as the 'fine line' between personal and professional involvement. The use of the word 'professional' appeared as a protective facade to justify her non-involvement with patients. Gayle struggled with the contradiction between her intention to be involved with Hector and realising this in practice. Her ensuing anxiety prompted her need to hide behind previous learnt and apparently safe norms.

Part of Gayle's intrapersonal conflict can be framed within the diverse meaning of advocacy within the nursing literature (Pullen 1995). Rather than dichotomise advocacy with paternalism, it makes more sense to view advocacy and paternalism along a continuum of therapeutic responses to helplessness within the situation, although the intent is always towards empowering the patient (Curtin 1979, Gadow 1980, UKCC Code of Professional conduct clause 5, 1992).

Levels of conflict

Different levels of conflict are evident within Gayle's experience [figure 6.1]. These levels are hierarchical. Consequently, Gayle needed to resolve her intrapersonal conflict, and ensure she had no conflict with Hector before she could resolve her conflict with Maggie.

Figure 6.1

Levels of conflict within Gayle's experience		
• Intra-personal conflict	-	Gayle 's struggle to accept her involvement role with Hector
• Interpersonal conflict with patients and families	-	No conflict with Hector
• Interpersonal conflict with other workers/ organisation	-	Conflict with Maggie

Unresolved conflict

Gayle's responsibility as Hector's primary nurse was to give Maggie feedback as to Hector's best interests. Her ability to achieve this was limited by her perception that she didn't know Maggie very well. She was also uncertain of her relative status and authority for decision making, socialised into a hierarchical pecking order where she had previously deferred to social workers over managing social aspects of care. The experience exposed the dimensions of conflict within teamwork that generally lay hidden behind facades of 'teamwork'. Failure to work to mutual goals within shared understandings of beliefs and roles emerged as a source of considerable conflict and frustration. Gayle's ability to resolve these differences was further limited by her need to avoid conflict. The conflict between Gayle and Maggie had been going on for some time, reflecting a failure of communication to be open and honest with each other and the difficulty of confrontation and giving feedback.

Working-with doctors

Pru hit a metaphorical 'brick wall' when she attempted to assert her nursing with doctors. This 'brick wall' had the power to humiliate her and reinforce her sense of helplessness. Her distress was very evident. Jenks (1993) found that nurses in hospital settings sought co-partner relationships with doctors in decision making, but found little common understanding between them.

However, knowing physicians was recognised as a important determinant in being acknowledged as able to make effective decisions. Prestcott, Dennis, and Jacox (1987) exposed how nurses lived the contradiction of decisions they wanted to make and decisions they could actually make. These decisions were dependent on the degree of significance given to them by doctors, i.e. reflecting a lack of value accorded to decisions within the domain of nursing and outside the domain of differential diagnosis and treatment. Doctors 'allowed' practitioners autonomy in aspects of work which they cannot be bothered with, usually less technical aspects of work. However Prestcott, Dennis, and Jacox (1987), like Jenks, noted how practitioners who knew their patients and the doctors well were more likely to be involved by physicians in decision making. May (1992) noted how nurses acknowledged the importance of nurses knowing patients as individuals. This raised the question of nurses' powers to acknowledge this through practice and challenge the culture whereby

> "the order and arrangement of the patient's career is founded on his or her status as the object of technical knowledge, and how the significant decisions about the trajectory of the body are the prerogative of medical staff'." [p474]

May concluded that nurses asserting their 'knowledge of the patient' would lead to an increasing conflict with doctors. The difficulty for nurses to assert collaborative relationships is highlighted in Leslie's experience with Dr Bradstock.

Leslie and the GP

Leslie [S18] shared how the hospital manager had received a letter of complaint from a patient's GP, following a patient's discharge. The patient had gone home constipated, with a lack of communication between the hospital

and community personnel. Leslie had acknowledged the validity of the complaint: *"I was committed to promoting excellent care in hospital and the community and happy to accept any valid criticism ... I accepted responsibility for his care."*

CJ: *"It certainly exposed to you what your responsibilities are. Did he respond?"*

Leslie: *"He didn't mention it - given that I have seen him several times since then."*

CJ: *"I might be tempted to confront him - 'Did you receive my letter?"*

I informed Leslie of the history of GP complaints at Windrush, how they were not usually directed initially at the practitioners involved, but directed to the Unit General Manger, with the outcome that the complaint had to be justified. The hospital manager's response had been to urge Leslie to reply to the letter. I felt Leslie's response was an act of deferring to the authority of the GP, which Leslie rationalised in terms of the need to maintain effective relationships.

Leslie noted [S19]: *"The GP was very impressed by my letter and apology and looked forward to continuing our relationship. I saw him later in the surgery - he again mentioned it - a good lesson in accountability and assertiveness."*

I argued that in fact, this was a self-deception. That it was in fact, a good lesson in reinforcing their power differential. Leslie felt my interpretation was distorted: *"I see my responses as pragmatic - necessary to keep communications and collaborative potential, but NOT medical hierarchy led decision making except where deliberately chosen."*

Pike (1991) considered that moral outrage ensues when the nurse's attempt to operationalise choice is thwarted by constraints, and intensified when forced to a course of action that violates her moral beliefs. The choice of collaboration or conflict? Yet the power differential between nurses and doctor mitigates against this being a realistic choice against the background of nurse-doctor relationships embodied in domination and subordination. On an everyday

basis, the practitioner had autonomy to make decisions based on her own judgement. Doctors only appeared to take sanctions when something went wrong or where their own interests became compromised. Delacour (1991) suggests there is little room to manoeuvre a shift in these relationships. Indeed, this resonated within practitioners' experiences. Some practitioners described ways of manipulating situations to get their feedback or suggestions listened to in ways reminiscent of Stein's (1978) 'doctor-nurse game'. In this game the nurse is allowed to make suggestions in such a way that it seems the doctor has made it himself. If both parties play the game, then conflict is avoided. If not, then chaos ensues, with the nurse left feeling humiliated and anxious that their patients won't be compromised as a result. Primary nursing may well cause doctors to perceive nurses as being a threat to their natural rights to determine the patient's career, through claiming 'ownership' of patients (Pearson 1985). This is perhaps more so within community settings where much of the nurses' work appeared to be self-determining, although not without conflict, usually where the doctors failed to listen or to respond to what the district nurse had said or where the doctor had unreasonably tried to control the district nurse's work. The outcome of such conflict was usually the doctor's insistence and a reminder of the status quo. Pru's narrative exemplifies this situation. Nurses did not report experiences that demonstrated their 'voice' was influential within discussion. It was evident that nurses generally didn't challenge the status quo of the relationship with doctors, which explains why so few experiences were grounded in this type of conflict. Work generally took place within the normative context of medical dominance.

Relationships between primary nurses at Windrush

Pru's struggle to work with Tilley was characteristic of many peer relationships. Gill often expressed her frustration at the way the two primary nurses at Windrush were in persistent but stifled conflict. In exploring Gill's

frustration, it was evident how these primary nurses sought to control the work environment as their own, what I have previously labelled as 'ownership' (Johns 1992). Each was motivated to exclude the other from interfering with their patients. 'Ownership' was an attempt to protect self from the anxiety of direct responsibility of managing a group of patients. 'Ownership' typically involved the primary nurse not involving others in decision making and avoiding seeking advice. Gill's experiences suggested that a number of factors exacerbated this conflict.

- Value differences in what constituted care.
- The pervasive culture of the harmonious team which limited the expression of feelings and the resolution of conflict.
- Cumulating mutual hostility which reinforced a cycle of separation.

The impact on others was frustration. The primary nurses only communicated with each other to fulfil responsibility to communicate care issues at handovers. Neither involved the other in mutual care planning or were available to each other for mutual support. Any notion that the relationship between these two primary nurses was idiosyncratic rather than cultural was illustrated through a sequence of relationships between primary nurses through the four years at Windrush and evident to varying degree within all the other units. This is supported by reflecting on the relationships between Jade and Myrna, and subsequently between Jade and Leslie, and between Leslie and Gayle.

Jade and Myrna

A continuous focus of Jade's experiences was her 'problematic' relationship with Myrna, her primary nurse colleague. In contrast, Myrna appeared oblivious to this conflict. Because of her low self-esteem, Jade needed to be acknowledged and valued by Myrna. However, Myrna was pre-occupied with herself, and thus generally failed to acknowledge Jade. Jade [S3] compared

herself with other staff, noting how threatened she felt in her new role, a threat magnified by her desire to be effective. She noted how Myrna wasn't defensive towards her but didn't reciprocate her own openness. I noted how this raised doubts in Jade's mind about what Myrna was thinking, feeling, and whether Jade should be so open with her. The unrequited openness towards another person was a risky business (Schein and Bennis, 1965) because it left Jade vulnerable when she needed feedback to affirm her effectiveness. Jade reflected [S6] on: *"little things that are really niggling me... the way doctors and staff go to Myrna rather than to me even about my own patients and how she [Myrna] tends to organise the morning."*

In other words, things that reinforced Jade's sense of inferiority. Whilst Jade shared her feelings of anger at Myrna she was also shocked by these feelings. Despite occasional positive experiences working with Myrna, Jade's sense of conflict with Myrna persisted. Months later [S13], Jade read out a list of list of negative characteristics about Myrna and then added: *"I'm not as good, I'm meaningless, I don't have her status, I get no support from her. She only thinks about her needs not anyone else's. For example she makes sure she gets off on time - I'm always late. She's in the office all afternoon to get her notes done. She doesn't answer the phone or call bells, she leaves it all to me! I feel our relationship has plummeted!"*

Jade felt bad about telling me this because she feared being seen as childish and telling tales. Jade knew she needed to confront this issue for her own integrity and comfort. I challenged her with her responsibility to establish a therapeutic relationship with Myrna, even though this might be hard. By session 16 Jade could report 'evidence' of improved relationships and certainly felt more relaxed towards Myrna. This coincided with Myrna feeling more confident in her role, having worked through her own unresolved intrapersonal conflict in her supervision.

Jade and Leslie

However, if Jade had come to an understanding with Myrna this was shattered by Leslie, who replaced Myrna as a primary nurse. In session 19, Jade shared a series of negative experiences associated with developing this new relationship. It made her confront herself: *"Thinking of Myrna - is it really true that primary nurses are competitive? I'm trying really hard not to be hostile towards Leslie but my gut reaction is hostile."*

In session 21, Jade shared how she had given Leslie feedback about arranging transport for a patient, which Leslie had failed to do. Jade had to arrange it the day the patient was discharged, which had irritated her.

Jade: *"I said to him - 'we were lucky to get transport - you appreciate I have to tell you things you have to know'."*

CJ: *"You felt the need to offer this feedback?"*

Jade: *"Yes, because I don't know Leslie at all. I can't work it out at all. I have the feeling he is just going to fall apart."*

CJ: *"He was having a bad time that day."*

Jade: *"He made me feel bad. I made a point of talking to him. I kept getting comments like I don't want to come to work. Everytime I see him now it's making me feel really low. I want him to be honest but I can't cope with his honesty. I think he's going to burst into tears."*

It was evident that Leslie was suffering, and yet he lacked support from Jade because of her aversion to him. Jade had difficulty giving Leslie feedback because she wanted to avoid conflict with him. Paradoxically the harder Leslie tried to 'fit-in' with Jade the more she rejected him. Jade recognised her guilt at this situation but felt unable to help either herself or Leslie deal with it. Jade had constantly perceived herself as 'inferior' to Myrna. Now Myrna had gone, did Jade subconsciously assume the mantle of 'superior' primary nurse, reflecting a persistent hierarchical orientation to work? Or did her own lack of self-esteem re-emerge with the threat of proving herself to another new

primary nurse? Most likely it was these factors interacting. On the espoused level, Jade deplored this situation but in practice she was unable to take appropriate action to resolve this conflict. This pattern of conflict was subsequently replicated between Gayle and Leslie. The consequence was that primary nurses were unavailable to support each other within the espoused 'therapeutic team' [see Figure 1.1].

Situations of conflict with nurses outside the practice setting.

The issue of 'who owns the patient' was evident within frequent experiences of interpersonal conflict between hospital and community nurses. Both Pru and Rachel shared these experiences concerning hospital nurses whilst Leslie shared these experiences about one community nurse. This conflict was grounded in the need to control decision making. Leslie's experience with Alec alluded to his unresolved conflict with the district nurse. Pru's narrative had a strong focus on this type of conflict.

The impact of ownership behaviour on associate nurses

Primary nurses did not tend to involve associate nurses in decision making. Gill noted how she felt 'pushed out', not being acknowledged', and 'not being valued'. Whilst this behaviour was not intentional, it did not role model 'collegial' behaviour to Gill, exposing the contradiction between espoused values of the therapeutic team and practice. Primary nurses unwittingly acted out controlling behaviour towards associate nurses as they strove to fulfil responsibility for work and to manage their anxiety associated with this. This phenomenon is reported in anecdotal accounts (Miller 1991, Taylor 1991, Heslop and Sparrow 1991, and Sears and Williams 1991). The primary nurses often described experiences that illustrated how they excluded seeking advice or involving colleagues in these decisions. Where such decisions are of an ethical nature, it raised the issue of how can a primary nurse prescribe care for

others to follow if the others have not been able to work through their own thoughts and emotions about that care? To ensure a consistent approach to caring for a patient and family, the associate nurses needed to feel involved with that patient's care. Otherwise care became fragmented, and nurses responded to patients' needs in idiosyncratic ways.

The primary nurse's concern with control is evident in Mary's experience. In her first session with Brian, she noted her frustration at people not willing to carry out the care she had prescribed. In session 2, she re-iterated how she often felt that care plans were written and priority problems identified, but when she was away the care was not always given, and that she could not see a way out of this situation. In session 4, Mary noted the recurring theme within her experiences of 'trusting staff' because of care plans not being followed and the different values between herself and associate nurses. When Mary did give associate nurses feedback she noted: *"they think I am getting at them"*. In other words, the associate nurses were defending themselves. A contradiction emerged in that Mary needed to ensure staff followed her prescribed care, yet this was within a culture where associate nurses didn't follow care plans or were involved with decision making. Brian's response was to encourage her to fulfil her responsibility by giving feedback to the associate nurses to ensure care was carried out as planned. However, this only created more anxiety for Mary because of her greater need to avoid conflict with her colleagues. Mary never resolved this problem. Karen's experience of 'reporting' Hank's complaint about a night staff nursing auxiliary exemplifies this type of situation.

'Hank's complaint'

Karen shared [S11]: *"One night last week Hank complained to me about the actions of one of the night staff. He was very angry about it, so I wrote an account of it in his*

notes if only to cover my own back as he was so worked up about it. I didn't state who was involved or the nature of the incident. Kirsty [night associate nurse] read this and told me she felt - 'very sad I had to write that - some things were better said not written'. She didn't deny the incident but criticised my documenting it."

CJ: *"The criticism was in the way you handled it?"*

Karen: *"Right - I re-read my account because I had written them in a hurry - I realised I had used a word that could have been replaced with a better one."*

CJ: *"An antagonistic word?"*

Karen: *"Yes - I made a further comment and replaced my initial account to make it more clear to people... what got me was Kirsty criticising me about my way of documenting it when in the Nursing Times it goes on about 'whistle -blowing' and how complaints should be documented. I also felt she was trying to cover up for the person involved even though she acknowledged the event happened."*

CJ: *"And now?"*

Karen: *"I shared it with Leslie - he said he would have a word with the person involved. I went home and worried all night - worried how she would take it - what she would say."*

CJ: *"What would you do differently given the same situation?"*

Karen: *"To ring her at home and ask her to explain her viewpoint."*

CJ: *"What response might you have got?"*

Karen: *"From my perspective I would have appreciated it."*

CJ: *"And knowing the person involved?"*

Karen: *"I can't say."*

CJ: *"Do you think this action was out of character for her?"*

Karen: *"I think it was an exaggeration of her normal character."*

CJ: *"You think?"*

Karen: *"I don't work with her - its difficult to know how she is with other patients - the event itself is quite trivial - its Hank's anger that got to me."*

CJ: *"Do you think his anger was justified?"*

Karen: *"I felt that at the time - I would have been upset and angry"*

CJ: *"You can see links with Ben - with the care assistant treating Hank as a child?"*

Karen: *"Yes - inflicting her values on him - not respecting him."*

Karen could see that Kirsty had censured her for breaching the norms of the harmonious team. We explored how Karen might effectively respond within this situation. Karen felt very threatened by this experience and with the prospect of taking action to deal with the consequences of staff conflict.

In session 12, Karen recognised how terrified she felt at phoning the care assistant: *"I went home and phoned her. I felt terrified. She was angry. I couldn't stand up against her because I was in such a state."*

I helped Karen see how this situation had become twisted from being a patient related issue to becoming a secondary inter-personal issue. There was no doubt who was in the 'wrong' from the patient related issue. However, the issue had become the way Karen had exposed Mandy, breaching the rules of the 'harmonious' team. In this context, Karen was now 'in the wrong'. The consequence was to reinforce to Karen the culture of the 'harmonious team'; that 'it pays to belong' to escape further retribution. Karen agreed this was the likely scenario.

CJ: *"What were the consequences of not dealing with it for yourself?"*

Karen: *"I felt like a chicken."*

CJ: *"Damaging your self-esteem?"*

Karen: *"Yes."*

CJ: *"And impact on further action?"*

Karen: *"Now more difficult as I feel sucked into this harmonious team."*

Karen attempted to rationalise her anxiety by blaming herself: *"I didn't stop to think - I'm feeling very stupid. Why had Hank waited to see me - he just happened to see me."*

I helped Karen to see this experience in terms of her role responsibility to Hank. It was logical to write - 'patient upset because of altercation with night care assistant' as a reasonable statement that reflected the facts.

In session 13 Karen noted: *"I didn't want to come to the session - I felt it was going to be hard - but now I'm glad I did!"*

In terms of learning, Karen must resolve the dilemma between being primarily 'loyal' to staff or 'loyal' to patients. As I have illustrated, the consequences for Karen in being loyal to the patient was considerable conflict. There was no collegial support for Karen within this situation. The primary nurse chose not to get involved, reflecting his own need to avoid conflict. Karen noted how tired she felt and how she didn't want to come to the session today, noting how stressful she felt within this situation. Such conflict was exhausting.

The harmonious team

The harmonious team is concerned with maintaining a facade of togetherness. It does not talk openly about difficult feelings between its members and seeks to protect its members from outside threat. Conflict is brushed under the carpet or is inadequately resolved (Johns 1992). Jenks (1993) noted the prime importance of preserving inter-staff relationships for some experienced nurses. Nurses with most experience spoke of their need to preserve their relationships with staff whilst nurses with less experience emphasised their need to establish such inter-staff relationships. Jenks states :

" Differing beliefs among staff members often create conflict during collaboration for decision making. Peace keeping behaviours were observed in nurses when they recognised a conflict and acquiesce to another's opinion or wishes to resolve it [p402].. however, preserving a good relationship is important to nurses and is sometimes favoured over a decision the nurse believes is appropriate to a patient."

[p404].

Jenks's study supports the prevailing culture that the practitioner would fulfil her responsibility for maintaining the integrity of the harmonious team rather than fulfil her responsibility to the patient. As Rona noted [S2]: *"we [district nurse] should see things and work closely together... I don't want to knock the district nurse.."*

Gay noted her reluctance to be 'disloyal' to colleagues, even thought they were not effective. Yet she also realised *"how awful of me to say that."*

'Blowing your top'

As Kirsty highlighted, a consequence of the failure to be open with feelings was to 'blow her top' at Karen. Keeping the lid on feelings to maintain a harmonious team resulted in outbursts of feelings at times when the 'cork burst' because of the pressure of stress. The impression gained was that such outbursts were an embarrassment and everyone seemed to try and 'smooth the waters'. The ironic thing about such outbursts was that it appeared to reinforce the need to keep feelings bottled up because of the mess they caused. Despite the frustration practitioners often felt at their colleagues, 'blowing your top' was not a common phenomenon. Rather practitioners tended to 'stew in their juices' and suffered as a consequence.

Giving feedback

Time and time again practitioners were unable to give other staff uncomfortable feedback because of the threat of disrupting 'the harmonious team'. This anxiety disabled them from fulfilling their role responsibility and consequently limited their therapeutic potential. Once practitioners had learnt to overcome the fear of resulting conflict, the reality of giving feedback was never as uncomfortable as they had envisaged. Indeed, not giving feedback was more stressful, although practitioners could not perceive this except in hindsight. Giving valid feedback to nurse colleagues was both an ethical

concern and an issue of personal integrity for the practitioner to act out her responsibility to ensure effective care.

Dialectic of Visibility

In Hank's complaint, Karen gave feedback to associate nurses via the notes. Although this action avoided the immediate verbal conflict, it led to a wider conflict because Karen had made her criticism visible and public. Street (1992) believes that this invisibility is related to the inability of staff to give negative feedback in a constructive manner and leads to a non-recognition of distress in nurses by other nurses. Not being visible protects the practitioner from their competence being exposed. And yet, primary nurses were frustrated by their colleagues who failed to follow planned care, indicating the limited impact of written communication. Within this culture, practitioners did not actively seek feedback to monitor their own effectiveness and were defensive to feedback that suggested poor practice. This culture was generally resistant to change.

Horizontal violence

The extent of interpersonal conflict between nurses and possibly between nurses and other professions, but excluding doctors, was reminiscent of what Freire (1972) described as 'horizontal violence'. Horizontal violence is symptomatic of how people who belong to 'oppressed groups' might respond to each other in 'violent ways' as a reflection of their alienation from each other and as a consequence of being unable to direct their felt violence toward their powerful oppressors. Defence systems, such as the 'harmonious team', maintained illusions of 'good teamwork', to protect each other from the public manifestation of this 'violence' that simmered just below the surface of everyday practice. Street (1992) noted the existence of horizontal violence within nursing culture. Drawing on Freire's work and Roberts (1983), she noted

"An effect of horizontal violence has been to isolate nurses from other nurses and reduce their potential for engaging in collaborative critique as a basis for transformation of oppressive structures for their patients, and the enlightenment, empowerment, and emancipation of themselves." [p246]

The nursing culture within the study felt remarkably similar to this culture of 'partial visibility' and 'horizontal violence' that Street makes visible. Her work helped me to understand why nurses were unable to deal with their interpersonal conflict more appropriately. The consequence was to limit the extent that the practitioners were available for mutual support.

Managing conflict style

The high percentage of experiences grounded in interpersonal conflict within this study indicated how managing conflict was a significant part of everyday practice. It was evident that avoidance was the predominant strategy. This corresponds with the findings of Thomas and Kilmann (1974) and Cavanagh (1991). In these studies, practitioners primarily resorted to avoidance and accommodating styles of managing conflict, whilst acknowledging the desirability of a collaborative style.

As practitioners, for example Pru, were helped to feel empowered to assert their views, they tended to become more competitive rather than collaborative as a consequence of challenging existing power differentials. Practitioners became less willing to accommodate differing values or compromise their own best interests. Closely linked to this shifting management of conflict style was the development of assertiveness. Being assertive did not appear to be a cultural norm (Johns 1989b). Feedback from the SEQ questions 23 and 25 indicated how giving positive feedback correlated reasonably with assertiveness [see Table 6.1].

Table 6.1
Assertive/ confronting colleagues SEQ ratings

SEQ 23

I am now always assertive in my work	10_____0	I am unable to be assertive when I need to be

SEQ 25

I am able to confront my colleagues in a positive way	10_____0	I am unable to confront my colleagues in a positive way

	q 23	q 25	q 25 comments
Gill	5.0	5.8	
Jade	8.3	7.5	*"I'm able to do this- there was a time I was unable to"*
Myrna	8.3	2.6	*"I still find this difficult"*
Karen	7.0	7.5	*"I'm more assertive than I was and can be assertive in a gentler way" [q 23]*
Leslie	4.5	4.8	*"Sometimes problematic, but I'm more able now"*
Gayle	6.7	7.2	
Abbi	7.0	1.0	*"This is an area which I know I need to work on. I would still rather skirt around an issue if I can, rather than confront it."*
Jeanne	8.8	9.2	*"I feel that I can confront colleagues but in a gentle manner which will avoid them feeling threatened."*
Rona	8.3	10.0	*"much quicker recognition of a sensitive issue"*
Lucy	10.0	10.0	*"If it is something that affects my clients"*
Pru	6.3	7.0	
Alice	7.0	6.8	
Rachel	5.0	5.0	

Notes

1. The high ratings of Jeanne and Lucy do not match with the evidence from their shared experiences.

The feedback from Table 6.1 suggests that practitioners perceived themselves as moderately assertive, yet this was misleading. For example, Lucy perceived herself as very assertive, yet her experiences illustrated her complete disregard for the feelings of associate nurses and nursing auxiliaries whom she gave feedback to and whom she expected to carry out her orders. She mistook being assertive for being authoritative.

Being assertive did not appear to be a skill that could be easily learnt. Gill recognised her lack of assertiveness, so she attended an assertiveness course. However, she was no more assertive. In understanding why, it was apparent that she could not replicate the context-free conditions of the course in specific context-bound work situations. Similarly, whilst the supervisor could role model and encourage assertive responses within supervision, the transferability to clinical situations was difficult to achieve. However, these situations were picked-up and developed in subsequent sessions. The practitioners' comments [Table 6.1] reflect the general difficulty for the practitioners to develop the ability to confront their colleagues in a positive way.

The practitioner's sense of being assertive reflected their self-esteem. As I shall explore further in chapter 7, being assertive was the manifestation of empowerment. Moving from a self-perception of passivity to a self-perception of being assertive was one of four developmental themes I identified as being integral to self-esteem. I used these themes to construct the 'Developmental Themes Movement' scale, an heuristic device to enable practitioners to monitor the development of their self-esteem [see appendix 5d].

Sustaining self

The significance of managing conflict as an aspect of effective practice has been established. Conflict and the inability to resolve conflict appropriately was a major source of anxiety. As such, managing anxiety in ways that sustained self

to achieve desirable work was an important aspect of development. As with other aspects of practice, the practitioner's anxiety rippled along the surface of every experience. It could not easily be hidden because it was so influential in the way the practitioner responded within situations. Indeed, many experiences were shared because of the felt degree of frustration, anger or distress that practice situations often engendered. This is apparent throughout Pru's dialogue and the practitioners' experiences I have used to illustrate the 'being available' framework in chapter 5 and this chapter.

Sources of anxiety

I identified five sources of anxiety [Table 6.2].

Table 6.2

Sources of anxiety within shared experience
• 'Being exposed' - the threat of accountability.
• Working with difficult or distressed patients.
• Workload/ organisational issues (generally not being able to give the type of care the practitioner wanted to give).
• Dealing with interpersonal conflict.
• Not being acknowledged/valued/ supported adequately.

The pattern of anxiety at work was unique to the practitioner. I constructed the '100 points sources of stress scale' [see appendix 5b]to help the practitioner to focus the sources of her stress.

'Being exposed' - the threat of accountability

Using the 100 points sources of stress scale', Myrna highlighted her particular concern with issues of accountability [figure 6.2]. She monitored this 10 months after commencing work at Windrush.

Figure 6.2

Myrna's sources of stress scoring

Focus of stress	Score	Dimension
* making a wrong decision about a patient's care	20	accountability
* missing something important clinically	20	accountability
* the possibility of offending other colleagues, of rubbing them up the wrong way	20	interpersonal-conflict
* letting Windrush down by not being good enough to do what is asked of me	20	accountability
* having a major casualty that I couldn't cope with and not being able to get a doctor quick enough	20	accountability

Although Myrna had been a G grade sister in her previous post, she had lost confidence in her competence. As a consequence, she had tried to manage her anxiety through self-reliance self rather than seek appropriate help. However, her self-reliance had quickly been exposed as inadequate, leaving her very vulnerable. I asked Myrna: *"How do you think your sources of anxiety have changed since commencing work here?"*

Myrna wrote: *"My anxieties initially were to do with whether I was good enough, what people thought of my work, whether I was liked or not, the possibility of making wrong decisions about patient care which would be all my fault. They changed after a while to be more concerned with ethical issues to do with patients and management, although vestiges of the former group will remain.".*

Being in control

"Being in control - that's important" [Karen]

Myrna's effort to manage her anxiety through self-reliance involved an attempt to control the care environment. Cherniss (1980) noted the relationship

between personal control and a sense of competence. Competence *is* the ability to control the environment to ensure desirable work is achieved. Guided reflection quickly exposed practitioners to themselves, and hence potentially *increased* their anxiety, especially as supervision was with their managers with whom they particularly wanted to be perceived as competent. Gill commented: *"on my previous ward you could just merge into the background, but here there is nowhere to hide."*

Her comment was prompted by feedback received from a district nurse that was negatively critical of a patient's care. As a result, Gill felt worried about not being able to cope as a primary nurse, her response to being exposed to anxiety that she had previously been protected from through role diffusion (Menzies-Lyth 1988). This diffusion is to protect the nurse from the inherently stressful nature of decision-making for the nurse. Menzies-Lyth (1988) noted :

> "Making decisions is always stressful because it implies making a choice and committing oneself to a course of action without full knowledge of the outcome. The resultant stress is likely to be particularly acute when decisions directly or indirectly affect the well- being, health or even life of patients" (p105).

Hence practitioners struggled to manage their ambivalence to learning, reflected in their attempts to maintain the facade of competence whilst coming to realise and accept they lacked competence. For example, Karen was concerned that confronting Mrs Kitchen might expose her lack of competence. Hence she avoided this intervention even though it was most appropriate. Whilst this, in the short-term, relieved one aspect of her anxiety , she also felt anxious that she was avoiding it. As such, avoidance was a double edged tool that reinforced the self's lack of competence.

Shortly after she commenced work at Windrush, Karen noted: "I'm *finding it difficult to adjust from the student role -I need support in making decisions independently."*

Jade: *"Have you given any thought to how this could be done?"*

Karen: *"I think it has to come from within, for example - working alone is OK but when I'm working with you or Leslie I take a step back.. I feel I'm being watched, being checked to see what I'm doing is OK."*

Jade: *"Like when you were drawing up the drugs for the syringe driver with me?"*

Karen: *"No - I didn't feel confident with that - its the way I interact -I feel as though people are watching and judging me."*

Jade: *"You need to think about why you've been trying to ignore it."*

Karen: *"I'm too sensitive..... I'm OK when it's patients. When its me I take it too far I become over-sensitive."*

Karen recognised she needed to seek appropriate help but found this difficult to seek because she also needed to be seen as competent and coping in her role. Exposing these fears in her supervision with Jade enabled Karen to acknowledge them as valid and to receive the support she desperately needed.

Fear of making mistakes

Menzies-Lyth (1988) noted that nurses reduced the fear of making mistakes by reducing the need for decision-making through ritualised task-performance and checking and counter-checking. The deconstruction of tasks and construction of holistic practice exaggerated this fear of making mistakes, and led to defensive manoeuvres. Mary noted that: *"accountability relates to ensuring that work is managed on paper and that this is linked to management and organisational issues... as long as it is documented I cover myself."*

Practitioners often talked about defensive nursing to cover their backs to offset any potential criticism from relatives. Yet, ironically, conflict with relatives was largely due to a lack of involving relatives in care management or conflict

between the patient and relatives where the practitioner's interests became divided. Whilst Gill recognised [S2] the need to appropriately involve patients in their own care, she also expressed her concern about patients reading their own notes which meant she had to be careful what she wrote in them.

In session 3 Gill described her *"feeling of panic"* that she had made a drug error. Gill had written 'Brufen 200 mg.' on the woman's self-administration 'calendar' with the instruction to take two at breakfast and supper. However, the pharmacist dispensed 400 mg. tablets, but Gill did not think to change the patient's drug calendar. Gill's panic was offset by the patient's own realisation of the difference in 200 mg. and 400 mg. tablets. Gill learnt that patients can be competent and responsible in their own care. Gill's fear only existed because she viewed the patient as passive and dependent. She had given the patient no credit for being able to distinguish the error or be competent to manage her own drugs.

Working with difficult or distressed patients

It was evident that the greater the practitioner's concern for the patient then the greater the practitioner's vulnerability to absorb the patient's suffering. As Benner and Wrubel (1989) have noted

> "Because caring sets up what matters to a person, it also sets up what counts as stressful, and what options are available for coping." [p1]

Wilkinson (1988) felt that nurses who suffer moral distress at work may be those most committed and self aware to ethical issues. As Menzies-Lyth (1988) noted, the

"core of the anxiety situation for the nurse lies in her relation with the patient. The closer and more concentrated this relationship, the more the nurse is likely to experience this anxiety." (p51)

This was apparent within the practitioners' experiences. Yet, ironically and profoundly, as practitioners allowed themselves to become more involved with patients, and became more skilled at managing self within such relationships, so caring became more valued and satisfying. This emergence of caring satisfaction appeared to neutralise the situation as stressful. It was as if practitioners found meaning in everyday practice that lifted the soul. Benner and Wrubel (1989) consider this uncovering of the 'primacy of care' is one of the most effective coping resources. This understanding flies in the face of 'the folk-lore idea' that a detached stance was a protection from the distress of suffering. In fact the opposite viewpoint emerged - *once* practitioners had learnt to cope in ways that could sustain being available to work with patients. Becoming more involved within relationships is a threat to existing social defence systems against deep and intense anxieties which cannot easily be swept away because they constitute who the practitioner is. Embodied coping mechanisms cannot be undone merely by telling people to do things in a different way (Menzies-Lyth (1988). Menzies-Lyth noted that

"a necessary psychological task for the entrant into any profession that works with people is the development of adequate professional detachment." (p54)

Of course, words like 'adequate' are open to interpretation. I would re-state this as 'adequate professional involvement'. As Jade said [see page 153] - *"We don't come to work dressed in a suit of armour to protect yourself from all this [emotional] shit.. you just feel you are a target for people to aim at."* As Noddings (1984) notes, the practitioner's sense of being over-whelmed resulting in feelings of guilt and conflict are "the inescapable risks of caring" [p18]. The balance between concern and being overwhelmed was a fine line.

Workload/ organisational issues

Pru suggested she was constantly rushed in her everyday practice. She felt pressured by organisational demands, especially those she felt took her away from direct-patient care. Rachel, another district nurse, similarly focused strongly on resisting this organisational demand. 'Being busy' did not appear to cause undue stress in relation to work with patients and families. As Jade observed [S4], the pressure of workload only emerged as an exacerbating factor where it interfered with therapeutic work. This fits with Marshall's (1980) observation, from a review of the nursing stress literature, that

> "certain pressures, for example work overload, appear to accentuate the effects of other [sources of stress]." [p22].

Betz and O'Connell (1987) drew the conclusion from their research data that the transition to primary nursing contributed to two types of role strain - role overload and role ambiguity. Role overload was being responsible for more tasks than an individual could perform within shift time. They note that role overload was particularly greater when associated with perceived 'low-level' tasks and greater paperwork. As Leslie noted [S6]: *"When I focus on patient care my stress goes down and when I focus on workload, interviews, case conferences my stress goes up."*

Role ambiguity seemed to occur under primary nursing because of the simultaneous occurrence of greater responsibility and greater isolation from other practitioners. There was a significant degree of isolation felt by practitioners within their roles that served to reinforce the sense that completing the workload was their individual responsibility rather than joint responsibility with their colleagues. When practitioners felt valued, when they had a choice about issues, and when they felt in control of their use of time, then stress was accommodated. Otherwise they resisted and resented intrusion on time that distracted them from their primary work of patient care.

Interpersonal conflict

I have highlighted in some detail the nature of interpersonal conflict. These situations of interpersonal conflict were by far the most frequent focus of work shared in supervision, even though some practitioners were extremely reticent to share such experiences in a culture where talking about colleagues was akin with 'telling tales'. Inter-personal conflict as a source of stress is evident in other studies. Vachon (1988), from her sample of 581 care-givers from a variety of countries, health care professions and settings, noted

> "Perhaps unexpectedly, most of the stressors, caregivers reported, when asked about the stress they experienced in caring for the critically ill and dying were not related to work with clients and their families but, rather to difficulties with colleagues and with institutional hierarchies." (p 150)

Vachon did not indicate the variables of nurses' belief systems or how nursing was organised, which might have been significant influencing factors in understanding interpersonal conflict. Vachon supports my observation that caring was not the major stressor but others interfering with the practitioner's caring in some way.

Not being supported

Practitioners generally seemed isolated in role, depending largely on self reliance to bear the brunt of daily strain. This was reinforced by a lack of mutual availability between staff, despite explicit acknowledgement of the desirability of the 'therapeutic team', for example - as espoused within the Windrush philosophy [Figure 1.1]. This did not mean practitioners were not supported at work, but support depended on personality rather than an organisational recognition and response to the significance of support. Cherniss (1980) observed that receiving feedback from colleagues was important for new professionals to confirm their competence. Whilst Gill was not a new professional, she was in a very new role that accentuated the professional values of responsibility, autonomy and accountability. She often commented in supervision how nice it was to get positive feedback from me and shared several experiences where patients and relatives had given her positive feedback. Yet she clearly would have appreciated positive feedback from the primary nurses. Jade [S9] reflected on situations where she was cross with me when I had come on duty on a late and had gone straight into a long meeting with the district nurses. Jade was feeling very stressed with her workload that morning and needed recognition. Supervision created the space for her to give me this feedback.

Burn-out

The analysis of practitioners' experiences painted a picture of their contradictory and stressful work-lives. Each experience could be viewed through a lens of managing the tension between being available to work in desired ways and managing one's own anxiety. Failure to achieve effective

support resulted in a relative state of burn-out. Cherniss (1980) describes burnout[1] as a process in which

"the professional's attitudes and behaviour change in negative ways in response to job strain." [p5].

Maslach (1976) suggests the major negative change in people experiencing burnout in people centred work is the

" loss of concern for the client and a tendency to treat clients in a detached, mechanical fashion." (p6).

As such, the extent of available support became a critical component in sustaining self. Yet, Nicklin (1987) noted that 85% of managers considered stress as only a moderate problem which they had no specific policy with which to deal with. The Briggs report (1972) noted that services supporting nurses are rare, inadequate, fragmented and not targeted to those most in need. Where practitioners felt they had lost intrinsic satisfaction with caring they became focused on the conditions of work, for example off-duty rosters, workload issue, etc., characteristic of bureaucratic models of organisation (McNeeley 1983). McNeeley believed that bureaucratic conditions were antithetical to human service work and strongly advocated that such organizations needed to move to collegial ways of working with staff to off-set the risks of burnout. Taylor (1992) noted a theme within the literature of how nurses have been dispossessed

[1] There exists an extensive literature on stress and burnout within nursing available to the reader to frame the experiences of stress and burnout experienced within this study. I have drawn on the work of Cherniss (1980) and Maslach (1976).

"of their essential humanness as human beings and people, by emphasizing their professional roles and responsibilities" [p1042].

Taylor draws attention to the fact that nurses are human too and as such are vulnerable to the same issues as their patients and families. The lack of recognition of humanness within nursing through a focus on roles and responsibilities led the practitioners to strive to be something they clearly were struggling to cope with. As Taylor noted:

"they didn't recognise, understand or rejected their own ordinariness as human beings." [p1044]

Consequently, practitioners became alienated from themselves in their efforts to cope and live out the contradictions within their lives. Jourard (1971) noted that such striving damages 'the self' and reinforces the need to cope in a vicious downward cycle of self-destruction towards burnout and a state of anomie. Being patient-centred may just perpetuate a denial of self and self-interests that merely reinforces contradiction and consequently is ultimately self-destructive. With support, through guided reflection, Jade could see she was wearing armour, and be helped to take it off. This left her vulnerable in her struggle to put on some new, more appropriate armour. Dewey (1933) also uses the metaphor of 'armour' -

"unconscious fears also drive us into purely defensive attitudes that operate like coat of armour - not only to shut out new conceptions but even to prevent us from making new observations." (p30)

Dewey noted that anxiety would limit the practitioner's ability to learn through experience. 'Armour' is akin to professional detachment. Benner and Wrubel

(1989) belief that the answer is not the development of an adequate professional detachment to cope as advocated by Menzies-Lyth (1988), but the reconnection of the self with caring.

Support

All the practitioners lived with an amount of stress that limited their availability for therapeutic work. It was as if this stress was a way of life and something to adapt to as best one could. Practitioners highlighted a number of support systems - such as support at home, time out, and regular holidays as helpful. However, more formal support systems were not available within everyday practice beyond an acknowledgement that support existed from colleagues. Yet stress within work was generally hidden from colleagues.

Good nurses cope

Exposing ways of coping as inadequate was itself anxiety provoking, particularly in a culture where 'good nurses cope'. Gill [S3] shared a situation where she felt overwhelmed with work: *"Yesterday was a bad day, though in actual terms no heavier than other days in the week. I have W—— today as backup, yesterday I had the ENB student who was not supportive, who was reluctant to take the initiative, wanting to do everything as a pair. My expectation was that she would help."*

I asked Gill why, knowing I was working upstairs at the time, she had not asked me for help. She felt she could cope and sort it out for herself: *"It's a personal trait. If I take something on I like to see it through and feel I can manage it."* She noted her reputation for coping and not asking for help in her previous work. She had resisted asking me for help because she felt she might be judged in a negative way and felt that if I came to see how she was managing more often I might be checking up on her. However, she expressed some

ambivalence about this feeling because she simultaneously felt she would like me to spend more time with her. Gill reflected on how angry and tired she had felt at the end of this day: *"little things had got out of all proportion, for example Brad's [patient] incontinence was the final straw."* This comment highlighted how Gill tied up energy in order to balance this stress, limiting the energy she had available for the patient. Gill recognised: *"I need to call on people when I need them rather than just battling through. Yesterday I felt I was walking through treacle."* Gill acknowledged that trying to cope alone was not satisfactory. Her negative feeling that I might be checking up on her reflected how she perceived me in a hierarchical way. This perception was reinforced in session 4. She had been seeking assistance to help with a patient, and although I was standing in the doorway to the patient's room, she went to the other primary nurse for help. Gill said : *"I felt silly afterwards. I wondered if you would notice and think me stupid. I can only speculate reasons why I didn't ask for your assistance, possibly trying to give a good impression."*

In session 5, when Gill shared her anxiety about a patient, I asked her whether she had thought about seeking advice. She had not even thought of telephoning me or the primary nurse at home. She identified her reticence to call a primary nurse at home even though primary nurses accepted this as part of their role: *"when she's off duty she's off duty, you just don't ring people at home."* She felt she should be able to use her professional judgement and that if she did ring: *"the primary nurse would think I couldn't cope.. seeking help is a sign of weakness".*

The 'Good nurses cope' norm emerged as counter-productive in coping with work, because it deprived practitioners of access to the support they needed. It forced the practitioners to rely on their own resources.

The therapeutic team

In an ideal world, the therapeutic team, as espoused within the Windrush philosophy, would sustain its members to achieve therapeutic work. The therapeutic team demands its members are responsible to be available to mutually support each other on a day to day basis. Support for the therapeutic team is offered by Vachon (1988) :

> "the most effective antidote for the alleviation and prevention of stress ... had to do with a sense of team philosophy, team support and team building." [p157]

Norbeck (1985) found that social support from fellow nurses was the most effective way to reduce stress. Despite its espoused desirability, this team did not exist within any of the care settings, creating an impression of care environments that did not support its members. Nor was this team easy to develop, suggesting that the inability to care for each other was deeply embedded within the cultures of the Units. It was evident how individual practitioners were inward looking, concerned with sustaining self [albeit to limited effect] and hence unavailable to support each other in ways that reciprocated therapeutic relationships with patients, although colleagues did generally appear to be helpful and friendly on a superficial level. One pervasive norm that mitigated against the therapeutic team was the notion that practitioners didn't want to burden their colleagues. Jade [S3] noted she felt guilty about seeking support from her colleagues because it put pressure on them - *"I've tried to use other people more rather than saving things up but I don't want to burden other people."*
Jade's comment was typical, reinforcing an image that practitioners were generally unable to support each other.

Towards collaborative teamwork

The failure of teamwork to adequately support its members to sustain desirable work, reflected a prevailing culture where professional relationships were constituted in terms of personal interests behind a facade of professional concern. Bishop and Scudder (1987) asserted how nurses needed to focus on developing collaborative teamwork within the context of striving to achieve excellent practice, rather than a focus on individual autonomy as advocated by Yarling and McElmurray 1986. Bishop and Scudder noted that such teamwork was difficult to achieve when members were concerned with their own autonomy, which would only lead to conflict within the system. This was clearly evident within Gayle's experience with Maggie. However, whilst a rhetoric of collaborative teamwork was an espoused value, Gayle's experience illustrated how this may be difficult to achieve *unless both* persons within the conflict are comfortable with their own sense of autonomy and respect that of others.

The rhetoric of collaborative teamwork may actually be unhelpful because it forced health care workers to act as if this teamwork really existed, which made conflict difficult to expose and resolve. The challenge was to create situations of shared values and open dialogue. Bishop and Scudder's argument rests on an illusion that practitioners could be equal partners within decision making - which was not supported even with nurse colleagues.

Recognising this issue in supervision challenged the emphasis on autonomy as a desirable characteristic of the primary nurse as generally espoused in the primary nursing literature (for a summary see Ersser and Tutton 1991, p1). I considered that *attachment* (Gilligan 1982) with its emphasis on interdependence (as opposed to independence), and mutual ways of working was a more appropriate characteristic of the effective primary nurse. Attachment would naturally lead to ways of relating with colleagues that recognised that primary nurses were not independent practitioners but worked with others in a nursing team; had shared values with their colleagues; did care

about and were sensitive to the needs of their colleagues for support and appropriate help; and could both give and receive feedback in such a way that any conflict could be positively resolved. I felt the emphasis on autonomy encouraged primary nurses to become unilateral decision-makers, assertive for themselves with a need for self-reliance, self-protection, and avoidance of conflict and dealing with uncomfortable feelings, both their own and others. These are characteristic of the harmonious team and ownership.

Gilligan (1982) illustrated how women tended to define moral issues using an ethic of care in contrast with an ethic of justice. She challenged Kohlberg's (1981) conceived dominant viewpoint of moral development as an inadequate description of moral development for women. An ethic of care is grounded in attachment and responsibility to others for caring although, as Belenky et al (1986) note within their concept of the "subjective woman", this may lead to efforts to avoid conflict rather than resolving it. Creating a dichotomy between an ethic of care and an ethic of justice may only serve to polarise conflict between nurses and the organisation/ doctor, and reinforce the stereotype of the 'male oppressor'. However, practitioners did endeavour to assert their presence with doctors and generally illustrated a growth in assertiveness and self esteem. Tronto (1987), commenting on Gilligan's work, warns not to jump to hasty conclusions about gender differences as the basis for the differences in men's and women's moral development but to consider wider social and cultural factors. The problem of subordination and professional domination may offer a more realistic explanation of conflict than gender. Nurses, as an occupational group, have been unable to identify and work towards the good when it has entailed interfering with the interests of powerful others. Nurses, in general, conform to the existing social order as if it were morally sound (Yarling and McElmurray 1986, Packard and Ferrara 1988).

Support through guided reflection

From the advantage of a retrospective viewpoint, I can see clearly how guided reflection was primarily the means to help practitioners connect self with desirable work. McHaffie (1992) commented that reflection-on-experience *is* the means of connection by drawing on and learning through experience. Drawing on the work of Lazarus and Folkman (1984), she noted that:

> "in order to understand coping it is essential to be specific to describe concretely what people think and do cope with harm or threats in their lives'... it is not enough to ask what the individual would do in a specific situation, one must ask what the individual actually does, or thinks, or feels." [p933/4].

Guided reflection enabled practitioners to access these concrete situations in order to begin to confront contradiction and work through conflict towards learning to cope in new ways that supported desirable practice. A number of questions within the SEQ were aimed to elicit the practitioners' perception of :

- The extent guided reflection enabled practitioners to cope with stressful work [SEQ q9].
- The extent the practitioner learnt to cope more effectively [SEQ q14].
- Practitioner's perceived levels of stress with work [SEQ q26].

The rating scores are shown in Table A4.1 [Appendix 4]. The extent of perceived stress and the extent supervision offered support or enabled coping is mixed, reflecting the unique circumstances of supervision. Overall, supervision was perceived as both supportive and enabling of new ways of coping to be learnt. The extent that guided reflection was perceived as supportive was complex. For some practitioners, the supervision session was an oasis, a refuge from the frenetic activity that characterised everyday practice. It was literally 'time out' to off-load. Lawler (1991) noted how stories, or anecdotes are a form of coping behaviour. For a minority, the supervision session was an added anxiety, where one's quiet attempt just to get on and

cope were to be exposed. I use a number of practitioners' comments [SEQ] to illustrate the breadth of practitioner perception of supervision's supportive value

Myrna: *"I cannot imagine how I would have coped without the opportunities supervision provided for supporting me."*

Karen: *"I don't know how I would have got through some situations without supervision!"*

Gayle [S5]: *"When I came here I felt like fish out of water - the enormity of what I had been and this new role hit me . Thinking about supervision - 'I can let that out'. I say to visitors - 'don't go into it without that support' it is no good keeping things close to your chest. It's OK to talk to you about decisions. In larger hospitals that doesn't go on - oh yes, they say they are progressive but they don't know what they are letting themselves in for!"*

Jade [S4]: *"Yesterday I thought - when have I got supervision. It felt good - because I had the opportunity to say what an awful day I've had and why I feel so horrible. On the negative side - 'do I want to think about it at all?"*
CJ: *"Why wouldn't you want to?"*
Jade: *"Perhaps because you start to bury it and then you bring it all up again. I felt I wasn't coping. I was uncomfortable feeling that and admitting it because I want to be able to cope."*

Cherniss (1980) noted the significance of sharing work with another person :

"The new professional we interviewed frequently told us how helpful it was to ventilate their feelings to a co-worker when they were tense, worried, or frustrated...

receiving feedback and the opportunity to share worries with colleagues was *critical* to their development of a sense of competence." [p73]

Gill [SEQ] felt the opportunity: *" To raise worries and queries was very supportive. Feedback was particularly reassuring in instances where I was not sure of my actions had been appropriate, as another viewpoint often highlighted other issues involved. "*

Supervision, with its explicit intention to support practitioners, legitimated practitioner's anxieties. Supervision enabled practitioners to use 'stressful' experiences as positive learning opportunities. Bottling up feelings does the self harm (Tonnesmann 1979, Hall 1964) , As Hall noted-

"the energy made available by the body in a state of anxiety can be put to use in exploration of feelings through participation in the struggle to face and solve problems underlying the state of anxiety." [p153]

To appropriate Schön's metaphor of the swamp (1987), supervision was a plank across the swamp of complex practice, where practitioners stripped of their normal coping mechanisms could safely traverse the swamp until they reached the firm ground of new understandings and strengthened by commitment and new, more congruent defence mechanisms.

Limitations of supervision as support

However, this positive view of supervision needs to tempered. Supervision was not always available when needed. Myrna noted: *"Sometimes I would have liked an 'instant' supervision session if something stressful happened. This must be an acknowledgement that supervision helps with stressful incident."*

Supervision may increase anxiety. I asked Jade [S5] whether the act of reflecting on stressful experiences increased its force by bringing it to a

conscious level? She responded: *"I find it quite helpful to look at it in a positive way. Burying it is destructive."*

Yet, when I challenged her reluctance to share her negative feelings towards Myrna she responded :*"It churns me up reliving it.. all this stuff in my diary."*

Practitioners were confronted with their anxiety and the way they managed it. Anxiety could not so easily be rationalised away, leading to an increased perception of stress. Supervision may have distracted practitioners from seeking other, more appropriate forms of support. If the next supervision session was some time away the practitioner often shared how they lived with that stress until supervision because no other effective avenues of support were available. It was striking that issues that were so anxiety provoking for practitioners were not talked about and dealt with on a day-to-day basis. The lack of effective support evident within practitioners' everyday practice relationships was a stark contrast with the dialogue within supervision. The reliance on supervision as a support system may have initially fostered an ironic sort of dependence. Ironic - because, it intended quite the contrary.

Summary

Creating conditions whereby being available was possible proved difficult work. I felt this reflected how nurses had been socialised into perceiving themselves as relatively powerless to change these conditions. The difficulty to shift norms was a reflection on the way these norms were deeply embedded within the practitioners' health care environments and maintained through the complex machinations of power. This is the focus of chapter 7.

Chapter 7
Empowerment: Storming the barriers that limit the achievement of effective work

Norms

In chapters 5 and 6 I have indicated the way that 'norms', embodied within self and embedded within the environment, constrained the practitioners' ability to achieve desirable work. As such it was necessary for practitioners to understand and shift these norms or 'barriers'. The metaphor of barriers suggests both something to hold the practitioner back and something to push against. Figure 7.1 categorises the extent of this shift. Hence, a measure of growth could be indicated by the extent the practitioner moved to new norms congruent with realising desirable work.

Many of the practitioners were newly appointed in role. It was evident that the need to 'fit-in' with existing norms was itself a powerful norm. Gayle [S10] noted: *"When I started I was finding out about my role. I felt overwhelmed really. The approach here, the team, everything was different."*

The need to 'fit-in' with existing norms has been widely acknowledged (Peterson 1988, Melia 1987, Cherniss 1980). New practitioners struggled to focus constructively on learning through reflection until they felt secure within the prevailing work culture. However, the prevailing work culture often reinforced inappropriate norms. In contrast, experienced practitioners, struggled to see beyond the grain of normal practice. Gill's reflections illustrate her 'normal' mind-set on appointment to Windrush.

Figure 7.1

The movement from old norms to new norms congruent with achieving therapeutic work

Movement from old norms	---------->	*Towards new norms*
Belief system		
Nursing centred belief system - health care perspective of knowing what's best for the patient	---------->	Patient centred belief system - concerned therapeutic practice grounded in working with patients
Managing work		
Managing work based on task-centred practice and getting through the work within shifts	---------->	Managing work based on knowing and responding to individual needs
Coping		
Good nurses cope by - maintaining a facade of competence - use of incongruent ways of defending self	---------->	Good nurses cope by - seeking appropriate help - recognising self limitations and sustaining self to work in desirable ways.
Power		
Perceiving self as powerless, dependent and responding in hierarchical-bound ways	---------->	Accepting role responsibility and responding appropriately to others in assertive ways

Gill's mind-set

Gill's initial approach to work was a mind-set characterised by: *"I must get the work done and have everybody sorted out by 11 am.."* She acknowledged: *"the pressure to do this comes from myself"* and *"there is a different emphasis at the hospital- no overwhelming feeling that work should be done in a certain way or by a*

certain time." She identified the 'one-eye-on-the-clock' syndrome with its emphasis on getting through the work: *"Working on Rowan ward* [her previous ward] *you always took control because there wasn't time to do it any other way... it was akin to bullying the patient."* Gill [S4] shared an experience concerning a patient who did not want to get up, reflecting on her previous experience: *"usually I'm going 'round getting everybody up".* She now felt no pressure to do this. She felt she had previously acted in this way to avoid criticism from other staff, and, as a consequence, always seemed to be rushing about. She had become aware of this and its impact on patients. Over the sessions Gill came to speak differently, for example of- *"winding down to work at the pace of the patient, a chronically disabled woman who was very sensitive to staff rejecting her because of her slowness"* [S12].

Gill noted the rules of normal working grounded in 'getting the work done'. For example, Gill reflected that, because of the demands made on her time by staff and other patients, winding down was not done easily: *"You have the feeling that if you take too much time with one patient other staff will get angry with you."* She noted the way other staff: *"come to your rescue when they thought you had spent enough time with one patient and you weren't "pulling your weight. For example, the other day someone knocked on the door and said- 'I need a hand with Vance'. When I got out of there, they said, 'I didn't need a hand at all, I thought you needed rescuing'... you get the feeling that if you take too much time with one patient other staff will get angry with you."* Gill communicated her displeasure to the care assistant, who, rebuffed, said, 'sorry!' and walked off. The care assistant was clearly used to being appreciated for such action. Gill noted how nurses, in her previous post, competed with each other to get through the work and expected that others would work in this way. Gill tried to resist this pressure, but acknowledged this patient was extremely frustrating to look after because everything for her takes so long: *"I have to make a conscious effort not to take over from her."*

Norms such as managing a workload by 'getting through the work' and 'pulling your weight' have been acknowledged in other studies (Clark 1978, Melia 1987, Pearson 1985). These norms could only begin to be shifted once recognition of what it means to be available to the patient became known. However, efforts to shift norms often led to conflict with others who were motivated for whatever reason to maintain the status quo. Gill's reflections reflect the way norms were embodied and embedded and were not easily shifted despite espoused new norms.

Power

Norms are a reflection of power interests. Simon and Dippo (1986) note

> "Power operates not just on people but through them. Power relations are those that structure how everyday life will be lived; that structure how forms are produced and reproduced to limit and constrain , as well as contest and redefine what one is able to be." [p197]

The practitioners struggled to assert themselves against power gradients within their relationships with others to varying degrees. 'Struggled' reflects a lack of collaboration or an illusory collaboration dependent on the patronage of more powerful others. People do not think or go in search of freedom unless they hit barriers that resist achieving their desired "impulses" (Dewey 1933 p286). In this sense, barriers are at once both empowering and resisting. A sense of *becoming* exists only if practitioners were motivated to move from somewhere. The practitioner's struggle to shift norms against power gradients was assisted by the supervisors, who were themselves striving to move to more collegial type relationships with the practitioners. They were intent on undermining their own hierarchical power norms and, in doing so, to shift power norms towards more relational sources of power (French and Raven 1960). Yet the collegial 'bubble' of supervision was not easily transferred

into normal practice relationships. Because of this, the supervisors were not active norm shifters. Whilst the shifting of norms was acknowledged as legitimate work, the norms were resilient to social change. The focus of development was on individual practitioners. Perhaps social change required a group supervision milieu. It is interesting to speculate on the possible limitations of individual reflection to bring about social change at the level of shifting norms.

Professional domination

There is a substantial literature that exposes and critiques how nurses have struggled as a subordinate work-force in the face of medical domination, and how both nurses and doctors have been socialised into these respective power relationships (See for example, Keddy et al 1986, Kalisch 1975, Oleson and Whittaker 1968, Capra 1982, Hughes EC 1971, Hughes D 1988, Clifford 1985, Brunning and Heffington 1985, Webster 1985). This literature reflects the task that faced nurses in their struggle to assert nursing values against a gradient of professional dominance. Buckenham and McGrath (1983) illustrated how nurses are traditionally socialised into passive, subordinate and powerless roles vis à vis medicine, which left them unable to fulfil their self-perceived role of patient advocate. Practitioners in their study rationalised compliance to medical domination because of the need to be valued. As Oakley (1984) informed nurses, it was natural for dominant professions such as medicine to remain dominant by ensuring subordinate professions such as nursing remain subordinate. Chapman (1983), in widening Menzies-Lyth's (1988) psychoanalytic explanation of social defence systems, suggested doctors reinforced nurses' subordination through using humiliation techniques, which became a normal way of relating between doctors and nurses. As Pat noted [S7]: *"The GP says when he sees me - 'here comes the academic'."* Pru's narrative has a strong theme of such doctor behaviour.

Patriarchy

Relationships between doctor and nurses have a significant tradition grounded in professional dominance that reflects a wider patriarchal view. A characteristic of patriarchy is that someone else always knows what is best for the person, and that if this knowing is challenged then some punishment or sanction will ensue. In this sense the practitioner is coerced to submit to the general view around them irrespective of individual belief or thought (Greene 1988). Where this general view is prescribed it becomes difficult to stand outside it and see it for what it is. People become immersed in this general view and accept it as their own reality. Indeed, practitioners felt it was often easier to accept norms as a fact of life and passively to maintain the status quo to which these factors contribute (Smyth 1987), despite the inner conflict of contradiction. There is a natural tendency to fall in with the beliefs wielded by social influence for the sake of harmony even when these are detrimental to one's own interests (Dewey 1933). Dewey believed that shifting norms would likely disrupt normal working relationships and practices, highlighting how norms serve a social purpose in regulating what is accepted as normal practice. Action outside these norms is at once labelled as deviant and likely to result in conflict and sanctions to restore order. Delacour (1991) framed these dynamics in the wider culture :

"Nursing has been constructed by powerful discourses including those of medicine and gender, in which our society's dominate ideologies are enshrined. From the level of connotation, socio-cultural myths are produced from female stereotypes which circulate in common currency as part of 'common sense' notion - those which go without saying - operating to foreclose a space for alternative representations and meanings." [p413]

Medical domination was just one manifestation of patriarchy, how what counts as significant is determined by male values. Watson (1990) considered the limiting and debilitating impact of patriarchy for nursing, and how outdated

this concept was for the changing world. There exists a feminist, critical, and sociological literature that explores how patriarchy and power relations have limited the potential of women and nurses (Street 1992, Watson 1990, Bullough 1975, Moccia 1988, Porter 1991, Freidson 1970, Gamarnikow 1978, Hearn 1982, Hughes 1971, Ashley 1972, Roberts 1983, Lovell 1980, Oleson and Whittaker 1968, Capra 1982). Street (1992) noted how:

"The myth of the female who was born to nurse casts its shadow over modern nurses. The relationships that society contracts between nursing, mothering, homemaking, and femininity have meant that the role of nursing has been culturally submerged into what women do within our culture [p183].. these gender relations are integral to an understanding of the actions of nurses because they are historically and culturally formed long before becoming nurses and doctors." [p210]

Reverby (1987) explored how caring is viewed as an extension of being a women, indeed as a women's duty in contrast to her work. She asserts that this lack of power is largely as a result of the relationship between womanhood and caring and the subordinate relationship of nurses to doctors where traditionally caring has been interpreted as the obligation to carry out the doctors orders, an obligation that deprives nurses of rights. The effect of this history is a struggle to assert these rights even when nurses have a vision of caring as work. Some practitioners reflected how they had been socialised into gender roles, for example Gill seeking permission from her husband to be contacted at home, suggesting a norm that women didn't take work home with them. Socialised gender roles may be a significant barrier in filling professional roles that impinge on women's family roles (Johns 1989b). Jade wanted to be perceived as intellectual but felt this was beyond her. I asked her: *"What is it that drives you?"*

Jade [pauses]: *"I want to be recognised as ME, not as Mrs. Somebody - once you are married people assume or say you are going to do this or do that - you are written off."*

Freire (1972) and Roberts (1983), who draws on Freire's work to consider nurses as an oppressed group, highlight how oppressed people come to internalise the values of dominant groups as their own, for example that the medical model and technical work was the most valued type of nursing work. Caring could be 'given away' to students and untrained personnel. Although practitioners all professed strongly caring values these values were not well articulated except at Windrush hospital. The failure to articulate and assert caring values was disempowering.

Visualising and valuing care

Patriarchy manifests itself in what counts as valid knowledge. Lawler (1991) and James (1989) have both noted how caring in nursing was largely invisible, devalued by nurses themselves, and seen as largely unskilled, being the natural extension of women's roles. Lawler's research was concerned with body-work, whilst James' was concerned with emotional work. Within the study, this work became visible through reflection. This recognition led to a positive reinforcing cycle of acknowledging and affirming these values. The connection between practice and values was a significant empowering factor through visualising and realising caring within everyday experience. The practitioners did feel powerful when caring became a reality in their practice. As Reverby (1987) asserts, the focus is on caring and the conditions whereby caring can be a reality are the real issues, not professional concerns with autonomy which acts to blur the nursing purpose. Guided reflection contributed to a process of undermining patriarchy and enabled the charting of practice knowledge. However, the disciplinary recognition of such knowledge faces a barrier erected by nurse academics in their need for nursing to be recognised as valid knowledge within a dominant university and medical technology-positivist paradigm where knowledge needs to be observable to constitute disciplinary knowledge (Kikuchi 1992). Kikuchi justifies this

position by creating a dichotomy between knowledge nurses need to practice and the disciplinary knowledge of nursing. In this way, intuitive and tacit knowing can be marginalised as significant but not observable, and therefore not valid disciplinary knowledge. Such a dichotomy is witness to the dominance of positivist thought, that what counts as knowledge needs to be observable and verifiable. Yet, through reflection-on-experience, the intuitive *becomes* observable and available to inform other practitioners, although not with any prescriptive intent. Because it is the knowledge used in everyday practice it properly constitutes nursing's disciplinary knowledge.

Enlightenment, empowerment, and emancipation

"Reflection and deliberation do not come easily to us, as mankind cannot bear very much reality" (Griffin 1983 p292)

The stages of enlightenment, empowerment and emancipation within critical social theory (Fay 1987) offer a useful framework to perceive the development of self through guided reflection. Thompson (1987) referred to the sense of enlightenment as awakening to self and the world. She captured the mixed emotions of awakening as both joy and pain

"as more and more practical assumptions and values are brought into question." [p34]

Enlightenment gave the practitioner a sense of control and is one level of learning through guided reflection even though it does not necessarily result in changed action. It is only through enlightenment that one can feel empowered to take action. The recognition that one's best interests are not being fulfilled is experienced as the conflict of contradiction. Hence it is important that the seeds of doubt are based primarily on the practitioners' own beliefs rather than those of others. Boyd and Fales (1983) noted in their work with counsellors, how

reflective practice engendered an energy and excitement about practice, based on the development of commitment and meaning. I have already noted the significance of 'concern' as a dimension of the extent the practitioner is available to work with the patient and family. The extent the practitioner chose to pay attention and learn through experience, and take subsequent action, is a parallel concern or commitment. Gadamer (1975) noted it's significance for reflection :

"the opening up and keeping open of possibilities is only possible because we find ourselves deeply interested in that which makes the question possible in the first place. To truly question something is to interrogate something from the heart of our existence, from the centre of our being." [p266]

The intensity of the practitioner's commitment varied considerably between practitioners. It could not be hidden or easily distorted because it was such a powerful force. When commitment was numbed or blunted, practitioners' tended to be defensive because they had no real interest in working towards effective work. Indeed they resisted reflection because it appeared uncomfortable for them to realise that they lacked commitment. Fay (1987) noted how wilfulness and active curiosity [or commitment] were requisite to reflection. This is the hallmark of responsibility; to ensure the practitioner is constantly striving towards increasing effectiveness in her practice. As Dewey (1933) noted:

"Knowledge of the methods [of reflection] alone will not suffice - there must be desire, the will, to employ them. This desire is an affair of personal disposition "

[p30]

Considering Dewey's words, all practitioners reported that guided reflection was a positive experience [response to SEQ q6 - Appendix 4A], even by those

practitioners whose commitment seemed lacking. Technique can be learnt whereas commitment needed to be nurtured. This is not to say that practitioners cannot work in supervision without commitment. The supervisor's appropriate response to a practitioner whose commitment was blunted is to focus and nurture this commitment. For example, Abbi and Karen both went through crises of being confronted with their commitment to reflection and caring before emerging with a new found sense of purpose about the nature of their nursing practice. This was a considerable motivating force as evident within Abbi's and Jane's supervision dialogue.

In her fifth session with me, Jane reflected on her frustration with Abbi that had reached a climax in their last session [S6]. Jane noted how Abbi had cancelled two sessions. I challenged Jane whether Abbi saw supervision as low priority. She felt this was true due to Abbi not having reached her own 'mental threshold' necessary for involvement in the session. I challenged Jane whether Abbi was avoiding the sessions, not wanting to share her work?

Jane responded very negatively: *"I don't think she has any issues."* This response prompted me to challenge Jane about the impact of her negative view of Abbi for supervision.

Jane: *"Its my sarcastic self."*

CJ: *"Do you think it might be a coping mechanism?"*

Jane: *"Sub-consciously possibly, but she doesn't strike me as that sort of person - it's as if she can't see things unless she is in close proximity."*

CJ: *"Like detachment- she doesn't get involved therefore doesn't get anxious about things?"*

Jane related this to a recent situation shared by Abbi about a patient who's mother was having difficulties with what was happening to her daughter. The daughter's health had deteriorated and the mother was questioning whether she should go to high dependency unit. The nurses were concerned about this - they felt they didn't want her to go anywhere else.

Jane had discussed this with Abbi. Abbi' s response was: *"Shame.. but if that is what happens it happens."*

Jane had then asked Abbi whether she had discussed this within her team. She responded in a detached way: *"Umm - that's a good idea."*

We noted how Jane's negative feelings were reflected in the session dialogue.

In her next session with Abbi, Jane had asked Abbi to reflect on their last session and to consider where supervision was taking them. This chat had jolted Abbi into a greater sense of responsibility for her work in supervision, rather than something she had reluctantly done to her. It was also a coincidence that Jane had asked Abbi to read a chapter on therapeutic work and that this topic was also discussed in college which she could relate to a particular experience. By Session 10 Abbi was talking about her work very differently, much more involved and enthusiastic. Abbi reflected on the way her relationship with one patient had developed therapeutically: *"I want to say how positive Alison has been and how much I have learnt from her. At first I was making decisions for her but now it's as if she's coming to terms with things - like the catheter... she said she felt supported by us. That's a very positive thing for her to say. The last six months has been a rocky ride... you did say to me that perhaps I was blinkered and could only see one path. Now I've stepped back and waited for things to happen. I suppose I tried to speed things up. Now she's decided for herself."*

Jane : *"That's very positive. Can you see changes in other ways?"*

Abbi : *"With toileting her - I've noticed our relationships with her. I was talking to Katie [associate nurse] about our facial expressions - the looks we have when she asks us for the fourth time to go to the toilet. Alison looks as if she is about to burst into tears. We've tried to change that and be different. It shows, Alison is so much happier. Sheila [nursing auxiliary] noticed it as well. She's stopped rolling up her eyes and Alison is much happier and easier to help."*

Abbi moved on to share a situation of conflict with the physiotherapists about standing Alison. Abbi clearly illustrates her focus on Alison's needs in contrast with the physiotherapist's viewpoint.

Abbi: *"She wanted it all her own way. She didn't think about the benefits to Alison."* The physiotherapist had raised this at the team meeting, reminiscent of Gayle's situation with Hector and Maggie competing for who knows best for the patient. I commented in Abbi' narrative - "The experience highlights how professionals tend to make decisions about the patients without their involvement. Abbi is able to relate this to the concept of 'individualised care' and is challenged to consider the function of the meeting and her involvement in this meeting. She sees that patients could ideally be involved in these meetings and in the decisions made about them. Jane helps Abbi to put this into a practical context with the result that Abbi is empowered to take action to explore this matter within her team. She has moved from a sense of obligation to being committed. Her practice now seems to matter to her. She is infused with a strong sense of concern for Alison that is empowering.'

Karen also noted a sense of breakthrough in her supervision with me that reflected a new commitment to practice and reflection: *"Sessions 1-6 were very much led by the supervisor, but in session 7 we had a sudden breakthrough and I took control. From then on I felt I was growing through supervision - I remember telling Chris I felt like a seedling in spring which has felt the sun and is now growing big and strong into a tree."* [Reflective Review -see appendix 6] -
The growth of commitment and empowerment was an emotional experience. Karen noted how she increasingly came to look forward to her sessions: *"I knew how much I benefited, but I also knew how much energy it took and I often felt drained afterwards."*

van Manen (1990) captures this emotional experience;

" Retrieving or recalling the essence of caring is not a simple matter of simple etymological analysis or explication of the usage of the word. Rather, it is the construction of a way of life: a willingness to live the language of our lives more

deeply, to become more truly who we are when we refer to ourselves [as nurses]"

[p59]

Empowerment is the sense of freedom to do something significant in changing one's life. It is the energy and will to move from passivity, the perception of self as powerless, often reflected in uncertainty and aggression, towards becoming assertive, able to take confident action considering self's and others' needs.

I noted in Gayle's narrative: *"Gayle believed she was not an assertive person , yet she could demonstrate a growing ability to be assertive. She has had to battle through a dilemma of win-lose relationships which are naturally aggressive by nature, most notably, a willingness to respond to Leslie in ways that are helpful to him rather than to just 'win'.*

This sense of battle is reflected by Greene (1988);

"To become [different] is not simply to will oneself to change. There is the question of being *able* to accomplish what one chooses to do. It is not only a matter of the capacity to choose; it is a matter of the power to act to attain one's purposes. We shall be concerned with intelligent choosing and, yes, humane choosing, as we shall be with the kinds of conditions necessary for empowering persons to act on what they choose." [p3]

Emancipation by definition is changing the established power relations which act to keep people subdued. Kieffer (1984) studied the process of empowerment amongst community leaders in USA. He noted how this empowerment process involved;

"reconstructing and re-orientating deeply engrained personal systems of social relations. Moreover they confront these tasks in an environment which historically has

enforced their political repression, and which continues its active and implicit attempts at subversion of constructive change." [p27]

This could be recognised in the way practitioners such as Abbi and Karen came to talk differently about their work over time. For example, Jade's talk reflected her growth from a sense of discomfort to a sense of fulfilment in working with patients and families. An analysis of her shared experiences in supervision indicated that:

Sessions 2 - 9 were characterised by Jade's feelings of discomfort.

Sessions 10 - 17 were characterised by Jade's growing feelings of acceptance of herself.

Session 18 onwards were characterised by Jade's feelings of fulfilment.

This pattern of feelings reflected Jade's increased availability to work with patients in desirable ways and were significant markers of development. The participants in Kieffer's (1984) study refer with great emotional intensity to the importance of the external enabler. The supervisor's role is primarily to facilitate this sense of empowerment, to support and encourage the practitioner towards taking appropriate action. Belenky et al (1986) argue that language alone does not lead automatically to reflective thought but requires connection with others. Without doubt, the practitioners were isolated in many respects in their work. Guided reflection became the connection to themselves and to others, and enabled them to engage with the intellectual life of their work community. This connection needed to be made on several simultaneous levels. On one level, the practitioner needed to connect with Self, to know and value these beliefs as significant. On a second level, to connect with the supervisor as representative of the wider community, as if the supervisor was the gatekeeper and guide to this world. In order to do this, the supervisor needed to connect with the practitioner in terms of their existing reality, whilst connecting in terms of new potential reality. Torbert's (1978) concept of a

'liberating structure' provided a useful framework to consider guided reflection as leading people towards new horizons. Torbert notes;

" To educate towards shared purpose, self direction, and quality work, an ironic type of leadership and organizational structure is necessary, which is simultaneously educative and productive, simultaneously controlling and freeing, is necessary." [p113]

Torbert sets out his agenda for a collaborative style of leadership that was congruent with guided reflection [figure 7.2], that undermined old norms whilst *simultaneously* reinforcing new norms.

Figure 7.2

Supervision as a process of simultaneous leadership

- How the focus of work needs to be centred in practitioners' concerns.
- The need to establish a constant cycle of feedback on the nature and effectiveness of practitioners' practice.
- How the leadership uses and shifts power towards a collaborative leadership based on mutual goals.
- The need to create an open structure of inspection and challenge - where conflict is surfaced and becomes an educational opportunity.
- The need for leadership that becomes transparent and vulnerable, but at once more secure because it is based on mutual values and support.
- The need for an ethical leadership - committed to seeking, recognising, and righting personal and organisational incongruities.

However, in practice the movement towards new norms often put the *individual* practitioner into an invidious situation of actively undermining old norms that others continued to adhere to. Hence, this movement was complicated for the practitioner by being *simultaneously* exposed to two sets of

influences, one from the supervisor and other like-minded practitioners who shared similar beliefs about the nature of nursing, and from other practitioners who, to varying extents, were motivated towards action that preserved the status quo. In truth, practitioners were thrown into this maelstrom contradictory world, largely unwittingly and unprepared. It meant that the practitioner was often trying to change others viewpoints to fit-in with new norms, or battling to defend herself where the old norms constrained her through the actions of other staff.

Habits of mind

Margolis (1993) considered that new ideas competed with existing ideas. The success of adopting new ideas depended on the robustness of existing ideas and the force of argument available to support the new idea. Margolis suggested that habits of mind competed for dominance, and thereby generated contradiction. The supervisor's role was to mobilise forces to plant *seeds of doubt* within the landscape of habits of mind and to water this doubt in order to eventually overthrow the dominant habits of mind that feed an accepted order of things. Accepting the new idea was just the beginning. Ensuing congruent action could not be guaranteed. Practitioners do not change simply because they come to understand an issue differently (Fay 1987, Allen 1987). This point highlights the folly of *imposing* liberating structures on people, in that nurses who have been socialised to be powerless are unable to respond to liberating opportunities when they present themselves. The emphasis is on the practitioners coming to see themselves rather than merely having this 'reality' explained to them. For example, all shared experiences concerned with conflict had a fundamental power inequality at their root which manifested itself through different attitudes, beliefs, and behaviours. This was not difficult to see or understand provided it was looked for and not just taken for granted as part of the 'natural' background of experience. This 'natural' background of the way constructed social relationships was exposed and challenged so that the

practitioner could see the way such relationships constrained achieving desirable practice within the particular situation.

Summary

This chapter has been concerned with understanding the way power and knowledge was embedded within the practitioners' everyday experiences and how these forces constrained the practitioner's ability to take desirable action. They emerged as 'barriers'. The extent of empowerment and emancipation through guided reflection was influenced by a number of factors:

- A sense of concern and commitment that things matter.
- A force of conflict felt within contradiction.
- Understanding the issues [enlightenment].
- A sense of vision and knowing what needs to be done.
- The control to take effective 'political' action.
- The courage to take action.
- The support to sustain self - in the face of consequences.

Chapter 8
Knowing the practitioner

"The supervisory process is defined by the context in which it occurs"

[Robiner 1982 p259]

Preamble

The supervision dialogue between the supervisors and the practitioners, and between myself and the six supervisors, represents the unfolding experience of guided reflection over the four years of the study. This part of the thesis is an account of the dynamics of guided reflection, moving towards an understanding of the conditions under which guided reflection was most effective in enabling the development of the effective practitioner. The organisation of this account is structured through the being available framework that I used to described the essence of being an effective practitioner. Hence, the core dynamic of effective guided reflection is the supervisor 'being available' to work with the practitioner. By using the 'being available' framework I acknowledge the parallel nature of therapeutic work within clinical practice and within guided reflection. The parallel comparison is outlined in Figure 8.1. However, my use of the term 'parallel process' needs to be distinguished with the term as used within psychotherapy, where it has a more exact meaning, concerned with how the therapist acts out transference forces within the supervision relationship, in ways that parallel how the client has projected similar transference with the therapist (Doehrman 1976, Ekstein and Wallerstein 1972).

Figure 8.1

The parallel pattern of 'being available'

Clinical context		Guided reflection context
Concern		Positive regard
Knowing the person		Knowing the practitioner through her shared experiences.
Responding with appropriate ethical, informed, and skilled interventions	Being available to work with the client/ practitioner	Responding with an appropriate helping style
Knowing and managing self within a relationship	<- parallel -> process	Managing own concerns
Creating and sustaining an environment where being available is possible		Creating and sustaining a guided reflection environment where being available is possible

- In Chapter 8 I discuss the significance of 'knowing the practitioner through the experiences shared with the supervisor, and creating a supervision climate that facilitated the sharing of experiences.
- In Chapter 9 I discuss the significance of the supervisor responding to the practitioner with an appropriate helping style.
- In Chapter 10 I continue the theme of responding with an appropriate helping style by considering the dynamics of the supervisor's balance of challenge and support.
- In Chapter 11 I discuss the significance of the supervisor knowing and managing self in order to be available to the practitioner. This includes the supervisor's regard or concern for the practitioner.

The nature of shared 'experience'

The practitioner was known through the experiences they talked about in supervision. These experiences were largely grounded in issues of felt anxiety for whatever reason. Boyd and Fales (1983) noted that in their research participants described the beginning of a reflective episode as :

> "an awareness that something does not fit, or does not sit right within them, or of unfinished business. This sense of discomfort, the itch that wants scratching, is not a willed or intended state of mind; it occurs." [p106]

In total, I labelled 568 discrete experiences shared in supervision. Of these, 75% were essentially anxiety focused. 20% were essentially affirmative. The remaining 5% were prompted by the supervisor. The overall classification of anxiety focused experiences is shown in Table 8.1.

Table 8.1

The nature of anxiety within experience		
1.0 Organizational	8%	
2.0 Accountability	5%	
3.0 Interpersonal conflict:	48%	
.1 With peers		- 50%
.2 With N/A's		- 16%
.3 With 'outside' nurses		- 9%
.4 Other workers		- 7%
.5 With doctors		- 15%
.6 With ancillary workers		- 3%
4.0 Difficult patients & relatives	35%	
5.0 Intrapersonal conflict	5%	
	100%	

The two major foci for shared experience were situations of interpersonal conflict with other health care workers, and situations of working with patients and families. Paying attention to 'satisfying' experiences was not usual even when supervisors encouraged this. Jeanne [S8] noted: *"After the last session you asked me to look at some positive things. Nothing else has happened that has been difficult to handle.. its difficult to note down positive things at the end of the day - I only think of negative ones. I suppose I think of the positive ones as being routine - such as doing a good lift or giving information about an situation. But if it is tackled appropriately as routine [then] it must be positive? I did write down a few things I thought went well and pleased me."*

Jeanne's comment highlighted that practitioners often felt they had no experiences to share because nothing unusual had happened. Initially practitioners often did not know what to reflect-on. Jade said: *"I always think I'm missing something - for example, there are days when I feel there's nothing to write."*

Abbi noted: *"Either I was blind to critical incidents or they just didn't happen! The incidents I did reflect on jumped up and hit me in the face but they were few."*

Rona illustrates this phenomenon.

Pat [S4]: *"How long is it since the last session?"*

Rona: *"I have just looked - 4 weeks! But maybe that's due to me not having any issues to bring up."*

Pat: *"What do you mean - things that go wrong?"*

Rona: *"Yes - things or situations where I think - 'I could have done that better."*

Pat: *"Do you think you should bring good achievements too? That seems important?"*

Rona: *"I've never thought of that. I can not see why we need to discuss things that go right. Why should we?"*

In other words nothing *stressful* had happened. As Pru [S9] noted: *"Reflection normally stems from a problem - perhaps I don't notice when I reflect on positive things."*

Myrna [S7]: *"I sometimes wondered how I chose my critical incidents -I suppose I wrote about things which were 'on top' for me without really selecting them consciously, and so therefore they automatically reflected the things which I needed to work on."*

Myrna had just returned from holiday feeling very relaxed. She said she hadn't written anything in her diary because *"nothing was happening"*. I noted she was currently caring for two terminally ill patients, prompting my challenge that there must be lots going on in their care especially as both were relatively young. However, Myrna felt this care was not 'problematic' and therefore didn't present itself for reflection.

I have taken the concept of 'experience' as simply what practitioners talked about within the session. Retrospectively I labelled these as discrete, although they were never separated from the flow of experience over time. Discrete was merely an analytical ploy. For many practitioners, identifying 'an experience' was difficult, although why this was so was not easily understood. This may be due to the practitioner's difficulty to extract self from the situation in order to stand back and look at self 'objectively', when in fact, 'experience' was the active engagement of self within the situation. The focus of an 'experience' was the particular situation that the practitioner was or had been involved in. However, I am conscious of my limited exploration of the theory of reflection in terms of defining 'the clinical experience' and its relationship with the nature of 'the learning experience'. MacLeod (1996) exposed the complexity and general limited understanding of these issues within current educational literature, some of which I have drawn on in chapters 2 and 3.

When practitioners had no 'discrete' experience to share, the supervisor's tactic was to 'render the normal problematic'. For example, Jade [S15] went quiet after 35 minutes, having rehearsed how she was going to give feedback to a doctor. This work had been both intense and profound. She was pre-occupied by this anticipation and didn't know what else to share.

I asked Jade: *" What about some of your patients?"*

Jade: *"Its okay."*

CJ: *"No issues at all?.. which patients do you have?"*

Jade: *"Well... Lucy Lambert."*

CJ: *"OK - tell me about her."*

Jade: *"Lucy.. it felt very warm sitting on her bed, she held my hand.. it was enough to be there with her."*

Jade then explored this situation. The tactic of 'tell me about your patients' helped Jade to focus on this patient. As Jade began to talk about Lucy Lambert, she offered cues to pick-up. As Karen [SEQ] noted: *"I was often amazed how things I mentioned in passing could become critical incidents. I obviously wasn't very good at identifying them."*

Jade's experience suggested her difficulty focusing on another experience when the previous experience had been intense . As such, my effort for her to fill the supervision time by focusing on other experiences may have been misplaced. Having an hour to fill may create its own pressures, although this was generally not a significant issue. Other practitioners resisted this intervention by the supervisor. Abbi noted: *"This sense of making the normal problematic... I don't see the need. I get to thinking about it before my sessions but I can't do it."*

Taken for granted experience was by its very nature, not available for reflection. Perhaps satisfying experiences were taken for granted, or at least not seen as significant to share because they were not invested with anxiety. Yet, when satisfying experiences were shared, I felt them to be very significant

because they were affirming. It enabled practitioners to be acknowledged and valued for good work within a culture where this was not the norm.

Model for structured reflection

The model for structured reflection is an heuristic device to enable practitioners to access their knowing in practice implicit within experience. It was constructed by analysing the interaction dynamics between myself and practitioners [see chapter 3]. Its reflexive nature is reflected in its evolution through a number of editions, evolving into the eighth edition within this thesis.

Keeping a reflective diary

Encouraging the practitioner to use the model of structured reflection and write their reflections within a reflective journal was intended to prepare them for sharing their experiences within supervision. Keeping a diary was intended to encourage practitioners to reflect as a daily activity rather than something to 'pull out of the hat' for supervision sessions. Feedback from SEQ q.12 [see appendix 6A] indicated that practitioners found keeping a diary was a difficult activity. Pru had a strong sense of guilt because she had agreed to keep a diary but had not envisaged how hard it would be. At first she avoided it and shrugged off encouragement in terms of being busy. In session 8 she said: *"I've been wanting to do it but I've been working such long hours that I can't just face it."*

Maud : *"How has that made you feel?"*

Pru : *"I'm very aware I haven't used it. I feel guilty because I wanted to see how it worked. I wanted to do it but I've had such long hard days. It's a busy time of the year."*

In her next session [S9] Pru noted: *"I have written the diary."*

Maud: *"For me?"*

Pru: *"Partly - I wanted to do it before this session but I don't like writing things down. I prefer to talk things through. I didn't know how to go about it.. I used the model of SR. I don't like writing but I'm glad I used the diary."*

By session 12 Pru noted: *"I've tried to use the model of SR. for this experience from last session.. but something else has happened - I wrote about that too but didn't use the model. I'm not quite sure about a couple of things - I seem to repeat myself. I shall see if you think it is a reflection or just a description... describe the experience' - I'm not sure what that means."*

Maud: *"You mention you found writing your diary using the model of SR. clumsy. Do you want to explore that?"*

Pru: *"Yes - it was interesting to think it through. I was trying to follow the process but felt that I was repeating myself. I didn't find it easy to start with, but I think it comes with practice."*

Pru: *"I think I could get as much from just discussing it - not writing it down... the other experience I shared - I just wrote down how I felt - I let it flow. I didn't use the model..."*

Pru's descriptions of the experience were often muddled. She clearly struggled with using the Model of Structured Reflection, as if it was a new technology she had yet to master. Yet she felt that using the model would help her to think and write more coherently. Her comments suggested a dilemma with imposing diary keeping. If keeping a diary was perceived as something you do for someone else rather for self, the risk was that it became [yet] another oppressive task, in a world that was already dominated by tasks. Yet, for those practitioners who learnt to keep a diary for their benefit, this effort enhanced the learning opportunity. Jade noted [S6] on reading her diary, she hadn't realised what she had written and was surprised at how she felt. This she felt was an important dimension of her self-realisation.

The cultural strangeness of writing reflective accounts was reinforced by a reluctance to think about work after the event. As Jeanne noted: *"I found it extremely difficult to write the diary. As soon as I was back at home I wanted to forget about work and therefore I always found it a struggle and effort to rethink my work. I never enjoyed the exercise."*

Other practitioners struggled to keep a diary because it required 'discipline'. For example, Abbi commented [S2] - *" I haven't been keeping the diary - I've tried to keep 10 minutes at the end of the day but it hasn't worked. Sometimes I've already solved things so I don't see the need to write things down."*

In Session 5 she commented- *"First of all I haven't kept a diary... nothing has happened I needed to write about and I'm also too busy thinking about other things... the course and essays to write."*

Yet, by session 9 Abbi had become much more committed to her nursing, and had discovered that reflecting and writing about her experiences was a meaningful activity. She shared from her diary her involvement with a patient she had become involved with. She noted: *"I did look at the structured model. It was useful - like looking at the choices I had but I couldn't see what I was trying to achieve?... that's why I used the model of SR.... but I didn't like to think about it whilst it was happening."*

Gayle highlighted the benefit of perseverance: *"Keeping a diary requires self-discipline which sometimes slips. But the activity is valuable in developing at work... the diary definitely helped me focus on relevant issues.. underlying issues often surface that are not immediately identified."*

Beyond the practical difficulty with time and effort, I was struck with Street's (1992) concept of nursing being an 'oral tradition', and the way this tradition was "recreated daily in the formal and informal rituals in which nursing engage" (p177). Street suggests that nurses may avoid writing because it makes them visible and hence vulnerable. Street argues that the oral tradition is a women's

way of communicating and as such needs to be recognised and valued, rather than emphasising written modes of communicating. Talking about work 'allows' the subjective viewpoint, whereas writing about work demands a more rational and objective stance that practitioners are uncomfortable with. Considering Street's theory, I felt that some discounting process was taking place, as if practitioners subconsciously discounted their experiences as meaningful or significant. This made sense in terms of the extent to which caring practices and emotions had been de-valued, and the way exploration of conflict was culturally taboo. Dewey (1933) suggested that practitioners may resist suspending judgement or engage in intellectual inquiry because of a cultivated habitual mind set or where doubt may be "regarded as evidence of mental inferiority" [p16].

Jade's comments [S7] reflected Dewey's words: *"I never seem to make any important decisions.."*

CJ: *"That sounds to me you that you don't perceive yourself as intellectual?"*

Jade: *"That's uncanny"*

Jade lacked confidence that she could think in critical ways. She felt intimidated by 'intellectual things' and avoided discussing these things to protect herself from being exposed as ignorant. This avoidance was so deep that it interfered with her ability to reflect.

Alice [S4] suggested that reflection had confronted her normal competence and ways of coping: *"In a way I feel less sure [about myself] since I have been using a diary. Maybe its because I used to shut off."*

I thought that perhaps talking about distress and conflict may be uncomfortable for practitioners to both write and talk about. I challenged Jade [S16] with her throw away remark about her conflict with a colleague. She responded: *"I haven't written about it in my diary - I suppose I was trying to avoid the issue - you churn it all up again writing the notes."*

Supervisors often expressed a sense of inadequacy when the practitioner had used the model because they didn't know what else to ask. This suggested that supervisors had a need to be useful, and found it difficult to think beyond the reflective questions. In this respect, the model may limit imagination if seen from a prescriptive perspective. Maud's pattern of asking questions reflect the model cues, but not in the sequence as set out in the model. In general, supervisors rarely followed the sequence of cues, except when they deliberately set out to role model the use of the model in practice. The supervisors did not keep reflective diaries, and consequently were poor role models for practitioners. I challenged Pat [S3] about not keeping a diary -

Pat: *"I have so many issues in my head I have diarised quite well in my head."*

CJ: *"What benefit do you see in writing them down?"*

Pat: *"You may be able to explore them a bit more when you write them down... I've had a pretty traumatic time since we last met and not enough time to write it down. I accept that but some of the issues have been quite painful and to be honest some things you don't want to reflect on - are better left alone... but I'm quite prepared to bring them up again but I had just wanted to go and forget about it."*

CJ: *"To avoid the issues?"*

Pat: *"No - I don't want to avoid the issues otherwise I wouldn't be bringing them up - but sometimes work can be extremely stressful and sometimes you have to forget about things and walk-out... I don't feel a lot better when I am writing this down."*

Pat challenged the assumption that writing about stress was helpful. This was an interesting comment because it was the only comment made by a supervisor about keeping their own reflective diary.

Myrna [S5] reacted defensively to not writing her diary: *"Its been very busy - the last thing I want to do is think about work. I resent writing the diary."*

However she was ambivalent about this. On one hand she expressed regret, and recognised she was dealing with stress by reverting to 'old methods'. She

wanted to accept responsibility and recognised her need for self-discipline. On the other hand, she felt she had transferred her anger at one particular patient and therefore resented writing the diary because it made her face up to it rather than repress it. It was as if rejecting her diary paralleled rejecting her patient. When Myrna was asked what she needed to do about improving her present support system, her response was: *"To make myself write my diary even when I don't feel like it. I find this very hard - the more stressed I am the less I want to write about it."*

Jade [S11] supported this view: *"The diary feels like a bit of a blip at the moment.. I think I used the diary in a very negative way - focus on negative things. Over the past few weeks.. because I felt I dealt with the situations I haven't used the diary. I still think about situations but haven't written it down."*

The difficulty with keeping a reflective diary was evident within the literature. For example, Gray and Forsstrom (1991) noted

> "The process of 'journalling' may sound simple and easy to execute, but at times it was extremely difficult. Mostly the incidents recorded were identified because there was an affective component. This may be related to feelings of our personal inadequacy to cope with the demands of the situation. Alone, it was emotionally painful to journal events that were largely self-critical." [p360]

Yet practitioners suggested that writing about stress enabled them to make sense of their feelings within the knowledge this can be worked through in supervision. Gayle noted [S4]: *"When I get home - I go through it [using the model of SR.] and work out exactly what is effecting my decisions. It takes the panic out of situations."*

Keeping a diary was a constant struggle for Karen. She initially resisted this activity because it was time consuming, difficult and unhelpful. She avoided

her diary by not bringing it to sessions. She felt guilty because of her failure to comply with our contract that she would keep a diary. In session 18 Karen brought her diary to the session for the first time in a small brown envelope.

CJ: *"Your diary?"*

Karen [looking protective]: *"Yeah - if you can call it that."*

CJ: *"Is it easy to write in terms of time?"*

Karen: *" Difficulty is in finding time to write - once I start writing I could write for ever.. it's great!"*

In session 19 Karen shared an experience using the model of SR. She noted: *"It was more helpful to write it down than previously - the comments I expected from you I found myself writing down."*

CJ: *"What does that tell you?"*

Karen: *"It tells me that I am beginning to work out things better for myself now."*

Karen noted that what she liked best were her feelings of being more vocal and in control of the session. After this session, I no longer had to ask Karen reflective questions, she asked them of herself. In session 21 Karen noted: *"How easy it all flowed"*. This comment suggested she had integrated reflection into her world view. It was no longer an effort but a natural part of her practice which she felt was meaningful and comfortable. Karen like Abbi had struggled to find keeping a reflective diary meaningful. Yet, like Abbi, she persevered with encouragement and learnt to value this activity. She commented: *"I have always seen the relevance and value of supervision but have been put off at times by the effort demanded of me in terms of time. However, I have been heartened by some of my results and amazed at some of the sub-conscious learning that has occurred. And finally, I intend to be more committed to keeping a reflective diary, since this review has shown to me that more was achieved in the sessions where I had already reflected in some depth and this gave such a good feeling!"* [Karen's reflective review - appendix 6]

Some practitioners such as Leslie, Myrna and Rona were good at keeping a reflective diary. Indeed they revelled in their journals. Leslie wrote poems as a way of reflection. For the majority keeping a diary was a struggle, but in the light of experience, a struggle worth perseverance in terms of development.

Establishing a culture for disclosure

Practitioner disclosure was essential in order to know the practitioner through their shared experiences. The expectation that practitioners would share experiences from their practice with their supervisor was contracted within all guided reflection relationships. As such, disclosure required a climate where the practitioner felt 'safe' to disclose. Central to this climate of self-disclosure was trust.

Establishing trust

Hammond, Hepworth, and Smith (1977) emphasise the characteristic of authenticity within counselling type relationships, which include such qualities as being open and non-defensive. Jourard (1971) identifies the quality of 'being transparent' as essential to the development of collegial relationships. These are the foundations for establishing trust. Establishing trust can never be taken for granted and always has to constructed. Sharing feelings was something new to practitioners, perhaps reflecting a culture where feelings were generally not shared. I suggested in chapter 6 that the nurses believed that 'good nurses cope'. Heron (1981b) supports this observation:

> "The prevailing norm about feelings is that they are to be controlled - the message is unmistakable - the intelligent, educated adult is one who knows how to control her feelings." [p5]

For a few practitioners the supervision space was an immediate opportunity to disclose themselves, taking trust on face value. Pat shared how Rona disclosed her pent-up feelings in her first session.

Pat [S1]: *"The first session with Rona. I said - 'before we get into the issues let us just consider your performance over the past 6 months. She just burst into tears - I always felt she was having some problems - she talked graphically of her problems - stress with student, her marriage break-up. The whole session dealt with all her anguish which she had bottled up. I gave her feedback that she had done a good job - helped her believe that she had come out the other side. It was a mind blowing session - she was grateful for it."*

Although it hadn't been Pat's intention, the impact of asking Rona to reflect on her work was cathartic. It enabled Rona to share feelings about her work and her personal life which she had previously been unable to disclose with anybody. This illustrated how supervision transcended 'normal' working relationships, what I termed 'the privilege of supervision'.

Brian noted [S4]: *" Supervision does bring people to say things that they wouldn't say in normal [ward] conversation."*

Jade and Pat referred to supervision as like 'going to confession', a metaphor which reflected how practitioners were able to disclose feelings within supervision that they were quite unable to share 'outside' in a culture that implicitly discouraged this. The focus of supervision was always intended to be the practitioner *in the context of their work.* This emphasis is intended to distinguish guided reflection from a focus on self per se, or personal therapy. Platt-Koch (1986) advised:

> "the supervisor should not probe any more deeply than is necessary into personal conflicts to support the therapist's professional role." [p 10]

However, a large part of 'who the nurse is' was visible within their reflections, requiring the supervisor to make a judgement about the extent the 'personal' was pursued. Hence, Pat needed to make a judgement about counselling Rona with her marriage breakdown. However, this type of disclosure rarely occurred.

However, Rona's experience was not the norm. In general, practitioners felt threatened by the idea of guided reflection. Jade disclosed how she felt both nervous and excited when she commenced supervision. She felt the learning style was new to her. At the beginning of her second session she commented: *"I felt very nervous coming over here - going to see a senior nurse was usually connected with being "told off" - very rarely you go along to be patted on the head."*
CJ: *"Do you expect me to do that?"*
Jade: *"No not really - I expect honesty - something very new to me - I'm looking forward to honesty and what that means, to accept criticism positively."*
Jade suggested her previous experiences of communicating with senior nurses had usually been concerned with receiving negative feedback, which had not prepared her for the process of guided reflection. By session 3 Jade commented: *"I felt a little bit nervous - not so bad as last session. I'm just getting used to this sort of relationship.. the openness, and because I want it to work... I want to succeed."*
Gayle commented [SEQ]: *"Initially I felt very threatened by supervision. The openness and authenticity of both supervisors helped me work through this difficulty."*
These comments by Jade and Gayle were typical of how practitioners generally felt about the prospect of supervision sessions. They depicted a pattern of anxiety and uncertainty that was usually resolved within the first few sessions as trust was constructed.

Telling tales

Some practitioners were reluctant to share experiences that concerned colleagues because they felt they were 'telling tales'. I gained an impression that practitioners *not* in guided reflection feared being talked about.

Jane [S4] noted: *"Nurses outside supervision are beginning to ask -'What's going on in there?' are they talking about us? "* [gave example of E grade nurse]

CJ: *"How are you dealing with this paranoia?"*

Jane: *"By getting those in supervision to deal with it."*

CJ: *"Is there an ethical issue about offering it wider?"*

Jane : *"It is open to everybody."*

The emphasis on confidentiality restricted the practitioners talking to their colleagues about supervision. This often seemed to lead to a subsequent sense of suspicion and elitism, for example care assistants at Windrush saying "she's upstairs" in a manner that expressed disapproval. In a culture where supervision was not the norm and where work was valued as what was visible, it seemed necessary to inform all staff adequately of this work.

Brian noted how one primary nurse felt she was getting a 'raw deal': *"They go in for their 'confessions' what about me?"*

Brian was sensitive about how divisive supervising only 2 out of 4 primary nurses was becoming. He eventually extended supervision to all four primary nurses and established group supervision for associate nurses. Yet, some practitioners *only* talked about their colleagues and avoided issues concerned with their patients.

Breaching confidentiality

Any perceived risk to confidentiality threatened disclosure. Gayle noted the signficance of confidentiality within a climate of trust: *"Initially I was worried that confidentiality would be broken but this tied in with my initial feelings of being threatened. The knowledge that the session was confidential helped. I later came*

to appreciate how knowledge gained by the supervisor from one session might help facilitation of a problem with the parties concerned. This is only possible where supervisees feel able to be honest about their experiences."

Yet situations did occur when the sense of confidentiality was threatened. Understanding the significance of these events reinforced the need to establish confidentiality. Karen [S6] expressed her concern that I had used an example from Jade's supervision to illustrate managing feelings involved in relationships: *"You know you used Jade as an example regards being involved and sensitive to peoples' reactions. I thought supervision sessions were confidential although what you said at the time was useful looking back."*

CJ: *"You see how and why I used it?"*

Karen: *"Yes."*

CJ: *"Does your discomfort stem from the fact that I might do the same with your experiences with someone else?"*

Karen :*"Yes, partly - I wonder if Jade would tell me the same thing?"*

CJ: *"Does that make you feel suspicious of me?"*

Karen : *"No [smiles] - I needed to check out the confidentiality bit... maybe it would have worked better if you had said 'a previous supervisee' - I might have worked out who it was but you wouldn't have said who it was."*

I had breached confidentiality of Jade's supervision and attempted to rationalise this in Karen's best interests. Supervising more than one practitioner within the practice setting inevitably gave the supervisor information about other practitioners. The sensitivity of disclosing this knowledge was evident when I raised with Karen the issue of her taking action to resolve her conflict with a GP. This GP had criticised Karen and another nurse for attempting to resuscitate an elderly lady who had just been admitted to the hospital. Karen hadn't shared it with me. I had been told about this situation by two other people in separate supervision sessions because of their own involvement in the situation.

Karen said she didn't like: *"The fact you knew about that and I hadn't told you - I didn't want it to come into supervision."*

Karen said she felt very angry towards this GP. She felt she needed to defend against it rather than explore it with me. In my defence, I shared my predicament of supervising three people within the Unit. This highlighted my dilemma of whether I should have disclosed to Karen what I knew about this situation, as part of being authentic. The dilemma had arisen because I had raised the issue in the first place. If I had respected Karen's 'control of the agenda' then this would not have been an issue. Karen's comment reflected the significance of 'control of the agenda' in constructing trust. Abbi commented: *"When I initially started supervision, I did not feel at all safe about talking about experiences with my supervisor. Confidentiality really worried me. However, after several sessions, I started to 'open-up' and I felt happier about discussing experiences. I did feel that I was being assessed and monitored at times - not really because of anything my supervisor did or said but because she was my manager."*

Whilst Abbi was 'happier', she remained cautious with her manager. Some practitioners struggled to overcome this barrier, even when the supervisors strove to be open and authentic with the practitioners. [The dynamics with supervisors being managers is discussed in depth in chapter 11].

Third parties

Despite the 'rule' of confidentiality, some supervisors disclosed issues within supervision with colleagues who they felt needed to know. Jane noted that she had disclosed information gained from supervision with Hilary [her deputy].

CJ: *"Do you think that might cause you a problem - knowing through supervision but not knowing because of confidentiality?"*

Jane: *"We have this system - giving each other clues about what we know - I can indicate to her this is an issue I know about [although] I can't break supervision contract. I did think of approaching them to ask if I could share the notes with Hilary.*

If I thought Hilary 'needed to know' I would tell her - if I thought the patient's welfare was at stake."

This dialogue with Jane highlighted the fragility of trust and the thin edge of Jane's commitment to confidentiality when measured up against her managerial role. Jeanne, who was also in supervision with Jane, noted: *"I observed the way Jane, at times, would discuss with me incidents relating to other staff which I perceived to be private affairs. For this reason I felt that confidentiality could at any time be broken."*

Brian reflected on his dilemma whether to disclose issues with Grace, the unit's manager: *"I am continuously conscious of the tension of confidentiality with Grace. It is imperative in our working relationship that we do not leave gaps where staff can find a route to expose weaknesses. This is not to imply that we should always appear omnipotent but it is important we are both giving the same message. A lot of the issues I deal with in supervision involve Grace - and therefore it becomes difficult not to disclose issues to her. She is aware of this problem and sometimes finds it difficult to accept that I am unable to discuss many of these issues. However, by ensuring that the supervisee takes responsibility for some of the confidentiality issues, some of the problems have been resolved -in doing so I feel I am entering the high challenge-high support mode with them as they know that I will support them in relation to these issues."*

Brian's solution to his dilemma was to encourage Mary to deal with the issue herself concerning Grace. In this way Brian avoided becoming 'piggy-in-the-middle' for other peoples' interpersonal conflict. Dealing with conflict, as I have shown in chapter 6, was central to being an effective practitioner.

Reciprocity of disclosure

Maud easily disclosed her experience when she contracted with Pru. However, whilst all the supervisors espoused a genuine intent to be open and authentic

with practitioners, the extent they disclosed their personal selves to practitioners was generally very limited. I was also sensitive that I didn't disclose much of myself. As Myrna noted: *"You rarely reveal anything about yourself except in carefully chosen situations and in a controlled way and amount."* Jourard [1971] defines self disclosure as

> "the act of making yourself manifest, showing yourself so others can perceive you." [p19]

Jourard highlights the significance of self-disclosure in generating trust in much the same way as nurse philosophers have identified the same phenomenon in working with patients (for example Hall 1964, Paterson and Zderad 1976). Whilst self-disclosure is a phenomenon of social relationships (Jourard 1971), the expectation within supervision is that practitioners will disclose themselves. Hence should self-disclosure be mutual? It reminded me of how practitioners expect patients to disclose but hide themselves behind their 'professional' manner. However, supervisors did not become more disclosing as their relationships with practitioners developed as might be expected with the development of collegial relationships. I feel that avoidance of self-disclosure is a cultural issue within nursing, within the broader stance of professional detachment (Young 1988). I did disclose my personal experiences in context of working with patients and families. For example, when Karen [S16] felt hostile to Mrs Fenner [see chapter 5], I shared with her how I had transformed my negative feelings towards a man with Parkinson's disease by asking him what it was like to have Parkinson's disease. Through his story I came to understand him, and, as a consequence, I felt positive towards him. My response had also enabled him to work through his negative feelings towards himself and being dependent on nurses. By disclosing my own experience, I informed the practitioner that I was human too, and suffered the

same pains and distress as she did. In not disclosing self, supervisors perpetuated a culture of one-sided disclosure within hierarchical relationships that may have limited the practitioner's own self-disclosure and failed to role model the therapeutic benefit of such disclosure in their work with patients and families.

The environment of supervision

Besides the interpersonal dynamics that facilitated the development of trust, a number of environmental factors seemed significant. In general, the practitioners felt that the physical environment was not conducive to supervision [feedback from SEQ q2 [see table A4.1 - appendix 4]. Factors that negatively influenced the practitioners' perceptions of the environment were the time of day, 'changing mode', interruptions and sense of privacy.

Time of day

It was difficult to gauge a 'best time' for supervision. This varied between practitioners and supervisors. Mornings were universally dismissed as impractical because mornings were seen as busier times. In general the last hour of the early shift seemed the best time. This fits within the 'traditional' overlap, where developmental activities were often scheduled to take place. Myrna commented: *"The 15.30 -16.30 session was probably best because I could then reflect on care. If I was hurrying to fulfil my responsibilities to patients and colleagues I sometimes felt harassed at trying to make the time and so it would take a while to focus in when we started the session."*

Karen and Leslie often came in one hour early for a late shift for their supervision. However this was always their decision to use their time in this way. Time of day seemed less of an issue for community nurses because they had greater control in planning their work priorities in contrast with the hospital based practitioners.

'Changing mode'

Myrna [S9] identified her *"problem of changing mode from 'down there' to coming 'up here' and talking about difficult issues - snapping into a situation where you are exposing yourself - creating a situation where residual feelings may need time and space for the dust to die down."*

Myrna felt she tried to organise herself and prepare herself mentally for the session but when she was really busy it was still difficult to change mode. This was a recurrent theme for practitioners. At Windrush, if the practitioner knew it was 'busy downstairs', what she often 'liked least about the session' was this concern for their colleague[s]. This was less a problem if they had 'finished' their shift.

Interruptions and privacy

The physical environment was also important in terms of interruptions and privacy. I made numerous notes of interruptions during my sessions with the 'I' grade supervisors, either phone calls, or people interrupting. Although not ideal, these interruptions did not really interfere with the flow of the sessions. In most instances, we were able to seclude ourselves, inform others we were 'not to be disturbed', and ensured that telephones were re-directed or that the room did not have a telephone. Privacy was significant in terms of confidentiality. Gill noted: *"On several occasions we met in the staff room which I felt was too open and not private. Quite inhibiting to conduct supervision amongst distractions and interruptions. Also other staff, particularly care assistants often resentful of losing access to this room."*

Summary

The need to establish a climate of trust within supervision was a crucial dynamic of guided reflection. In general, self disclosure was generally not a problem for practitioners despite its one-sidedness, although some practitioners assiduously avoided disclosing themselves. Indeed I was constantly astonished at what practitioners did disclose, as if supervision had become a safe haven in a hostile world. Whilst the environmental factors did not seem to significantly influence the development of trust within the sessions, these factors did seem to contribute towards creating and sustaining an appropriate environment for supervision.

Chapter 9
Responding with an appropriate helping style.

In this chapter I discuss the significance of the supervisor responding to the practitioner with an appropriate helping style. When the practitioner discloses her experience the supervisor must grasp and interpret what this experience means to the practitioner and then respond in ways that best enables the practitioner to learn through the experience. This chapter is concerned with the *helping style* of this response. A number of heuristic devices were developed during the continuous analysis of the supervision process that could then be subsequently used to guide the supervisor's response -

- Model of structured reflection.
- Framing perspectives.
- Balance of high challenge and high support

In this chapter I discuss the significance of the model of structured reflection and the framing perspectives. I discuss the significance of balancing high challenge and high support in chapter 10.

Model of structured reflection

I have already noted the value of the model of structured reflection as an heuristic device to help practitioners access their knowing in practice. By cueing the practitioner and supervisor to ask certain types of questions, the model of structured reflection incorporates a particular helping style that pays attention to cognitive, affective and temporal processes. A perspective on the model of structured reflection as an appropriate learning style was gained through using the Cherniss and Egnatios's Helping Style Inventory [HSI]

(1977). This compared practitioners' preferred helping style with actual helping style. The inventory consisted of five distinct helping styles [figure 9.1].

Figure 9.1

Helping styles (Cherniss and Egnatios 1977)

Didactic-consultative -	Supervisor offers advice, suggestions and interpretations concerning patients' dynamics and clinical techniques.
Insight-oriented -	Supervisor asks questions designed to stimulate the supervisee to think through and solve problems on her own.
Feelings-oriented -	Supervisor encourages the supervisee to question emotional responses to the clinical process.
Laissez-faire -	Supervisor leaves the supervisee alone most of the time and is rarely available for consultation on work problems.
Authoritative -	Supervisor allows the supervisee little autonomy; the supervisee is told what to do and how to do it.

Feedback from practitioners using this scale [see appendix 1] illustrated a pattern where supervisors generally responded to practitioners preference for helping style [see Table 9.1]. The feedback suggested the most preferred styles were insight-oriented, feeling-oriented, and didactic-consultative. Laissez-faire and authoritative were not perceived as desirable. The emphasis on feelings-oriented and insight-oriented reflects the nature of reflection as highlighted through the model of structured reflection. Hence it could be expected that insight-oriented and feelings-oriented would rate highly. However, under certain conditions, practitioners preferred a more didactic-consultative approach. The high rating of the didactic approach appeared to be a reflection of the practitioners' need for answers and the extent of the supervisors' need to provide them. For example Abbi and Jeanne were new in post, within a different type of clinical environment, and desired more guidance than other practitioners who were experienced within existing roles. Worthington and

Roehlke (1979) noted that beginning counsellors found that supervision was most beneficial when supervisors directly taught skills and when sessions were highly structured.

Table 9.1

Helping style ratings :		
	Most desired	Most like
1. Insight oriented	116	109
2. Feelings oriented	114	104
3. Didactic-consultative	105	104
4. Laissez faire	24	32
5. Authoritative	16	14

Jeanne only ever wanted supervision for advice, although this could be seen to be a defensive gesture to avoid disclosure of feelings. Abbi primarily valued supervision for being given information to use in her practice. She said to Jane [S11] *"the educative function of supervision has always been very good. You've provided me with references, for books and contacts to follow up..."*

Jeanne and Abbi's didactic orientation may have led to many of the difficulties they experienced with Jane , who tried essentially to help them become insight-oriented. More experienced practitioners who were settled in their role seemed to prefer a less didactic approach. However, on analysis of their dialogue, they were also more closed to suggestions about other ways of working. This often led to tension where the supervisor wanted the practitioner to grasp new ways of seeing and responding within situations. The feedback from the HSI suggested that practitioners did not discriminate well between the different styles. For example Jeanne scored insight-oriented and feelings-oriented 10 respectively but this was totally incongruent with her experience of supervision. The low authoritative ratings reflect how practitioners perceived guided reflection as practitioner-centred. Lucy's high score reflected how her

relationship with Pat progressed. Alice was the only practitioner to score <5 for desired 'Laissez-faire' helping style which reflected her free floating anxiety throughout her relationship with Melissa. This was matched by her low desired rating in all the other helping styles.

The value of the HSI is to help people consider and challenge the appropriateness of their learning styles. The 'results' become the focus for a discussion between the supervisor and the practitioner, as part of a review of the supervision relationship.

Setting tasks

One didactic approach was to set practitioners 'tasks' concerned with applying and exploring ideas developed during the supervision session. The nature and pattern of these tasks set during Jade's supervision is shown in figure 9.2 The intent of this activity was to encourage practitioners to take responsibility for certain sorts of action between sessions. I was conscious of setting fewer tasks as the supervision progressed. On reflection, I felt this was because Jade had demonstrated her commitment to this work and had consequently reduced my anxiety to move forward quickly with specific issues. I had believed that setting a task would prompt action. I came to realise this was incongruent with the growth of practitioner responsibility. Jade could just as easily set herself the task by summarising what action to take between sessions. By way of contrast, Jane didn't introduce tasks until later into supervision with a poor response from both Abbi and Jeanne. I had pointed out to Jane that she tended to explain at length the practitioner's experience for them, and that setting tasks might be a preferable alternative. Jane responded by setting Abbi [S6] a number of tasks after an 'awful' session, as if 'setting tasks' were a tactic to assert some control. On reflection, Abbi noted [SEQ] :*"I strongly disliked being set 'issues' to think about in preparation for the next session. This only happened several times when I did not have an experience to talk about."*

Figure 9.2

Tasks set during Jade's supervision

Session		Description
2	.1	Check out 'vibes' with nurse you gave telephone feedback re - drug error
	.2	Visit patient - give her a message you care for her
3	.1	Write care plans as a part of everyday practice [not as a task at the end of the shift]
	.2	Write care study to share with colleagues [clinical practice group]
	.3	Identify two decisions you made to share next session
4	.1	Get feedback from patients about their care environment
	.2	Confront care assistant
5	.1	Look back over diary - identify one incident from each category of learning domain [[developed from Gill's work] to discuss
	.2	Draft case study for publication
6	.1	Arrange case study presentation
8	.1	Reflect on pervious discussion - what have you learnt from this?
9	.1	Read Kramer's 'Reality Shock'
13	.1	Read Morse paper on involvement with patients
15	.1	Work through 2 experiences using the MSR
17	.1	Reminder to use MSR
18	.1	Give associate nurse feedback about her assessment

Doing homework

Two practitioners who always responded to set tasks were Mary and Jeanne. One consequence of setting tasks was to create a sense of 'doing homework' - a metaphor that reflected their dependence in doing it for 'teacher', rather than from a sense of personal responsibility. Brian felt that tasks were a means of making Mary more 'constructive' in her supervision. Some of these tasks involved pushing Mary to achieve things she felt unable to do. Brian

confronted Mary's resistance to this as "being childish", that the work wasn't compulsory, and tried to get Mary to focus on her responsibility. Brian's intention was that Mary should do the task. His response was his frustration of this goal. I challenged Brian: *"How important is it to you that she does her "homework"?"*

Brian: *"Its crucial to the sessions to get the most out of it - we both see it as valuable but doing something is another story! - learning to reflect on a day-to-day basis - supervision is not the time to reflect."*

Brian had expectations which Mary could not match at this time without help. In pushing tasks he was responding to his own concerns and failed to see Mary's real needs. From this perspective, Mary was merely an instrument to bring about change and this reflected a hierarchical relationship where the supervisor had the 'right' to prescribe how work should be done (Eisner 1982 in Smyth 1987). The extent supervisors set tasks seemed to reflect the extent of this orientation.

Structuring the reflective diary to focus on significant experiences

A different type of task was to guide practitioners to focus on specific aspects of practices. The intention was to help practitioners quickly apply new insights within similar situations. However practitioners always focused on meaningful experiences for them, and these meaningful experiences tended to be recurring, thus fulfilling the original intention. In general, supervisors did not attempt to guide what experiences the practitioner should reflect on. When they did, they rarely followed this up in the subsequent sessions, irrespective of whether the practitioner had followed the guidance. This created an impression that work within supervision tended to be more focused on what was happening in the moment, rather than what had taken place in previous sessions. As a consequence, continuity of issues through sessions was diminished.

Movement within helping style

The supervisor's appropriate response to the practitioner was always a question of judgement. The helping style needed to be flexible but geared towards developmental growth. This understanding was in tune with the literature. Gaoni and Neumann (1974) found that supervisees required a movement from more didactic/ authoritative approach to a more insight-oriented approach in response to their developmental growth. However, this literature was concerned with students. Dreyfus and Dreyfus (1986) identified how people progressed from a reliance on rule following to an increasing use of intuition in decision making as they developed 'expertise'. Cherniss (1980) observed that during the transition from student to professional, the lack of specific rules was more often experienced as a burden than a blessing, but as the professionals became more secure and confident, their desire for autonomy and freedom became stronger, and they came to resent limitations and constraints.

Being approachable

The 'personality' of the supervisor did not seem to be significant within the helping style. Perhaps this was because practitioners, had volunteered to participate in the research. I have noted that Myrna, Leslie and Karen were obliged to enter into guided reflection as a part of their work contract. In general, practitioners felt the supervisors were approachable. One notable exception was Jane's relationships with Abbi and Jeanne. Abbi noted [SEQ]: *"I didn't always feel comfortable talking about my innermost feelings with somebody whom I didn't really know and wasn't that 'approachable."* Jeanne noted [SEQ]: *"I found that Jane was very intense during supervision. I think this may have contributed to my anxiety. She would maintain direct eye contact for such a time that*

on occasions I felt very awkward or feel threatened. I responded by looking out of the window whilst talking - I was consciously aware that I was doing this. The communication style seemed formal thereby inhibiting my thought processes. I found it very hard to be myself. When I challenged her I felt that she was being so careful as how to word the sentences that she was only choosing to share a small part of her view; she thereby appeared closed."

Jane acknowledged how imposing she may appear to staff: *"I can be very serious and appear hard. I've always had this problem...* [reminisced] *I'm aware of how I look and try to make people feel that I am approachable but at the end of the day I am a business women with a job to do. I feel I am assertive, sometimes aggressive when I am in a bad mood or lacking in confidence, and that I do have an [internal] conflict between being 'open -developmental person' with a senior nurse hat on."*

I challenged Jane whether she consciously promoted collegial relationships with Abbi and Jeanne? Jane: *"Yes - I've tried to do that - but if you ask the staff they see it differently - they might see collegial as getting what they want - its a no-win situation for me. If I make a decision they would see its as authoritarian action - a situation not helped by my complexity of roles, for example - going to business meetings and acting in the way they act as these meetings - and then to switch into a different mode but carrying over the effects of the previous meeting - It has left me thinking if 'collegial' is natural behaviour? Maybe I have become insecure about perceived negative feedback about myself - 'too serious etc.' - that sort of thing - perhaps that's what's influenced it - but partly I tried to do it because my practice complements theirs and I was a role model for them - striving for excellence - what I did and how I did it. The other side of it - why should I go out of my way to be this nice person when I'm not - I am blunt! If I accept other people as they are why shouldn't they accept that in me? You have to be true to yourself.. the other thing is that it is convenient for people to use this sense of powerlessness - to say they are 'victims of the system'. Its*

something that needs to be confronted - they blame it on the senior nurse when things get difficult. I do think they do come to see you differently over time as long as you keep to the guidelines."

Jane's need to 'be herself' and not conforming to some stereotype is an essential element of authenticity and using self in a therapeutic way, whether in practice or in supervision (Jourard 1971). And yet her 'manner' had alienated her to some extent with practitioners and limited the possibilities of supervision. It interfered with her ability to see and respond to Abbi and Jeanne on their terms. Consequently, supervision became an increasingly anxious experience for Jeanne. Jeanne's fragile competence was exposed by the very person she needed to create a good impression with. Abbi adapted to Jane's style much better than Jeanne, but was never comfortable despite achieving much good work.

Framing perspectives

Framing perspectives are ways of focusing on key aspects within the learning experience that contribute to effective practice. These were identified through the analysis of learning dynamics, which then became available as a methodical way of reflecting on development [Figure 9.3].

Figure 9.3

Framing perspectives: summary

- *Philosophical framing*
  - confronting & clarifying the beliefs/ values that constitute desirable practice.
- *Role framing*
  - clarifying role boundaries/ relationships/ legitimate authority & power within practice.
- *Theoretical framing*
  - assimilating theory and research findings with personal knowing.
- *Problem framing*
  - focusing problem identification and resolution that emerge within experience.
- *Reality perspective framing*
  - acknowledging that practising in new ways is not necessarily easy - whilst helping the practitioner to become knowledgeable and empowered to take necessary action.
- *Temporal framing*
  - recognising how reflection is not an isolated event but connected through experiences over time and anticipating future experiences.
- *Framing the development of effectiveness*
  - recognising reflexive learning in adequate ways.

Philosophical framing

Philosophical framing was intended to enable practitioners to understand their experiences in terms of their understanding of 'desirable work'. Fay (1987) argued that the significance of defining 'what is desirable' is to resist others defining this in terms of their own interests, and to give meaning to their

everyday practice. Only when practitioners were able to articulate their beliefs about desirable work could they seek to connect these beliefs with everyday practice through identifying and resolving contradiction made visible within guided reflection. Beliefs that practitioners held were also exposed for their ideological appropriateness. Burbules (1992) identified five levels of ideology critique, each level offering a different critical position. These are shown in figure 9.4 with my interpretative reflective questions alongside.

Figure 9.4

Levels of ideology critique		
Rational critique	-	What are your /unit's beliefs and values?
Immanent critique	-	Are your beliefs and values valid?
	-	Are they contradicted in practice?
Deconstructionist	-	Let's analyse your beliefs and values for what they are?
Argument from effects	-	Your beliefs and values are outmoded - try these beliefs for size.
Counter-ideology	-	You must hold beliefs like these!

In practice, the district nursing supervisors generally avoided all levels of ideological critique. Indeed virtually no discourse took place regarding the meaning of district nursing. For example, Pru's narrative illustrates how her beliefs were always implicitly accepted by Maud on face value. Consequently Pru's beliefs were largely unexplored although their impact on action was clearly visible. In contrast, the three primary nursing supervisors tended to use each level of ideology critique. Counter- ideology was evident in the way the hospital based supervisors often strongly asserted their own values in the construction of supervision dialogue, when they judged the practitioners'

beliefs were inappropriate. They were their Units' cultural flag-bearers with limited tolerance for differing values practitioners' held. A well developed philosophy, for example at Windrush, meant that claims for legitimacy of values could be judged against the Unit's values, rather than individual or personal values. This imposition of supervisor's beliefs could be done subtly, as within Abbi's dialogue, where Jane takes up an 'argument from effects' position, implicitly telling Abbi her beliefs are outmoded. Jane doesn't go as far as saying explicitly what values Abbi should hold. Abbi shared how she wanted to approach Alison, a patient with multiple sclerosis, about being catheterised based on the team's perceptions that it would increase her quality of life.

Abbi [S5] : *"You can guess who I want to talk about - Alison and the management of her urinary incontinence. I want to start planting seeds about catheterisation. But I want to see it as helpful and I don't know how to go about it."*

Jane: *"What do you think you can do to help?"*

Abbi: *"Talk to the consultant. She might be more likely to co-operate if it comes from a medical person but it shouldn't be up to him. He shouldn't have the final say."*

Jane: *"You seem to have already made a decision that she will be catheterised. Have you thought about it and in what ways?"*

Abbi: *"I've discussed it with the team two weeks ago. We feel the positive side of catheterisation need to be explained to Alison - her husband's inability to toilet her, increase her quality of life. She won't need hoisting so much. She hates the hoisting. She likes going out and she couldn't do that. I don't know where to start."*

Jane: *"Why catheterisation though?"*

Abbi: *"She 's not getting to the toilet in time. She 's probably wet at home and during the night -the problems have not gone away."*

Jane: *"Have you considered a toilet regime?"*

Abbi: *"She goes every two hours. I suppose we could try every 11/2 hours, but - look at today! - she'd been before lunch and she was wet when we got to her."*

Jane: *"What does before lunch mean? It could have been 11, 11.30, or 12 when she went last?"*

Abbi: *"It happened yesterday - she was wet all over the nurse. It's quite distressing for all the nurses. It's not nice. It's difficult to say anything. She's very anti-nurse at the moment. She thinks the whole world is against her. Look at her standing! She can't do it."*

Jane: *"Perhaps she needs to experience failure?"*

Abbi: *" Lisa [auxiliary] tried to stand her. It was good of her to offer but she couldn't do it! Alison's legs went. It was the morning and she's not so good then."*

Jane: *"Perhaps she is able to ignore these failures. You could re-assess her standing weekly and document it, if you do it she may accept it better. You will need to discuss the assessment with her and reinforce the limits of her ability. I think there is something in what Alison just said to us about the knocks her body has taken this year and that she is just starting to pick herself up. I would like to believe her. Perhaps we have under-estimated the affects the changes in her life had on her body. We could give her the benefit of the doubt for a bit longer. Regular re-assessment will help all of us be clearer. Have a think about it. Let's get back to the continence issues- how would you prove she needs catheterisation?"*

Abbi : *"Look at her future I suppose?"*

Jane: *"Would you assess her need first? What would you look for?"*

Abbi uncertain...

[Jane explained the techniques for ruling out underlying causes.]

Jane: *"What if you did all this [investigation] and she refused to be catheterised?"*

Abbi: *"She wouldn't.* [looking surprised]... *she's too particular."*

Jane: *"It may prove to be a point of principle with her - how would you manage that?"*

Abbi: *"I don't know. Alison can be selfish at times. She doesn't understand the reasons behind things. She listens to reason but still goes and complains. She still expects some of the nurses to stand her."*

Jane: *"Why doesn't she accept it?"*

Abbi: *"I don't know -she agrees to be fed in front of other clients. That's just as degrading as using a hoist. Maybe it's an accumulating of the other events that are making it difficult for her."*

Jane: *"So you have your plan. In the meantime you could start toileting her more regularly and on time, not only when she feels the urge. You could also try reading some of Norton's book on continence. This may help you understand what's happening to her bladder."*

Abbi responded to this clinical situation from a nursing centred perspective that contradicted with the Unit's philosophy. Yet her ambivalence to the situation is also evident. She wants to impose solutions on Alison, as if Alison is some object to be fixed, and yet she also wanted to respond to Alison's needs as a person. Jane exposed this contradiction and undermined Abbi 's 'object' perspective, helping Abbi to 'see' Alison, whilst moving her towards new perspectives congruent with the Unit's philosophy.

A consequence of philosophical framing might be the practitioner's sense of being moulded to think in certain ways. I noted [S9]: *"Myrna feels she is speaking 'Windrushese ' - giving herself confirmation that she is assimilating ideas."*

Jade said a care assistant had told her that she sounded just like me - in her challenge to her response to a patient ringing her bell. I asked: *"Did you ever think that you might be re-socialised into a certain sort of nurse?"*

Jade: *"Yes, I have thought that."*

CJ: *"If that was true would that disturb you?"*

Jade: *"Yes - I wouldn't want to lose my individuality."*

CJ: *"That suggests being socialised means losing your individuality? - if anything I would socialise you to enhance your individuality and the individuality of your patients?"*

Jade: *"Yes, but not as a clone. I don't think what I did was imitating you. I now have the confidence to say these things and perhaps my values have changed."*

This was not as oppressive as it may seem because both Myrna and Jade openly held similar values to myself. I had merely exposed the contradiction between espoused values and practice - the position of immanent critique. Immanent critique could also be affirming. Brian [S8] challenged Mary with the norm of doing hands-on care until the shift was finished. Mary responded by saying how she had prioritised care and spent most of the morning reassessing her respite care patient's care. Brian affirmed this: "*more appropriate for primary nurse not to be doing hands-on care but to be doing this assessment - trusting auxiliaries to take responsibility for delivering care.*"

Deconstructionist critique always challenged practitioners to know what their beliefs meant *in practice,* a constant challenge to the validity of the Unit's philosophy. This position acknowledged that stated beliefs were simply that- 'stated beliefs'. Their interpretation in practice may be very different. Philosophical framing gave meaning to 'desirable' practice.

Role framing

Effective practice is always known within the context of role definition and responsibility. Role framing intends to help the practitioner know the boundaries of her role responsibility and her role relationships with others with whom she worked with. For example, Pru illustrated in her narrative that issues of authority with the hospital nurses, with doctors, and with her own G grade colleague Tilley, were a major source of conflict. She clearly felt a sense of responsibility towards her patients yet she doubted her authority to act accordingly because of cultural norms that constituted how she should behave. This conflict was related to issues of authority to make certain types of decisions at the boundaries of role that overlapped with others. It is at the boundaries of roles that Batey and Lewis (1982) note the significance of

discretionary autonomy, in terms of the degree of autonomy the person believes he or she has to take action. It is only through understanding how people interact with each other that role conflict can be understood. Maud illustrated in Pru's narrative that role responsibility for taking certain types of action and barriers that limited taking action, were constantly addressed. Hence role framing always had an empowering intent through clarifying responsibility and challenging the practitioner's sense of authority where this limited taking congruent action.

Theoretical framing

"By listening too readily to accepted theories and to what they lead the practitioner to expect, it is easy to become deaf to the unexpected"

(Casement 1985, p4)

Theoretical framing is a process whereby practitioners are guided to use theory in meaningful ways to help them make sense of practice or to inform practice from new perspectives. In either event, such theory always needs to be interpreted for its significance to the practice situation. Dewey (1933) called this a 'sceptical eye', which ensures that theory is never accepted on face value, or as a prescription for practice as some form of technical solution to be applied (Nolan and Huber 1989). Carper (1978) noted that 'empirics' always needed to be interpreted creatively within the clinical situation rather than applied as a prescription. Within theoretical framing, extant theory is juxtaposed with personal knowing accessed through reflection, transcended and assimilated as constructed knowledge (Belenky et al 1986). Belenky et al view this as the most significant form of knowledge because it acknowledges the primacy of subjective knowing but informed by objective sources applied in meaningful and critical ways. Much nursing literature has commented on a need to close the theory-practice gap (Speedy 1987, Conway 1994), yet

practitioners within the study did not seem to consciously theorise about their practice. This is not to say they didn't practice from theoretical perspectives, only that they couldn't name these theories. Within reflection, this 'gap' is realigned as the dialectic between objective and subjective within praxis. Brian [S6] suggests that feeding-in theory was not an easy task: *" I have not found any common pattern to the way I feed-in theory. On the occasions that I have, it has always felt appropriate and yet I find it difficult to pick out the particular aspects that may be most appropriate. I am conscious of the fine line between theoretical overload and allowing the supervisee to generate their own theory through their reflections."*

Brian helped Mary to simultaneously frame and confront her experiences using extant theory: *"I suggested to Mary that perhaps there was a mix of reasons why she disliked this patient. Suggested that there was an element of the patient being more demanding than she was prepared to accept and secondly, this appeared to relate to the research about the unpopular patient."*

Abbi [S7] noted the impact of theory introduced to her at college to frame what she was trying to achieve in her practice: *" I'm doing my essay about therapeutic relationships and helping people to go from ill health to health. It's difficult to measure therapeutic relationships."*

This theory was instantly meaningful, and enabled to focus on developing the meaning of therapeutic relationships through subsequent reflection-on-experience.

Despite these positive examples, supervisors were not adept at theoretical framing. It is evident throughout Pru's narrative that Maud did not feed in much theory. Why was this? To feed-in theory, supervisors needed to have access to relevant theory. The district nurse supervisors acknowledged this concern - suggesting the more removed from practice they were, the less able and confident they felt to use theoretical framing. The primary nursing Unit supervisors [including myself] were all lecturer-practitioners. This assured a

sound knowledge base although not necessarily within the scope of the practitioners' experiences. A general picture emerged of practitioners and supervisors who generally did not think of practice in overt theoretical perspectives. An indication of my theory input with Jade is shown in figure 9.5. There is no obvious pattern with this theory input into Jade's supervision. It was in response to Jade's experiences. Certain key topics were revisited or developed throughout the supervision, for example, involvement within relationships with patients and relatives, and assertiveness.

Historically professions, such as nursing, have accepted the superiority of technical knowledge over more subjective forms of knowing (Schön 1983). The consequences have been the repression of other forms of knowledge in nursing which has perpetuated the oppression of nurses and of their clinical nursing knowledge (Street 1992). Since The Briggs Report (DHSS 1972) emphasised that nursing should be a research based profession, nursing has endeavoured to respond to this challenge. However, the general understanding of what 'research based' means, has followed a positivist pathway reflecting a dominant agenda to explain and predict events. Researchers, who have endeavoured to understand why research is not used in practice (Hunt 1981, Armitage 1990), have suggested the blame lies with the practitioners for their failure to access and utilise research. In reality the problem may lie in the complexity of human encounter where technical solutions are inadequate to solve the problems of human encounter and complexity (Schön 1987). The effective practitioner is an *informed* practitioner, and as such, theoretical framing is therefore a significant learning activity within guided reflection.

Figure 9.5

Theory input into Jade's supervision

Session	Input
1	Nature of accountability
2	Therapeutic use of self
	Transactional analysis
	Theory of ownership
4	Developing relationships with patients
	Concept of 'control' within relationships
	Concept of advocacy
	Nature of individualised care
	Concept and significance of assertiveness
	Personal integrity - ethical action
5	Involvement with patients
6	Defence and coping mechanisms
	Ethical dilemmas in decision making
7	Therapeutic and the harmonious team
	Gender issues in being a primary nurse
8	Concept of 24 hour care
9	[Revisit] ownership
	Coping with work
	How nurses might traditionally deal with stress
	Labelling theory
10	Concept of 'collegial' support
11	Coping with chronic illness
12	Specific wound treatments
13	Handling feelings - self and others
	Involvement with patients
16	Organisational versus professional work
17	Using notes to communicate care
	Ethical decision making
	Coping mechanisms
	Respite care - needs of carers
18	Primary nurse- associate nurse relationships
19	Assertiveness
20	Note taking in supervision
	Being directive - non-directive in supervision

Problem-framing

"Pru saw supervision originally as a form of support, but now she sees it more as improving her practice - she sees more purpose to it now and wants to continue it... one of the things she said initially was that it wouldn't be a problem 'getting rid of problems', but now she could see it wasn't getting rid of her problems but using them to learn through." (Maud-CJ session 8)

Practitioners shared experiences were often grounded in issues of human concern and uncertainty reminiscent of Schön's (1983) 'swamp' which he describes as a complex and messy world of problems that have no easy answers because "they are confusing messes incapable of technical solution" [p42].

Dewey (1933) considered reflective thinking was

" a state of doubt, hesitation, perplexity, mental difficulty in which thinking originates and a set of searching, hunting, enquiring, to find material that will resolve the doubts, settle and dispose of the perplexity." (p12)

Dewey highlights the focus on searching for appropriate ways of resolving these problems. However, unlike Schön's concept of reflection-in-action whereby these solutions can be immediately applied to the situation, reflection-on-experience can only anticipate new situations. Therefore, this knowledge was always tentative because situations of human encounter were never entirely predictable, and hence solutions could never be simply applied. New perspectives could be generated and made available to the practitioner to consider within future situations. On occasions, the practitioner was able to leave the session and immediately apply 'the solution', although the context may have changed and that people did respond as predicted. Karen [S14]said: *"I was hoping we could rehearse how I'm going to put it [to make an appointment to*

see] to Joan." We explored how Karen might do that and possible consequences. In our next session [15] Karen reflected-on her anticipated action: *"After all our rehearsing I just had to ask her outright. I was ready for shock horror like I forecasted but I got none of it. She said - 'Yes, fine, when?"*

Despite the situation not turning out as anticipated, the problem was still resolved. The discussion within the supervision session had prepared Karen for taking action and enabled her to adjust her response within the situation[1]. Reflection on experience had sensitised Karen to the situation and facilitated Karen's ability to reflect within the situation. Abbi's dialogue with Jane illustrated the framing of 'the problem' with Alison's catheterisation. As Abbi says: *"I don't know how to go about it."* Jane's response was to help Abbi clarify the problem and generate a plan of action. The focus on problem-solving is indicative of van Manen's (1977) first level of reflection concerned with technical 'know-how', solving 'how' questions - 'how do I respond to Alison's problem? 'How do I make an appointment with Joan?'

Having clinical credibility

Melissa and Maud expressed their anxiety about their 'clinical credibility'; their ability to respond to the practitioner's shared experience with 'expert' knowledge. They felt that for their own confidence, it was necessary to be seen as credible, although no such concerns were expressed by the practitioners.

Melissa [S10] gave an example of using a TENS machine that Alice didn't know to use. Whilst Melissa acknowledged she didn't need to know all the answers, she felt she needed to know *"for her own reassurance"*.

Maud [S 5] shared similar concerns: *"One thing I'm finding out about myself is wanting /needing to have a solution to everything. I feel that when Pru raises these*

[1] This experience shared over several supervision sessions was the focus for a published paper. Johns C and Butcher K (1993) Learning through supervision: a case study of respite care. Journal of Clinical Nursing, 2: 89-93.

things that I need to offer an example and I don't have them - perhaps I am not skilled enough."

Melissa's and Maud's concerns seemed related to how they felt about being removed from everyday clinical practice. The supervisors within the hospital based units were much closer to clinical practice and shared no such doubts. I felt Melissa and Maud's anxiety reflected a hierarchical-parental attitude associated with a 'fix-it' mentality. My response was to help them shift attitudes towards a *collaborative* problem posing/solving approach.

Reality-perspective framing

Reality perspective framing acknowledges the difficulty practitioners face in responding to situations in desirable ways because of barriers that seemed to limit this potential. Street (1992) considered such barriers were:

> " Embedded in traditions, historical constructions, and a specific nursing culture. This culture daily shapes nurses and is shaped by them" [p254]

These barriers exist within contradiction. Reality framing was intended to enable the practitioner to understand the way these barriers were embodied and embedded in everyday practice, and therefore could not necessarily be easily shifted. It was aimed to balance any felt frustration.

Leslie [S21] said: *"I knew I was avoiding giving the feedback directly to Kath, being soft on the issue and prolonging Kath repeating the behaviour."*

I acknowledged Leslie's underlying feeling: "It *is tough - it would be tough for me as well. Its okay not to take action.. it is how things are.."*

It was important to give Leslie permission because of his own expectation that he should give this feedback. Acknowledging the 'toughness' of the barrier was supportive. Yet my response was always a question of judging the extent of the barrier and the practitioner's ability to deal with it at this moment in time.

Acknowledging reality was strongly evident within Jane's work with Jeanne. For example [S2]:*"Sylvia is difficult to understand at times."*

Self-disclosure as reality framing

Supervisors often drew on personal experience to help practitioners frame their reality. This enabled the supervisor to utilise her/his clinical competence creatively and role model appropriate disclosure and vulnerability. For example, with Jade [S10], I responded to her frustration in trying to help a dying patient, by disclosing how helpless I had felt about this patient on her admission.

Reality framing is very much a process-oriented action. It acknowledges that we live in a world shaped by the norms and power interests that limit practitioners' ability to take appropriate action within situations. The failure to acknowledge the practitioners' reality incurs the risk of either hurtling them into brick walls of unrealistic expectations, or imbuing them with a sense of threat.

Temporal framing

Temporal framing acknowledges that an experience is never an isolated event but part of an unfolding narrative linked with past experiences, which anticipates future experiences. The practitioner is tuned into this temporal perspective through reflective cues, such as -'Have you experienced anything like this before?', 'How might you act differently?' , 'How might you respond when you meet her tomorrow?' , 'What would you normally do?' Temporal framing intends to facilitate the continuity of meaning between the present and past experience that Marris (1986) believes is crucial to focus on the future in a meaningful way.

The value of note taking

The temporal and spatial nature of guided reflection was reflected within the session notes. These accumulated, each session's notes building on previous session notes, to construct the reflexive narrative. Besides taking notes as my method of collecting research data, they offered the opportunity for -

- the practitioner to agree the content and meaning of the session;
- the continuity of experience through supervision by picking-up issues;
- the practitioner to experience further levels of reflection through reading the notes;
- the practitioner to 'look back' and make reflexive sense of experiences over time;
- the supervisor to reflect further on the session.

Agreeing the content and meaning of the session

Practitioners were generally very sensitive about seeing themselves in print. In particular they were sensitive that what they had said might be misconstrued. This sensitivity was a reflection of being made visible through the notes. Gayle illustrates this [S2: *"I think they reflect the session except for one word - it reads as if Mary doesn't need care whereas it should say 'doesn't want care' - that conveys a very different meaning - creates an impression that I thought she didn't need it when in fact it was that she didn't want it."*

CJ: *"Was it strange seeing it written down?"*

Gayle: *"It was - it was telling me how I came across."*

CJ: *"Are there any images from the notes that you want to pick-up on?"*

Gayle: *"No - not really. The overall impression was that it was very tentative.. I was surprised how much it reflected... well basically I just talked about me .."*

CJ: *"That's maybe because it is YOU - it is subjective, not objective, to look at yourself and the prejudices you bring to caring."*

The continuity of experience through supervision by picking-up issues.

By reviewing the previous session notes at the beginning of each subsequent session, issues were picked-up and developed in light of new experience. This facilitated a sense of continuity through the sessions.

Pat illustrates this [S7]: *"Are there any issues from the last session?"*

Lucy: *"The issue with Bob seems to have been resolved, it doesn't seem to have upset him. One issue regards Agnes and her diagnosis. I spoke to her daughter and she said that she has spoken to her mother about it but that her mother just forgets and doesn't seem to want to talk about it."*

To experience a further level of reflection through reading the notes

Gayle suggested that reading the notes prompted her to reflect further [S8]: *"When I read the notes I hadn't realised how wound up I was about Jess - but after reflecting on the notes I realised I was... I realised I hadn't listened to you - some of the strategies you suggested I didn't hear."*

Jane : *"Can you remember how you felt?"*

Gayle : *"I just wanted to get it off my chest."*

Reading the notes had triggered a deeper level of reflection. The sharing of experience was often emotional which made it difficult for the practitioner to take in all that was discussed. Gayle hadn't heard what Jane was saying because she was wrapped up in her feelings. This brief dialogue illustrates the importance for the supervisor to respond to the practitioner's feelings within the session. Reading notes often had a cathartic impact, and, although uncomfortable at the time, further reflection highlighted its therapeutic potential.

At the beginning of her session 9, Myrna commented: *"I felt uncomfortable at reading what had been discussed in the last session written down.. my sense of*

embarrassment at the things that were said being in black and white - feelings that are now more permanent and not so easily forgotten."

Our conversation at the end of session 8 had been very profound - focusing on Myrna's feelings of being seen as competent. This reflection on the notes had opened a door into deeper aspects of Myrna's being. She recognised that she couldn't hide from these feelings- either unconsciously through defence mechanisms or consciously through controlling the input of our sessions although she quickly confirmed her control veto: *"I can steer the conversation any way I want to and share situations I want to. I want to be honest I am looking to develop trust but also seeking reassurance that I am doing okay."*

Reading the notes often prompted defensive reactions. Mary [S6] requested that the notes from the last session *"be scrapped?"* Brian responded that even though Mary felt as she did about the last session, it was important she had reflected on it and identified the weaknesses. The uncomfortable experience of being confronted with oneself in the notes, and the consequent need to protect herself from this visibility was starkly illustrated by Jeanne. Jane asked Jeanne [S7]:*"Why did you ask me not to take notes... [no reply]... is it that the notes are not accurate?"*

Jeanne : *"No, they're fine...its just that I am anxious. I wanted a chat.. it seems like not a chat."*

Jane : *"Well I understand but we are not here for chat.. we wouldn't do it like this...this is supervision. If we don't take notes you may 'lose' what we talk about."*

Jeanne : *"Its just they are not important issues - just little problems.. I didn't think it was important...carry-on - takes notes it's alright."*

However, by session 10 Jeanne's anxiety remained unresolved. She said that the notes had been a continuous source of discomfort for her: "I've *found supervision stressful. I never feel completely relaxed. I know I've questioned you about writing things down so its no good going over that again."*

Jane acknowledged Jeanne's discomfort and negotiated to summarise notes, in the belief that summarised notes were better than no notes or supervision. Avoidance of notes maintains Jeanne's ways of coping by masking reality.
In contrast, Rachel was continuously anxious that the notes would get into the wrong hands, and used to judge her. This highlighted further manifestations of a culture where non-visibility was the norm (Street 1992). Like Jeanne, Rachel could not be reassured.

To 'look back' and make reflexive sense of experiences over time.

The supervision notes offered an account of experience over time, enabling the practitioner and the supervisor to look back and review how practice had changed. Melissa [S7] highlighted the value of review: "*It was really interesting because I really felt I knew what it was all about, I had never felt that way before. Instead of focusing on individual sessions I had much more idea of the process of supervision. We reviewed where we were at and we both felt it useful. The value of reflection came home to me.*"
Having notes was like having one's own text-book. Abbi noted [S11]:"*Actually I looked at my notes last night and read some of the issues that I took to the first sessions - I thought - 'did I really talk about that? I was wanting advice really.*"
Gayle highlighted how reading session notes triggered issues that would otherwise have slipped from consciousness: "*My thought processes start off when I read things I've previously written. The sort of thing I've written 2-3 months ago and thought were finished with or something.*"
In her session 4, Gayle highlighted how feedback from the notes increased her self-awareness: "I *have been aware in the past that people have misunderstood what I have said - these sessions have really made me listen to what I say - make me more careful of what I say now.*"

Gayle drew the parallel process of being listened to in supervision and how she listened to her patients.

To enable the supervisor to reflect further on the sessions

When I word processed the session notes I often noted things I felt to be significant which had not been paid attention to during the session. I marked these with an NB in order to draw attention to these issues to pick-up in the following session as appropriate. For example, Leslie picked up my NB [S2] : *"Looking through the notes... you have put this piece at the end - the NB - yes I do feel my performance is judged - like being on a stage. I've often said to people that I've been waiting to be found out, and I feel I want to achieve in this primary nurse role."*

CJ: *"Were you surprised at the NB?"*

Leslie : *"No.. [but] I don't recall talking about my performance - did you pick that up as an undercurrent?"*

CJ: *"That's right - do you feel happy about that?"*

Leslie: *"Well, it does correspond with something that fits in with my thoughts at the time - it was accurate."*

Brian noted this was a useful technique: *"I've often found it difficult to focus on all of the issues that are raised [within a session], it is only when I am writing up the notes after supervision that I become aware of some issues that have been raised. I am now more comfortable with noting these issues and raising them in the following supervision session. This could appear to be the supervisor defining his agenda but I feel they have been necessary to tie up loose ends."*

Practicalities of note-taking

Whilst the value of note taking was significant, the supervisors generally found it difficult to take notes during the sessions and write them up afterwards. Maud [S3] felt her focus on note-taking had limited her listening to what Pru

was saying: *"I sat down and listened more rather than trying to write down everything she was saying and got her to be more specific and wrote those points down. In previous sessions I had been so anxious to get everything down that I hadn't really been listening."*

Alice noted[SEQ]: *"The fact that my supervisor had to take notes constantly was a disadvantage as this led to a lack of eye-contact which made me feel she wasn't really listening or didn't really care about what I was saying. This is probably not true but that's how it came across."*

Alice suggests that eye-contact was an important element to know if the other person was paying attention. However the detail and accuracy of notes gave the practitioner feedback that they had been listened to and responded to appropriately.

Melissa noted [S2]: *"It was as you saying [with note taking] I couldn't keep eye contact going because I was writing so much but Alice kept talking and talking and at times I know she was looking for advice giving."*

CJ: *"You weren't picking those cues up?"*

Melissa: *"I was picking the cues up and in a way I found the writing helped because I do have a tendency to offer my opinions, so it was quite a useful device at times to give her space because the silences gave her the chance to think about it whereas before I would chip in."*

CJ: *"So the note taking was useful?"*

Melissa: *"There were two sides - I mean I'm hedging my bets. It was unnatural for me - I prefer to look at someone and prefer not to write but it did serve a purpose - became a counselling session and when she started darting around it was useful to say - 'Shall we go over what we've talked about so far?' and then pick it up... In the second session Alice was very distraught and there I was carrying on writing - I didn't know when to stop or start writing. I wanted to pick up cues from what she was saying but when I wanted to pick it up she had moved on - the gap between listening and responding was about 2 seconds."*

Melissa suggests that she was learning tactics both to create space in which to write an adequate set of notes and to use the notes as pointers within the session. Numerous tactics for creating space for note taking were evident within my supervision:

- simply noting the need to catch up with the notes;
- posing a reflective question to consider whilst making notes;
- asking the practitioner to clarify or explicate the key issues;
- speaking aloud what was being written;
- making key points - "this feels important" ;
- asking practitioners to give the supervisor a copy of the shared experience.

Writing up session notes

Maud noted she had written up the notes "verbatim' in her first 2 sessions: *"It was very laborious to write up.. took about 3/4 hour."* Jane and Gay also wrote up the notes by hand. Brian word processed the notes. Despite their difficulties, all the supervisors managed to keep adequate notes throughout the study, except for Pat and Melissa, neither of whom wrote their notes up after the sessison. They gave them to the practitioners as written. I found these notes difficult to read and interpret from the research perspective. I compensated for the paucity of these notes by clarifying issues from the notes in our supervision sessions. I assumed these notes were also inadequate for the practitioners. Pat felt he didn't have time to write up the notes after the session. He also felt considerable pressure within the session to write adequate notes. Pat noted [S5]: *" I have a real difficulty with note keeping - its becoming a chore writing quality notes and the difficulty of condensing the notes in such a way that I can get across the meaning of the experience. I can't write them up later - I haven't got the time - I can only do it there and then, but notes are vital - to make a record and refer back to."*

Pat acknowledged the value of note taking and his dilemma with time. Despite the time involved, the other supervisors felt the time spent writing up

notes was useful, in particular the opportunity this created for reflection on their supervision and for getting my detailed feedback to develop their supervision ability.

Jane [S2] felt that doing 2 sessions in one day made it tough on her to write up the notes: *"its pooping me out - it might be a problem filling the detail out if tired."* This was also my own experience. I actively avoided doing more than one session per day. This wasn't just because of the effort required to write the notes and the time for supervision, but also because the work was often emotionally demanding, required intense concentration, and because I needed to avoid the risk of confusing the issues between practitioners.

Frequency of supervision sessions

Besides time available to write an adequate set of notes, time was also required for the supervision session itself. How frequently should supervision sessions take place to ensure continuity of learning through experience? There was no definitive literature to inform this question. Hawkins and Shohet (1989) noted 'regular' sessions, but they did not pay specific attention to this question. Intuitively, I had felt that a session every two weeks for one hour was reasonable with Gill. With slippage for reasons of holidays, illness and work pressure, the average time span between sessions with Gill was 30 days. However, Gill noted [SEQ] that supervision sessions were:*"very useful and helpful but more frequent sessions would have increased efficacy of supervision for me"* and that sessions were *"helpful at the time, but pressures of work all too quickly took over again"* and that *"...long periods without opportunity for supervision left me brooding over certain issues and increased feelings of stress on the ward."*

Gill suggests that the time span between sessions made it sometimes difficult: *"to get back into"*, suggesting that the sessions needed to be more frequent. Working with Gill confirmed my intuitive belief for two-weekly sessions,

which I advocated throughout the study. A time span exceeding four weeks seemed to disrupt continuity between sessions. As Jane noted with Jeanne: *"Sessions flowed more easily when they were more frequent."*

Maud had set aside a half day a week for practice but recognised that this commitment to practice was the first thing that got squeezed when: *"time is so short .. and difficulty in fitting things in - like this session today."* The supervisors lived within the effort to resolve the exposed contradiction between valuing staff development, within a culture where staff development was a low priority in the face of the exigencies of everyday practice. Yet only Pat really struggled to fit supervision into his work priorities, as reflected in the pattern of sessions he had with Rona and Lucy [See Table 12.1]

Table 9.2 - Session frequency and span

Practitioner	No: of sessions	Session span
Gill	16	30 days
Jade	22	19 days
Myrna	12	31 days
Karen	23	23 days
Leslie	24	22 days
Gayle	13	30 days *
Abbi	12	22 days
Jeanne	11	27 days
Liz	7	39 days
Rona	7	36 days
Lucy	7	39 days
Mary	16	23 days
Pru	15	21 days
Rachel	9	19 days
Alice	10	32 days

Notes:

This averaged 20 days with myself over the first 5 sessions and averaged 35 days with Jane over her remaining 8 sessions.

When I challenged Pat with the frequency of sessions with Rona and Lucy, Pat noted: *"I was supposed to have a session with Rona yesterday which she put off because she needed to do a dressing for a lady who had just arrived on the ward"*

CJ: *"Is there an issue of them not wanting supervision?"*

Pat: *"No, I think its because they've been really busy. They get a lot out of it even though its hard work for them."*

CJ: *"Is it the thought of supervision that deters them?"*

Pat : *"It deters me especially when I'm flying around at a million miles per hour. We also had a lot of sickness."*

CJ: *"It may be an issue with Rona - is it reasonable to cancel her supervision appointment just to do a dressing?"*

Pat: *"She's had a couple of difficult discharges... she sobbed yesterday when one lady went home saying that I didn't have an hour to spare this week which fitted in with her off-duty except for that one hour we had planned."*

CJ: *"You rationalised that for her?"*

Pat: *"Me? I'm trying to be supportive of her and protecting myself.. there is no question that supervision is not being planned as well as it could be - it' a bit of me and a bit of them... there's just a lot happening."*

Supervision was low on Pat's agenda in the face of competing priorities. Feedback [SEQ q. 20] indicated that practitioners felt it was difficult to accommodate supervision within their practice. Whilst both supervisors and practitioners generally acknowledged the need for more frequent sessions this was generally not achieved. Gayle felt her session frequency with Jane was adequate: *"In between sessions I was keeping a diary. Working with Jane on the ward also helped as she questioned care and care planning. One of the major stumbling blocks in my development concerned Leslie. I needed time - not only to accept the need for confrontation but also to build up the courage. More frequent sessions probably would have led to frustration with my inability to do this. I felt then and still do, that*

timing is crucial when dealing with such issues and forcing the issues is counter-productive."

Gayle's comments suggest the value of practitioners maintaining a reflective diary between sessions to ensure continuity. This activity also seemed significant in promoting reflection as a daily activity rather than something done in supervision. Practitioners at Windrush were also encouraged to reflect daily through writing reflective patient notes as advocated by the hospital's reflective model of nursing which I introduced in 1989 (Johns 1994a). Gayle's comment also supports the value of the line manager being supervisor. Jane spent up to 30% of her time as an associate nurse, creating opportunities to discuss work related issues with Gayle *in a reflective mode* . Gayle also suggests the need for 'breathing space' between sessions. Perhaps too frequent supervision may have been over-whelming. Other practitioners were initially defensive about supervision and resisted the idea of frequent meetings. For example Mary arranged to meet with Brian monthly. I challenged him if this was adequate?

Brian : *"I don't think it is. I am having difficulty persuading her for the need to meet more often. I didn't push it though... but it is too long a break between sessions. I insisted the sessions were one hour - I was dogmatic about that any less time wouldn't be worth the effort."*

I presented Brian with the pattern of time span between Mary's sessions, in particular noting that the span between sessions 6 and 7 had been 41 days, and the span between sessions 7 and 8 had been 34 days. Brian noted Mary's explanation was that she had to cancel a session because of 'work crisis' and 'personal distress time' in working with one particular patient. Whereas Mary might have been expected to use supervision to get support for her distress, she avoided it because she was too distressed. Practitioners sometimes felt that supervision would only heighten their distress when it was preferable to avoid it at that moment. A supervision culture was generally developing whereby

supervisors did not 'push' supervision with practitioners. The organisation of work legitimised cancellation in the face of competing 'direct care' priorities. Mary [S3] felt she didn't really have time to be at this session due to pressure of work : *"lots of discharges to arrange, behind with paperwork, and new patients who need assessments doing."*

In an already busy world, the introduction of guided reflection was perceived as difficult. There was no pattern to suggest any difference in difficulty between hospital based nurses and district nurses.

Pru: *"The demands on district nurse time is so great with all the changes it isn't easy to put aside one hour every 2-3 weeks but it is probably necessary... the times when I didn't look forward to the session were when clinical work was pressurised and time was lacking - I think we usually tried to cancel that session rather than attempt a negative session."*

Rachel struggled to accommodate sessions because she was merely complying with the expectation of participating in supervision, which she had agreed to do. Because she did not particualrly value supervision, she resented time spent on this activity, as she did with other activities, such as computer work, that deflected her from direct patient care. Accommodating guided reflection into everyday practice required a commitment to this work, to compete with other priorities on time. In session 8 Rachel challenged Gay: *"What are we achieving from this? It's an hour every two hours for support but I'm not sure that I see the purpose - it's hard to see you as a peer when you are my manager.... I know I feel I moan about no time."*

In session 9 Rachel continued this theme: *"The business of time - why should I feel guilty? My priority is with patient so any meetings are always a stress... my nursing care takes 37½ hours a week so anything else is extra.."*

Rachel, like Pru, resisted supervision because she felt it interfered with her time she spent with patient care. At least Pru valued supervision as something

helpful. Rachel failed to see this because she felt it was a management imposition. In this respect, supervision had become a source of stress, fuelled by Rachel's failure to resolve the perceived split between Gay's managerial and supervision roles, and her fear of being judged.

At the end of a tiring day practitioners may not want to make the intellectual effort or relive stressful events. Karen [S13]: *"I didn't want to come at all - not because I didn't want supervision but because I didn't want to make the effort."*

Karen said she was still exhausted by sharing a distressing experience in our previous session 12 days earlier, recognising that supervision can be a stressful event in itself.

The defence of being busy and competing priorities was a recurring theme within all practitioners' narratives to varying degrees. The prevailing impression was that supervision was 'not work'. Hence, whilst supervision exposed and confronted the congruence of the work culture in relation to desirable work, supervision was itself challenged by the very culture itself. This created a sense of contradiction and a widespread sense of guilt within practitioners being in the session.

Abbi: *"I felt I should be doing something else sometimes."*

Gayle: *"The difficult part is fitting it into the rest of the priorities at work - an ethical dimension."*

Pru : *"The demands on district nurse time is so great with all the changes it isn't easy to put aside one hour every 2-3 weeks, but it is possible and necessary."*

Exposing this contradiction created the opportunity for supervisors to undermine the existing work culture and promote a new culture which valued this work, and in doing so, to help resolve this guilt in positive ways. This new culture challenged the norm that practitioners were 'shift bound' and that development was primarily the practitioner's responsibility rather than a management expectation. As such, this new culture sees role responsibility as a

job to do rather than be confined to particular shift times. Whilst such a culture might reflect professional roles, it can also be exploited. I noted that practitioners at Windrush became increasingly willing to use their own time to ensure supervision took place as they increasingly came to value supervision. 7 of the 15 practitioners achieved supervision every three weeks [+/- 2 days]. As such, I felt that a session every three weeks for one hour may be the optimum session span to ensure the continuity of the learning experience.

Framing the development of effectiveness

The primary approach for monitoring the development of effectiveness was the temporal flow of experience through the sessions. This development was ultimately illustrated within the individual narratives structured through the the learning domains, and ultimately within the 'being available' framework.

Monitoring tools

Besides the narratives, I constructed a number of monitoring tools for the practitioner to reflect on specific areas of development.

Heron's intervention analysis

This tool was designed to enable practitioners to reflect on their use of Heron's six category intervention analysis (1975) within experience. I explicitly encouraged practitioners to use Heron's framework as possible responses to different situations. Burnard and Morrison (1991) indicated that nurses tended not to use/or were uncomfortable in using confrontational/ cathartic/ and catalytic responses. Yet, these emerged as very significant responses within relationships with patients, relatives, and even other health care workers. Only Jade and Myrna used this tool [see appendix 5]. Although they felt the tool was time consuming to complete, it did help them focus attention on their use of Heron's different responses.

100 points reflection

This tool was constructed to help Jade and Myrna focus on sources of satisfaction and frustration that became apparent within their experiences [see Appendix 5].

Source of stress tool

This tool was developed from the sources of stress identified from Gill's narrative. At the time I thought this would support the emergence of these sources and help weight their significance. It replaced the 100 point reflection anxiety tool. However the practitioners struggled to fit their stress into my derived categories, suggesting the categories were not discrete but inter-related.

Developmental themes movement scale

This scale was constructed by explicating key developmental themes related to practitioner self esteem. Practitioners marked the extent they felt they had developed along each of these developmental themes. [Gayle's developmental theme movement is illustrated in Appendix 5d].

Summary

The framing perspectives offered the opportunity to juxtapose issues arising from the practitioners' experiences with philosophical, theoretical and contextual ideas. In this way both ideas and experiences were ceaselessly scrutinised for meaning and relevance to ensure learning was fundamentally grounded in the practitioners' experience rather than from ideal, abstract or theoretical positions (Lather 1986b).

Chapter 10
The balance of challenge and support

"The supervisor who communicates warmth, respect and genuineness, and positive regard will create a relationship in which the supervisee feels accepted rather than threatened and can be open rather than defensive. In this environment the supervisee can 'hear' straight forward feedback and challenge to risk and grow; the supervisor's main task can then be to monitor the balance of challenge and support in the learning environment."

[Blocher 1983 cited in Borders and Leddick 1987 - p47]

The essence of the helping style of guided reflection is the balance between high challenge and high support. Challenge is inherently threatening and needs to be balanced with support in order to avoid the perception of threat. Daloz (1986) suggests that the learning environment of high challenge and high support lead to 'growth', whereas an excess of challenge over support leads to 'retreat'. Karen noted the significance of this balance [SEQ]: *"I did feel very supported... the balance of the challenge did not exceed available support. I feel supervision forces the issues and challenges so much that you can't fail to develop."*

Myrna noted [SEQ]: *"Supervision was very supportive but at the same time sometimes stressful. But it validated my stress so did not undermine me and challenged me to confront stressful issues and assume responsibility towards their resolution, e.g. issue relating to colleagues."*

The dynamics of challenge

Within all supervision dialogue a tension existed between the practitioner's self-challenge and the supervisor's challenge. It was as if the force of the supervisor's challenge was a reaction to the practitioner's self-challenge. In the following dialogue between Pat and Rona, Rona's self-challenge is strong.

Rona [S6]: *"A patient who had 'given up' - he turned his face to the wall - and I was about to go off-duty. I went home to give it some serious thought - a quite difficult patient."*

Pat: *"So what did that serious thought conclude?"*

Rona: *"I decided that our previous relationship was not so good once we had talked about a nursing home - he didn't want to talk to me."*

Pat: *"Do you think he felt betrayed?"*

Rona: *"I wondered... we couldn't find the right time when he was in a good mood to explain that this was the only option - and it was rushed. I was a half-day and needed to go home."*

Pat: *"Is there a case for saying that you should have stayed and not taken your half-day and discussed this with his wife?"*

Rona: *"Yes - it would have been better if I had gone back and discussed it."*

Pat: *"So why were you unable to do that?"*

Rona: *"I wasn't prepared - and it was out of the blue as the social worker decided to come and discuss this then without prior arrangement. I had tried to do it at other times and arrange it but to no effect."*

Pat: *"Have you spoken to the social worker about the problem this has caused you?"*

Rona: *"Not yet - as there are other issues but I made sure that next time we had more time to discuss these issues."*

Pat: *"So what do you think are the issues here?"*

Rona: *"I made up my mind that my aim was to restore the relationship - yet face him with some tough issues. And I made time to offer him a bath so we could be alone and be able to talk.. it was what he wanted and it seemed ideal."*

Pat: *"Did it work out?"*

Rona: *"Yes - it did because.. I almost couldn't believe that by Friday morning I had actually got him to start asking me where he stood and his options. We talked about a lot of things. I reminded him that we could talk again in one week's time. I really worked hard with him!!"*

Pat: *"I don't doubt you worked hard with him but was it just a coincidence - that you had time and he felt liked talking?"*

Rona: *"No -I worked hard with him all week!"*

Pat: *"But what 'did you do' to get here? Can you identify how you made that journey?"*

Rona: *"Well - I worked with him as often as I could. We reflected for long periods on his past and we shared that. We also sorted out together some quite personal issues which he responded to. One day he said he was quite like his old self!"*

Pat: *" So what have you learned from all this?"*

Rona: *"I always knew this stage of Fred's life would be difficult for him as I have known him for a long time - and that you must jump on any positive opportunity that he presents. Also you must not let him down and you must listen to him. You can tell when you talk to him if it is a good or a bad time. He has his own 'holding off' tactic which means he, for example, will want to confide in only certain people and will need time."*

Pat: *"I suppose he deserves time to think about all this although he has been through all before."*

Rona: *"Well - that's right but he can be dangerous- he recalls how he got a nursing home member of staff the sack because 'she didn't do well by me'."*

Pat: *"Does that mean he can be threatening?"*

Rona: *"Yes - he could use it in a threatening way... if you ask him to do things he isn't inclined to do."*

Pat: *"Is that a problem to you?"*

Rona: *"I know his background and this situation has changed. I really think I faced a real issue in this case and challenged his aggression - into something positive instead of continuing to look at bad things."*

Rona illustrates her sensitivity in confronting herself. As such, whilst Pat still challenged Rona, his significant role was to support Rona and help her explore positive ways of resolving the issues she had raised. Their agendas were in unison.

Threat : more challenge than support

However, where the practitioner did not self-challenge, then the supervisor's response was to challenge. When the supervisor's challenge exceeded the balance of support, then the practitioner perceived this as threat and responded defensively. Hammond, Hepworth, and Smith (1977), drawing on the work of Lieberman, Yalom, and Miles (1973) noted how:

"High challenge [i.e where it exceeds the balance of support] is not only unnecessary for change but it is negatively correlated with outcome.. the supervisor needs to have a deep appreciation for the tenacity and the self-preservation function of defence mechanisms." [p435]

This threat was not conducive for learning. The following dialogue [S6] between Pat and Lucy illustrates Lucy's increasing defensiveness created by Pat's challenge:

Pat: *"I thought it might be useful to discuss what happened with Bob yesterday which created conflict. What is your version?"*

Lucy: *"He didn't tell me he was going at 2 pm. and he watched me make the bed and never said anything - we don't have each other on bits of string and I don't think he should have let me strip the bed."*

Pat: *"He didn't ask you if he could lie on the bed?"*

Lucy: *"No - and I was watching him that day and he never mentioned the fact that he was going home late."*

Pat: *"What did you say to him?"*

Lucy: *"Nothing - the auxiliary came and asked me [to help him onto his bed] and I said we have to get it ready for the next patient coming in."*

Pat: *"Was the bed needed?"*

Lucy: *"No it was used today."*

Pat: *"What does this episode tell me about you and your patient working in partnership?"*

Lucy: *"I was cross that he was afraid to ask me."*

Pat: *"What do you think he is afraid of?"*

Lucy: *"I don't know."*

Pat: *"Do you think he might have thought he didn't need a rest?"*

Lucy: *"Possibly, or that he may not have remembered."*

Pat: *"If he didn't remember - do you think you were fair with him?"*

Lucy: *"Well, we are normally busy and it isn't something I want to encourage."*

Pat: *"But can you accept that it may have slipped his mind?"*

Lucy: *"Yes - it could have. I thought when he asked you to go to bed that he must be tired."*

Pat's challenge led to a win-lose battle as Lucy defended her integrity in the face of this 'attack', although Lucy went on to accept 'defeat' by admitting that she had not handled the situation as well as she could have. Lucy expressed her concern at the high level of unnecessary challenge in this session, reflected in her liked least comment to Pat -*"I thought you were making more of the situation with Bob than was needed."*

The more defensive Lucy became the more pressure Pat applied in his frustration. Their dialogue reflected how Lucy lacked insight and how her practice was riddled with contradiction. Yet how should Pat respond to an experienced primary nurse who lacked this insight? This could only be a

question of judgement. Just as the practitioner had to 'tune' herself into the patient in order to know the person and respond appropriately, so the supervisor had to 'tune' into the practitioner to know the person and respond appropriately with the balance of challenge and support in order to deal with any sense of threat. In his own supervision, Pat could 'see himself' and the situation he was in. Just as Lucy could not quickly change who she is, neither could Pat, even with insight and understanding of the issues. Pat noted: *"It's uncomfortable sometimes when you feel you are threatening and challenging everybody, putting them under pressure and knowing they hate you for this and think - 'why are you doing this' - if I challenge them, which I feel I do in an encouraging and helpful way, its telling them that they are not doing things right - which I can understand because if someone challenged something that happened on this ward I would feel threatened too because you feel responsible for everything."*

Pat was ambivalent about challenging and threatening practitioners because he was sensitive to having the ward's competence exposed, and, ipso facto, his own competence challenged. It was helpful to draw comparisons between Rona and Lucy because they were both supervised by Pat. The contrast was stark because, on one hand, Rona was very open and vulnerable to her experiences and committed to realising the Unit's philosophy in practice, whereas Lucy lacked insight or commitment to her practice. This dialogue between Pat and Lucy highlighted that Pat [ab]used supervision to confront Lucy with her work performance in contrast with confronting her as part of everyday practice.

The sense of threat was evident within the supervision relationship between Brian and Mary. Brian [S4] highlighted Mary's defensive response to his pressure: *"Mary said she had been annoyed with me during the week because I had challenged her about a patient going home. She felt she took this challenge personally and that although she knew she was taking a risk, she knew it was the right thing to do.*

She felt I was challenging her to take risks but when she had done so I was telling her not to! I questioned as to why she got so annoyed with me for challenging her. Professional challenge should be OK. Mary felt she knew the patient well and knew what she was capable of. Mary felt that I was undermining her knowledge of this patient. I offered the comparison of the 'consultant's round', where challenge in a professional context happens without question. Therefore why should a challenge from a nurse colleague be any different in principle?"

Brian espoused an 'ideal' challenge milieu but without acknowledging Mary's reality and her need for support to sustain this challenge.

Resistance and game playing

Perceived threat resulted in defence tactics that manifested themselves as game playing. Borders and Leddick (1987) advised the supervisor to intervene to help the practitioner to find new coping strategies that do not inhibit learning . I labelled this as 'surfacing the dynamic' - or in other words, bringing the conflict into the open so it could be mutually resolved. Whilst this advice is sound, in practice it was difficult for supervisors to disentangle themselves from the games, because of how these games reflected their own concerns and defensiveness. This was very apparent within Jane's relationship with Liz where every session was the management of the game between them [I have summarised this relationship in Appendix 8]. Their underlying conflict could not be exposed and was played out on this manipulative level. Jane shared her feelings and expressed her understanding of this dynamic with me, but was unable to break free from it. She was entangled in Liz's manipulative web. Liddle (1986) described game playing as:

"maladaptive coping strategies to ensure that topics that make the supervisee uncomfortable will not be raised" [p117]

A vivid example was offered by Melissa's [S10] reflection on her difficulties in supervising Linda, a G grade district nurse, with whom Melissa had commenced supervision. Analysing their dialogue we identified a number of games being played out. In "The *dog on the floor with her legs in the air"* game, Linda responded to challenge by crumpling, crying 'crocodile tears' and saying things like- *"I'm never going to be the nurse you want me to be"*. The aim of the game was to persuade Melissa to stop challenging her. If this game failed Linda then played-*"Don't kick me whilst I'm lying on the floor"*. This game attempted to protect her by eliciting sympathy and pity. This was effective because Melissa had noted in earlier sessions: *"I noticed when I started supervision I was high challenge but I backed off as that was too hard on people."* [S6] Linda also played *"I'm not prepared for the session"* game, where she attempted to reduce the expectations of the session and shift the responsibility for the session by forcing the agenda onto Melissa. Melissa tried to inject some effort into the session, to which Linda responded with *"I wonder if this is an effective use of your time?"* game. This game intended to lower expectations and shifts the agenda onto Melissa. Melissa responded by reassuring Linda that it was a good use of her time. When the pressure becomes too much for Linda she played an extension of the 'dog on the floor' game by playing *"talk about leaving"*. This game distracted Melissa and quietened her challenge. The game might also be called *"If you push I'll leave"*. Linda was a psychiatric trained nurse and when psychological issues emerged in the session Linda played the game *"I'm a psyche nurse"*, suggesting she knew how to handle these issues which Melissa couldn't know because she wasn't a psychiatric trained nurse. Melissa noted how she felt trapped in a game of *"I see her socially"* and, as a consequence she couldn't upset Linda. This indicates that close personal relationships between supervisors and practitioners may be contra-indicated. Do personal relationships interfere with supervision relationships? The existence of this game suggests this is likely. Certainly Melissa was unable to

confront these games because of her own need to avoid conflict with Linda. The consequence, as with the relationship between Jane and Liz, was the collapse of the learning milieu.

Control of agenda

From the outset I assumed that the practitioner having control over the content of supervision was significant for disclosure, by reducing any perceived sense of threat. This would ensure the content was primarily grounded in their interests rather than the supervisor's interests. As Pru noted [SEQ]: *"I felt in control enough to be able to decide what was appropriate or not for supervision."*

This perception of control was widely shared. Leslie noted [SEQ]: *"The general content of supervision was brought up by me, but maybe some things interested him more."*

Karen [SEQ]: *"I only revealed what I wanted to reveal and there was no pressure to do more than this."*

Gayle [SEQ]: *"I felt supervision has been about my work and development within my work. As I lead the session the discussion centred on issue concerning work. If Jane had a particular issue to discuss during the session, she stated explicitly at the end of the session if I had nothing further to discuss."*

Whilst these comments acknowledged the practitioners' control of the agenda, the extent to which practitioners actually controlled the agenda was more complex. Where practitioners had nothing specific to share then the supervisor would steer the practitioner in certain directions. One way was by raising issues from the practitioner's practice. Such intervention seemed linked to how well the supervisor knew the practitioner's practice. Prior to their session 7, Gay had spent the morning with Rachel. Gay reflected on this experience within her supervision with me. Gay noted: *"I went out with her last Friday morning followed by supervision in the afternoon. Rachel said it was useful. We saw*

this lady.. she had the works. Rachel's care was thorough. We saw a new patient who lived in rather poor conditions.. we discussed management of this woman's diarrhoea."

Rachel felt this led into a deeper reflection on the patient's care in the subsequent supervision, in marked contrast with Rachel's 'normal' focus on management issues. This suggested that the more the supervisor knows the practitioner's practice then the more opportunities were open for *mutual* reflection. Rachel needed Gay to know and value what she did. In contrast, the hospital based supervisors tended to be more invasive than the district nurse supervisors because they did know the practitioner's practice. This is exemplified by Pat. In our first session I asked Pat :*"Has it been easy to confront people?"*

Pat : *"It's a natural thing to do - it seems safe for both parties. I have been comfortable although there are things not addressed because they haven't been brought up by the supervisee and should be addressed within the ward situation... my job 'out-there' - i.e. not using supervision as a stick."*

As Pat illustrated within his dialogue with Lucy, he was constantly tempted to use the supervision space to pursue issues that might be more legitimately done as part of everyday practice. However, Pat was also conscious of the 'legitimacy' of his actions. He commented [S3] : *"It's obvious that the longer I've been here, the longer I know their patients and the more I question what is going on. When I start challenging I sense the hairs on their back of their necks will start to rise and they become defensive."*

I often brought to Jade's attention my observations of her practice or from working together. For example, I reminded Jade she had said in handover that she liked a couple of patients [S11]. Jade responded: *"It was something you said about feeling warm about a patient, and that I hadn't experienced that. Well Daisy make me feel warm I have this rapport with her about really caring for her."*

This led into exploring Jade's relationships with different patients. My agenda, but an agenda I felt to be in Jade's best interests. On another occasion [S12] I

noted: *"The vibes I had picked up when I put my nose around the library door during your session with Troy* [Jade's student]."

I felt concerned for this relationship and wanted to create the space for Jade to explore it. I challenged myself 'why didn't I deal with this *as* part of everyday practice'? I realised the difficulty in giving feedback in the situation because people are focused on other things and were therefore likely to react defensively. I hijacked the agenda because these situations bothered me. As it was, Jade responded well because this issue also concerned her. I knew Jade trusted me. Within a relationship of trust, control of the agenda was less an issue providing the supervisor's interventions are in the *practitioner's* best interests. This was always a question of judgement.

Picking up cues

Whenever the practitioner disclosed an experience the supervisor was faced with numerous cues to focus the practitioner's attention. Yet which cues *should* be picked up? Jane [S1] highlighted the significance of this rhetorical question: *"People give you so many cues in a sentence.. you don't know which cues to pick up... why one rather than another?'*

I suggested that Jane could acknowledge the various cues and negotiate which to pursue. The risk is that the supervisor will only pick up cues of self- interest, rather than the interest of the practitioner. To 'safe-guard' against this risk, I built into the model of structured reflection [figure 3.2] the clarifying cue - 'What are the key processes for reflection in this experience?' This dynamic was a constant focus for discussion within my supervision of the 'I' grade supervisors. Control of the agenda was not just about what was disclosed but how the disclosure was explored. Hence, a further threat to the practitioner's control was the extent the supervisors allowed the practitioners to tell their stories. It was apparent how some supervisors, in particular the hospital based supervisors, asked numerous questions and made numerous inputs that

tended to disrupt the practitioner's sharing. I gave Pat feedback [S3] that there was a lot of interaction in Lucy's notes and suggested this interfered with her reflection.

Set agendas?

Knowing the patterns of becoming an effective practitioner created expectations of what practitioners might reflect on. Jane [S2] noted: *"I've had two sessions with Abbi. They were both very brief and to the point. She doesn't see what the issue is - the only thing she brings up are patient situations. She doesn't bring any relationship issues."*

CJ: *"Do you want Abbi to talk about relationships? Abbi may not feel this is an issue at this time or doesn't want to take that risk."*

I advised Jane to 'pick up on cues' to prompt a reflection on relationships, for example - 'How did other staff feel about that?'. I challenged Jane why she wanted Abbi to focus on staff relationships - was that what *she* wanted to hear about? Where the practitioner didn't reflect on certain types of experiences, the supervisors often felt pressured to confront the practitioner with this phenomenon. This suggested a danger with preconceived frameworks that imposed some normative expectation of what the practitioner should reflect on. On the other hand there were many different aspects of role that the effective practitioner must strive towards. The supervisor's legitimacy to confront the breadth of role, for example 'teamwork' can be assured through contracting and reviewing expectations. Although contracting was intended to minimise threat, this did not mean that practitioners will not feel threatened. Rosenblatt and Mayer (1975) undertook a study with 39 second-year social work students to determine objectionable supervisory styles from the students' views. They note the student's response to threat:

"none of the students openly confronted their supervisors, despite the presence of norms of communication that exhort students to be open and honest in supervision sessions. This behaviour was not surprising [given that] the supervisor is a powerful figure." [p187]

In other words, espousing intent was not enough; open and honest communication had to be actively created and power actively deconstructed. Rosenblatt and Mayer note that failure to achieve these conditions will inevitably lead to spurious compliance to "convey the impression of compliance or willingness to comply." [p187]. This phenomenon was very apparent in several of the supervision relationships. Yet the strain of compliance inevitably took its toll with the premature termination of several of the hospital based guided reflection relationships due to unresolved perceptions of threat.

Threat to competence?

There was also a sense of threat whereby the practitioner became aware that perhaps they were not as competent as they had believed. This undermined their sense of competence. As Alice noted [SEQ]: *"Initially my confidence fell because I became more sensitive and analytical, maybe reading things that weren't there. However I feel it helped me make sense of what was happening and gradually to find some answers and to be stronger. I feel I needed to work through what was happening with working relationships to improve the care I was giving my patients."*

Similarly Rona said [S 6]: *"I didn't feel intimidated by supervision but it did undermine my confidence particularly in issues where things went right but I had excluded the management aspect... that focuses everything and ties it together."*

Pat: *"Did you have any other thoughts about supervision?"*

Rona: *"Yes - the emotion, but I had read that this is important ..it was worth looking back and reflecting to see how far we had got... my confidence which was eroded has built up and I needed to unfreeze and re-look at my practice."*

Pat: *"Is it uncomfortable being unfrozen?"*

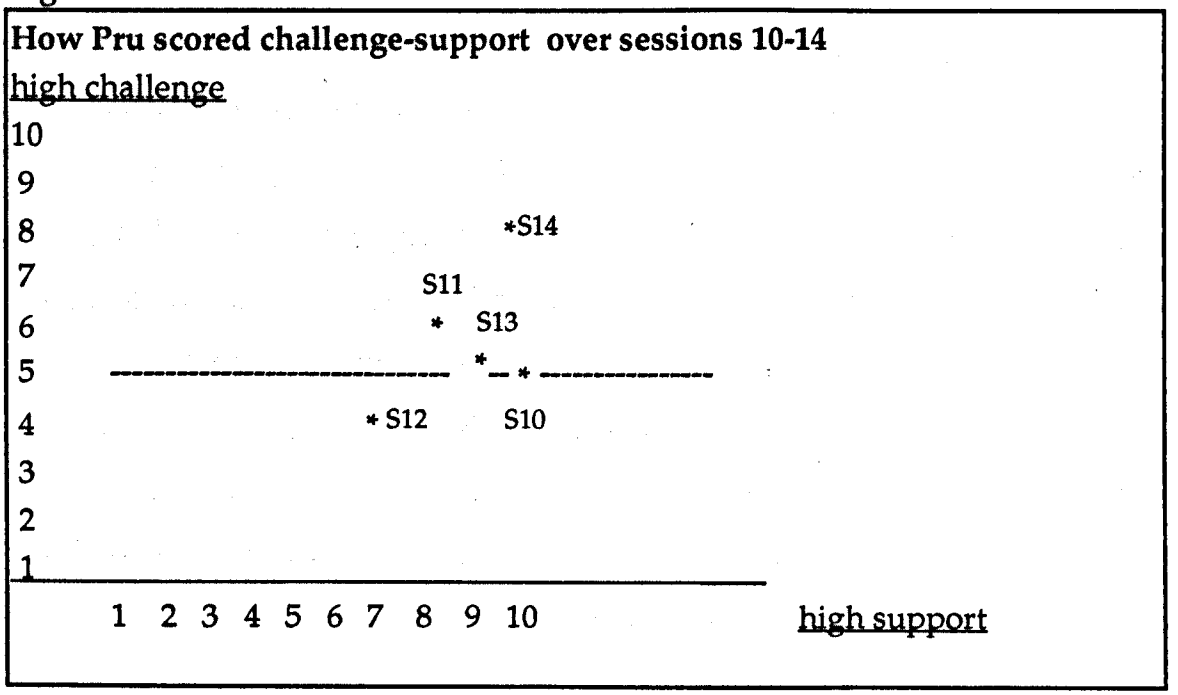
Rona: *"Yes it is - I don't like the emotion. I feel I have to go through with it."*

Rona had responded to guided reflection by being very self-critical. Whilst she felt this undermined her confidence, she suggests she grew through this discomfort towards a new self understanding. This threat to confidence was evident within all the practitioners' supervision. Perhaps it was to be expected considering the need to be seen as competent and coping, when in fact the evidence of experience suggested that perhaps this was an illusion. I felt this led to a sense of crisis which the supervisor needed to acknowledge and respond to sensitively.

Comfort: More support than challenge

Pru felt that Maud did not challenge her enough. I also gave Maud this feedback within our supervision. Failure to challenge seemed to impoverish the learning milieu. To help practitioners and supervisors monitor the balance of challenge and support, I developed a scoring map. Figure 10.1 illustrates how Pru had scored this balance in five sessions with Maud.

Figure 10.1



Maud acknowledged her objective was to move the session higher up the challenge grid, to enhance the 'Growth area' (Daloz 1986), as indeed Pru desired. Yet, Maud recognised her allegiance to a conflict avoidance culture. I noted [S6] how Pru dumped her anxiety into the supervision space. I suggested that perhaps this was inappropriate and that perhaps a more challenging approach would be to help Pru acknowledge and explore this anxiety. Maud felt: *"I'm not so comfortable about the idea of working with conflict within supervision because I'm not very good at it myself."*

In session 7 Maud noted : *"I felt guilty that she should feel guilty because she hadn't written anything in her diary -I kept saying to her -'don't worry, don't worry and thinking to myself -'old rats' that I should feel like that!"* This typified Maud's relationship with Pru, feeling guilty if she put pressure on Pru, and feeling guilty that she didn't put pressure on her. This culture was also strongly evident within Gay's relationship with Rachel. I pointed out to Gay [S8] her lack of challenge with Rachel: *"How much is your not challenging people because you don't want to upset her or protect her?"*

Gay: *"Probably quite a lot. I agree I am high on support. I feel I didn't get a lot of support when I was a district nurse and I feel I have to remedy this. I feel nurses are stressed enough without me adding to it."*

I drew Gay's attention to how suppressing Rachel's feelings and sense of conflict gave certain messages that were perhaps incompatible with Rachel's becoming effective. We identified the possible consequences of suppressing feelings:

- that feelings were not important;
- that feelings should not be expressed, i.e. kept invisible;
- that suppressing feelings reinforces the notion that 'good nurses cope';
- that feelings were 'dirty' work - so lets keep it clean;
- that feelings of conflict were to be avoided.

Gay shared how she had commenced supervising a newly qualified district nurse besides Rachel. She said: *"I was astonished at the difference between supervising her and Rachel! Rachel used to rush in, breathless, pouring out her stress, whereas Carie is calm, cool, controlled - she did all the work, she structured the whole thing. I hardly had to do anything myself."*

Carie had exposed the weakness of Gay's challenge, scoring her challenge as 4/10. Gay responded: *"What can I say? I just find it difficult to be challenging. I just make excuses for people."* [S12]

Maud and Rachel portray a pattern where support constantly exceeded challenge due largely to their own concerns. However, there were times when it was important for practitioners to simply dump their distress into the session via a sympathetic ear rather than be challenged to work through it. However, this was always a question of judgement. For example, Jade [S13] spilled out her pent-up anger towards Myrna, and her sense of helplessness at not being able to do anything about it. Whilst acknowledging Jade's distress I could challenge the helplessness. I asked Jade to remind herself of the purpose of supervision. She said to be constructive not destructive, for support and to develop. I responded: *"the destructive issue is very profound - see it as an analogy with constructing a new building and having to knock the old one down - recognising what needs to be demolished -before we can build new stuff, but also recognising the chaos of demolition and the excitement of the new building emerging."*

My judgement led me to help Jade convert her helplessness into positive energy. Such judgement was always based on knowing the practitioner, as with any therapeutic intervention. In the face of shared experience, the supervisors needed to make such judgements whether to empower practitioners to take action, or to act on their behalf in some appropriate way, or simply acknowledge that some barriers were difficult to surmount.

Paternalism

On occasions supervisors did take action on the practitioner's behalf. Jane noted on two occasions how she had intervened with patients who were giving Jeanne a hard time based on what Jeanne had shared. Jane [S1]: *"I confronted Sofie [a patient] about this saying that she could have helped Jeanne - that she was only making things tough for Jeanne. I suggested she had a word with Jeanne and sort things out. Sophie reacted grudgingly but positively to this.."*

CJ :*"It raises the dilemma of using supervision stuff outside supervision?"*

Jane recognised this dilemma but felt okay about it as Sophie had approached her, telling her about this incident prior to Jeanne's supervision. This raised the issue of whether Jane's primary responsibility was towards clients or towards staff, and the degree that unsatisfactory performance could be tolerated. Jeanne's response to these interventions was defensive. She felt it exposed her weakness in front of the patient although she had realised how her relationship with Sofie was difficult. Jeanne's defensive reaction suggested that taking [paternalistic] action on behalf of the other was better negotiated than unilaterally decided.

Melissa [S2] shared how she took action because she was disturbed by what Alice had shared concerning a district nurse that a patient had complained about: *"The reason why I had to intervene was that Alice was telling me things about this nurse but there was no change in her behaviour... [yet] she knows she has to change - so in that instance I thought that supervision was ideal - we [both] thought it was a useful approach."*

These examples draw attention to the therapeutic difference between taking action on behalf of the practitioner and taking action because of the supervisor's own anxiety. This difference needed to be distinguished because of the threat to confidentiality and control of the agenda. From a

developmental perspective, such action required to be negotiated. When it wasn't it risked undermining trust.

Summary

The balance of high challenge of high support was a critical factor in achieving effective learning. The supervisor's response needed to be a question of judgement within the relationship. In general, the hospital based supervisors were more challenging than supportive, and the community based supervisors more supportive than challenging. Despite recognising their particular emphasis on challenge or support, this supervisor behaviour was difficult to shift. This suggested that supervisor's high challenge - high support response was influenced by managerial style and the supervisor's own concerns. In particular, supervisors with strong personal agendas were more challenging. Developing this understanding of the impact on supervision of 'who the supervisor was' is the focus for chapter 11.

Chapter 11
Knowing and managing self

"The supervisor [nurse] needs to learn who she is so that her own concerns will not interfere with the practitioner's [patient's]exploration of his concerns."

[Hall 1964]

The values, attitudes, prejudices, commitment, and concerns of the supervisors influenced the way they responded to the practitioners within supervision. This chapter is structured through a number of significant dynamics:

- ***Positive regard.***
- ***Process versus product emphasis.***
- ***Gender barriers?***

I then summarise the significant dynamics within the question -'who should the supervisor be?'

Positive regard

Blocher (1983) considered *positive regard* to be a significant dimension within supervision relationships, a position widely accepted within the counselling literature as being central to the therapeutic process (Egan 1990, Hammond, Hepworth and Smith 1977). By 'positive regard', I mean the supervisor believes the practitioner has the undoubted potential to develop. Positive regard is also a reflection of the supervisor's concern for the practitioner's development. The extent of the supervisor's regard towards the practitioner can be sensed within any supervision dialogue.

I was conscious of labelling Myrna as 'not having the right norms', even though I knew her difficulties when I appointed her as a primary nurse at Windrush. I had planned to support her and yet it took seven sessions before I was able to feel 'positive' towards her. I noted in my diary [24 March, 1991] *"Very conscious of my generally negative vibes towards Myrna -I believe these stem from my perceptions of her suitability to be my image of a nurse at Windrush".*

I could hear my irritation with her during the early sessions, but when I was eventually able to discuss these feelings with her, she said she had not perceived this. When I fedback [S8] my perception of her compulsive behaviour of tidying, her rigidity, her unpredictable moods, all within the need to control her environment, she said: *"I fear being seen as incompetent for caring for people physically - I have been socialised into that."*

I sensed Myrna's profound discomfort: *"Is it uncomfortable to talk with me like this."*

Myrna: *"I'm feeling quite tearful at the moment."*

CJ: *"Because I might see you as incompetent?"*

Myrna [difficulty in responding]: *"This is important - to be as seen as competent but not in traditional nursing eyes but competent in new ways. "*

This was an important turning point in our relationship. I wrote in my diary: *"I feel a wave of compassion in reading how I confronted Myrna with her compulsive behaviour in order to control the environment."*

It was a very intimate and emotional moment, and converted my residual irritation towards her into 'positive regard'. Myrna let go of her need to control and it marked the beginning of her real involvement in supervision, that paralleled her real involvement with her patients. Perhaps this was the right time to act. Perhaps confronting her earlier may have been too destructive. Egan (1990) noted that such challenge may lead to a sense of temporary disorganisation or disequilibrium even within an established relationship. However this was not to be avoided because such disequilibrium reflected

contradiction. I felt I had 'judged' Myrna in some way and found her to be lacking to the extent that it interfered with my being available to her. Failure to deal with such negative regard led supervisors to 'label' practitioners as 'difficult' in some way. However, through their own supervision, the supervisor's negative regard could be acknowledged, understood and worked towards converting into positive regard. The existence of negative regard was evident within a number of relationships.

For example, Gay's total experience with Rachel was tinged with her frustration at Rachel's behaviour. She shared [S7]: *"I don't think we are going to get Rachel to change that much - the way she is so engrained - she's never going to take responsibility for everything she does - for example - we gave her an answer phone because the surgery were fed up taking her calls - 5 months later she hasn't used it - the message from the practice manager is - why is this? - I told Rachel to sort it out - she says she doesn't have the time to read the pamphlet - you could strangle her! I don't think I'm getting anywhere - maybe everyone has the potential for change. I think Rachel functions very well in an old time 'G' grade nurse but she's not moving on."*

Pat's regard for Lucy had disintegrated over the sessions because she failed to respond as he wanted. This was underpinned by his disclosure that he had never felt comfortable with Lucy, suggesting a degree of 'personality incompatibility'.

Although Brian always claimed to have a positive regard towards Mary, he tended to reflect a sense of frustration in the notes. He admitted [S11] that other primary nurses now in supervision were much better than Mary.

Brian's and Pat's experience illustrate the way supervisors, who supervised more than one practitioner, tended to compare and judge practitioners in terms of their competence within guided reflection. The consequence was to view certain practitioners in low regard. The consequence of low positive regard was a lack of authenticity on behalf of the supervisor. This led to game playing in an effort to manage a facade of authenticity and avoid conflict. The 'ideal'

notion of positive regard was threatened within practice because of the human tendency to discriminate, hierarchical frustration, and need for control. As with practitioners' work with patients and families, 'knowing and managing self' was a significant factor in being available to work with the practitioner.

Gender barriers?

Understanding the power dynamics in terms of gender was not easy to ascertain although I certainly felt gender was an issue. The supervision relationship was often charged with distress and elation. I noted on several occasions how warm and close I felt to practitioners, both male and female, in response to our intense work together. I also noted on occasions that I felt an inclination to hug practitioners in response to their distress. However. I was also extremely sensitive to how this might be interpreted. Pat's experiences suggested a gender tension appeared to interfere with him establishing effective relationships. He had abandoned one early supervision relationship because of having a relationship with this nurse. He had initially intended to supervise three primary nurses but the third rejected the invitation because of personal dynamics with him. The limited literature on gender in relation to supervision suggested that men and women may respond quite differently as supervisors. Petty & Odewahn (1983) noted that male social workers responded negatively to female supervisors and positively to male supervisors whereas female social workers responded more positively to female supervisors than they did to male supervisors. They suggested that male supervisors did not respond well to assertive women. However, they do not comment on reasons why female social workers responded less favourably to male supervisors. Munson (1987) commented on research studies that had found no differences between the perception of practitioners supervised by either men or woman. More insightful is the work of Rozsnafsky (1979), who noted:

"my experience and observation have convinced me that the most important considerations in therapy and supervision are the integrity and maturity of the therapist.." [p190]

Rozsnafsky argued that immature male supervisors follow

"a pattern that repeats itself with distressing regularity.. devoted to his need to prove his masculinity by conquest over women" [p191]

Rozsnafsky describes this as 'the hunter-huntee game'. She identified five types of immature males and four types of female immaturity that presented itself in game playing. She noted that the immature supervisor was blind to his or her own needs. Whilst I made no attempt to fit the supervisors into possible immature stereotypes, it did reinforce my belief that supervisors needed their own supervision to enable the growth of their own integrity. It is difficult to draw any conclusions about gender except to say that both men who were supervisors experienced difficulties with female practitioners. They were more concerned for their own agendas and subsequently lacked sensitivity to the experience of the practitioner. The only male practitioner was supervised by another male. Yet female supervisors also had difficulties with female practitioners as I indicated with Jane's different relationships. The district nurse supervisors [all women] tended towards a 'maternal' attitude with practitioners [all women] , reflecting their own concerns not to increase the practitioner's anxiety.

Process - product focused

The supervision milieu was a fertile ground for manipulating the practitioner towards certain outcomes. Indeed a distinction could be made between a

'process' model of supervision that focused on creating the learning environment, and a 'product' model of supervision that focused on producing a certain type of practitioner. The process- product tension is then a question of *emphasis* [figure 11.1].

Figure 11.1

The continuum of being product - process focused

Being product focused	-	*emphasis* on producing a practitioner with specific feelings, attitudes and behaviours [sees the practitioner as essentially an object to be manipulated
^ | | | | | v		
Being process focused	-	*emphasis* on enabling a practitioner to become fulfilled [sees the practitioner as essentially a person]

The supervisors' variance of emphasis could be plotted along this continuum. However the relationship between being product or being process focused was not clear cut. The *intent* of all practitioners was to be process focused but due to the dynamics of the particular relationships, this intent emerged as a contradiction that reflected the prevailing culture and reality of the practitioners and supervisors involved. It also highlighted how supervision could easily become a new 'technology' to produce a certain type of practitioner, and how it could actually reinforce the power differentials between manager and practitioner by creating a space where this power can be formally manipulated.

In Pat's supervision with Lucy, he acknowledged the pressure he felt in terms of people looking at *his* unit. In essence Lucy's competence was a reflection of his own competence. As a result he felt under considerable stress 'of expectation' with regard to guided reflection to change Lucy to fulfil his image of what a primary nurse should be.

In a similar vein, Brian acknowledged [S2] how he struggled with the tension between enabling Mary and producing some sort of outcome: *"I felt really pressurised in the session to get things done. I didn't want it to be me sitting there - the font of all knowledge, solver of problems. I see it as much more helping Mary solve problems of her practice. I'm here to help her explore, not to provide answers. How much structure do you put into it? - with me giving advice that's actually quite difficult. I was trying to listen to her, trying to get her to do all the exploring and at the same time I was conscious that I should be saying things - 'how about that'?' - in some ways that would have been easier."*

Brian linked this to a nursing role of helping people: *"You want to be the person to solve problems - its natural for me to think like that. I'm trying to get rid of these feelings in order to make supervision more useful - at this moment I should let it just flow."*

I challenged Brian's ambivalence about seeing himself as being the 'font of knowledge'.

Brian: *"I'm sure your right - people do expect you to be this - but I know this is not what the job is all about - people see things changing slowly - you are right - at the end of the day I would like to be prescriptive - getting things done - I would get more satisfaction - my knowledge tells me it wouldn't last though."*

CJ: *"There must be pressure on you - people judging you? "*

Brian: *"That pressure is there."*

I offered Brian the words of Hammond, Hepworth, and Smith (1977)

"it is not unusual to find supervisors who confront in an impatient and demanding manner, expecting the practitioner to 'leap tall buildings in a single bound." [p281]

Brian acknowledged these words represented his reality. He had recognised [S3] that being product focused was counter-productive to learning when Mary had given him a strong message that she didn't want to be there. The session had been overshadowed by her feelings of discomfort which had left him wondering why. Brian wished he had explored these feelings. He felt that a reason for this might have been his focus on outcomes rather than processes which made him miss some process issues, i.e. not seeing Mary enough. Brian had picked up cues in the session because of their relevance to his agenda. Hammond, Hepworth and Smith's words (1977) were again helpful to put Brian's experience into perspective -

'a highly confrontational style may be a clue to the counsellors needs to establish his "rightness", to validate his perceptions as superior, or to overpower, control and manipulate.. supervisors should always remain aware of the temptation to use confrontation to validate one's sense of power.' [p282].

By session 4 Brian felt "out of control" He couldn't see where he was going because he was entangled in a web of conflicting emotions and agendas. The consequence of being outcome focused was to get lost in the feelings because he was not paying enough attention to them. He wanted to push Mary into being more self-reliant and but Mary resisted this because she was not ready for it. One of Brian's concerns was to 'use' Mary as a force to bring about change with her peers and to challenge the prevailing culture of the Unit. He noted: *"At the next primary nurses' meeting I persuaded her to share with the others what she was doing - and for me - so others could say that they might want to try it."*

I challenged Brian with the way he had 'told' Mary not to use a particular dressing. She had accepted this and understood the reasoning behind this. Her response was, in turn, 'to tell' the associate responsible for not following her planned care. As a consequence, Mary felt the associate nurses felt that she was 'getting at them' but were getting more used to this. She rationalised this by reiterating how Brian had emphasised to her in the previous session the importance of her acting out her responsibility for her particular grade and position. The word 'told' was symbolic of Brian's directive stance and reflected a judgmental attitude and accompanying sense of frustration. Yet, it was a great temptation to be prescriptive with 'dependent' practitioners, and difficult for supervisors to stand by and observe ineffective practice. Mary responded in similar ways with the associate nurses. She expressed her anxiety with this situation and blamed Brian, reflecting a 'hierarchical dependency', the way orders are pushed down and responsibility pushed upwards. This attitude led to a tension of 'who was right' and the risk of disintegration into win-lose games. This was most evident with supervisors, who held strong values such as Brian, who were convinced they were right. However such a climate was not conducive to learning and the growth of practitioner reponsibility. Doehrman (1976) noted

"when a student challenges his views, the supervisor may patronise the practitioner and/ or feel hostile towards her; or he may hide his hostility behind a facade of paternal kindness and over attentiveness or mask genuine affectionate feelings behind a distant, detached, excessively task-oriented approach" (p11/12)

Brian's 'control' was illustrated in the way he imposed his own values into Mary's experiences. He exposed and confronted Mary's values as they emerged through her experiences and framed these in terms of his own values, as credible as they were and as sympathetic as Mary was towards them. By

session 6, Brian was in crisis. He shared the extent of his frustration at the Unit's lack of commitment to changing practice: *"I've had an appalling two weeks coping with the job to the extent that I even wrote a letter of resignation expressing how I felt. I thought I was emerging from these feelings, then Thursday I had organised this unit meeting - 48 staff and lots to feedback on. Only 3 turned up. I thought 'What the hell am I trying to do. You work yourself into the ground and nothing happens. It really exposed to me peoples' agendas rather than an interest in professional practice. I was surprised because I've never had that before. I can't believe that so many nurses are not interested in professional practice. I became angrier and angrier - I took it out on the lawn when I got home and wrote the letter of resignation."*

Brian referred to our previous talk of 'omnipotence', of needing to put up this front and how it was now being battered: *"I haven't given myself permission to fail."*

The 'product focus' was more apparent with the 'I' grade supervisors within the hospital settings who had strong expectations of themselves. These were also the most committed to a certain set of values. Supervision had given these supervisors a lever for pushing change. Yet it only led to mutual frustration.

Being the supervisor-manager

To re-iterate, the supervisors within the study had line management relationships with practitioners except Brian, who was a clinical nurse specialist, although he was still invested with considerable authority to manage the development of clinical practice. Being the manager possibly encouraged an emphasis on 'product'.

Jane asked Abbi [S11]: *"Do you feel I am able to put aside my management role during these sessions?"*

Abbi responded: *"The first two sessions I found very intimidating - its been OK now, but at first - I did see you as my superior - that's how I felt. I don't know if it*

showed? In the sessions I feel I am performing- as if I have to talk a lot. I feel as if I have to make an impression on you and perform in particular ways. .."

Jane reflected on her continued supervision with Abbi after she had left Cairns Unit: *"I can't monitor her effectiveness in practice. There is a missing link in supervision - if I was 'on-site' manager I would be in a position to evaluate her development more clearly. How much is the contradiction in what I say effective - would it be more effective if I was there? Essentially I believe the supervisor should be the manager - otherwise there is or could be a large part of practice that may not be shared. If I was in practice I would be a contradiction to her by just being there making her everyday practice problematic - now, I am reliant on her being open and honest - she can hide whatever she wants from me."*

Jane exposed the extent she felt she needed to control this relationship. She suggests she didn't trust Abbi to tell the truth about her practice. She clearly highlighted that she saw supervision as evaluating Abbi's development. Jane's need for control was further reflected in a developing tension between myself and Jane regards my supervision of Leslie and how this impacted on her relationship with him. Leslie's experiences became focused on his conflicts with her. I was very conscious he was talking to the wrong person about these issues as they were not being resolved. Jane was making such comments to me as: *"I was concerned he used your comments as the reasons for action."*

I shared my 'discomfort' at being in the middle of these issues between them and didn't want to tread on Jane's toes. This made me confront Leslie to take action with Jane and to terminate our supervision relationship. This dynamic felt very significant and may be a significant barrier to external supervision.

Judging performance?

For learning to be achieved, it was crucial the practitioner felt safe to disclose difficult incidents without fear of being judged or censured. Practitioners alluded to a sense of discomfort with being judged by their manager.

Gay [S2]: *"Rachel is feeling better about that now we have talked supervision through. She feels she reveals too much of herself in front of me in the sessions and is concerned that it could be held against her."*

Rachel struggled throughout her relationship with Gay to accept Gay's dual role as supervisor and manager. Rachel was anxious that what she said or what Gay wrote might be used to judge her performance. There was no evidence that this fear might be actualised. It was simply Rachel's fear which could not be reassured. Rachel's fear reflected her socialisation into hierarchical roles and the way she had come to perceive herself vis à vis those who managed her. Doehrman [1976] considered it *inevitable* that the practitioner will have strong feelings towards the supervisor characterised by an ambivalence towards the supervisor due to reasons of ambivalence towards authority figures, imbalance of status, and consequent feelings of fear, envy, and hostility. Atherton (1986) raised the issue of supervision as a form of social control, which may be resisted by social workers (Kadushin 1985). The term 'supervision' itself may be perceived in an overt hierarchical sense reflecting a traditional meaning of 'supervision' associated with ensuring work is closely prescribed and directed by a superior, and competently carried out (Platt-Koch 1986). A traditional role of supervision was to ensure quality of the product, and indeed, supervision created an opportunity for the supervisor to give the practitioner feedback about their performance. The managerial role of the supervisors *was* to ensure overall quality of care for their units. Charged with this responsibility it was inevitable that the supervisors made judgements about the practitioner's performance based on shared experiences. It was again the extent of emphasis. When judging performance was even suggested, practitioners became quickly defensive. Robiner (1982) noted that:

"Administrative responsibilities, particularly those involving judging the practitioner, invest the supervisor with a degree of authority relative to the supervisee.

This inequality of power engineered into supervision profoundly influences the relationship" [p260]

One consequence of this role was a universal tension within the supervision function between the quality assurance aspect of the supervisor's role and the supportive/ personal growth role. I acknowledged and managed this tension by de-emphasising the quality assurance aspect because of its potential threat of judgement whilst simultaneously emphasising the practitioners' responsibility for monitoring and ensuring their own effectiveness. The potential for conflict within this role was very evident. Greenberg (1980) has noted this tension, reflecting the traditional hierarchical distance between manager and practitioner (Marshall and Confer 1980). Tenenbaum (1970) confirmed that power differentials can influence the nature of communications and the content of messages, i.e. how subordinates tended to leave out certain types of information and shift attitudes more than their superiors, suggesting a tendency to the status quo. Gayle exemplified the desirable perspective: *"Jane, as my manager and supervisor, cannot escape using the insight she gained to evaluate my performance. However, I felt her primary concern however was to help me develop and feel safe to do so."*

Being elsewhere

Being managers, the supervisors had their own roles to fulfil. My supervision relationships with the 'I' grade managers had been contracted with the dual purpose of supervising them in their everyday roles besides supervising their supervision with practitioners. Through sharing their own work-related experiences, their everyday concerns emerged, largely grounded in issues of intra or interpersonal conflict, paralleling the dominant focus of practitioners' shared experiences. It was evident from these shared experiences that the supervisor's availability was influenced by their own concerns.

Jane [S2] felt she projected her sense of 'flatness' into others. Her experiences were concerned with conflict with other therapists that painted a picture of competing values and conflict over control. Pat and Brian shared conflicts within their own units. Pat talked [S3] about the pressure he felt himself under: *"I have become quite despondent -I've been getting at everybody and I've felt under a lot of stress with the ward. I remember lying in bed recently, thinking that I have to tell Chris about this because I could easily jack the whole job in at the moment. I felt that the primary nurses were not helping me at all and I really wasn't sure about putting it right... I didn't feel I was tackling these issues very well and I was flying off the handle easily which is not like me and the staff knew I was quite unhappy... I just thought - this mountain is too high to climb. I felt overwhelmed with the amount of work to do, yet other people come on the ward and say its good, its improved so much- and I don't know if that is my expectations - that I want it to be a wonderful place overnight but it doesn't work like that. Sometimes I can accept that and sometimes I can't but when I can't I am my own worse enemy - I go around like a bear with a sore head and I'm not the best person to work with when I'm that way. I'll give you an example which I handled wrong..."*

Supervisors sometimes struggled with their own concerns and those shared by practitioners. Sometimes the two coincided. Jade had commenced supervising Karen. She reflected on her second session with Karen [S2]: *"I didn't want to be here. I felt down. I didn't think I could give anything. I just felt empty... I can't explain why. Karen was talking about relationships. I thought this is what I should be doing.. I was thinking -'is this enough?' Her talking or should I be giving her more than this... with a relationship you don't know do you? I wanted to hold back a bit and let her have control. I should have more insight than this but I can't because everyone is different. It makes me feel quite vulnerable as well. There was a situation in the session where Karen was talking about a patient and her son. She didn't want to talk about it but*

needed to get it out. I was worried my own feelings will get wrapped up in Karen's... I didn't know what to do."

A picture emerged of supervisors feeling generally unsupported in their work roles. Maud felt supervision would be a: *"support thing for me - I don't feel in my job I have support from anybody."*

Brian [S2] noted how he liked best about one session: *"the time to off-load. I have no-one to talk things through - a lot of my stresses onto someone else."*

Yet Brian worked closely with the unit manager and was part of a wider educational unit. He was ambivalent towards supervision due to his reluctance to seek support because it exposed his lack of competence as a supervisor. The more vulnerable the practitioner's or supervisor's self-perceived sense of competence, the more defensive they are likely to be. In general the supervisors were insecure about their ability to be effective supervisors, and being exposed as incompetent by the practitioners they supervised. Just as practitioners needed to know self in order to be available to work with patients and families, the supervisors needed to know self in order to be available to work with practitioners within supervision.

Maud [S2] noted how supervision had opened her eyes to see her relationship with Pru: *"I genuinely didn't feel I had barriers to break down but now I realise I have. I told Pru we were just colleagues in supervision. It's useful for the first time to have someone questioning me, making me look at myself, why I am doing what I am doing."*

Melissa noted her concern with her manger: *"I have a problem with my manager - some of the comments she makes really disturbs me. For example a situation where she was telling me to be two-faced...she wanted me to tell the staff something I didn't feel was right. She also implies I am a novice [in management]."*

CJ: *"Did you confront her?"*

Melissa: *"I feel I am always confronting her. I felt uncomfortable. I felt I needed to give her a chance. I didn't feel it was appropriate to confront her at that time. In management meetings I have begun to get very anxious because she bulldozes the agenda, imposing her views on the rest of us. However, on the basis of these tensions she did organise an away-day although she really pissed me off because she didn't participate herself.. didn't give herself whereas the others really tried to explore the dynamics. I've wasted a lot of energy worrying about this but I don't know to resolve it."*

In exploring this issue, the different value systems between Melissa and her manager emerged, how her manager constantly reinforced a bureaucratic model of management whereas Melissa strived towards 'professional' relationships with her staff. Melissa felt unsupported, poignantly expressed as: *"I need people to tell me I am doing a good job"*

Gay talked about Agnes, a newly qualified district nurse who intended to enter supervision: *"She's been to see me - she's finding it hard to cope with her job. Her standards are high, but she's finding it impossible to work with these standards within the hours she works and with members of her team. I find her hard to deal with - her care is excellent, however its not practical in the busy team she works in. She's got to learn to come to terms working in a busy team. She's giving a Rolls Royce service instead of a 'maestro' service - that's hard to say I know - she's working 10-11 hours a day..."*

Gay revealed her constant contradictory world of being a district nurse manager struggling to balance resources in the face of practitioner demand for resources to maintain standards'. Pru's narrative also exemplified this situation for Maud. Traynor (1994) highlighted how achieving 'caring' brought with it considerable satisfaction but dissatisfaction when it could not be achieved. The district nurses in his study attributed this failure to

"management being out of touch with reality, about the pressure of heavy workloads and the intrusion of paperwork and meetings into their daily work." [p102]

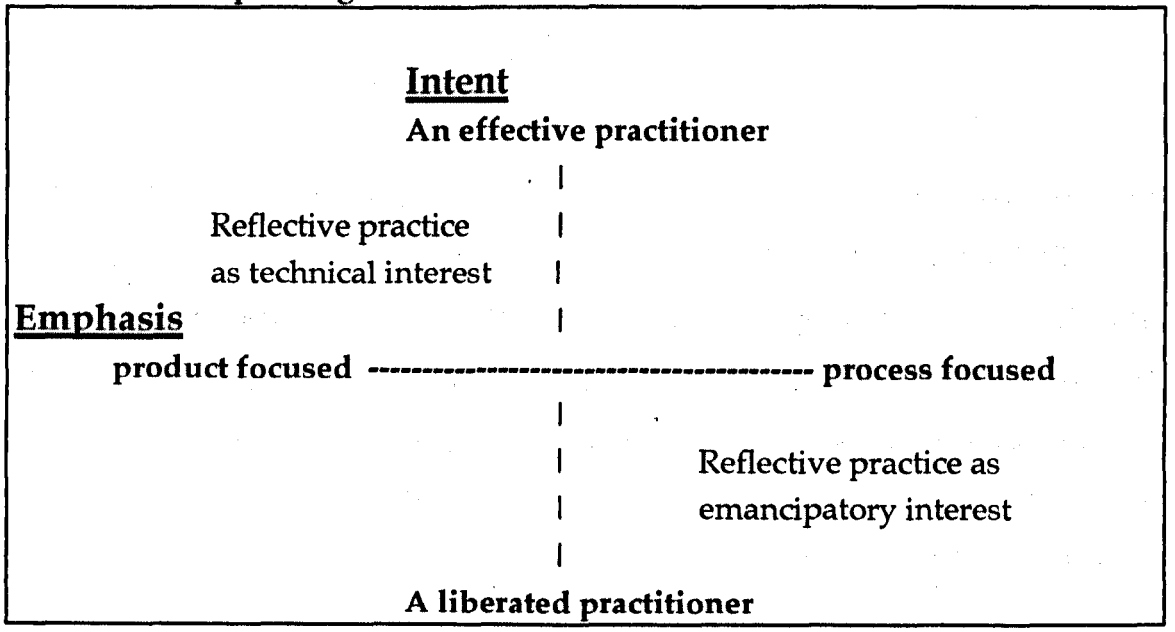
The district nurse supervisors, whilst 'sympathetic' with the practitioners' concerns, had 'managerial' concerns that were potentially adversarial to effective supervision relationships.

Intent - emphasis

The supervisors' concerns influenced their responses to the practitioner in terms of the intent of guided reflection and the emphasis they placed on either process or product. It was evident that this response sometimes presented as a contradiction between espoused intent and response. *The intent factor* is defined as the extent to which the supervisor intended to produce either an effective practitioner [as defined by the supervisor] or a liberated practitioner [as defined as desirable by the practitioner]. *The emphasis factor is* defined as the extent the supervisor was either process or product oriented toward achieving the intent. These two dimensions can be juxtaposed [figure 11.2].

Figure 11.2

The intent- emphasis grid



Habermas's conceptualisation of 'knowledge-constitutive interests' provided a framework to consider the type of work resulting from different positions within the intent-emphasis grid. Habermas differentiated three areas of knowledge based on different interests or intentions as to the purpose of generated knowledge [figure 11.3 - interpreted from various sources; Habermas 1971, Mezirow 1981, Van Manen 1977, Bernstein 1983, Carr and Kemmis 1986].

Figure 11.3

Habermas's concept of knowledge-constitutive interests

The technical	-	concerned with achieving mastery over work situations through technique that can be applied to produce effective outcomes.
The practical	-	concerned with patterns of communication and understanding that constitute and sustain normal relations within a society.
The emancipatory	-	concerned with self-knowledge and how various forces within society act to limit one's own self-interests and fulfilment.

From different knowledge-constitutive interests, guided reflection can be viewed as serving different interests. From the 'technical' perspective, guided reflection was a technology that can be inserted into the workplace to produce an effective worker -that can be monitored against specific criteria of what constitutes effectiveness. From a research perspective, the researcher would be interested in the factors [variables] that aided or hindered this process.

From the 'emancipatory' perspective, guided reflection can be viewed as a liberating structure intending to enable the practitioner to identify and fulfil her own best interests. From a research perspective, the researcher would be interested in understanding the conditions of oppression and the dynamics of liberation from these factors. From the 'practical' perspective, guided reflection was the structure for understanding the patterns of communication and relationships within the wider vision of shared objectives. In other words, depending on intent and emphasis, guided reflection can be framed as a method within any of these perspectives. I am aware of how I imposed guided reflection as a technology towards producing a certain type of practitioner. I am also aware of my attention to collaborative principles towards creating and working towards a shared vision of desirable practice. Whilst still a technology, this perspective shifts the power relations within interests. I am also aware of how reflection exposed the contradictions within practice and how reflection became a liberating structure to resolve these contradictions. From the 'practical' research perspective, guided reflection was the structure for understanding the dynamics of guided reflection, a clearing where the dialectical tensions between technical and emancipatory interests were played out. Hence, as the researcher, I wore all three hats - attempting to mediate between technical and emancipatory interests within the hermeneutic cycle of practical intent.

The dialectical relationship of technical and emancipatory interests is paralleled within the meaning of nursing, whether nursing is fundamentally something that nurses do to patients in response to need, or whether it is fundamentally a process of working with people to help them fulfil their [health] potential as human beings. This dialectic is central to nursing ideology as it struggles to emerge from the shadow of medical domination to define itself. The movement from reflection as technical interest towards reflection as

emancipatory interest is characterised by an increasing level of critique of the conditions under which practice takes place. This critique intends to expose a contradictory world of competing interests and power differentials that must be addressed if desirable work is to be achieved.

Guided reflection as surveillance

An emphasis on producing an effective practitioner was reflected in a more overt judgement of the practitioner's performance. Supervision emerged as a tension of opposing forces -

was supervision really a liberating structure grounded in practitioners' best interests	<---------->	was it really a new, subtle technology of surveillance disguised as the practitioners' best interests ?

Supervision, with its expectation of self-disclosure could be viewed as a control mechanism akin to Foucault's notion of surveillance to produce a self-regulating competent and docile work-force (Dreyfus and Rabinow 1982)[1]. In retrospect, my supervision of supervisors was a balancing mechanism to expose contradictions of emphasis within the therapeutic intent. And yet was the liberation of practitioners really in the supervisors own best interests? Was this intent self-illusory within an ideological pull? Will the technology of guided reflection introduced into an existing surveillance culture become a new subtle form of surveillance? Guided reflection could easily become a new form of oppression - you will think like this, you will feel like this, you will act like this. There was always the risk of supervisors imposing the 'right' values as an alternative hegemony, or in other words replacing one type of ideological

[1] This somewhat summary comment precludes a discussion of how Foucault in his texts Discipline and Punish: The Birth of the Prison (1979) Random House, New York, and The History of sexuality . Volume 1: An Introduction (1980), Random House, New York explore the concepts of 'surveillance' and bio-power, as how power is transmitted through people rather than on people, but always with specific aims. Hence it can always be de-constructed for its purpose.

oppression with another. Mezirow (1981) quotes Habermas's recognition of the problem -

"We are never in a position to know with absolute certainty that critical enlightenment has been effective - that it has liberated us from the ideological frozen constraints of the past and initiated genuine self- reflection. The complexity, strength, and deviousness of the forms of resistance; the inadequacy of mere "intellectual understanding" to effect a radical transformation; the fact that any claim of enlightened understanding may itself be a deeper and subtler form of self-deception - these obstacles can never be completely discounted in our evaluation of the success or failure of critique." (p8)

This understanding set up the paradoxical notion of being oppressed by the very structures of liberation. Freire's (1972) distinction between cultural synthesis and cultural invasion offered a model to reflect on the degree that collaboration had been achieved. Cultural synthesis reflects how the practitioners were enabled to become active participants in resolving the contradictions to achieve their best interests. Cultural invasion leaves the practitioners as passive, despite good intention, to be manipulated within the interests of others. Good intention does not change the status quo or create the conditions of freedom. Power structures are essentially unchanged. Cultural synthesis is reflected in the non-oppressive mutual commitment to resolve the contradiction between ideal and current reality reflected in the co-creation of supervision dialogue.

Who should the supervisor be?

This question has no easy answer, at least within the understandings gleaned from this study. However, a number of advantages for line-management

supervision were evident [Figure 11.4]. Of these, the need for the supervisor and practitioner to share a vision of what was 'desirable' was fundamental .

Figure 11.4

Advantages of line-management supervision

- Working together to realising a shared vision of practice.
- Takes place within the context of known practice - therefore more meaningful.
- Opportunity for manager to pay attention to and fulfil clinical leadership role.
- Opportunity to role model and create desirable role relationships.
- Opportunity to acknowledge and value practitioners.
- Opportunity of mutual understanding and action towards tackling the barriers that limit realising desirable practice.
- Reinforces reflective practice within practice.

It will take other studies where supervisors are not managers to gain different perspectives of this question. Drawing a comparison with supervision in Social Work practice, Kadushin (1985) and Fineman (1985) suggest that social workers do not desire line management supervision *because of* socialised traditional hierarchical roles. From a psychiatric nursing perspective, Rolfe (1990) claimed that many students found it easier to build-up a trusting relationship with someone to whom they were not managerially accountable. However, this did not necessarily mean that line management relationships were not more beneficial than non-line management supervision. Rolfe (1990) believed supervisors should be practicing nurses. He disagreed with Reynolds and Cormack (1987), who argued strongly that the task of supervision should not be undertaken by practicing nurses because nurses may not have the

teaching skills, the time or motivation to teach. All the primary nurse supervisors held joint lecturer-practitioner posts with the local Polytechnic for undergraduate nurse teaching. The district nurse supervisors felt they lacked clinical skills, and consequently felt less secure about their role in facilitating clinical competence in others. However this did not seem a major concern to the practitioners, possibly because they tended to focus on non-technical issues. However the practitioners had no yard stick against which to know effective supervision. In general, the skills of the supervisor were the skills of an effective practitioner. Whether managers have these skills, the time or motivation for this work were significant issues.

Summary

Despite the difficulties the supervisors had with managing their own concerns and the risks inherent within the intent-emphasis tension, guided reflection did create the conditions where collegial relationships could be developed *if* this was desirable. The extent hierarchy was a barrier to disclosure varied depending on the practitioner's previous experience of management, their commitment to practice, existing relationships with the supervisors, their own concerns, and the extent the supervisor facilitated the climate for disclosure.

Chapter 12
Closing relationships and postscript

Closing supervision relationships

"The final supervision session is similar to the termination session with a client, in that it can be an important catalyst for change, not just 'the end'"

[Borders and Leddick 1987 p60/61]

The guided reflection relationships at Windrush had been contracted on an 'open-ended' basis. Gill left on maternity leave. Jade and Myrna left to pursue other employment. I terminated my supervision relationship with Karen and Leslie, as part of managing the research programme. However, they both negotiated continuation of their supervision with Jane, alongside Gayle.

The supervision relationships between the 'I' grade supervisors and practitioners had been contracted for a 12 month period for the research purpose. Except for Brian's relationship with Mary and Maud's relationship with Pru, both of which continued after the contracted research period, these relationships all closed before the 12 month contracted period for various reasons [see Table 12.1 for the closing schedule]. After Jane had left Cairns Unit, her relationships with Jeanne, Abbi and Liz disintegrated. As I have indicated within the previous chapters, these relationships were characterised with a sense of resistance by the practitioners towards Jane's supervision style. After Jane had left, released from a sense of managerial expectation, they collectively decided to quit the programme.

Table 12. 1

Closing schedule

Supervisor	Practitioners	Closure of relationship
Brian	Mary	Continued after the contracted research period.
Jane } @ Cairns } }	Jeanne Abbi Liz	} Closed by Jeanne, Abbi and Liz } after Jane had left - after 11 months of the research period
@ Windrush	Gayle	Continued after the research period
Pat	Rona Lucy	Pat resigned and left Iowa ward after 7 months prior of the contracted research period.
Melissa	Alice	Alice left the Unit after 10 months to take up another nursing position.
Gay	Rachel	Suspended by Rachel 6 months prior to end of the research period.
Maud	Pru	Suspended after 10 months due to Maud's personal circumstances. This relationship was recommenced 9 months later and continued after the research contract had been extended and ended.

Despite her willingness to participate in guided reflection with Gay, Rachel had never felt comfortable with her practice becoming 'visible' for management scrutiny. Eventually she quit the programme. Gay noted: *"Rachel rushed in last time and said I don't want to continue because its just stressing me out etc. which I was half expecting really."*

CJ: *"How did that leave you feeling?"*

Gay: *"A bit mixed really.. relieved in a way. I had felt that I wasn't getting anywhere with her, but on the other hand, you feel disappointed... I could have done it better and she would have got more out of it - and that I wasn't changing her."*

CJ: *"Or helping her to change herself?"*

Gay: *"It had to come from within herself but on the other hand it may be quite good to have a break - that when we get more support for her she will come back into supervision."*

I suggested that Gay did a performance review [IPR] with Rachel to close the relationship on a positive ending. Gay did this and noted [S10]: *"IPR was a very good way of tying up supervision... she was good at identifying her strengths and weaknesses. She was much more positive than I thought she would be. I thought she would rubbish herself but she was confident about her abilities in patient care and thought she was easy to get on with, which wasn't my perception of her."*

When I completed my narrative of Gay's work with Rachel, Gay used this narrative as the means to discuss with Rachel her development from 'our' perspective. This approach was used with all the completed narratives, as the means for ensuring the practitioners 'face validity' with the understanding of their own development. The narratives, like the Reflective Reviews were a way of looking back and making sense of the development that had taken place within the guided reflection relationships. As such, they provided a good opportunity to close each of the relationships in a formal and positive way. In general the practitioners accepted the narratives, with just minor differences of opinion which could be discussed.

Closing

From a personal perspective, and one I felt shared by all the supervisors, it was important for me to recognise the humanness of my relationships with the Windrush practitioners, and to acknowledge that if these relationships did parallel practitioners' desirable relationships with patients and family, then it was natural to expect a similar sense of involvement. Jade and I had spent 23 sessions together over 14 months, We had worked through tremendous emotional turmoil. The need to work through our termination feelings was an

important development of our evolved collegial relationship as it was with all practitioners I had been involved with. Closing needed to be not just a positive experience of looking back to make sense of what has been and looking forward to what might be. It also needed to be an acknowledgement of the emotional nature of our relationship. It was evident, that the unsatisfactory way some of these relationships were closed left supervisors, such as Jane, with a strong sense of frustration. Understanding this frustration reinforced the need to close relationships in positive ways.

Expansion

That all three district nurse supervisors contracted relationships with other nurses whilst still in the research programme strongly suggested how much they valued guided reflection for themselves and for practitioners. Maud [S8] disclosed she was going to enter into a supervision relationship with another practitioner who was: *" weak in her practice and has an 'attitudinal problem'. She has been avoided by everyone in the past 'umpteen' years and now come to the surface. I feel I owe it to her to help her so she can recognise how she is. I said I wanted her to see her every month and use the MSR. - I fedback to her examples of her unsatisfactory practice.. It would be more stressful not to do it"*

Maud had become very conscious of her support role responsibilities. She had seen the possibilities of imposing supervision as a 'solution' for dealing with problem staff although espoused within the intent of supporting and enabling this practitioner. Jane extended supervision at Windrush to include other practitioners. Gayle has now been in guided reflection continuously for four years with Jane. Brian entered into individual supervision with all four primary nurses on his Unit and commenced group supervision with associate nurses. Following his eventual departure, this work was continued by his successor. Both Jane and Brian commenced supervision of other senior nurses, including Pat's replacement following his departure, and also Maud, who felt

she needed her own supervision. Jane also commenced supervision with Maud's job-share partner.

The expansion of guided reflection within the supervisor's practice reflects the significance the supervisors felt about this work. Melissa commented *love supervision - it gives me a sense of the real world - their way of being - you can only do this from where they are at. I also feel nourished, it actually helps when I get on the same level as them and empathise with their practice and feelings - I think I have a real fear that I am going to impose on them.."*

Melissa's comments reflect the *mutual* sense of growth experienced by all the supervisors and a new sense of relating to practitioners with whom they worked with on a more personal, understanding and collegial way. Melissa's comment also reflects her fear of imposing on the practitioners, a new found sensitivity to monitor her own agenda and her own concerns so as not to manipulate supervision to respond to her own agenda or that of the organisation. This was a crucial understanding from the study that will have immense repercussions with the emergence of clinical supervision for nurses as a Government driven agenda. From my own perspective at Windrush, this collegiality was an explicit intention, that emerged as a real achievement. This recognition reflects the *potential* of guided reflection as a model for clinical leadership.

Reflecting-on the significance of the study

In chapter 1, I stated the aims of the project were to:

- Test the efficacy of guided reflection in enabling practitioners to become effective practitioners.
- To make visible and understand the nature of effective work, the essential skills in becoming effective practitioners, and the factors that constrain this development.
- To understand the dynamics of guided reflection that contributed or constrained it's efficacy as a developmental method.

These aims provide a structure to look back and consider the extent each of these aims were achieved and to consider the significance of this work.

- **Test the efficacy of guided reflection in enabling practitioners to become effective practitioners.**

The extent that the 15 practitioners within the study did become effective practitioners was evident through the narratives that were constructed of their guided reflection relationship. Of these narratives, only Pru's narrative was able to be included within the thesis because of space restrictions. Pru was already in many respects an effective practitioner as illustrated in her narrative. The development of use of reflexive narrative constructed through guided reflection as 'evidence' offers a radical new paradigm for considering nursing research concerned with knowing effective practice. This evidence is specific to the practitioner grounded in her practice. Yet it is grounded in valid frameworks that were constructed and continuously tested for their adequacy throughout the four years of guided reflection relationships. These frameworks are now available to other practitioners to know and monitor self development within practice. the evidence base to construct these frameworks has been significant in terms of 15 practitioners across six practice settings.

The most significant framework to be constructed was the Being Available framework. This became the major analytical framework to structure the narratives. Within all shared experience, the extent the practitioner was available to work with the patient towards meeting the patient's needs was very visible. The impact on this availability on effective practice was profound. The significance of this framework in terms of developmental and collaborative research processes became even more significant with the recognition that the therapeutic work within clinical practice paralleled therapeutic work with guided reflection. This recognition was pivotal to the coherence of the research. It is also of major significance to nursing curriculum in acknowledging that curriculum process needs to parallel clinical processes. From this perspective every moment of learning is relevant to becoming an effective practitioner. This is particularly when nursing and nurses explicitly advocate a humanistic and holistic approach to practice. It was also evident that a reflective curriculum enabled practitioners and supervisors to become very sensitive to themselves within the practice situation, leading to a more considered and sensitive approach to decision making and action. This inevitably leads to a challenge to habitualised practice and an openness to information and new ideas.

Understanding the growth of effective practitioners was aided by recognising a pattern of knowing. This pattern of knowing is summarised in figure 12.1.

The pattern was evident within the focus of shared experience and learning. It represents *in broad terms* the pattern of development that took place over time for each of the practitioners to varying extents depending on the openness to self/ and the extent this openness to self was facilitated within the guided reflected relationship. The pattern offers an adequate developmental model for effective practitioners.

Figure 12.1

Patterns of knowing effective practice

Level of knowing	Focus of knowing	Conflict focus and resolution
Knowing Self	Acknowledging that Self is the major therapeutic tool, influenced by who self is - the attitudes, values and concerns that self holds.	Intrapersonal conflict
Knowing therapeutic work	Acknowledging that to know therapeutic work with patients and families is dependent on managing self within relationships.	Interpersonal conflict
Knowing responsibility and knowing others	Acknowledging that therapeutic work does not take place within a vacuum, but within a health care environment that requires collaboration with others and management of finite resources	Interpersonal conflict

The significance of this understanding is that 'knowing self' needs to be strongly focused within curriculum. In this respect guided reflection was a powerful development force because each shard experience was grounded in self, offering the opportunity to explore and know self *within the context* of the particular situation. In other words knowing self is not an idealised knowing. Commentators such as Salvage (1985) have been very critical of nursing education for its failure to prepare nurses to work within an holistic perspective with people who are suffering. The recognition that practitioners had not been prepared to work in holistic ways with families was profound.

Guided reflection was less effective at enabling practitioners to change the conditions under which they practised when these conditions did not facilitate therapeutic work. However, these conditions could be understood and ways of changing these conditions considered and tried out as difficult as it sometimes was. In this context it is important to acknowledge that development was not simply demonstrated at the level of changed practice. It was also demonstrated at the level of understanding and self-esteem, or in other words, in terms of process markers. This reflects how learning through guided reflection was fundamentally a process of empowerment to realise the powerful self and overthrow the embodied barriers that limited the practitioners from taking effective action. However, the individual focus of development made it very difficult for the practitioners to accomplish widespread social change.

Benner (1984) has shown that nurses do become expert, although it is hard to discern from her work *how* expert nurses become expert. Her work does not pay enough attention to the competencies necessary for practitioners to transform the health care environment. It is at this level that real transformation takes place. Many commentators have been critical of nursing education in the way it has prepared practitioners to perceive themselves as essentially subordinate. As Meleis (1985) states

"nursing education has a long history of squelching curiosity and replacing it with conformity and a non-questioning attitude... nursing education prepared nurses to think of themselves as the handmaidens of physicians and the implementors of hospital policy." [p37/38]

The practitioners' narratives highlight how these embodied barriers were chipped away at through the sessions, emphasising again the process nature of developmental work. The significance of this understanding is acknowledged within the pattern of development to focus the practitioner on

deconstructing the conditions of practice and work at ways these conditions might be transformed. In other words, the development of the powerful self; a self who is assertive, with high self esteem, with strongly held values, who is politically oriented and adept at collaborative manoeuvres aimed at confronting and undermining tactics of un-therapeutic actions of others. The development of the Developmental Themes [Appendix 5d] helped to focus this aspect of development. The extent that the practitioners fitted this description was limited, yet the potential was significant within the narratives as evidenced within Pru's narrative.

Learning through reflection was not solely focused on outcomes in terms of changed practice. Using Fay's typology (1987) of enlightenment, empowerment, and emancipation, learning can be viewed as a developmental process. This is a significant insight of the limitations of the study in terms of monitoring development over chronological time. Perhaps another developmental stage would be *un-learning*, considering the extent practitioners had embodied non-therapeutic ways of responding to patients, and did not feel free to take action to change the conditions of practice. For example, Brian noted how well and how quickly other primary nurses had responded to supervision.

CJ: *"Why has guided reflection made so much difference?"*

Brian: *"Part of it is down to me being more knowledgeable about supervision.... she tells everyone how much it has changed her life - she felt it to be very difficult for her - she's 'old school' - doesn't recognise her skills - very much puts herself down - focuses on task allocation - experience where she had to physically stop herself from routinely making a bed - she shares that experience with her team - transferring this to other staff - i.e. challenging and deconstructing tasks."*

- **To make visible and understand the nature of effective work, the essential skills in becoming effective practitioners, and the factors that constrain this development.**

It is axiomatic to state that the development of effective practitioners is always in context of an understanding of what is *effective* practice. The development and analysis of the 'Being available' framework enabled the understanding of effective practice. A strong orientation to work with patients and families towards enabling them to meet their health needs was evident within all practitioners' narratives. Within each shared experience, the practitioner's reflection-on the contradiction between 'what the practitioner was trying to achieve' and 'the way the practitioner responded' created the opportunity to expose and understand the nature of desirable practice and the factors that constrained this work being realised within practice.

The background for this work was the NHS culture. NHS Trusts may not want nursing staff to become empowered and emancipated from existing power relationships. Klakovich (1994) plotted the history of nursing leadership resulting in the present turmoil within the USA health care system. In considering a 'new leadership paradigm' she noted -

"The changes occurring in health care and in the world require a new kind of leadership; flexible networks to replace hierarchies, empowered workers who make their own decisions, and the acceptance of loving and caring as legitimate workplace motivators ... to deal with the stress inherent within the current system, both nursing leaders and caregiver must have the means for renewal in order to care for patients and for each other.' [p49/50]

Klakovich supports her view by drawing on publications within 'Fortune' magazine that highlight how successful businesses are grounded in a similar

philosophy. She exposed the inappropriateness of prevailing health service management systems grounded in anachronistic bureaucratic organisation that is incompatible with achieving its service outcomes in terms of caring for, with and about people. Whilst Klakovich speaks from a USA perspective, I feel the issues she discusses were manifest within this project, in the sense of guided reflection symbolising a new approach to management and a model for clinical leadership. For such 'new' organisations, guided reflection [clinical supervision] will be a compatible and dynamic developmental method. For others, supervision will be implemented as gesture of conforming to the formal expectations set out within the 'Vision of the Future'. Yet, in a clash of cultures, supervision is likely to be 'accommodated' to fit within the existing culture rather than be viewed as a catalyst for changing the culture. However, in theory, supervision has the potential influence to change the organisation. This depends on the supervisors and practitioners. As such, supervision has a bleak future unless the resolve of practitioners and their chosen supervisors can overcome the barriers. Fielding and Llewelyn (1987) challenge the myth that -

"since organisations are made up of individuals that simply by changing individuals things can change... but which ignore the organizational culture which has an enormous capacity to nullify or reject the efforts of those who wish to change existing organizational practices, no matter how unproductive or destructive these practices might be."

Fielding and Llewelyn (1987) draw on Milne (1985) to note evidence from training programmes which consistently indicate that changes brought about in individuals during training are quickly nullified and reversed by their re-entry to the organization "no matter how good the training" [p287]. This suggests that practice based training that tackles organisational culture, as in guided reflection, is necessary to challenge existing cultural practices. Education for

effectiveness would need to focus on deconstructing the norms of practice and working towards creating conditions of practice that facilitate effective work. Yet the meaning of 'effective' work and who defines effective work become significant issues. Caring felt like a sub-culture in the project, pursued within a wider agenda set by organisational and medical practice. Reflection did enable caring to become visible and valued by practitioners. As it became valued it became empowering. I am reminded of the saying 'when ignorance is bliss, it is folly to be wise'. Yet bliss is a folly because it has encouraged nurses to conform to their own oppression and the subjugation of their best interests in caring for others to the will of those who perceive themselves to be more powerful and who have set the health care agenda.

Based on guided reflection, I constructed an educational course - 'Becoming an reflective and effective practitioner', enabling me to work formally with practitioners to learn through their lived experiences towards realising desirable practice. The course, validated through the University of Luton, offers 60 credits at level 3. The course has been validated by the English National Board for Nursing, Health Visiting and Midwifery [ENB A29]. The course has been running for 4 years. Publications of this work, illuminating the developmental significance, are now emerging (Johns and Hardy in press).

The impact on knowing nursing

The contextualised understanding of effective practice is a significant development of *knowing nursing* . The study has illustrated the way knowledge is constructed from lived experience constantly informed by extant theories. Within this process, existing theories from whatever source are assimilated for their relevance and transcended within personal knowing. The significance of this understanding within an agenda of evidence based practice is that it is only through reflection that evidence can be meaningfully assimilated within practice.

Reflection makes visible the nuances of caring for their significance as an integrated whole rather than as specific tasks. For example, the significance of the primary nurse helping the patient to bath emerged as a profound interpersonal activity rather than simply a task. Such insights challenge the wisdom of delegating tasks to unskilled practitioners. The technical aspects of work never emerged as problematic. The value of caring became very visible within the study through the practitioner's shared experience. These experiences reflected how the majority of decision making is intuitive, supporting Benner's assertion that expert practice is characterised by intuition. The significance of intuition is supported. Reflection made the tacit explicit and available as a learning opportunity to develop the intuitive response as evidenced within future experiences. Reflection may be the most significant and possibly the only way to develop intuition.

A further significant development of this study has been to empirically support the reflexive development of the Burford NDU Model: Caring in Practice (Johns 1994). This model offers nurses an holistic and reflective lens to view and respond to practice. Practitioner accounts within the Burford Model book were written by practitioners within the study based on their work within guided reflection. The model is now widely used within practice. A new book based on the Burford NDU Model, incorporating both Leslie's and Karen's narratives [65,000 words], has been completed. Each of the model's assumptions [figure 12.2] have been either constructed from, or supported within the study's findings. This work continues the reflexive process of juxtaposing knowing in practice generated from the study with relevant extant nursing theory towards constructing a reflective and holistic nursing theory.

Figure 12.2

The Burford NDU reflective model: caring in practice - Explicit assumptions (Johns 1998 in press)

- Caring in practice is grounded in a valid philosophy for practice underpinned by the unifying concept of human caring [Watson 1985].
- All persons are seen and responded as unitary human beings [Rogers 1986].
- The intent of nursing is to enable the other towards realising recovery and growth as expanding consciousness [Newman 1994], through appropriate caring-healing responses.
- The nurse works with the other through a continuing advocacy dialogue [Gadow 1980] mirrored by an internal dialogue with self [reflection-within-the moment].
- The extent the nurse can realise caring in practice is determined by the extent she is available to work with the person [Johns 1996]. Being available has six dimensions;
  - Knowing what is desirable
  - Concern for the other [Inside every nurse there is a humanist struggling to get out, committed and active to realise caring in practice]
  - Knowing the person
  - The aesthetic response
  - Knowing and managing self's involvement
  - Creating and sustaining an environment where being available is possible
- Caring in practice is made manifest, known & developed through reflection-on-experience.
- Growth is a mutual process of realisation.
- Caring in practice is a responsive and reflexive form in context with the environment in which it is practised.

- **To understand the dynamics of guided reflection that contributed or constrained it's efficacy as a developmental method.**

This thesis captured a moment in time, as this work is constantly evolving through new studies and developed understandings. The methodology and ontology were grounded in a critical and reflexive phenomenology of lived experience that was changing over time and generating new understanding and actions towards becoming an effective practitioner. My understanding of guided reflection can be expressed as 'a window for practitioners to look inside themselves and know who they are as they strive towards understanding and realising the meaning of desirable work in their everyday practices. This striving is fuelled by the felt conflict of contradiction between what is desirable and actual practice, the commitment that one's practice matters, and through guidance to challenge and support the practitioner's transformative journey towards new horizons of practice'.

To re-iterate, the dynamics of guided reflection were organised within the 'being available' framework, whereby the supervisor is available to work with the practitioner towards enabling the practitioner to meet her or his developmental needs. This understanding paralleled the practitioner being available to work with the patients and family towards enabling them to meet their health needs. Both relationships were essentially viewed as therapeutic. A major limitation to the supervisor 'being available' was the extent that the supervisors' own concerns interfered with the practitioners' development. The supervisors were themselves part of the normal conditions of practice and, as such, struggled to move beyond these normal ways of perceiving and responding to issues despite acknowledging the espoused nature of guided reflection. The new 'collegial' technology of guided reflection was introduced into a prevailing 'hierarchical' health care culture. I made an assumption throughout this project that supervision needed to be based on collegial relationships. The extent of contradiction between collegial and hierarchical

ways of responding was a focus for development within the supervisors' supervision with me. The supervisors as line managers could not be two separate people. The struggle to resolve the tension between these two roles was a strong focus of this work. 'Hierarchy' was the dominant culture with the consequence that supervision was viewed from and accommodated into practice from this perspective. Even when inappropriate ways of responding to practitioners were highlighted and understood, it was difficult for the supervisors to shift their behaviour to be more collegial. This was perhaps most evident within the extent the supervisor responded to the practitioner from either an essentially process or product approach to development. Efficacy was always associated with a process approach, although this required the balance of high challenge with high support. Becoming is a process that is never completed (Bion 1975). A product approach was emphatically counter-productive to development. Beckett (1969) emphasised the need for a process approach to development that linked the personal process of becoming with enabling others to become. He stated

"We are entrusted by our patients with their needs and their hopes. Impossible or not, our task is to help them become all that they are capable of becoming. If we have not met our responsibilities to ourselves, we cannot be capable of sharing the responsibility for another's becoming." [p170]

Guided reflection was a process of mutual development for supervisors and practitioners. Supervisors also required their own supervision to give them feedback to 'know themselves'. With the benefit of this *vision*, some supervisors were able to change their supervision style, whilst others struggled to move beyond normal ways of responding to practitioners, reflecting how deeply embodied ways of responding were resistant to change despite espoused intent and rational understanding to the contrary.

The emergence of clinical supervision

Since the project commenced, the NHS Management Executive published in 1993 'Vision for the Future' which has targeted clinical supervision, as one of 10 key targets within a blueprint for the future of nursing. This has formally established clinical supervision within nursing's agenda. The Chief Nurse stated in her CNO Professional letter 94(5)-

" I have no doubt as to the value of clinical supervision and consider it to be fundamental to safeguarding standards, the development of professional expertise and the delivery of care."

The document defined clinical supervision as

"a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills." [p3]

This initiative to implement clinical supervision has been influenced through a commissioned position paper from the University of Manchester. The authors, Faugier and Butterworth (undated- but published in 1994), draw heavily on a psychotherapy and counselling literature to establish the foundation of supervision for nursing. They pay little regard to supervision in other disciplines, for example social work and education. Within this paper they establish Proctor's key functions of supervision as the objectives of supervision for nursing [figure 12.3].

Figure 12.3

Proctor's functions of supervision

Formative	-	developing therapeutic competence
Restorative	-	sustaining therapeutic competence
Normative	-	safeguarding standards of care

There is an inherent tension within these functions between the formative/ restorative functions and the normative. Faugier and Butterworth report the normative function as -

"the crucial quality control element which is absolutely essential in all work with people. Even the most experienced nurse will have inevitable blind spots, human failings, areas of vulnerability and woundedness from her internal and external world, prejudices of which she may remain blithely unaware. This aspect of the model emphasises the fact that when someone becomes a supervisor, he or she is duty bound to ensure that the highest professional standards of nursing are upheld and that the policies and procedures of the authority are followed." [p18]

This strong interpretation of 'normative' might suggest the primary objective of supervision is controlling the quality of work. If this manifests, then clinical supervision will lean towards the technical interests rather than the emancipatory. From my work within the study, an emphasis on the 'normative' would be misguided. Practitioners were always suspicious of being judged. And yet the statement within the "vision' definition of clinical supervision on 'encouraging self-assessment and .. reflective skills' suggests the practitioner's responsibility to monitor and ensure her own effectiveness. This interpretation fits within my own vision of the effective practitioner. Practitioners such as Pru, Leslie, and Karen easily accepted this role in completing their reflective reviews with the support of their managers. Yet if the line manager is not the

supervisor, then how will the normative function be addressed in any adequate way? Faugier and Butterworth do not acknowledge this potential tension. If they had drawn on the social work literature they would have observed the reluctance of social workers to be supervised by their managers, reflecting how managers in social work have tended to emphasise the managerial function (Fineman 1985, Kadushin 1985, Satyamurti 1981, England 1986, Stevenson and Parsloe 1978) to ensure practitioners work in specific ways. From this perspective introducing supervision may *reinforce* managerial control rather than facilitate change. The UKCC response to clinical supervision (UKCC 1996) has suggested that supervision should avoid 'the perception or actuality of management imposition' [p4]. This position sets up a tension between supervision being essentially a managerial initiative or a professional initiative. Organisational response may be softened by a rhetoric of professional support development, yet the potential of clinical supervision to be a new subtle surveillance technology to monitor and control practitioners was clearly evident within the study. Of course time will tell.

The 'Vision for the Future' document also identified the development of clinical leadership as another target area. The narratives indicated the significance of guided reflection as a means for clinical leaders to fulfil clinical leadership roles. As such, line management supervision is an ideal model, yet it is the characteristics of individual supervisor that are all important. Despite its ideal nature what will happen when it is assimilated into a power differentiated hierarchy as characteristic of most health care organisations? In my subsequent research working with NHS Trusts as an external supervisor/ researcher [see bibliography -appendix 7] I identified four key variables of clinical supervision [figure 12.4].

Figure 12.4

Key variables within supervision models

Line management	<----->	Non- line management
Individual	<----->	Group
Voluntary	<----->	Compulsory
Single profession	<----->	Multi-profession

My approach to supervision within the study fitted the left side of figure 12.4. My subsequent research has enabled me to contrast these variables. Although the insights gained from these subsequent studies are outside the scope of this thesis, the insights gained from this study have significantly informed the debate for the successful implementation of an effective clinical supervision strategy. Constructing a technology of clinical supervision will be a major issue for nursing and nurses over the coming few years.

The emergence of reflection within nursing education

Prior to the emergence of clinical supervision, reflection has become increasingly topical within nursing education since the study commenced. Yet, as I found, the existing literature offered few guidelines as to incorporate reflection within curriculum. The frameworks developed within the study offer profound insights for others to consider in implementing reflection within nursing curriculum. Reflection has the potential to integrate the curriculum around the students' experience. Theory would then be fed-into the guided reflection groups and the student guided to assimilate sources of knowledge within personal knowing towards developing constructed knowledge. However this approach will have profound implications for the teacher and teacher development. Such re-conceptualising of the curriculum goes against the grain of an increasingly modularisation and consequent fragmentation of the curriculum. As such, the accommodation of reflection will

inevitably present as a contradiction. The risk is that reflection will simply viewed as another learning technology and itself modularised.

Besides the 'Being available' framework, the study led to the development of other significant reflective learning frameworks that have since gained widespread acceptance within nursing education. These are the Model of Structured Reflection and the Framing perspectives. The Model for Structured Reflection is an heuristic device to enable practitioners to know the breadth of reflection. It offers an answer to the question- 'how can I know how to reflect?' The Framing Perspectives are lenses or layers to view and focus on discrete aspects of learning through reflection yet without distracting from the whole.

Limitations of the study

The reflexive nature of the study meant that the research was always a learning process. The approach to the study was always consistent in terms of learning through reflection both the development of clinical practice and the development of guided reflection. As such, I would undertake the research again in a similar way. In this respect the study does not have limitations or weaknesses. Subsequent research will build on this foundation.

The major dilemma was to know how best to present the work. The development of the meta-narratives resulted in the individual narratives becoming a second level of analysis. Clearly, a thesis of 400,000 word would have been unacceptable. Consequently some of my original intentions of the work were not adequately presented in the final thesis. However, as I noted, Leslie and Karen's complete narratives have been incorporated as empirical evidence within a new book based on developing a reflective and holistic model for nursing. The experiences of practitioners have already been utilised to support a host of publications based on this study [see appendix 7].

The lack of my own supervision of supervising practitioners might be construed as a limitation. As I have noted, I became aware of this. Whilst to

some extent the process of co-creating meaning with practitioners off-sets any tendency to impose meaning, I was conscious of being a very powerful influence on the way meaning was co-created. My response to this criticism is to establish a research programme whereby I supervise both the developmental and research processes working with practitioners who research themselves within the context of their own practice towards achieving desirable and effective practice. This is a very exciting and significant development.

Final words

Karen - *"As I've said - my diary wasn't brilliant but my supervision was."*

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Appendix 1

Supervision Styles Inventory [c/f Cherniss & Egnatios 1977]

This questionnaire intends you to reflect on the supervisor's style in context of your perceived preference.

1. Please mark on **SCALE A** - the extent your supervisor actually resembled the description in each paragraph below.
2. Please mark on **SCALE B** - the extent you would have liked your supervisor to resemble the descriptions in each paragraph below.

Description	Most resembles	Least resembles
Didactic-consultative - Supervisor offers advice, suggestions and interpretations concerning patients' dynamics and clinical techniques.	----------	A
	----------	B
Insight-oriented - Supervisor asks questions designed to stimulate the supervisee to think through and solve problems on her own.	----------	A
	----------	B
Feelings-oriented - Supervisor encourages the supervisee to question emotional responses to the clinical process.	----------	A
	----------	B
Laissez-faire - Supervisor leaves the supervisee alone most of the time and is rarely available for consultation on work problems.	----------	A
	----------	B
Authoritative - Supervisor allows the supervisee little autonomy; the supervisee is told what to do and how to do it.	----------	A
	----------	B

Appendix 2

Balance of challenge and support scale

This scale is designed to enable the supervisee to score their perception of balance and support, and to give feedback to the supervisor towards improving this balance.

Score each dimension of challenge and support 1-10.
Use the 'Notes' to identify particular strengths and weaknesses of your challenge and support.

High challenge

10
9
8
7
6
5
4
3
2
1

Low support — 1 2 3 4 5 6 7 8 9 10 — High support

Low challenge

Notes:

Appendix 3
Profile of practitioners

Windrush

Gill

Gill was appointed as an associate nurse at Windrush in May 1989. She was in her middle 20's and had been qualified 2 years. She was married with no children. Her only previous post since qualifying had been as a staff nurse within a large general hospital.

Jade

Jade commenced work as a full time primary nurse in September 1990. She had previously been employed at Burford as a part-time district nurse. Prior to this she had worked as a staff nurse on a plastic surgery unit for 12 months after converting from SEN to SRN. She had previously been qualified 5 years as a SEN.

Myrna

Myrna commenced work at the hospital as a primary nurse in September 1990. For the previous six years had worked as a G grade sister on a medical ward. She had left this post for distressing personal reasons. She was attracted to work at Burford because she was interested in primary nursing and felt that 'supervision' offered the kind of support she needed to 'rehabilitate' herself to nursing.

Myrna agreed she would enter into guided reflection, but I had not envisaged her participating in the project. After 6 sessions, I realised this was a missed opportunity. Although the supervision notes of the first 6 sessions were brief, they were adequate for analysis.

Karen

Karen commenced work at Windrush in September 1991 as an associate nurse after completing her BNursing degree. She was 23, unmarried, although engaged. On interview she expressed great enthusiasm for Windrush's philosophy for practice - "*it is how I want to practice as a nurse.*"

Karen was initially supervised by Jade as part of a programme to cascade guided reflection within the unit. However, after two sessions Jade left. I then became Karen's supervisor. After I left in December 1991, I continued to supervise Karen as an 'external' supervisor for a further period of 16 months.

When the new manager and clinical leader commenced in April 1992, Karen chose to continue supervision with me, which was acceptable to all parties.

Leslie

Leslie was in his middle 30's. He had initially qualified as a SEN and then converted to RGN two years prior to commencing his primary nurse post at Windrush in September 1991. This was his first primary nurse post. He was unmarried.

Gayle

Gayle was 26. She commenced working at Windrush in January 1992. This was her first primary nurse post. Previously she had worked within team nursing on an acute medical ward. She was unmarried.

CAIRNS UNIT

Cairns Unit is a rehabilitation and respite care unit within a general hospital for physically disabled people. Jane had been in post as senior nurse for many years.

Abbi

Abbi was 25. She had been in post about 3 months as a primary nurse prior to commencing guided reflection with Jane. This was her first primary nursing post. She had previously worked as a staff nurse on an elderly care unit.

Jeanne

Jeanne was 23. She agreed entered into a guided reflection relationship with Jane in November 1991. She had been working on the unit 10 weeks as an associate nurse role. Previously she had worked as a staff nurse on an cardio-thoracic unit for 12 months since qualifying as an RGN.
Jeanne found working on Cairns Unit a stark contrast to her previous work. She expressed a very positive attitude to this shift in her career.

Liz

Liz had worked on Cairns Unit for several years, first as an associate nurse and latterly as a primary nurse. Hence, unlike Abbi and Jeanne, she was an experienced practitioner. She was in her late 30's , married with children.

OMAHA HOSPITAL

Omaha hospital is a 30 bedded community hospital. Brian had been appointed as a clinical development nurse and lecturer practitioner a year previously.

Mary

Mary is 26. She had worked as a primary nurse for 17 months. Previously she had worked on the unit as an associate nurse for 9 months. She had been qualified for 31/2 years.

IOWA WARD

Iowa ward is an elderly care ward within a large community hospital which had implemented primary nursing some years previously. Rona and Lucy had been appointed as primary nurses, both being very experienced. Pat was appointed as charge nurse 18 months previously. The ward has been a very traditional elderly care ward.

Rona

Rona was 48. She had returned to nursing after bringing up her family. She had been in post since August 1980, initially as a part time staff nurse and then as a full-time F grade primary nurse since 1988.

Lucy

Lucy was 51. Since returning to nursing she had worked as part time night sister between 1982-8. She was appointed as a full-time primary nurse F grade in 1988.

DISTRICT NURSING

Pru

Pru was 30. She was unmarried. She has been qualified as a district nurse for 4 years. Her narrative has been included in the thesis to illustrate an individual narrative [chapter 4].

Rachel

Rachel is about 50 years old. She is very experienced although returning to district nursing some years previously after her divorce.

Alice

Alice was in her early 30s. She was a district nurse, team leader and newly appointed clinical practice teacher [CPT]. She married during the research period.

Appendix 4
Monitoring effectiveness tools

This appendix includes a number of evaluation tools that were eietehr constructed from the analysis of supervision dynamics, or adapted from existing tools, to evaluate the supervision process:

4a - Supervision questionnaire (Hawkins and Shohet 1989).
4b - Supervision Evaluation Questionnaire [SEQ].
4c - Adapted Bernard Supervisor Rating Scale.

Appendix 4.a

Supervision Questionnaire' (Hawkins and Shohet, 1989)

Gill's completed Supervision Questionnaire is shown

Questions to help you consider ways of being more pro-active about your support and supervision:

1. What are the strengths and weaknesses of your present support system? What do you need to do about improving this?

Strengths	-	*bring to light incidences to work through*
	-	*enable an overview of coping*
	-	*examine out of the situation*
	-	*let off steam!*
Weaknesses	-	*often things occur which need to be discussed sooner than next session*
	-	*effectiveness depends on motivation*
	-	*often viewed with suspicion by care assistants*
Improvement	?	

2. How do you recognise you are under stress? What ways do you use to alleviate this stress? Do these coping mechanisms provide just short term relief or do they change the cause of the stress?

   Rush around. Curt with colleagues. Don't sleep. Get earache! Talk it through mainly with husband. Occasionally care assistant I'm on duty with in evening. Phone other in evening. Put in diary. Short-term measures.

3. What are your specific needs from supervision and how far do your present supervisory arrangements meet them?

   To feel supported and be able to talk through problems. Feel I'm not the only one people 'dump on'. Occasionally feel 'let down' by supervision sessions; mostly though they help.

4. Do you need to re-negotiate the contract with your supervisor? Make as many of the transactions and assumptions as explicit as possible. Are you and your supervisor clear about the purpose of supervision?

   Continue to evaluate and assess session, therefore improve understanding of the benefits/weaknesses.

5. Are there additional forms of supervision (for example, peer supervision) that you need to arrange for yourself?

   Peer support group would have been good–had good beginning but atmosphere not right at the moment.

6. How open do you feel to supervision and feedback? If not are there personal changes you could make to open up the communication?

   Feel I've changed a lot. More open. Still wouldn't like taped sessions but talking much easier.

7. Are you frightened of being judged and assessed? Have you tried checking out whether your fears are justified of phantasy?

   Mostly not–worse by peers. Not fiercely protective of work.

8. Can you confront your supervisor and give him or her feedback? If not, are the constraints internal or external?

   Occasionally feel like it but haven't so far. Both internal and external constraints. My own personality and ideas of traditional nursing hierarchy. External difficulty to track [supervisor] down.

9. Are you stuck in blaming others for what you yourself can change?

   Try not to. Difficult to approach others. Minimal success with this on occasions.

10. Do you carry some of the supervisor's anxieties, so that you have to look after them?

    Don't think so. Often I'm the one approached by care assistants to sort things out via informing [supervisor].

11. Is it feasible to have a more equal relationship? How far is it appropriate and is it what you want, given that more equality means more responsibility?

    Own internal ideas prevent more equality. Wouldn't feel comfortable.

Appendix 4.b

Gayle's supervision Evaluation Questionnaire [revised/2]

Please answer carefully the following series of scales. After each scale please comment descriptively on your score:

---

1 Supervision was very supportive for me —/— Supervision was not supportive for me

Comment:
But at the same time sometimes stressful. But it validated my stress so did not undermine me.

2 The environment where we met was conducive for supervision —/— The environment where we met was not conducive for supervision

Comment:
Sometimes I experienced a personal difficulty leaving the ward -i.e. making supervision a priority above the current patient care needs.

3 I felt my supervisor was open and authentic with me —/— I felt my supervisor was closed and defensive with me

Comment:
Initially I felt very threatened by supervision. The openness and authenticity of both supervisors helped me work through this difficulty.

4 I felt safe to talk about my experiences with my supervisor —/— I felt I couldn't talk about some things with my supervisor

Comment :
Knowledge that the session was confidential helped. I later came to appreciate how knowledge gained by the supervisor from one session might help facilitation of a problem with the parties concerned. This is only possible where supervisees feel able [safe] to be honest about their experiences.

5 I was worried confidentiality would be broken —/— I was confident confidentiality would not be broken

Comment:
Initially I was, but this ties in with my initial feelings of being threatened.

6 Reflecting-on critical incidents was an excellent way to develop my work ——/—— Reflecting on critical incidents failed to help me develop my work

Comment:
Reflection has helped me to be more open to my colleagues to help me develop my work. However, it continue sto be difficult to accept criticism from others - reflection enables me to take this on board, even if it is a day or two later.

7 I felt my supervisor manipulated the content of the sessions ——/—— I didn't feel my supervisor manipulated the content of the sessions

Comment:
My supervisors both allowed me to lead the session. If Jane had a particular issue to discuss during the session, she stated explicitly at the end of the session - if I had nothing further to discuss.

8 I felt supervision was an intrusion into my privacy /—— Supervision didn't intrude into my privacy

Comment:
Supervision for me has been about my work and development within my work. As I lead the session, the discussions centred on issues concerning work. Neither supervisor questioned beyond this central theme.

9 Supervision has helped me cope with stressful work. ——/—— Supervision hasn't helped me cope with stressful work

Comment:
Supervision has itself been stressful, in that I have been facilitated to confront stressful issues and assume responsibility towards their resolution, e.g. issues relating to colleagues.

10 My supervisor was primarily concerned with evaluating my performance ——/ My supervisor was primarily concerned in supporting and helping me develop than evaluating me

Comment:
Jane, as manager and supervisor cannot escape using the insight she gained to evaluate my performance. However, I felt the primary concern was to help me develop and feel safe to do so.

11 Supervision felt an effective way to prepare me for my primary nurse role ——/—— Supervision is not an effective way to prepare nurses for primary nurse roles.

Comment:
Supervision, as I have experienced it, is very supportive in growing into the primary nurse role, where the primary nurse is in danger of feeling isolated and being identified as such.

12 Keeping a diary was difficult. ——/—— Keeping a diary was no problem

Comment:
Keeping a diary require self-discipline which sometimes slips. But the activity is valuable in developing at work.

13 *1 The supervision helped me focus on relevant issues ——/—— The diary didn't help me focus on relevant issues

Comment:
Definitely - underlying issues often surfaced that are not immediately identified.

14 I learnt to cope more effectively with work ——/—— I didn't learn to cope more effectively

Comment:
Reacting at work seems to be a way of working as things occur. Developing as a proactive nurse seems to increase the work-load and does not take the stress out of the human issues involved. Being proactive is not always supported by colleagues as they do not always see why I might be working in one direction, e.g. visits to respite care patients at home.

15 I felt like a guinea pig ——/—— I didn't feel like a guinea pig

Comment:
I felt supported

16 Supervision is a strong motivator for personal growth — Supervision hasn't motivated my personal growth

Comment:
Supervision stimulates questioning

17 I am now much more aware of my weaknesses and strengths — I am no more aware of my weaknesses and strengths

Comment:
Each new situation however exposes new areas of strength and weakness.

18 I didn't look forward to the sessions — I always looked forward to the sessions

Comment:
Sometimes I didn't feel I had anything to discuss - or I was in the middle of situations where I was not ready to open up to my supervisor. problems with colleagues I found threatening and did not look forward to discussing them, although I knew I could not escape them.

19 *2 I am now able to get valid feedback about my work — I am not able to get valid feedback about my work

Comment:
I get more valid feedback, but my colleagues are not always willing to provide accurate feedback, even when directly requested.

20 Supervision was awkward to fit in with other work — Supervision fitted in easily with day to day practice

Comment:
Sometimes it did not feel appropriate to leave the ward

21 Collecting critical incidents became easier over time — Collecting critical incidents was always difficult

Comment:

Critical incidents are more easily identified following the end of the whole situation. I am identifying ongoing critical incidents but not all of them.

22 My ability to make good decisions is now excellent ——/—— I haven't learnt to make better decisions at all

Comment:
My decision making is better and I feel I can account for my decisions. I try to involve my colleagues in decision making. I'm aware however, that I don't always do this and that this then interferes with effective team work.

23 I am now always assertive in my work ——/—— I am unable to be assertive when I need to be

Comment:
I am becoming more effective in being assertive.

24 I feel like a second class primary nurse ——/—— I feel like a first class primary nurse

Comment:
I feel I still have the potential to develop further.

25 I am able to confront my colleagues in a positive way ——/—— I am unable to confront my colleagues in a positive way

Comment:
Sometimes I confront my colleagues in a too direct manner. I am, however, not aware that I confront them in a negative manner.

26 I am not stressed by work ——/—— I am stressed by work

Comment:
The nature of the work is stressful! When the team works cohesively stress is however noticeably less, even when the work is very demanding.

27 Supervision was a difficult role to fit into ——/—— Supervision was an easy role to slip into

Comment:
The difficult bit was fitting it into the rest of priorities at work.

28 I could challenge my supervisor if I didn't agree with his/her comments —/— I found it difficult to to challenge my supervisor's comments

Comment:
I feel supervision is a two way channel. To get the most from the session, the supervisee and supervisor need to feel equal.

29 I think my supervisor wanted me to be his/her clone —/— My individuality was enabled to blossom

Comment:
Yes- I have felt more self-assured and to develop my strengths in a way I feel comfortable.

30 I feel I am now an effective primary nurse —/— I am not yet an effective primary nurse

Comment:
Certainly more effective than February 1992, although as stated earlier, I still believe I have the potential to develop further.

31 I was increasingly able to control the content of the supervision sessions —/— I wasn't able to control the content of the supervision sessions

Comment:
Both supervisors enabled me to lead the sessions

32 Supervision was excellent at helping me reflect on my work —/— Supervision didn't help me reflect on my work

Comment:
It introduced another perspective. The sessions were not interrupted, as discussions so often are on the ward.

33	The input of theory in supervision made sense with my practice	/———	Theory input into supervision was largely meaningless

Comment:
Theory was introduced as a way of expanding/ explaining an issue being discussed.

Notes:
*1 Gayle interpreted this as 'diary' rather than supervision. Other practitioners either didn't pick it up or interpreted it as supervision.

*2 This was an ambivalent question. Gayle interpreted this as valid feedback from her colleagues. This could have been interpreted as from her supervisor.

Appendix 4c

Adapted Bernard Supervisor Rating Scale

[adapted from Bernard 1981 revised]

Name of supervisor .....

Name of practitioner .....

Date of evaluation .....

Please consider carefully each of the following 46 criteria designed to evaluate the supervisor's performance. Mark on the scale 1-7 your agreement or disagreement with your supervisor's performance.

NB : 1 - strongly disagree
7 - strongly agree

Please be as honest as you can - it is aimed to give the supervior feedback of his/her performance, to enable him/her to focus on areas of their own development as a supervisor.

	strongly disagree						strongly agree
1 Enables me to be open and authentic during supervision	1	2	3	4	5	(6)	7
2 Helps me feel at ease with the supervision process	1	2	3	4	5	(6)	7
3 Makes supervision a constructive learning experience for me	1	2	3	4	(5)	6	7
4 Provides me with specific help in areas I need to work on	1	2	3	4	(5)	6	7
5 Addresses issues relevant to my current concerns as a nurse	1	2	3	4	5	(6)	7
6 Helps me focus on new alternative interventions that I can use with my patients	1	2	3	4	(5)	6	7

	strongly disagree						strongly agree
7 Helps me focus on how I use myself with my patients	1	2	3	4	5	6	(7)
8 Encourages me to try alternative intervention skills	1	2	3	4	(5)	6	7
9 Structures supervision appropriate to my needs	1	2	3	4	(5)	6	7
10 Adequately emphasises the development of my strengths and capabilities	1	2	3	4	(5)	6	7
11 Enables me to brainstorm solutions, responses, and techniques that would be helpful in future nursing situations	1	2	3	4	(5)	6	7
12 Enables me to become actively involved in the supervision process	1	2	3	4	5	6	(7)
13 Makes me feel accepted and respected as a person	1	2	3	4	5	6	(7)
14 Deals appropriately with my feelings and emotions that have arisen as a consequence of my work	1	2	3	4	5	(6)	7
15 Picks me up when I feel overwhelmed	1	2	3	4	5	(6)	7
16 Motivates me to assess my own nursing behaviours	1	2	3	4	5	6	(7)
17 Conveys competence	1	2	3	4	5	(6)	7
18 Is helpful in critiquing written work	1	2	3	4	5	(6)	7
19 Appropriately addresses interpersonal dynamics between us	1	2	3	4	(5)	6	7
20 Willingly accepts my feedback of his/her performance	1	2	3	4	(5)	6	7
21 Helps reduce my defensiveness in supervision	1	2	3	4	(5)	6	7

	strongly disagree						strongly agree
22 Is open and authentic with me	1	2	3	4	5	(6)	7
23 Enables me to express opinions questions, and concerns	1	2	3	4	5	(6)	7
24 Prepares me adequately for our next supervision session	1	2	3	4	5	6	7
25 Helps me clarify my objectives in working with my patients	1	2	3	4	(5)	6	7
26 Provides me with the opportunity to work through major difficulties I am facing with my patients or colleagues	1	2	3	4	5	(6)	7
27 Uses his humour well	1	2	3	4	5	(6)	7
28 Motivates me to constantly strive to develop effectiveness	1	2	3	4	5	6	(7)
29 Challenges me to accurately perceive the thoughts, feelings and goals of myself and patients during nursing situations	1	2	3	4	(5)	6	7
30 enables me to discuss personal concerns related to work	1	2	3	4	(5)	6	7
31 Is flexible enough for me to be be spontaneous and creative	1	2	3	4	(5)	6	7
32 Focuses on the implications and consequences of specific behaviours in my nursing approach	1	2	3	4	5	(6)	7
33 Provides suggestions for developing my nursing skills	1	2	3	4	5	(6)	7
34 Uses appropriate learning methods within supervison	1	2	3	4	(5)	6	7
35 Helps me define and achieve specific concrete goals for myself during the supervision relationship	1	2	3	4	(5)	6	7
36 Gives me useful feedback about myself and my work	1	2	3	4	5	(6)	7

	Strongly disagree						strongly agree
37 Helps me organise relevant case data in planning care with my patients	1	2	3	(4)	5	6	7
38 Helps me develop increased skill in analysing critical incidents from my reflective diary	1	2	3	4	(5)	6	7
39 Helps me focus on areas of my work to reflect upon	1	2	3	4	5	(6)	7
40 Encourages me to evaluate myself	1	2	3	4	5	(6)	7
41 Has the gift of saying the right thing at the right time	1	2	3	4	(5)	6	7
42 Strikes the right balance between evaluation and support during supervision	1	2	3	4	(5)	6	7
43 Evaluates my work fairly	1	2	3	4	5	(6)	7
44 Demonstrates accurate empathy with my work situations	1	2	3	4	5	(6)	7
45 Helps to make the supervision sessions safe for me	1	2	3	4	5	(6)	7
46 Introduces theory into supervision appropriately	1	2	3	4	5	6	7
47 Inspires me with his optimism	1	2	3	4	5	6	(7)
48 easily identifies significant issues within my reflective incidents	1	2	3	4	5	(6)	7
49 Fills me with courage to face the future	1	2	3	4	5	(6)	7

Please make any specific comment -

Dinah has, like myself, been learning about supervision / supervisee. She has been a great help We both agreed I could have been challenged more but we I feel I have learnt a lot about myself as a professional

cj /SUPEVAL.1 File /PhD Disk /July 1991

Appendix 4d

Comparison with ratings beween the SEQ and the Bernard Supervisor rating

Table A4.1 sets out the comparative rating of practitioners using the SEQ. Table A4.2 is constructed from the SEQ ratings that focused on the process of supervision.

Table A4.2
Practitioner perceptions of supervision dynamics within the SEQ

SEQ	2	3	4	5	7	8	10	18	27	28	29	31	Ave
Gill	1.8		2.4	3.5	3.9	6.6		5.3	7.5			3.5	
Myrna	2.6	2.4	9.7	9.8	8.9	9.2	9.9	7.8	8.2	9.3	6.1	8.9	7.7
Jade	8.7	9.7	9.7	8.8	8.6	9.5	8.6	8.7	9.0	9.4	8.8	9.6	9.1
Karen	5.4	8.1	8.2	8.0	5.0	9.2	8.8	8.3	8.3	8.8	6.0	9.3	7.8
Leslie	9.5	9.0	9.0	9.5	7.6	10	9.6	5.5	10	9.0	8.6	9.5	8.9
Gayle	9.0	9.3	9.5	9.5	9.0	9.5	7.2	5.2	5.6	9.0	9.0	8.8	8.2
Abbi	5.5	8.7	8.6	8.5	7.0	9.4	8.4	0	0.5	8.0	8.0	3.6	6.4
Jeanne	0	1.5	0	0	7.0	0	10.0	0	0.5	0	9.0	10	3.2
Rona	3.7	9.0	8.0	6.0	4.3	8.0	8.0	5.0	8.0	7.0	8.0	8.7	6.8
Lucy	10	6.5	10	8.0	7.0	5.0	9.0	2.0	0.5	10	4.3	5.8	6.5
Rachel	3.0	8.8	4.9	2.0	8.7	5.0	9.0	1.4	0.4	9.5	8.0	9.5	5.8
Alice	7.0	7.5	7.8	4.5	6.8	3.0	7.0	4.2	6.5	7.0	6.0	7.5	6.2
Pru	4.6	8.6	7.0	7.3	7.5	9.0	10	6.6	7.5	5.3	8.6	6.0	7.3

Based on these results I would judge that :

< 8.0 - excellent supervision milieu
< 7.0 - good supervision milieu
< 6.0 - adequate supervision milieu
> 6.0 - inadequate supervision milieu

Table A4.3 sets out the comparison between total SEQ ratings, supervision process SEQ rating scores, and total Bernard supervisor ratings.

Table A4.1
Supervision evaluation questionnaire [SEQ] perceptions

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	Ave
Gill	6·3	1·8		2·4	3·5	7·6	3·9	6·6	2·4		6·0	5·0	5·1	4·6	8·1	5·1	9·2	5·3	5·9	0·5	9·4	7·8	5·0	3·2	5·8	0·4	7·5				3·5	8·0		
Jade	9·0	8·7	9·7	9·7	8·8	8·6	8·6	9·5	8·9	8·6	9·6	0·1	8·6	8·7	9·0	9·2	8·7	8·7	9·7	9·6	7·5	7·1	8·3	7·1	7·5	5·0	9·0	9·4	8·8	8·8	9·6	6·8	7·9	8.2
Myrna	10	2·6	2·4	9·7	9·8	9·3	8·9	9·2	9·6	9·9	7·4	4·4	9·6	9·6	9·8	9·8	7·7	7·8	8·9	2·3	5·7	8·4	8·3	–	2·6	8·8	8·2	9·3	6·1	8·6	8·9	9·3	9·5	7.9
Karen	10	5·4	8·1	8·2	8·0	9·5	5·0	9·2	10	8·8	–	0	–	7·0	10	10	5·3	1·4 9·3	7·6	1·7	5·4	5·5	7·0	–	7·5	6·7	8·3	8·8	6·0	–	9·3	10	8·0	7.4
Leslie	8·8	9·5	9·0	9·0	9·5	10	7·6	10	10	9·6	10	5·4	8·5	8·8	7·5	9·5	9·0	5·5	6·5	5·3	9·0	6·5	4·5	9·2	4·8	6·2	10	9·0	8·6	–	9·5	6·2	7·0	8.1
Gayle	9·0	9·0	9·3	9·5	9·5	7·5	9·0	9·5	5·2	7·2	8·6	5·3	9·0	5·2	9·0	9·0	7·2	5·2	6·0	4·8	5·0	5·6	6·7	7·0	7·2	3·0	5·6	9·0	9·0	6·7	8·8	9·2	8·8	7.4
Abbi	7·1	5·5	8·7	8·6	8·5	9·0	7·0	9·4	2·2	8·4	5·0	0·8	4·0	5·2	1·0	9·5	9·5	0	2·0	7·2	0·5	8·6	7·0	5·0	1·0	5·0	0·5	8·0	8·0	3·6	8·2	8·8	8·8	5.8
Jeanne	3·0	0	1·5	0	0	10	7·0	0	2·7	10	7·7	0	10	0·7	0	8·8	10	0	10	10	1·5	7·8	8·8	–	9·2	10	0·5	0	9·0	–	10	10	10	5.4
Rona	7·0	3·7	9·0	8·0	6·0	9·3	4·3	8·0	8·3	8·0	5·0	10	8·0	6·8	8·0	10	8·6	5·0	8·6	0	7·0	8·6	8·3	10	10	3·4	8·0	7·0	8·0	10	8·7	8·4	6·6	7.4
Lucy	5·0	10	1·5	10	8·0	9·0	7·0	5·0	5·3	9·0	4·8	0	5·0	8·0	5·6	6·6	6·7	2·0	–	2·4	4·7	5·0	10	10	10	4·6	0·5	10	4·3	10	5·8	10	7·0	6.5
Pru	7·7	4·6	8·6	7·0	7·3	7·8	7·5	9·0	7·0	10	7·0	1·0	6·5	7·2	9·0	7·1	8·3	6·6	6·0	5·3	5·3	5·5	6·3	7·3	7·0	3·3	7·5	5·3	8·6	8·4	6·0	6·3	–	6.8
Alice	7·8	7·0	7·5	7·8	4·5	6·5	6·8	3·0	6·5	7·0	7·0	4·6	6·0	6·5	5·0	7·0	7·7	4·2	3·0	5·0	7·0	7·0	7·0	7·0	6·8	5·6	6·5	7·0	6·0	8·8	7·5	7·3	5·7	6.4
Rachel	3·5	3·0	8·8	4·9	2·0	5·9	8·7	5·0	0·5	9·0	3·2	0·4	6·6	5·0	1·7	1·4	4·8	1·4	5·0	0·5	1·8	–	5·0	–	5·0	4·8	0·4	9·5	8·0	–	9·5	3·6	6·7	4.5

Based on these scores I would judge the quality of the total supervision experience:

Total SEQ

<8.0 Excellent
<7.0 Good
<6.0 Adequate
>6.0 Inadequate

Table A4.3

Comparison of practitioner perceptions between the SEQ/ SEQ supervision milieu and Bernard supervisor rating

	Overall SEQ	Supervision Milieu SEQ	Bernard supervisor rating
Myrna	7.9 - good	7.7 - good	5.7 - good
Jade	8.2 - excellent	9.1 - excellent	6.3 - excellent
Karen	7.4 - good	7.8 - good	7.8 - excellent
Leslie	8.1 - excellent	8.9 - excellent	5.6 - good
Gayle	7.4 - good	8.2 - excellent	6.4 - excellent
Abbi	5.8 - inadequate	6.4 - adequate	5.0 - adequate
Jeanne	5.4 - inadequate	3.2 - inadequate	4.5 - inadequate
Rona	7.4 - good	6.8 - adequate	5.6 - good
Lucy	6.5 - adequate	6.5 - adequate	5.2 - adequate
Rachel	4.5 - inadequate	5.8 - inadequate	4.1 - inadequate
Alice	6.4 - adequate	6.2 - adequate	4.4 - inadequate
Pru	6.8 - adequate	7.3 - good	5.6 - good

Based on the Bernard supervisor rating, I would judge the quality of supervision process -

> 5.0 - Inadequate supervision - achieving a weak outcome in terms of practitioner development / weak supervision.

5.0 - 5.4 - Adequate supervision

5.5 - 5.9 - Good supervision

< 6.0 - Excellent supervision

This is a risky prediction but nevertheless an indication. The comparison with the SEQ supervision dynamic ratings, suggests some correlation between the ability of the two scales to monitor a similar phenomenon. This could be tested through correlation statistics in the future. Many factors threaten the validity of such an instrument to make such judgements - for example is Leslie's score low because of his reluctance to score 7? Is BB's score high because she needs to avoid conflict? However the variables within this statement are very complex. However the tables offered useful feedback of practitioner perception to reflect on supervision dynamics and value.

Appendix 5

Monitoring tools

5a - Heron Intervention Analysis
5b - Sources of Stress Scale
5c - 100 Points reflection
5d - Developmental themes movement

Appendix 5a

Heron intervention analysis

Dear Myrna

Reflective practice

I feel it would be important for the research to have an understanding of how you have used different interventions in clinical situations with patients.

In order to achieve this - please list (from your reflective diary) each critical incident that involved an interaction between you and a patient.

From an analysis of these critical incidents can you please identify:

1) the main purpose of the intervention

2) whether the intervention was initiated primarily as a response to helping yourself or whether it was initiated primarily as a response to helping the patient

3) that if the intervention was initiated primarily to help yourself - did this also become therapeutic for the patient

4) the different types of interventions you used according to Heron's list :

giving information — being catalytic

giving advice — being cathartic

confrontation — being supportive

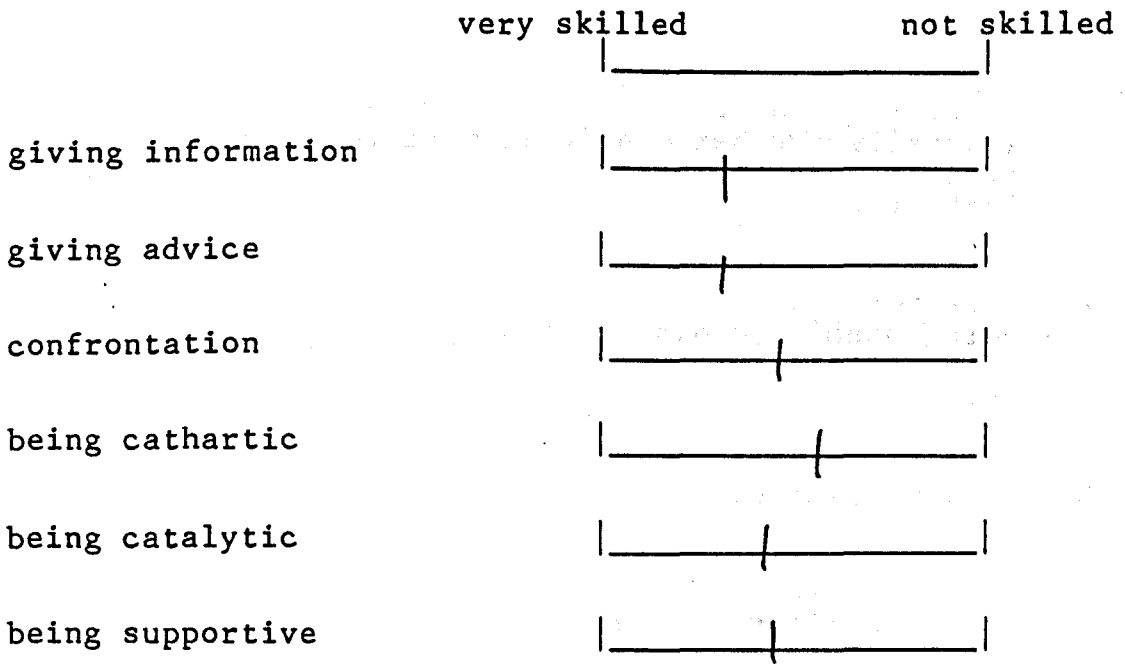
(if you need reminding about the nature of these different interventions - re-read Heron's description in the counselling file in the library)

5) the type of intervention you used initially

6) whether you were the primary or associate nurse in each situation.

Can you also indicate from this analysis the number of times you use these different interventions - do not count any intervention more than once for each incident

please rate your own skill in using each of the interventions alaong the following analogue scales



If you think your skills in using any of the these interventions has changed since working at Burford then please explain:

I think I became far more aware of the crucial nature of the way I communicated with patients and began to realise just how critical to patients my skills at handling each interaction could be. However, I don't think I became really skilled at using these interventions, and would like to do a lot more work on it. It is one of those things that, now I know about it, I'm shocked at how little I, and nurses in general, are taught about it!

If you have any difficulty with any parts of this exercise - then please see me for help with the analysis

Many thanks for yet more help with this research
Christopher Johns

cj /CI_HERON.Ays File /PhD disk /august 1991

Appendix 5b

Sources of stress scale

1) Workload issues:
- generally not being able to give the type of care you want to give
- lack of time

2) Interpersonal conflict:
- being unable to deal positvely with conflict with people you work with

3) Dealing with doctors

4) Being exposed:
- accountability issues

5) Not being acknowledged / valued by people you work with

6) Feeling of being inadequately supported

7) Working with "difficult" patients

8) Making decisions and choosing the best interventions about care

Appendix 5c

Jade's 100 Point Reflection Scale

1. You have 100 points to allocate to your sources of satisfaction with work.
2. You have a further 100 points to allocate to your source of frustration with work.

NB - You are not obliged to allocate points against all the criteria shown below - please spend all your 100 points carefully and honestly.
Your support for this work is much appreciated.

	Satisfaction	Frustration
* Having autonomy/ control for my own patients	5	
* Managing the Unit		10
* Being valued/acknowledged for my work		
* Seeing my patients achieve their goal	5	
* Working well with other health workers [not GPs]		
* Getting on well with my colleagues		
* Being assertive when I need to be	5	
* Mentoring students	5	15
* Talking with visiting nurse s to the Unit	10	5
* When the care assistants work well with me and patient		
* Being involved in caring relationship with patient		5
* Participating in the Standards group	5	
* Having supervision	10	

	Satisfaction	Frustration
* Getting positive feedback from patients and relatives		5
* Being valued by GPs		
* Not feeling rushed	10	
* Performing well at the multi-disciplinary team meetings		
* Staff following my planned care	15	20
* Harmonious atmosphere to work in		
* Involving other staff on my care planning		
* Getting through the work in time for lunch	5	5
* Writing/maintaining effective care plans	10	25
* Getting off work on time	5	5
* Developing my skills and knowledge	5	5
* Being involved in research	5	
* Seeing the place clean and tidy		
* Others [please add]		

100 points Reflection

How do you think your sources of satisfaction with work have changed since working at Windrush?

I now have autonomy and feel supported. This is a new experience- as is the opportunity to develop not only as a member of a group, such as the Standards group, but also by being part of a research project and having the peer support to develop on a day to day basis.
Also, being a mentor to both undergraduates and visiting nurse has given me positive feedback about myself and the work we do at Windrush - our philosophy and approach to nursing. Having positive feedback and support (supervision) has helped me to become more assertive - this would not have been the case in previous posts. On reflection, I wonder how I ever survived the system?

How do you think your sources of frustration about work have changed since you have worked at Windrush?

I believe I am reaching the end of a transition stage and that these changes I have undergone and am still undergoing have caused great frustration.
The differences in my relationships with patients has caused some frustration - the relationships are more meaningful as is the nature of my practical nursing - which is great but I get frustrated at not having enough time. This is also why managing the Unit frustrated me - in previous posts this would have been seen as important and although it is good to know I can manage the Unit - it is frustrating as it takes me away from what I am involved in with the patients. Time again [not enough that is] is the frustrating factor with mentoring -its another new experience that I am not able to give 'all' too. I recognise the importance of effective care planning and I recognise I need to improve- but I don't know how - this is frustrating - it wasn't important before.

cj /100 Points file/ August 1991

Appendix 5d

Gayle's Developmental themes movement

[Please score [by placing a mark] on the following 4 scales the extent you feel you personally developed whilst in guided reflection:]

Moving from a sense of :	Towards a sense of :
0	10

Obligation ----------> Commitment
[sense of duty to care] to care as a way of being

Gayle quickly demonstrated her commitment to therapeutic work despite the barriers of lack of support and previous learnt hierarchies of work. She was willing to confront the distinction between professional and personal roles necessary to be available and work with her patients and families in holistic ways.

Dependence ----------> Responsibility
within hierarchy for role
[sense of subordination]

The lack of leadership and support Gayle experienced when she commenced work at Burford quickly confronted her ability to take responsibility for her role. Much of this work was new for her - most notably working with respite care families. She demonstrates her responsibility to improve her effectiveness of this care. She was less successful in carrying out her responsibility to patients in giving feedback to others when this was necessary to ensure therapeutic work and in fulfilling supportive roles to her colleagues.

Self-doubt ----------> Personal security
[Who am I?] [Knowing who I am and
feeling OK about that]

Gayle's work in guided reflection was a catalogue of coming to terms with herself in the context of her work both individually with her patients and with her colleagues. She was well defended and self-reliant, yet was able to challenge herself to feel more secure in new, therapeutic ways. She was on the

threshold of mutual therapeutic ways of working with her colleagues although this has still had to be attained. She certainly felt more self-assured.

Passivity ----------> assertiveness	
[sense of powerlessness]	**[able to take confident**
uncertainty / aggression	**action considering self and others needs]**

Gayle did not perceive herself as an assertive person as evident within her experiences. Yet she demonstrated a growing ability to be assertive, for example in Ben's care plan, although she was less aware of the possible consequences of this type of action for others.

She has had to battle through a dilemma of win-lose relationships which are naturally aggressive by nature. she also retains her own sense of ownership of patients - with limited involvement of other workers in care planning, for example lack of communication with night associate nurse regarding Ben's sleeping in the chair.

To be assertive needs mutual responses from colleagues - it was difficult for her to be assertive in conditions where colleagues were unable to be, particularly her primary nurse colleague. Yet Gayle began to demonstrate a willingness to respond to Leslie in ways that are helpful to him rather than to just 'win'.

Appendix 6.a

Pru's Reflective Review

Pru completed a reflective review as a process of looking back and making sense of her development over the period of her guided reflection.

1. What did I want to achieve over the last 6 months?

The following list shows the areas where I wanted to improve /achieve:

1) Find a support network within my profession, a 'back-up" system. District nursing can be an isolated profession and I was feeling this effect.

2) To be acknowledged as a fully qualified district nurse - to feel my professional decisions were accepted/ correct. I also wanted to be challenged at times.

3) Help to address the "wider" issues of district nursing such as attending appropriate meetings, role as a teacher, implications of "community care" ...

4) Focus on my role to become more effective and develop a greater depth of understanding within this role.

5) Time - to evaluate /assess myself - to become a reflective practitioner.

6) Promote my teaching role; support nursing auxiliaries by developing my management role such as introducing IPR for the auxiliary within our team.

7) To improve quality nursing by doing a caseload review with a colleague.

8) To improve my knowledge base by attending specific workshops - doppler training, multi-cultural awareness.

2. What have I achieved over the last six months?

1) Through supervision I have now learnt not to get so involved with patients and carers. It has helped me to set up coping mechanisms by not taking this work home so much. I have learnt to identify how to detach myself by using/working with other professionals and by being proactive in difficult situations rather than reacting to them.

2) Starting to learn and understand my problems when faced with conflict and how to deal with this.

3) Reflecting on the supervision notes, I see how much I have to got to know myself better.

4) I have acknowledged that relationships with GP's were difficult and sometimes humiliating. I still need to set up more coping mechanisms but I feel that with my colleague we are very slowly making an impact.

5) Supervision, as a reflective process, has enabled me to "see" the stress building up in me and how to handle specific issues slowly and to deal with each one to achieve a better decision.

6) On the subject of "wider" issues, such as involvement in the changes in the NHS - I have found that I do not address them. I sometimes feel "swamped" by the demands as a manager and I cannot take them all in.

7) Other management achievements have been to increase the nursing auxiliary support network; set up a teaching programme for auxiliaries in group 5; and set an IPR date with Greer [auxiliary within my team].

8) I am also managing to attend study days without feeling unduly pressurised/ guilty. These have been useful and I plan to attend the three 'diabetic' study days in January. By being involved I have spoken with the diabetic liaison sister who has offered to set me set up a "refresher" programme for my team.

9) The case load review has not yet been achieved due to working schedule constraints. I feel it will take some time to set up a monitoring tool and with caseload pressures, I haven't felt like tackling it just yet.

10) Looking back on the reflective process, I am still learning and have along way to go. I do feel I have used it in situations of conflict with patients and it has assisted me in making decisions at the time.

3. *What have been the consequences of my achievements?*

(a) For myself -

I definitely am more aware of myself, how I react and try not to be drawn into patient's personal problems. I am recognising that a patient has to take control of the problem.

I am learning to be more proactive and plan action when faced with a problem - making life easier for myself. I am not "diving" in so quickly when assessing situations and feel less stressed when dealing with patients cases.

(b) For patients -

I am not allowing personal feelings to interfere as much with professional decisions which leads to more rational decision making. Patients are more involved in setting own goals. They are cared for by a more relaxed and self-controlled professional.

(c) For people I work with -

I require less peer support which in turn reduces the pressure on my colleagues. The nursing auxiliary feels included in the team. She is more valued. Indeed the whole team feels stronger now. For Tilley, I have come to realise how initially I had not fully accepted her as a replacement for Grainne. By understanding this situation we now work as a team and communication has improved.

4. *How do I know what the consequences have been?*

(a) For myself -

I recently had a situation when a patient and family wanted me to make a very important decision for them - should his wife stop working not knowing how long he may live (1-2 years or a few months!). In the past I would have reacted too fast. Now, I stopped and thought - then offered advice by suggesting they

do a list and analyse every issue and then make a decision. I strongly said that such a decision could not be made by me. Another example is a patient with a pressure area problem related to his chronic illness. He always refused a "research based, professional judgement" which led to the pressure sore occurring. I was constantly worrying about his non-compliance and couldn't accept it. Recently I wrote with him a care plan highlighting the need for compromise as a problem. In the last week, when the sore worsened, he accepted the suggestion of a particular treatment. He had decided himself.

(b) For patients -

By being proactive I have channelled a difficult situation - a patient's wife has been criticizing 'behind us' alternatively the hospital staff and our care - she cannot accept her husband's prognosis. The situation was becoming more difficult since everyone was feeling manipulated and I was anxious of the patient's return home. I decided to reduce the conflict by promoting a very high verbal and written communication between all professionals and the wife. Information /advice was given to the wife about the future community care her husband would receive. This information was made clear and realistic so she could make her own decisions. Since by being proactive, they were able to make their own decision without feeling pressured by my own "hang-ups" if a conflict had resulted from the initial situation of manipulation. The case at home is working well and his wife is feeling well supported.

Pru also responded to the following cues:

5) What factors have influenced what I have achieved?

6) How do I feel about my achievements?

7) What have I learnt from doing this activity? - Pru noted - "I am quite amazed by what my achievements have been" and "I need to pursue reflection since it is still not an automatic process".

8) What do I want to achieve over the next 6 months?

Appendix 6.b
Karen's Reflective Review

Supervision - 9 October 1991- 26 march 1993

This performance review is used as a summary to clarify issues raised during the 23 supervision sessions held between these dates. My position at Windrush Hospital is my first since graduating from university, therefore this review documents my learning through supervision since becoming an R.G.N. Sessions 1 and 2 were facilitated by Jade, a primary nurse at Windrush. On her departure my supervisor became Chris Johns.

Analysing my supervision notes, I identified 37 issues [see appendix] but for the purposes of this review I will follow the structure of the learning domains of becoming a primary nurse. Some of the issues are outside this structure which I will consider separately.

Learning domains

1. Becoming patient centred

I identified only 4 clear issues relating to this domain -

i] The harmonious team.

This initially came to light in the first session where I spoke of an impending clash with another member of the team. I was reluctant to speak of it, worried that it would involve Jade unnecessarily, but with encouragement I was brave!

Jade: "How are you dealing with it?"

Karen : "I sound off at home..."

Jade: "Have you thought about confronting the person?"

She then set me the task of confronting the other person and we discussed various methods of doing this. In session 2 we talked further of this, of the outcome of the confrontation, and I said that I now felt better. Had these

feelings not been challenged by Jade, I may have continued to moan at home and brush the conflict under the carpet.

ii] Being possessive about patients

This again arose from one of the initial sessions (session 2) when I was explaining my relationship with a patient. I suggested that I was being protective about planning the care for this man and Jade asked *"could it be termed as possessive?"* Whilst this did not occur to me at the time. I realised how easy it could be for nurses to be protective about patients, especially primary nurses. This clearly would hinder development of collegial relationships amongst staff and I have remembered it on several occasions since.

iii] Realising parts of the role of primary nurse

Along with the above, I realised though taking my own primary patient some of the demands of a primary nurse. Myrtle was close to death and I wanted to be with her but due to other demands I couldn't and I realised how primary nurse can be torn through their involvement. Another example of my realisation of the role came through attempts at discharge planning when I experienced the difficulty of setting a specific date.

iv] Discharge planning

Related to iii] - I also discovered how lack of knowledge hinders discharge planning, and how important it is to seek help and advice rather than trying to be invincible.

2. Working therapeutically with patients and family

I identified 14 incidents relating to this learning domain but have chosen to focus on 7.

i] Sensitivity

In session 1, I explained my avoidance of confrontation with a staff member as *"I'm too sensitive"* and this was interpreted negatively. However in session 5, discussing my reactions to a relative's complaint to the Community Health Council about the care of a lady to whom I was acting as a primary nurse, Chris discussed the need to be sensitive as a coping mechanism -saying *"the greatest gift of an effective primary nurse is her sensitivity"*. Now I see it as an attribute which dealt with positively can greatly enhance care giving.

ii] Transactional analysis

As well as using this in my relationship with George as I have discussed in the past, I was also able to use it in explaining the behaviours of a primary patient who seemed to want to mother me, who had pet names for me, and who did not treat me as the person I wished her to (i.e. an equal, an adult with knowledge). Prior to session 7, I was feeling frustrated, even angry at her behaviour towards me, but following the session, I realised that if I wanted to continue to be available to her, I had to be able to rationalise this which I did through the use of TA.

iii] Maternalism

This is an issue throughout my early sessions, beginning in session 1 until session 10. Maternalistic instincts were apparent in my care of several patients, which on analysis with Chris, showed themselves to be linked (all elderly, heavily dependent men). I originally saw this as negative:-

Karen " I have negative feelings associated with a connection between favouritism and mothering"

Chris "Perhaps we can link it to a sense of responsibility.. likelihood is - the greater the responsibility the greater the involvement'

Maternalism became rational to me and I no longer felt guilty.

iv] Prioritising

Casualty work versus ward work, physical demands of patients versus psycho-spiritual demands, creating time/ using time effectively. Whilst my earlier examples were of poor prioritising, in session 8 I was proud when I told Chris *"I spent time with Mrs Cook... feeling confident."*

v] Using confrontational skills

This is an area Chris often seemed to be suggesting to me which I then managed to implement successfully. Yet it seemed that although I had had positive results, I still did not feel able to use it independently. Situation were always rehearsed in the sessions. Chris always seemed to have a more gentle approach to it but achieving the same results. I finally learnt the art and implemented it with Mrs Cook when encouraging her to use her sticks rather than her frame:-

Karen: "so I challenged her and said if she wants to be as independent as she was prior to the accident - why was she holding herself back - and it seemed really funny because she hadn't thought about it - hadn't realised it at all..."

Chris: "So how did she respond?"

Karen: "A lot better than I thought.. I thought she would withdraw or retaliate - fight back - but she was thoughtful for a couple of minutes - and then she agreed with me - she could see it."

vi] Mutuality of caring

Following a case conference with the relatives of a primary patient, the relatives told me - *"If there's anything we can do for you in the world, anything, then please tell us and if we can help we will."*

Karen: "I definitely got across that I cared - they appreciated that - I wasn't sticking my nose in where it wasn't wanted."

vii] Ethical issues

In session 20, I described how I perceived that a primary patient may need increased respite care yet I realised that this would be a drain on the resource of the hospital. This was linked to an earlier discussion relating to a patient I was planning discharge for in Leslie's absence who was waiting for a nursing home placement but who was inappropriately placed at Windrush - and may need to decide whether or not to hurry the family who seemed to be stalling.

3. Giving and receiving feedback

In 6 of the sessions this [giving and receiving feedback] emerged as an issue, ironically it sometimes seemed as difficult as confronting a patient with a difficult issue! Actively seeking feedback emerged as a problem on a couple of occasions, for example -when I had written a 'Special Intervention' sheet. I had written one for George and placed it in his notes expecting someone to comment on it as they noticed it.. they didn't. Chris and I discussed tactics for overcoming this in the future which I then implemented with Mavis's notes. I actually handed what I had written to both Leslie and Gayle - non-verbally asking for feedback, but they just grunted and handed it back! Perhaps none of us are good enough at giving feedback!

Giving feedback in negative situations has improved throughout my time in supervision, especially with Leslie, as shown in session 6, but I still do not find this easy. Receiving feedback from patients and their relatives can be difficult for me - as with Joy whose family kept thanking me for saving her life:

Chris; "You have to be BIG -i.e. be gracious and accept it."

4. Coping with work

Three parts comprise this learning domain for me

i] Insecurity relating to my own skills

This was much more in evidence in the early sessions with Jade when I discussed how I felt I was being watched and how I did not like to work with other nurses because of this -

Karen: "My own lack of experience frightened me."

When I took on primary patients, the situation worsened to such an extent that I handed them over to Leslie -

Karen: "Passing the buck - I got Leslie to take over the care which means I don't immediately have contact with Mrs. W."

However I feel that I can ask for much more guidance, and my knowledge base has increased considerably so that this sort of stress has lessened.

ii] Personal feelings interfering with care

On a couple of occasions the strength of my own feelings has interfered with the care that I offer. The first example was in session 2 - Mickie's grandson had wanted to be with her when she died, But Mickie's daughter did not allow this. Because I felt so strongly that he should have been there and because I did not get to speak to him, I found that I could not empathise with the daughter as I felt I should. These sorts of issues re-emerged with Jack and his wife -

Chris: "Consequences of this experience was Karen's withdrawal from Mrs Fenner - in the need to cope - which didn't help either Karen or Mr Fenner (both losers)."

iii]Acknowledgement of humanity

The best example I can use here is of the grief I felt at George's death -

Karen "In the past I have felt very sad for patients but with George - I identified similar feelings for him as I would for a member of my family... I saw it as a learning relationship but not quite how much it mattered to me... having identified these feelings has helped the process to complete itself."

Other learning areas

The major other area to surface from supervision has been that of clearly identifying my role as an associate nurse. From session 1 this has been identified -

Karen:"Working alone is OK., but with you or Leslie I take a step back."

This eased somewhat until Gayle took her post when I became conscious of *"stepping on her toes"*. I felt I took a step back when Gayle arrived; Chris suggested that I regularly negotiate for one or two primary patients to *"avoid boredom"*.

Other issues to emerge have been my varied feelings towards supervision and my fluctuating level of interest. This is reflected in the many comments by Chris and myself about my diary (or lack of!). I have always seen the relevance and value of supervision but have been put off at times by the effort demanded of me in terms of time. However, I have been heartened by some of my results and amazed at some of the sub-conscious learning that has occurred.

Structure of sessions

Sessions 1-6 were very much led by the supervisor, but in session 7 we had a sudden breakthrough and I took control. From then on I felt I was growing through supervision - I remember telling Chris I felt like a seedling in spring which has felt the sun and is now growing big and strong into a tree.

What did I gain from these sessions?

From the sessions as a whole I have built up a reserve of information which I have used and will be able to use in the future. I have certainly been challenged mentally. I have also gained an incredible amount of support from Chris and although he sometimes 'despaired' of me a little he also seemed to take pride in my achievements. I have learnt how to use confrontational skills when relating to patients, the value of a therapeutic team, and the necessity of

giving and receiving feedback. Although these are the major areas of learning there are obviously many more subtle ones, and ones I probably have not yet realised. This is not an exhaustive list as that would take forever.

For the future...

I intend now to negotiate individual supervision with Jane as I can see that without it I would loose some of my desire to continue to develop as a therapeutic nurse. I am already a member of the group at Windrush who have group supervision. And finally, I intend to be more committed to keeping a reflective diary, since this review has shown to me that more was achieved in the sessions where I had already reflected in some depth and this gave such a good feeling!

Appendix - Themes throughout my supervision sessions

1. Role of associate nurse; visibility
2. Insecurity of skills
3. Prioritising
4. Maternalism
5. harmonious team
6. Using Heron's interventions
7. possessiveness of patients
8. Fear of unknown
9. Own feelings interfering with work; negative energy
10. Giving and receiving feedback
11. Patient choice and advocacy
12. Involvement with primary nurses (+ & -)
13. Appreciation of primary nurse role
14. Diary problems
15. Discharge planning
16. Control factor of nurses
17. Carers' feelings
18. Sensitivity
19. Coping mechanisms
20. Documentation
21. Feelings towards supervision
22. Assertiveness
23. Manipulation by patients
24. Subconscious learning
25. Therapeutic work
26. Transactional analysis
27. Autonomy and attachment
28. S. I. sheets
29. Use of supervision, e.g. - support/ rehearsal etc.
30. BNDU Assessment questions
31. Mutuality of caring
32. Reflection-in-action
33. Using model for subtle events
34. Continuation of issues for period of time
35. Ethical issues
36. Being 'in control'
37. Grief; lack of professional detachment.

Appendix 7
Publication anthology

Ownership and the harmonious team: barriers to developing the therapeutic team nursing team in primary nursing. Journal of Clinical Nursing, 1992, 1: 89-94.

This paper is centred in the phenomena of 'ownership and the harmonious team as barriers for practitioners to act out therapeutic potential. It drew heavily on Gill's experiences to support the emergence of these phenomena from my earlier research.

Professional supervision. Journal of Nursing Management, 1993, 1:9-18.

This paper is centred on Gill's case study to answer the question - "How can essential skills to achieve effective work be learnt within role through guided reflection?' The paper superficially explores the dynamics and efficacy of guided reflection.

Learning through supervision; a case study of respite care. Journal of Clinical Nursing, 1993, 2, 89-93. [With K. Butcher]

This paper was centred in an experience Karen shared in supervision in working with a respite care family. It unfolded the dynamics of helping Karen to focus on more effective action within an understanding of the situation.

On becoming effective in taking ethical action. Journal of Clinical Nursing, 1993, 2: 307-312.

This paper is grounded in a series of Jade's experiences to illustrate her reflexive development in taking ethical action and her involvement within caring relationships. The paper is developed to propose the validity of a situational ethic framework as the basis for making effective ethical decisions regarding care and the centrality of emotions to ethical decision making.

Nuances of Reflection - clinical note. Journal of Clinical Nursing; 1993, 3: 1-4

This paper explores the rationale and reflexive development of the 9th edition of the model of structured reflection [from the 8th edition]

Guided reflection. In - Palmer A, Burns S, Bulman C [Eds.]; Reflective practice in nursing: the growth of the professional practitioner. Blackwell Scientific Publications, Oxford, 1994.

This chapter is an account of guided reflection based on the research dynamics. I used one of Karen's experiences as its focal point.

The value of Reflective practice for nursing'. Journal of Clinical Nursing, 1995, 4: 23-30.

This paper notes the dawning of reflective practice on the horizon of nursing practice and sets out to explore its value for nursing based on interpreting key factors from the study that highlights reflective as a significant development for nursing practice and nursing knowledge.

Achieving effective work as professional activity. In Schober J & Hinchliff S [eds.] Towards Advanced Nursing Practice. Edward Arnold, London, 1995.

This paper highlights how guided reflection can enable the practitioner to fulfil their 'professional responsibility'. The text uses one of Gayle's experiences to illustrate the potential of guided reflection to achieve this. I also use Pru's reflective review as an example of reflective review.

Framing learning through reflection within Carper's fundamental ways of knowing in nursing. Journal of Advanced Nursing, 1995: 22 226-234.

This paper explores the relationship between the Model of Structured Reflection and Carper's Ways of Knowing

Understanding and managing inter-personal conflict as a therapeutic nursing activity. International Journal of Nursing Practice, 1996, 2: 194-200.

This paper is constructed around an extended analysis of Gayle's experience with Maggie Bryant, the social worker.

Visualising and realising caring in practice through guided reflection. Journal of Advanced Nursing, 24: 1135-1143.

This paper outlines 'Being available' as a framework for understanding how caring can be visualised and realised through guided reflection. The paper uses one of Leslie's and one of Karen's experiences to illustrate this.

The paper was given at international conference in Iceland.

Reflective practice and clinical supervision. Part 1: The Reflective Turn.
Reflective practice and clinical supervision. European Nurse; 2.2: 87-97.
Part 2: Guiding learning through reflection to structure the supervision 'space'. European Nurse; 2.3: 192-204.

These two papers unfold the parallel therapeutic process of guided reflection, using material from the thesis, developed around one of Leslie's shared experiences.

Understanding communication patterns within Transactional Analysis'. In Gray C [ed.] Communication: Key to Caring. [John Wiley - in Press]

This paper takes a sequence of seven experiences from Karen's guided reflection dialogue to illustrate how transactional analysis offers the practitioner a framework for understanding and learning effective communication patterns as a useful technique within guided reflection.

Based on guided reflection as a joint collaborative research method and developmental process I have completed a number of research studies:

Clinical supervision as a model for clinical leadership. Centre for Reflective Practice, University of Luton, November 1996

This project spanned two years funded by Smith & Nephew Foundation Scholarship. It involved me working with 14 nurses, mainly wards sisters within individual guided reflection relationships, to focus on the development of clinical leadership. The Report was in 15 volumes. Each relationship was developed as a case study.

Publications

- *Time to Care? Time for reflection. International Journal of Nursing Practice, 1995, 1: 37-42.*
- *Caitlin's story: realizing caring within everyday practice through guided reflection. International Journal for Human Caring, 1997; 1.2: 33-39. [based on paper given at IAHC conference, USA 1996].*
- *Clinical Supervision as a model for clinical leadership. In Meyer J. and Batehup J [eds.] Facilitating change in practice - studies in action research [In press- Churchill Livingstone].*
- *Knowing and realizing advanced practice through guided reflection. In Rolfe G. and Fulbrooke P. Advanced Nursing Practice [In Press- Butterworth Heinemann]*

Implementing guided reflection within an intensive care unit. Centre for Reflective Practice, University of Luton, November 1996.

This project involved me working with a team of intensive care nurses within a guided reflection group over 18 months to facilitate the development of clinical supervision.

Implementing guided reflection [clinical supervision] within a children's nursing unit. Centre for Reflective Practice, University of Luton, October 1996.

This involved me working with a team of wards sisters within a children's' hospital within a guided reflection group to facilitate development of reflective practice and subsequently clinical supervision.

Appendix 8

Liz's narrative

Liz was one of three primary nurses on Cairns unit. She had urged Jane to commence supervision with her Abbi and Jeanne. As such, she was initially included in the study. She commenced guided reflection in January 1992. She had 7 session spanning 7 months. I did not write a narrative of Liz's work in guided reflection with Jane because Jane had left the Cairns Unit and her relationship with Liz was so tense. Indeed Jane did not have a positive regard for Liz from commencing their supervision relationship and their work together unfolded as a struggle of manipulation and resistance to this. I have structured this narrative through the sessions to highlight this 'struggle'.

Session 1

Liz talked about a team meeting she had had with other team members and exposing interpersonal dynamics based on unspoken conflict. This was a recurring theme pursued through all sessions. It exposed Liz's tension between needing to control her team and her failure to control them because of inadequate communication. She projects unacceptable bits of her into one of her associate nurses and then blames him for these reasons. Liz was dismissive of the ability of team members to grow. This was paralleled by Jane's similar feelings of Liz. Liz does not talk about her clinical work. Although Jane does little to focus Liz's reflections, she is sucked into Liz's scheme of things - as if they are competing - putting each other down in sly ways.

Session 2

Liz talked about having a team workshop, which she recognised was aimed at getting her team to see her point of view: *"bring them round to my way"* - recognised and fedback by Jane. Liz asserted her 'ownership' of work: *"patients*

are my responsibility - care is delivered as I say so." This was reflected in the associate nurses' complaint that they felt not listened to. However Liz played a game of admitting her weaknesses : *"I know I really don't share."*
Liz repeatedly made such comment and appeared to respond positively to Jane's comments which made it difficult for Jane to criticise her. Liz repeatedly says how happy the team is - an issue challenged by Jane.

The failed communication between Liz and Jane is highlighted with the way Liz used words and how Jane pursued their literal meaning rather than the meaning behind the words - e.g. ' mothering'. Jane 'jumped' on these words because she sought to confront Liz. This exposed the underlying game of 'struggling for control' within practice that was acted out in supervision. These dynamics were repeated throughout the remaining sessions.

Session 5

Liz shared an experience in which she rationalised her failure to give feedback [to avoid conflict] as laissez faire management and at other times notes: *"I know there is a side to me that is autocratic."* She justifies this as necessary to being a primary nurse: *"I see the care as my responsibility I need to have control over what's happening."* Jane exposed the central issue of this work as issues of power and control - *"the issue is all to do with power and control' with her team management* [and within the supervision relationship].
Jane recognised these dynamics within her own supervision with me, but she was so entangled in this dynamic that her actions were limited - anger/ guilt/ frustration and her own power needs- that can't easily be surfaced without exposing herself. It paralleled how practitioners became entangled with patients.

In session 7 -

Jane asked Liz: *"Do you think your clients might feel insecure with you?"*

Liz :*"Not now [i.e they were - Liz reflected on this] - they've adapted to my way of doing it. I've learnt to offer only what they cope with. The older clients take time to get used to it.'.....I've spent a lot of energy on the physical care but its different now. I can do it now as part of my day. I can concentrate on psychological care."*

Jane :*"Perhaps you can integrate this into your care rather than seeing it a s a task?"*

Liz :*"What you have to remember is that I've had few years of experience really.... it's taken more effort than I had acknowledged and my credibility was undermined."*

This highlights how Liz has defended herself from exposed competence by avoiding sharing clinical issues. She immediately sees her work with patients as issues of control - which parallels her concerns with her colleagues within her team. Liz again highlights her game of admitting her faults but does nothing to change her ways of acting. She tosses around issues like therapeutic nursing and therapeutic touch as if they were gimmicks - paying energetic lip service to Jane's needs to pursue these issues.

Negative regard

This exemplar illustrates the impact of negative regard on the supervision relationship and emotional entanglement results in games playing. This can be made more explicit as a form of summary -

Session 2

Jane said how Liz had given her feedback that she didn't feel supported, i.e - was not in supervision and who had challenged Jane 'why wasn't she important enough to have supervision and that it wasn't fair'

Jane: *"I said I would have difficulty with doing it, which wasn't the whole truth. I avoided saying how I completely felt ... am I pre-empting what I'm expecting because she features in other peoples' sessions - maybe there is a predisposition on my part not to see her in such a positive light as other people - that's affecting me."*

Jane camouflaged this reason behind an excuse of Liz being busy, which Liz acknowledged was the case.

Jane said: "I *don't always tell people what I honestly think of them. I weigh up the impact for myself and them - to protect myself and them."*

When I challenged Jane about this stance she said: *"It could be that I don't give feedback because it might ruin my relationship with them in our mutual roles - I don't feel bad about that."*

Session 3

Jane felt she had *"been sucked dry like a prune"*. She was struggling to balance her negative regard but she felt unable to surface and deal with this conflict with Liz because she was afraid that she would be exposed as not coping or upset by Liz. Liz had told other people within the Unit that her supervision: *"was brilliant, wonderful, we are talking to each other, I don't have to worry anymore."*

Jane noted the impact of this feedback: *"I felt under pressure -where I am this wonderful person - that made it very difficult for me to challenge her- to show her what she is like and what is acceptable."*

Jane noted how uncomfortable she had felt when Liz had challenged her about what she had said about an associate nurse in Liz's team. Liz had a way of giving feedback that undermined Jane's authority. Another example was evident in session 6.

Jane: "*I want to talk about Liz - I rang her up on Saturday to change the time of supervision. She said - 'that's fine - how are things in your new post?' I said - 'I'm bearing up under the strain'. She said - 'I hear you reputation has gone before you and everyone was frightened of you'. I put the phone down saying :'I will see you on Sunday'. I felt very upset that she could be so callous over the phone...I was hurt by it.. thinking who might have said something.. I knew it shouldn't bother me but I'm trying quite hard to be nice to people or rather learn from my mistakes!... When I think*

about that session - I feel I used it for my benefit but I didn't feel satisfied at all - I did it out of my need for revenge."

I gave Jane feedback from Liz's previous notes and felt how Jane's negative feelings hadn't shown through. Jane: *"We talked about this last session - how I prepared myself for this session centring myself to deal with this."*

Session 5

Jane moved from being internal to external supervisor. At this time I asked: *"Do you think Liz is 'moving' or is just manipulating supervision?"*

Jane: *"Up to the time I left I thought she was moving - for example her physical symptoms such as her smell, shrill voice went - and I felt she was getting a grip on things but I do think its more personal things that she is doing rather than supervision.....I genuinely believes she values supervision but she lacks insight into herself and her impact on others. She blames other people very readily for events. I think she's been like that all her life and I don't think she will change. I sometimes think I delve too deeply into people's psyche - I can't help it - its just normal for me...I see too much, read too much in people perhaps."*

This is why she lets Liz gets to her because it becomes a psyche battle between them.

Jane recognised her difficulty with positive regard for Liz: *"It will be interesting to see what she says in her next session...how she responds to the team changes - she will focus again on issues of power and control...am I thinking that because I'm pre-empting what I'm expecting? or because she features [negatively] in other peoples' supervision... maybe there is a predisposition not to see her as positively as others. When I left the unit I felt that Liz had exhausted me...baffled me. I went for a time thinking she was very manipulative.. with no insight into what she does. Now that I am not exposed to her so much I feel guilty thinking that way - I'm back to my 'everyone has room for development ways' ."*

I suggested that she should drop Liz because of the continuing difficulty to establish a therapeutic supervision relationship. Jane was reluctant to admit defeat, as expressed through her liked least: *"Perhaps the thought of having to stop supervision with Liz- giving in, loosing".*

Once entangled there is no easy way out. Liz's work in guided reflection presented as a contradiction. She seemed very open about herself i.e., she could see her ownership of patients as an issue, and seemed motivated to develop, and yet contradictions exist at every turn, for example saying: *"I'm bored with work."* The work gives an impression of an iceberg, of playing around in the rhetoric on top that allowed Liz to play a game of self-indulgence with Jane, who seemed unable to confront this dynamic.

Session 9

I analysed the supervision dynamics as games:

- "Don't hit me whilst I'm down" - the ability of the supervisee to be self-deprecating to disable negative feedback and prompt positive feedback.
- "I'm only being honest and open ?" - Being self-deprecating but allowing the supervisee to say honest and hurtful things to the supervisor.

Jane felt that Liz had manipulated Abbi and Jeanne to drop supervision with her. Jane noted: *" Liz had an arranged session for 6.30 pm.. She rang me to cancel it just as I was about to go there. She said 'there was nothing to talk about'. I said I would come anyway - would like to talk to her. Liz responded the unit as very busy which made it difficult. I arrived - the Unit was not busy. She rationalised this -'I was thinking of stopping supervision because of the doing the diploma - I don't want to get confused."*

Jane noted how she responded positively and used the session as a tutorial.

Liz then challenged Jane: *"I wonder how useful it is to have supervision anymore?"*

Jane responded that she felt the same way and shared her frustration with Liz about how Liz avoided certain issues and not making progress. Liz felt she

wasn't making any progress either. She had been through the notes and thought it read of page and pages of the same thing.

Jane challenged this: *"Yes and why!?"* and challenged Liz that she blocked progress at every attempt - particularly around patient care issues. Liz found this difficult to accept and then admitted that she was more interested in nursing and nurses rather than her patient care. Jane challenged Liz that she was trying to protect herself by avoiding talking about her patients and defending herself from potential criticism. The outcome was that future supervision appointment were left for Liz to contact Jane. Jane was doubtful if this would happen.

On reflection Jane spoke at length about her relationship with Liz, about the way Liz left her feeling insecure. She labelled Liz as the 'master manipulator' [or game player extraordinnaire]. Liz reflected on the emotional overlays to this relationship and her difficulty in being rational. She felt the mixed feelings came afterwards as a result of the way Liz came over. We labelled the other games Liz played :

- "I never thought that would upset you" [extension of I'm only being honest]
- "I don't see you like that, others might but I don't"
- "I'm not upsetting you, it's not personal"

Liz picked out Jane's Achilles heel and exploited it ruthlessly. Jane could see how Liz had 'got to her' - she would go home and rant to her partner about it. The ultimate game was for Liz to ask Jane to recommence supervision : *"Liz has asked to go back into supervision -clamouring to make an appointment... I'm playing for time [game]."*

CJ :*"Did your old feelings arise in you towards her?"*

Jane: *"No they didn't."*

CJ: *"Maybe you should make her come here for sessions....?"*

Jane: *"I want to say No - but there will be this big scene - 'my mentor has let me down'- which I will have to cope with."*

During our last session [S13] we briefly reviewed all the issues Jane was involved with. Liz was summarised in just one word - *"despair!"* I noted the extraordinary amount of time Jane spent on talking about her relationship with Liz within our own supervision- illustrating the enormous effort and emotional drain this relationship had been on her. At the end of the day it was difficult to identify one aspect of growth for Liz. However it had been a salutary lesson for Jane in understanding who she was and in supervising practitioners like Liz.