

Abstract

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Previous research on clinical supervision maintains that emotional themes are prominent in clinical supervision and that supervisees often feel more confident after supervision. There has been little systematic investigation of how clinical supervision is actually conducted in practice, of how 'emotional themes' might be a part of such practice and of the ways in which supervisees proceed after supervision. This dissertation aims to remedy this situation: First, I investigate the clinical supervision intervention itself as a particular discursive practice: A 'language game' for emotion work. Second, I explore how supervisees proceed and do emotion work at interdisciplinary conferences after clinical supervision is introduced in a palliative outpatient ward. The dissertation consists of five articles and the findings are primarily based on video-recordings of the clinical supervision sessions and conferences before, during and after supervision was instigated in the ward.

- The first article looks at how the palliative team manages the emotional nature of their practices in talk about a younger dying patient at an interdisciplinary conference without supervision.
- The second article is a methodological article in that it illuminates the ways in which field work relationships are constantly interactionally constructed and reflexively situated by taking as a point of departure a case study of interactions between a terminally ill patient and the researcher in the palliative outpatient ward.
- The third article explores how reflection on emotions is practiced in supervision by looking at the construction of supervisors' reformulations and the ways in which these reformulations invite supervisees to do emotion work.
- The fourth and fifth articles present analyses of the changes in how the team does emotion work at conferences after supervision. Firstly, these articles demonstrate the ways in which moderators' reformulations of emotional topics are similar to supervisors' during clinical supervision. Secondly, they show how structural alterations of the conference inspired by supervision change the manner in which the palliative team does emotion work.

Key-words: Clinical supervision, emotion work, palliative care, interdisciplinary team work.

Foreword

Clinical supervision can be like the situation in the photo on the front page of this dissertation. It can – as the word ‘super-vision’ implies - make you look at your practice from a distance. Five years ago I started the education as a clinical supervisor and I experienced that my fellow students came back and told the rest of the group about the way in which their colleagues were complementing them for moderating meetings differently and better than before they started the education as clinical supervisor. These stories inspired me to look into the literature and find out what kind of research had been made on the impact of clinical supervision (CS) on supervisees’ practice. I discovered that the research on what actually happened in clinical supervision was scarce. Moreover, there was no research on the ways in which meetings were conducted after staff members had received supervision. I, therefore, formulated my initial project description – and in this description not a word about emotions was mentioned. The purpose was to explore the impact of CS on staff’s daily practice. The emotional focus was born more than a year after I started the project and three months after I finished collecting data. I conducted the empirical part in a palliative outpatient ward and I was surprised at how little the team explicitly talked about emotions in their daily practice. However, this situation was completely different in CS in which the same team members got very emotional during several sessions. Evidently, emotions were communicated differently in the two different practices and in this dissertation I explore how and why. Furthermore, I investigate if there is a connection between CS and the way in which supervisees proceed and do emotion work in their daily practices after CS.

I am, therefore, walking on new ground in this dissertation in that I am bringing together two areas of inquiry for the first time: Clinical supervision and emotion work. Furthermore, my research is informed by an interactional approach and based on natural data: Video recordings of supervision sessions and interdisciplinary conferences in the field of study: a palliative outpatient ward. This approach focuses on actual recorded or observed events in the present. I do not make any claims about participants’ emotions prior to or after these observations. Rather, my analytic approach is set up to show how *“interactants themselves display orientations to emotions that in some way become relevant in the ongoing talk”* (Sandlund 2004: 7) This approach is based on the notion that we bring emotions into interactions although we do not necessarily use emotion words and that the methods for doing so are socially available and can, therefore, be uncovered by the analyst.

Before I continue with an outline of the dissertation, there are some acknowledgements I have to make. Firstly, I want to thank the palliative outpatient ward for letting me spend ten months in the ward. I deeply admire your professional aspirations of giving patients and relatives a good death. With regard to the patients: Most of you are no longer in this world. Still, you have been with me all through my writing process and I have been amazed at your strength and will power to live until you died. To the two supervisors who took on the challenge to be a part of a research project I want to say: Thank you for your persistence! To my supervisor, Dennis. Without you I would not have made it. Thank you to my fellow ph.d. - students at SDU and RUC for all our conversations about the 'joy' of being in the academic business! To Janne, my faithful local librarian who have always met my demands to obtain an infinite number of books and other writings swiftly. To Kirsten and Torben, together with you I have relaxed many times after a long day at SDU with good food and Mozart! Last – but not least I thank my family and my friends for being there when I needed it. Writing a dissertation both a professional and a personal process. More than anything is has been a personal process in finding out who I am, want to be and how I get there. I feel like I climbed Mount Everest – here is my view!

Outline of the dissertation

The first part of the dissertation presents theoretical and methodological perspectives guiding the analytic process. The second part is an account of the empirical study, the findings and, moreover, considerations with respect to ethical aspects and rigor of the study. This dissertation is based on ten months of fieldwork. Naturally, the articles in part three of the dissertation only reveal a minor part of my theoretical considerations and observations. Part one and two are, therefore, dedicated to provide the reader with the theoretical and empirical framework for the articles.

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PART THREE: Articles I – V

PART ONE: Theoretical and methodological perspectives

1. Clinical supervision

1.1 Emotions in a rationalized workplace

During the past decade the Danish health care system has undergone a major change and as a former nurse and a clinical supervisor in health care settings, I sense staffs' growing concern for the quality of the care the health system can produce in the future. The health sector has been rationalized with the introduction of a management culture and this move can be seen as a challenge to the working climate in a hospital ward and raises a number of profound questions. How can an emphasis on flexibility and development of individual competences with the introduction of a concept such as 'new pay'¹ be combined and coordinated with a caring culture? And how can social platforms and a sense of community be secured in which the development of social relationships, solidarity and a mutual professional identity is inspired? At the same time the expectations of both the management and the patients are increasing with regard to the professional care and treatment. Patients expect an integration of a professional technical knowledge and skills in caring and treatment. Furthermore, the management expects a professional practice that is based on an "sober scientific basis" (Larsen 1999: 15) with the introduction of an 'evidence based practice' in which departures from this 'sober scientific basis' often is treated as "a breach of sound professional practice" (Nikander, in press). Emotions seem to be associated with the irrational "the internal, the potentially unwise and the chaotic"(ibid). Both Nikander and Arber (in press), for instance, describe in their research of health care settings, respectively elderly and palliative care, the way in which emotional displays and talk not are welcome at institutional meetings in that they are "thought to belong to a realm of rationality, neural information delivery and balanced deliberation and decision making"(Nikander, in press).

This ideal of rationality can be said to be a dilemma in that staff working in the caring sector are confronted with many emotions on a daily basis i.e. the emotions of the patients and their relatives as well as their own emotions and the emotions of their

¹ 'New pay' means that the individual employee must negotiate his or her wage with respect to the personal and professional competences he or she might possess.

colleagues. In her study of midwives, Hunter found that it was *"more often interactions with colleagues and the 'organisation' that required management of emotion"* than the interaction with patients (2004: 266). The caring profession, moreover, encompasses a dual nature because *"care giving often involves not just caring for someone (in the sense of servicing their needs) but also caring about someone (in the sense of feeling affection for them)"* (Ungerson 1983: 31). Finally, I would like to add, the handling/or the non-handling of the health sector's present challenges/problems both at a management and governmental level seems to be the source of much frustration among staff members in hospitals. At the same time, workers within service sectors such as the caring sector are expected to be able to control their own feelings *"while attempting to enhance the positive feelings of others"* (Thoits 1989: 324). This management of emotions has been called 'emotion work' by the sociologist Arlie Hochschild who coined the concept in her seminal book from 1983 in which she investigated the work of flight attendants. The imbalance between the demands of the work environment and the staff's ability to meet these demands is also called a *"moral imbalance"* by Severinsson & Kamaker (1999: 88). According to Severinsson & Kamaker, this imbalance related to the degree of independent analytical thinking and *"to the ability to recognize moral issues"* (ibid: 88). In CS supervisees get an opportunity to talk about their experiences from practice and get moral support and understanding. Reports from CS for nurses show that they – and, I claim, also other staff members – need this moral support (ibid). These researchers, moreover, argue that CS promotes supervisees' analytical thinking and ability to *'recognize moral issues'* in that it develops *"personal qualities, integrated knowledge and selfawareness"* (Severinsson & Kamaker 1999: 88).

CS can, then, be seen as a practice attempting to deal with the increasing 'anti-emotion discourse' in health care settings. The establishment of and the popularity of CS in which staff are given the time and opportunity to reflect on practice and express their emotions appear to be nourished by the challenges staff is currently facing in the health care sector (Lund-Jacobsen 1996; Arvidsson 2000; Severinsson 1995a; b; Pålsson & Norberg 1994)².

However, some studies into CS (Malin 2000) also report resistance towards CS because there can be confusion regarding *"the use of the term 'clinical supervision'"*

² Presently, there are approximately 500 educated supervisors in DK. It has not been possible to get exact numbers of how many supervision groups are active.

centred mainly in its purpose – whose interest are being served?” (550). Some researches see this resistance to CS in the light of the upcoming of evidence-based practice and enhanced consumer protection. The media, for instance, frequently reminds all health professional that they are not – by any means – flawless (Clouder & Sellars 2004). The attention on accountability in the health sector is increased to ensure a safe practice. In this context, CS appears to be a tool for making *“the individual practitioners visible and through this visibility subject to modes of surveillance”* (Clouder & Sellars 2004: 264). This fits nicely with the notion that CS can be seen as ‘a confessional practice’. According to Clouder & Sellars, the term ‘confessional’ *“implies that the person who is making a confession acknowledges or admits to some wrongdoing”* (Clouder & Sellars 2004: 266). Several researchers have, for instance, been critical towards the ways in which CS as a reflective practice incites people to reveal the truth about themselves and how they feel (Yegdich 1998).

To summarize, it can be seen how CS is being both praised and questioned as a young practice³ in the health care sector. In the review below I elaborate on these perspectives and specify the position and contribution of my own study to the existing research on CS.

1.2 Clinical supervision

The purpose of the review below is to give the reader a more specific idea of what CS is and the ways in which it has been/is practiced, researched and criticized. In a recent editorial to a thematic issue on clinical supervision in the Journal of Nursing Management, one of the prominent researchers into CS, Hyrkas, looks back on the research of CS until now. She stress that *“the CS intervention itself has remained almost without attention”*. This fact, she claims, makes all the previous studies on the efficacy of CS doubtful. Hyrkas, then, questions claims of CS’s impact/effectiveness since they seem to be – as she puts it: *“without basis, background or a ‘soundboard’”* (Hyrkas 2006: 574). In this dissertation, I anticipate to fill this gap by exploring what goes on in CS and, moreover, how supervisees proceed in their every day practices after CS in the field of study: A palliative outpatient ward. The starting point is a hypothesis in which I see CS as a particular professional language game in spite of both national and international differences in how CS may be practiced. This purpose means that it is not possible for me to draw directly on the findings of the research I

³ The literature indicates the CS gradually started in Scandinavian healthcare organizations in the 50ties. Initially, CS was performed by psychoanalysts in psychiatric units in primarily Norway and Finland (Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006). In Denmark the debut of CS was in 1982, where a group of psychiatric head nurses participated in a development project about CS.

present below. However, it does outline the field of CS and, therefore, provides me – and the reader – with a frame of reference before looking into the supervisory room.

1.2.1 Review of research into CS

CS is practiced worldwide, however, it has different implications and is practiced in different ways. In the USA the term is generally used to describe “*support and guidance for new practitioners prior to professional license*” (Teasdale, Brocklehurst & Thom, 2001: 217). The UK mentorship is also associated with supervisory practice in vocational education (Hyrkäs & Paunonen 1999). By contrast in Scandinavia, nursing education and its clinical practice does not involve CS “*it is a working method aiming at professional development after vocational education*” (ibid: 178). A main purpose of CS is, then, to support health staffs throughout their professional lives. As I illustrate in the paragraphs below the research based knowledge increased drastically during the nineties (Hyrkäs & Paunonen 1999). However, research on CS still struggles with major issues such as the national differences in how CS is performed but also the conceptual vagueness of the term. This ambiguity in using the term in the different cultures obstructs the development of CS through research (ibid).

Still, some universal characteristics can be outlined of the way in which CS is practiced. CS combines theory with practice in a professional and personal learning process where experience and wisdom initiate a reflective recognition on problems and/or issues from the professional practice. Anderson & Swim describe supervision as:

collaborative conversation that is generative and relational, through which supervisees create their own answers, and in doing so experience freedom and self-competence (Anderson & Swim 1995: 1)

CS can take place both individually and in groups. Group supervision is a forum where a group of six to eight employees meets regularly with a certified nurse supervisor. It can be said to be a learning context that builds on the knowledge, values and experiences of the members of the group. The role of the supervisor is not to be an expert in solutions but to be an expert on dialogue and help the employee develop new ideas and modes of action through a curiosity and inquisitiveness toward the situation in focus (Arvidsson 2000). Hence CS is described as a forum that stimulates a ‘meta-perspective’ on practice in the sense that the employees have an opportunity to talk

about and reflect on a situation or a problem from practice without having to act on it (Lund-Jacobsen & Holmgren 1996). 'Reflection' means a critical examination over one's actions in order to become aware of the foundations of one's professional basis (Arvidsson 2000). In this way, it is argued that CS can help provide understandings and possibly new knowledge on how to exercise one's profession rather than telling the professional how the profession should be properly exercised. As such CS can be regarded as a process of change from practical experiences to new experiences, understandings and perhaps actions (Arvidsson 2000).

The research on CS has been made in different health care settings such as elderly care: Edberg & Hallberg 2001; Edberg, Hallberg & Gustavson 1996, intensive care: Price & Chalker 2000; Lindahl & Norberg 2002 and mental health care Mullarkey, Keely & Playle 20001; Arvidsson 2000; Severinsson 1995b, midwifery: Deery 2005; home care: Malin 2000; cancer nursing: Pålsson, Hallberg, & Norberg 1994. With regard to monodisciplinary groups: Price & Chalker 2000; Lindahl & Norberg 2002; Edberg & Hallberg 2001; Edberg, Hallberg & Gustavson 1996 and inter- and multidisciplinary groups: Malin 2000; Mullarkey, Keely & Playle 2001; Hyrkas & Lethi 2003; Hyrkas & Paunonen-Ilmonen 2001; Hyrkas, Lethi & Paunonen-Ilmonen 2001; Hyrkas & Appelquist- Schmidlechner 2003. Many of these studies have focused on the efficacy of CS in one way or another. However, research on the experiences and actions of supervisors is missing in the body of research on CS (Hyrkas et al 2002). Generally speaking, most previous research, moreover, focus on the experiences of the supervisees and not the actual outcome for quality of care for patients. I have only been able to find three articles – i.e. two studies - that have included patients' responses in their study. Edberg & Hallberg 2001, Edberg, Hallberg & Gustavson 1996 and Hyrkas & Lethi 2003. Edberg et al (2001) have made an intervention study in a care unit for patients with severe dementia. The researchers conclude that quality of care has improved and that individually planned care and systematic CS reduces the nurses' perception of the patients' behaviour as demanding. Hyrkas & Lethi (2003) have used questionnaires for systematic patient feedback during the time staff received CS. They conclude that patient satisfaction is improved and also the overall quality of care.

1.2.2 Confirmation and ethical awareness

Many studies have documented that CS has a positive effect on the individual employee and deduce that the positive experiences supervisees express in both

individual and group interviews must be benefit quality of care for patients. Severinsson & Kamaker Severinsson (1999) assert that the development of nurse staffs' self-awareness *"is a prerequisite to quality nursing care"* (82). Pålsson et al (1994) and Severinsson (1995b) stress that nurses have a great need to talk about, receive support and confirmation after they have been through emotionally demanding situations in their practice. Importantly, the nurses told that they could not relieve each other in the immediate situation and therefore needed a space in which they could do this afterwards. This may explain why the studies report that the employee who has been supervised feels better equipped to cope with the daily professional challenges and interactions both with the colleagues and the patients after supervision sessions (Teslo 2000: 34-36, Gadgil 1997, Iskov 1997; Pålsson, Hallberg, & Norberg 1994; Lindahl & Norberg 2002; Rønning 2003). Severinsson & Kamaker (1999) also draw attention to the ethical competences, which can be developed in CS. They claim that: *"The method of clinical nursing supervision is an excellent process to develop and promote ethical awareness and behaviour in the nursing profession"* (82). In CS systematic reflection about the ethical quality of an act also promotes moral thinking.

1.2.3 CS in palliative care

In palliative care, Feld & Heyse-Moore (2006) and Jones (2003; 2005) report positive outcomes after staff has received CS. Jones argue that CS can play a role in the *"safe, effective and balanced delivery of care and promoting psychological health and well-being in palliative care nurses"* (Jones 2003: 168). Feld & Heyse-Moore (2006) along with several other researchers (Bégar, & Severinsson, 2006; Berg, Hansson, Welander & Hallberg, 1994; Mackareth, White, Cawthorn & Lynch, 2005; Severinsson & Kamaker, 1999) emphasize the importance of preventing burnout in health care with the implementation of CS in which it is possible for the employees to share their feelings and experiences from practice (Lund-Jacobsen & Holmgren, 1996; Arvidsson, 2000⁴). Moreover, two projects have shown that CS is a profitable method in economic terms since the time staff's sick days are reduced considerably when/after they have received CS (Hyrkas, Lethi & Paunonen-Ilmonen 2001; Lund 2004)

1.2.4 Multidisciplinary supervision

Studies of CS of inter- and multidisciplinary teams reveal that many team members feel more 'togetherness' after CS (Hyrkäs & Appelqvist-Schmidlechner & Paunonen-Ilmonen 2002; Hyrkas & Appelqvist-Schmidlechner 2003; Hyrkas & Paunonen-

Ilmonen 2001; Østergård 1995). Hyrkas & Appelquist-Schmidlechner 2003 describe how team members had come to know each other and this had led to both more open communication, but also more increased tension. This means that joint decision-making had improved, however, at the same time conflicts had emerged. Finally Hyrkas & Appelquist-Schmidlechner (2003) conclude that multidisciplinary supervision is a challenge to supervisors. They recommend that supervisors be very specific as to what multidisciplinary team supervision and collaboration is about. Different professionals have their own perspectives on practice and also their own history affecting their willingness and motivation to cooperate with other professions. Motivational aspects, therefore, present a challenge in multidisciplinary supervision. For some supervisees motivation was lessened by frustration which was caused by the slow process in the team. For others motivation had improved due to an awareness of shared problems in the group. Hyrkas & Paunonen-Ilmonen (2001) assert that the hardest in multidisciplinary teams is to transcend the traditional bounds of cooperation and find a “*collectively shared object of discussion or problem solving*” (498).

1.2.5 Vague models

Several studies point to other problematic aspects affecting the implementation and outcome of CS. Fowler (1998) draws attention to the fact that practitioners with little or no experience may see the reflective method in CS as frustrating since they do not know how to reflect and would be better served with directive teaching programmes. He, therefore, argues that CS should be structured to meet individual needs rather than imposing predefined models in individuals. However, exactly the existence of few well-defined models of supervision is a problem several researchers refer to. Many models are imprecise and they perhaps convey only a philosophy of an approach rather than being more specific and presenting a working model for CS (Mullarkey et al 2001). Mullarkey et al (2001) and Kilminster & Jolly (2000) argue that there clearly seems to be a need for a firmer and more concrete model both at an organizational but also at an individual level. This explains why Kilminster & Jolly (2000) find that the supervision relationship seems to be the “*single most important factor for the effectiveness of supervision, more important than the supervisory methods used*” (827).

1.2.6 Blurry boundaries

In the supervision relationship it has been brought up in Norway⁵ that CS is too influenced by psychotherapeutic methods and it is questioned if the reflections benefit the patient or the personal development of the nurse (Lind 2002). Most supervisors are confronted with participants' fear of 'getting undressed' emotionally and crying in public and critics⁶ go as far as saying that clinical group supervision is no more than an 'emotional outlet' where the employees can talk about and get relief from the emotional tensions connected to their job. Yegdich (1998) is very critical towards the blurry boundaries between personal and professional development and growth. She argues that many of the concepts supervisors apply not easily can be taken out of their context of 'their parent theoretical model' (Yegdich 2000: 954). She asserts that combining different concepts in the same conversation is confusing and that *"the utilization of certain techniques rather than their stated goals will dictate the form that supervision or therapy will take"* (Yegdich 1999: 1265). Unwittingly, the result seems to be that CS becomes a kind of therapy for nurses. According to Yegdich, the problem is that when a nurse participates in a learning process about a patient *"the self is an instrument in this process. It is not for personal use or for one's own needs and wishes; it is the professional self that is refined in supervision, not the personal self"* (Yegdich 1999: 1267). A focus on personal issues may not necessarily better the patient's problems – or advance understanding of the patient. And this is exactly where the heart of CS lies according to Yegdich. *"Talking about patients and one's therapeutic work, in preference to oneself and one's personal issues, is the cornerstone of supervision"*. Yegdich seems upset by the fact that it is therapy that is offered in CS without labelling it as such! In CS supervisees need to feel 'a freedom' from being 'therapized' she says (Yegdich 1999: 1273). Yegdich is, then, sceptical of CS as a mechanism that supports both professional and personal development and argues that it seems impossible to make a clear distinction between these two processes. In fact, CS may confuse the differences between two similar processes and ultimately distort the purpose of CS – to enhance the quality of care for patients. In this light, group supervision could be seen as being yet another tool in the service of the management culture in which the possible frustrations about economical and structural changes can be coped with emotionally. Supervision cannot change this

⁵ Egede-Nissen, Weslemøy (1992): Kunnskap eller terapi? Hovedoppgave i pedagogikk. Pedagogisk Forskningsinstitutt. Universitetet i Oslo. Gadgil, Inger Eikeland (1997): Sygeplejefaglig veiledning. Personlig vekst og økt faglig kompetanse - To sider av samme sak? Hovedoppgave ved avdeling for sygeplejevitenenskap. Institutt for Klinisk Medicin. Universitetet i Tromsø.

⁶ These critics are staff members in hospitals who do not approve of CS. It can be both managers and ordinary staff. I have met them during my practice as a nurse and later on at meetings and conferences I have attended.

development, but it provides a space for employees where emotional reactions are welcome. However, substantive issues initiating these reactions often remain unchanged.

The challenge for CS seems to be how to explain why it is *not* therapy in spite of the fact that it derives from and is built on therapeutic theory and methods (Konsmo 1994,⁷). Consequently it also becomes prominent to explicate difference between therapy and supervision. Clinical supervisors have responded in various ways to this challenge. One answer – which is frequently presented in supervision session – is that CS concentrates on *professional* and *personal* aspect but does not include *private* aspects in the talk. Moreover, these researchers claim that it is not possible to separate personal from professional development, when working with people in the health sector (Gadgill 1997). Another answer is that it is more important what supervision *does* than what it is *called*. Finally, some supervisors practice a kind of conversation they call neither therapy nor supervision but private-professional conversations. They claim that private and professional stories are reflexively interconnected and explore how and, moreover, the way in which these stories affect each other (Graff, Lund-Jacobsen & Wermer 2000).

1.2.7 Summing up: Research on clinical supervision

As it can be seen from the review of previous research into CS has been practiced in a variety of settings within the health sector. Positively speaking supervision could help the employees uncover new paths to walk within the given structures. Maybe the staff develops communicative competences from the supervision which may improve their interaction with the patients and colleagues in spite of the cut backs and rationalization in the health sector. Negatively speaking, CS lacks a clear description of its theoretical methods and models. Moreover, I find that talking about supervision as ‘an emotional outlet’ seems to propose the metaphor of the body being a container and that emotions are abstract entities “*contained within the container of the body*” (Frogatt 1995: 141) and that they can be let ‘in’ or ‘out’ - and, therefore, to a certain extent controlled. The container metaphor indicates that the split between mind and body still dominates the western conception of the body and emotions. According to Frogatt (1995) this split “*downplays the holistic nature of social life and an individual’s being*” (Frogatt 1995:141). By contrast this study draws – as mentioned - on interactional research on emotions in institutional settings focusing on emotions as social phenomena to be

⁷ Systemic supervision is, for instance, built on theory and methods stemming from family therapy (Boscolo, Cecchin, Hoffman & Penn 1991)

studied in the specific practical contexts of “*attribution, discursive action and accounting*” (Nikander, in press). Until now the CS intervention itself has remained relatively unexplored making all the previous studies on the efficacy of CS doubtful (Hyrkas 2006). As this review demonstrates, previous research has, then, to a large extent been based on interviewees’ post-hoc sense making of interactional events in supervisory sessions. In this regard, I argue that it is important to remember that these accounts are just that: Constructions according to hindsight. They do not “*yield reliable empirical evidence as to the particular actions and their precise location in a sequence of actions*” (Sandlund 2004: 316). To conclude, my study fills a gap in the research that has been made on CS in that I look at the CS intervention itself as a discursive activity and, moreover, anticipate to link this exploration with the ways in which supervisees proceed in their daily practice after CS. Finally, this point of departure implies that my purpose with this dissertation is not to evaluate a particular kind of CS over another.

2 Theoretical perspectives

2.1 Investigating social interaction

The theoretical frame of reference for my study is based on theories on language and interaction such as ethnomethodology, conversation analysis and discursive psychology. These approaches into the study of social activity have all been inspired ‘the linguistic turn’ of modern philosophy in the 20th century in which especially Wittgenstein (1953) made his mark. Wittgenstein argues that analysis of social contexts must start by treating language “*as something embedded in within the contexts of human action*” (Goodwin & Duranti 1992: 16). Human beings are capable of making definite sense out of talk in spite the indefinite resources language provides as a formal system because of the “*intrinsically context-bound nature*” (ibid) of language. So Wittgenstein looked at language as a form of action – a ‘form of life’ as he put it - and this implied that the focus of attention shifted from looking at language as something which could be studied independently of context to looking at context, and language as being intertwined and reflexively dependant on each other. According to Goodwin & Duranti (1992), Wittgenstein used context as a point of departure to uncover “*the multifaceted variety of thought and action made available by the different language games that human beings engage in*” (16). Harré asserts that most human collective activities are language games since human beings manage their

activities in ways which *"very often intimately involves the use of words and similarly symbolic devices"* (Harré 1998: 42) and words get their meaning as a part of a particular 'language game'. Wittgenstein draws attention to the point that the meaning of a word derives largely from its use. In 'Philosophical Investigations' § 116 (1953) he says:

When philosophers use a word – "knowledge", "being", "object", "I", "proposition", "name" – and try to grasp the *essence* of the thing, one must always ask oneself: is the word ever actually used in this way in the language-game which is its original home? What we do is to bring words back from their metaphysical to their everyday usage.

Wittgenstein's 'language game' metaphor, then, illuminates the practical function of language meaning i.e. that language use is oriented to action in practice in the sense that we do not only manage our activities for a certain purpose we also try to accomplish them in accordance to certain local norms or conventions.

Several years before Wittgenstein presented his philosophical theories, Malinowski put it this way:

A word is used when it can produce an action and not to describe one, still less to translate thoughts. The word, therefore, has a power of its own, it is a means of bringing things about, it is a handle to acts and objects and not a definition of them⁸

With Wittgenstein we have left a cognitive perspective on human interaction. This means that we do not have access to and can contemplate what goes on in people's minds as the quote by Malinowski above clearly indicates. According to Wittgenstein, 'understanding' is not, nor perhaps even primarily, a mental process but is considered to be more like 'a signal' that somebody is ready to proceed with what ever is going on. Coulter (1979) gives the example where a person suddenly understands the principle of putting a puzzle together. Here Coulter claims that it is the circumstances *"under which he had such an experience that justify him in saying in such a case that he understands"* (Coulter 1979: 38). So understanding here implies *"seeing connections"* (Wittgenstein 1953: 122) and I will add also *"making" connections*" (Shotter 1993: 61). Understanding, then, in this line of thinking means knowing how to proceed, to act – in a specific situation/setting.

⁸ Cited in Duranti and Goodwin 1992: 15. Comes from: Malinowski, Bronislaw (1923): *The Problem of Meaning in Primitive Languages*. In *The Meaning of Meaning* (Eds.) C.K. Ogden and I. A. Richards, pp: 321. New York: Harcourt, Brace and Eorld, Inc.

In other words, human mentality and activity can be seen as “*irreducible plurality of (language) games grounded in a variety of forms of life*” (Dror & Dascal, 2002: 222). The introduction of a new language game such as the supervisory language game, then, provides opportunities of the development new concepts in a variety of categories, and enables the use of these to evaluate, make connections and adjust actions in specific contexts (Sheppard 1998). This possibly implies a development in the ability to discriminate between and to articulate different categories of knowledge in our surroundings. With regard to the specific project ‘the supervisory language game’ may or may not introduce and legitimize a different approach to emotion work affecting the ways in which supervisees proceed, i.e. their interactions, in the specific setting. Following this line of thought, I, therefore, see learning as observed changes in interaction.

These considerations lead on to the following research questions:

- How can CS be seen as a ‘language game’ for doing emotion work?
- How do the supervisees proceed and do emotion work in their daily practice after CS – here exemplified by the weekly interdisciplinary conference?

Below I elaborate on my ethnomethodological perspective followed by a description of conversation analysis, institutional interaction and discursive psychology including methodological consequences of these theoretical points of departures.

2.2 Ethnomethodology

Ethnomethodology explores ‘ordinary’ social life dealing with peoples’ cooperation, their capacities and activities, as they negotiate and try to create some kind of social order. The word EM captures the simple idea that if one assumes, like the founder of EM called Harold Garfinkel, that the world is meaningful patterned and orderly in its character members of a given society must have shared methods for achieving this meaningful orderliness (Rawls 2002). Garfinkel’s argument is that the accomplishment of intersubjectivity is methodical (or accountable) in character – if not – the interaction would fail (Garfinkel 1967). Garfinkel claims that it is exactly the availability of shared methods for sense making, which makes “*social coordination and communication possible*”(Hammersley 2003: 754). EM, then, directs its investigation towards the resources through which: “*participants themselves produce their own actions and recognize the actions of others*” (Heath & Luff 2000: 23). In

other words, values, rules and norms are perceived as resources members may or may not orient towards. They cannot be employed as external explanatory factors in accounting for human behaviour. Rather they must be interpreted in specific contexts comprehend their function.

EM is not –as the word implies - in itself a method. According to Rawls (2002), it attempts to *"preserve the 'incourseness' of social phenomena"* (Rawls 2002: 6). 'Ethno' refers to members of a social or cultural group, and 'method' refers to the routine 'doings' by members to create and recreate recognizable social actions or social practices and 'ology' – as in the word sociology – captures the *"study of, or the logic of, these methods"* (Rawls 2002: 6). EM studies have used a variety of research methods aiming to uncover what people in particular situations do and which methods they use in creating orderliness.

Harold Garfinkel developed EM by reworking his teacher, Talcott Parsons' sociological project in the 50ties and 60ties⁹. Where Parsons relied on conceptual categories and generalisations Garfinkel insisted on contingent empirical detail and adequate descriptions. This focus requires an avoidance of theorized accounts and generalizations. The critique is that sociology has replaced theorized social order in the place of enacted social orders. So the use of preconceived theoretical concepts is avoided in order not to obscure local orders. Garfinkel argues that a sociology which is based on accounts or concepts blurs *"the fundamental role of enacted practices in the constitution of social phenomena"* (Rawls 2002: 21). The implication of Garfinkel's ideas is that the methodological production of social activities should be placed in the forefront and mundane aspects – even physical or biological events are seen as: *"a reference to organized activities of everyday life"* (Garfinkel 1967: vii)

Garfinkel challenged Parsons' explanation of the orderliness of social action. Parsons explained this orderliness *"in terms of socialization of actors into the values and norms characteristic of their society"* (Hammersley 2003: 753). Instead Garfinkel argued that every application of a norm requires:

interpretation; in the sense that it involves identifying a situation as being of a kind that is relevant to a norm, or to one norm rather than another, and

⁹ Parsons was a major sociologist in the 20th century. He opposed the mainstream sociology of his time in that he *"rehabilitated European sociological history by integrating works of Durkheim, Weber and others into a new 'theory of action'"* (Coulon 1995: 3)

recognizing what the implications of the norm are for action in that situation” (Hammersley 2003: 753).

The implication of Garfinkel’s argument is that common sense practices are members’ constructs. They use these as resources in their sense making and they cannot be taken for *”adequate descriptions of behaviour or treated as analytic devices for explaining behaviour because they do not include instructions for their own interpretation”* (ibid: 753). How these norms are applied has to be determined on each and every occasion meaning that it depends on practical rather than scientific rationality. This means that members’ methods must create order and

are therefore to found in witnessable interactional details; and, consequently, the production can be discovered if a researcher conducts close investigations of practical activities (Lindwall and Lymer 2005: 39)

My observations in the palliative outpatient ward where I collected my data, for instance, revealed that the palliative team in-interaction oriented towards the palliative ideal of providing ‘a good death’ for patients and their relatives (Nordentoft I).

2.2.1 Indexicality

In EM, this situated character of practical action is reflected in the concept of ‘indexicality’ pointing to the uniqueness of an activity. Indexicality means that all expressions are seen as being local and time-bound – in short situational depending on the concrete situation the expression is a part of. Indexicality, moreover, drives the analytic attention towards the constantly ongoing accomplishment of social actions. Social actions and activities, then, are *”treated as inseparable from, part and parcel of, the ‘context’ at hand; not as framed or influenced by prespecified characteristics of a context”* (Heath & Luff 2000: 24). ‘A good death’, for instance, has a specific meaning in a palliative context and cannot be fully understood without looking at the indexical nature of this expression. Indexical expressions can, then, be seen as inconvenient since they *”forbid one to use general propositions, to decide whether something is true, because to do that one must ignore the contextual circumstances”* (Coulon 1995: 19). Garfinkel, however, looks at the indexical nature of expressions as a resource we use in the intelligibility of our interactions (Garfinkel & Sacks 1970). He, therefore, proposes that we study the way in which we use ordinary language and apply indexical expressions in our local sense making instead of seeing this fact as a problematic flaw for scientific research.

Zimmerman & Pollner (1971) assert that one of the problems with more traditional sociological research seems to be that there has been a conflation of topic and resource in the research. They maintain that 'the world of everyday life' (Zimmerman & Pollner 1971: 80) seldom is the topic in its own right and claim that it is merely: "*employed as an unexplicated resource for contemporary sociological investigation*" (ibid). Zimmerman & Pollner propose an emphasis on inquiry into practical investigations themselves. Then, the topic would not be:

Social order as ordinarily conceived, but rather in the ways in which members assemble particular scenes so as to provide for one another evidence of social order as-ordinarily-conceived (Zimmerman & Pollner 1971: 83)

Members' accounts must, then, be treated as topics not as resources. It must be examined how they are constructed and

the social phenomena they portray thereby constituted; and for what this can tell us about the cultural resources available to members and/or about practices in which members participate (Hammersley 2003: 752).

In EM facts, then, are treated as accomplishments – meaning that they are seen as being produced in and through members' practical activities. This means that EM is not interested in a the purpose of practice per se but rather how it is constituted or the way in which the members display an orientation towards a purpose which has not been explicated prior to the research (ten Have 2004). Without an exploration of these primordial activities the researcher risk ignoring discursive practices of what she is looking for. The methodological problem is, then, – according to Pollner & Emerson (2001): "*not one of 'going native' but already being deeply and naively native*" (121)

2.2.2 Reflexivity

Rawls (2002) uses a game analogy to illustrate EM's essential idea. In order to play a game all players have to recognize and respect the rules of the specific game. Moreover the essential rules of the game are in important respects constitutive of the game. This means that "*the rules define the recognizable boundaries of the game*" (Rawls 2002: 5). Rawls does assert, however, that there are problems with the use of this analogy since Garfinkel not thinks of members' methods in terms of rules and they can, therefore, be seen as oversimplified conceptualizations of the constitutive features of social practice. Nevertheless the 'game analogy' illustrates some major points of EM. Firstly, that the methods members use to create orderliness of ordinary

social occasions are also constitutive of those occasions. This feature of social action is called reflexivity. Specifically, reflexivity refers to *"what actors 'know about' or 'make of' and 'do in' a setting is also itself constitutive of the setting and informed by it"* (Pollner & Emerson 2001: 121). In EM reflexivity is seen as an integral feature of practical activities because it directs the attention towards *"the seen but unnoticed methods' and reasoning on which people rely in accomplishing social actions and activities"* (Heath & Luff 2000: 24). Constitutive practices, then, are practices which *"can only meaningful exist if they are made recognizable by those who practice them"* (Rawls 2002: 6). Secondly, this means that members' accountability together with reflexivity are used to explain the understandability and the expressability of action as being sensible and at the same time an essential part of action (Garfinkel 1967; Heritage 1984). In Nordentoft II I, for instance, demonstrate the way in which a terminally ill patient, Iben, is critical of the services of the palliative ward. Her critical remarks, then, in turn makes the palliative team members frustrated with her behaviour and act accordingly in being more alert when they talk to her. Iben's actions, then, can be seen as an example of the way in which her actions appear to presuppose the conditions for their production and, at the same time *"makes the act observable as an action of a recognizable sort"* (Coulon 1995: 23). In sum reflexivity captures the point that describing a situation is to constitute it. *"The descriptions of the social world become, as soon as they have been uttered, constitutive parts of what they have described"* (ibid: 23).

In the following paragraphs, I expand on a recent development within EM called 'hybrid studies' (HS) I apply in my study. In HS the EM oriented researcher works together with practitioners in the research setting and is during the research process giving back useful instructions, i.e. findings which are seen as being capable of improving practice.

2.2.3 Hybrid studies

Within the last decade several researchers (Crabtree 2004; Hester 2000; Lindwall & Lymer 2005) in design, innovation and education have opposed a common notion within EM, namely the interpretation of the notion of the 'EM indifference' suggesting that EM cannot pass judgement or be prescriptive. By contrast they claim that the EM indifference merely means opposing from using exogenous theoretical categories in analyses and judgements. According to Lindwall & Lymer (2005), this indifference does not

present any principled objection towards the subsequent *use* of descriptions forming prescriptive judgements, only to accounts that *explain* and *analyze* interaction in terms of normative exogenous categories (Lindwall & Lymer 2005: 39).

As a consequence, these researchers have begun to use the notion of 'hybrid studies' (HS) to characterise their work. HS can be described as applied and practical research "*done by outsiders, who are also insiders*" (Rawls 2002).

Traditional EM along with other traditional modes of scientific research aims at describing reality, as it exists, and not changing it. HS, however, directly address practitioners in a speciality area and the research is seen as being capable of providing instructions that are usable to these practitioners. According to Crabtree (2004), the intention of the hybrid programme is to inform the ongoing development of occupational practices whose workaday objects are under 'praxological study' (Crabtree 2004; Garfinkel 1996). The insights of EM research could and should, therefore, be aimed at the development of the members' practice. The later Garfinkel also maintains that hybrid studies "*are written to be read alternately and interchangeably as descriptions and instructions*" (Garfinkel 2002: 102). Following HS, EM studies would be conducted for practical purposes of the social activity under study rather than for purposes of social science. It is seen as obligatory, however, that these insights are based on two analytical commitments. Firstly, that the researcher is vulgarly competent and that he/she is indifferent to formal analytic methods and secondly, takes her point of departure in members' concerns and actions to reveal the 'seen but unnoticed' (Garfinkel 1967).

A vulgarly competent researcher has investigated the phenomena he or she wants to explore thoroughly which means that he or she has an insight into the setting that makes her capable of understanding what goes on in the daily activities. This is mandatory in order to recognize "*what an event is, that is, what it is **heard** and **seen** as, by the members*" (Lindwall & Lymer 2005: 39). The idea of 'the vulgarly competent researcher' is similar to the EM ideal of achieving 'unique adequacy' in the practice under study (Rawls 2002).

2.2.4 Summing up: Ethnomethodology and hybrid studies

To summarize it can be said that EM has a commitment to 'real worldliness' of the phenomena under investigation. The distinctive character of these phenomena should

ideally speaking shape the way in which EM studies are done and presented (Hester & Francis 2000: 4). The task for EM is to document the social processes by which social life is constituted – rather than treating social phenomena as given objects in the world. In this respect, EM parts from other social scientific approaches such as phenomenology and constructivism in which

reality is forever beyond human reach because it cannot be perceived without being either conceptually constructed or constructed by the mind. For Garfinkel the world is 'really' there (as a locally produced social construction) and can as such be perceived in its own right (Rawls 2002: 32).

The commitment to 'real worldliness' makes ethnography an essential method in both more classic EM and hybrid studies in exploring the 'lived order' of specific practices. In the present study, I investigate the two practices: The palliative outpatient ward and the CS and the ways in which the social processes unfold in-interaction in these practices. I, therefore, did ten months of ethnographic field work and anticipated to feed-back the insights of my research in the development of the members' practice inspired by the HS tradition. The next paragraphs outline the relationship between EM and ethnography and the methodological underpinnings of and consequences for my empirical study. This relationship has not been straight forward and without tensions. These tensions revolve around issues of how the relationship between researcher and field of study can be conceived and described and, moreover, what the impact of this relationship might be for the outcome of the study. EM's criticisms of ethnography, then, revolve around issues of communion and collusion on the one hand and issues of disjuncture and distance on the other (Pollner & Emerson 2001).

2.2.5 Ethnography

Ethnography seeks to understand how people make sense of their lives (Moerman 1973: X). In EM terminology this implies exploring "*how the recognizable coherence of social occasions is constructed*" (Rawls 2002: 28). With respect to my study I am, for instance, interested to see the palliative ward from the members 'point of view' and to investigate how the palliative team members 'are doing being palliative team members' and 'the patients are doing being patients' (Sacks 1992). Moreover, in observing the clinical supervisory sessions I pose a similar question: 'How are the clinical supervisors/supervisees doing being supervisors/supervisees?' Interactions in this perspective are seen as being observable as regular, repeated patterns of interaction. By being in the ward day in and day out for a longer period of time I

should be able to capture the regularities of these interactions. In other words, I am looking out for 'emic' descriptions and meanings in my study of the palliative ward (Pike 1967). Emic descriptions "*provide an internal view, with criteria chosen from within the system*" (ibid: 38). This commitment, however, has methodological implications. Firstly, it is a challenge for the researcher to discover the nature of members' 'taken for granted methods and procedures' and most EM researchers, therefore, spend a lot of time in the field of study to achieve 'unique adequacy', i.e. working to be 'vulgarly competent'. Relevant to my study is, for instance, two famous studies of the social processes of dying in hospitals. Here I am, firstly, thinking of David Sudnow's study 'Passing on: the social organisation of dying' of the organisation of 'death work' in two hospital in the US. Secondly, Glaser & Strauss' study: 'A Time Dying' from 1968. A minority like myself is, moreover to a certain extent vulgarly competent before entering the field of study in that I am a former oncological nurse and I have, therefore, worked with palliation previously. However, I had never worked in or visited the palliative outpatient ward in which I conducted my study before.

Secondly, the ambition to explore the practices through which orderliness is achieved eliminate methods that rely on retrospective accounts of social order such as interviews and questionnaires in that they cannot expose member's methods. The methods used must, therefore, "*preserve the details of local order production 'over its course' for the analyst*" (Rawls 2002: 6). Furthermore, a focus on the observer's viewpoint is irrelevant because it is also retrospective reflective and it diminishes the validity of the findings. It "*takes the observer out of the action – and comments on their state of mind when they were not involved in the action*" (Rawls 2006: 18).

Trying to clarify the 'data' by clarifying the intentions and motivations of the observer only further obscures the actual situated details of action. The observer is not constructing the situation – the participants are. Focusing on the observer is a problem in itself (Rawls 2006: 17).

The observer must remain 'embedded' in the action and not ask question that take them out of the action. Observations must focus on data actors have in front of them, "*which can be observed – rather than focusing on ideas*" (ibid). This dissertation is, therefore, based primarily on naturally recorded data and ethnographic observations.

The reflexive character of interaction does, therefore, not refer to the quality of reflexivity of the mind. Ironically, Garfinkel's injunction: That interaction is reflexive

has often been misunderstood to mean exactly the opposite. In EM, reflexivity is a quality of the interactions themselves. The point is *"that social order of the situation has nothing to do with intentions and motivations"* (Rawls 2006: 17). Still, classical EM enquiries are haunted by the idea of the reflexivity of the inquiry itself. The pursuit of practice has its taken for granted practices of its own which *"are intertwined with and shape the very objects of its inquiry"* (Pollner & Emerson 2001: 124) – just as the *"eye does not see itself seeing"* (ibid: 125). Recent EM studies such as hybrid studies, however, have become more interested in 'living' the lived order and engaging in dialogues with the field of study. Criticisms of ethnography take on different forms with these different versions of EM. Inspired by Pollner & Emerson, I briefly outline two major oppositions towards ethnography below: The problems of getting too close or too distant to the field of study.

Too close?

'Going native' is considered to be a danger signal for most ethnographers doing field studies. As they apothegm goes: 'It is not the fish that discovers the water'. In other words it is a constant challenge not to 'lose the phenomena' and thereby the ability to fulfil the initial purpose of the study by failing to make a topic out of the 'taken for granted resources' members use in their sense making of situations. EM's solution to this problem is to *"treat natural facts as accomplishments"*, i.e. social doings (Pollner and Emerson 2001: 125). This implies that the researcher treat members' distinctions, explanations and concerns as analytic resources instead of making them a topic in their own right.

Another route to capturing the 'taken for granted resources', i.e. the phenomena – is to look for incidents i.e. deviant cases "where things go differently" – most typically, cases where an element of the suggested pattern is not associated with the other expected elements' (Peräkylä 1997: 292). The idea, then, is that by looking at 'unusual' interactions the observed regularities become more prominent. Sometimes, as I show in Nordentoft I, deviant cases can also exhibit participants' orientations to the same normative structures that produce the observed regularities. The illumination of deviant cases is, therefore, seen as an important method for validating your findings (Peräkylä 1997).

Too distant?

EM criticises ethnography for being too distant and non-willing to participate in members social practices. This, in turn, leads on to a diminished access to the detailed

richness of members' practices. Also an observational stance runs the risk of transforming members' worlds and experiences. The argument is that ethnography runs the risk of subjectivizing and psychologizing participants' relations to their social world. "*Ethnographers frequently formulate what are objective matters for the participants as matters depending on 'interpretation', 'beliefs' or 'concepts'*" (Pollner & Emerson 2001: 127). Pollner & Emerson assert that because EM studies increasingly focus on highly specialized research settings the earlier methodological goal of making the familiar strange has been replaced by "*efforts to make the strange familiar*" (ibid: 123). This development implies that the fusion of local and analytic knowledge is no longer seen as a 'problem' but a goal! Instead of observation EM, then, advocates for skilled participation since adequate description requires not "*mere observation but embodied presence as a competent participant in the field of action*" (ibid: 127). Moreover, EM contends that ethnography too often relies on a sociological conceptual frame of reference creating a greater distance to the field of study with "*its concern for context, meaning and intention*" (Moerman 1973: xi). EG, then, has its strengths but also its limitations. According to Silverman (2001)

It is able to show us how people respond to particular settings. It is unable to answer the basic questions about how people are constituting that setting through their talk (54).

Following this line of thought, Lindwall and Lymer (2005), inspired by Sacks (1995), state that the problem with educational research - and I would like to also add research within health settings - is that it misses the interactional 'what' of the practice. Too often, they claim, this research deals in theoretical abstractions. EM's contribution, then, becomes to provide

the missing interactional what of instructional innovations, what they are as 'brought to life' interactional achievements" (Lindwall and Lymer 2005: 42).

EM, conversation analysis (CA) and discursive psychology (DP) have been accused of not addressing core theoretical issues in their inductive research strategies and for their focus on the role of language in social organization of individual and collective human behaviour (Woofitt 2005: 75). However, I see sociology as primarily an empirical discipline and therefore agree with Sacks in his statement above since talk "*is at the heart of human existence*" (Zimmerman & Boden 1991: 3). This means that it is not possible to get proper insights into social action and interaction without examining talk - be it written, oral or non-verbal - in the specific setting under study

in that “*people are experiencing and producing their cultures, their roles, their personalities*” in every moment of talk (Moerman 1973: xi). In this regard conversation analysis offers “*exacting techniques*” for locating cultures “*in situ*” (ibid: xi). To highlight ‘the interactional what’ of the setting I explore I, therefore, draw on research based on conversation analytic techniques in institutional settings. The next paragraphs describe the ways in which this research contributes to my study.

2.3 Conversation Analysis

Ethnomethodology has increasingly become concerned with language use and social interaction due to the pioneering work of Harvey Sacks who was a student of Goffman and also collaborated with Garfinkel at UCLA in the 1960ties. Harvey Sacks was a major force in the development of conversation analysis (CA) together with Emanuel Scheegloff and Gail Jefferson. In his work, Sacks set out to construct a new social scientific discipline capable of capturing the details of social interaction rigorously, empirically and formally by examining language as social action. According to Arminen 2005, “*the basic idea of CA is so simple that it is difficult to grasp*”(2). CA investigates

what an utterance does in relation to the preceding one(s) and what implications an utterance poses for the next one(s) (ibid: 2).

In other words, the ‘reflexive’ dimension is central in social action (Heritage 1998) in that “*when we talk, we produce utterances which perform actions, which in turn invite particular next kinds of actions*” (Woofit 2005: 8). In this manner, verbal interaction appears to exhibit structure: “*the shape and form of ways in which contributions to interaction form a connected series of actions*” (ibid: 8). This basic construction, moreover, implicates that ‘context’ is both a project and a product of the participants’ actions. Hence, turns at talk are both ‘context shaped’ and ‘context renewing’ (Heritage 1997; Heath & Luff 2000). According to Heritage

a speaker’s contribution is both designed with regard to the local configuration of an activity and, in particular, the immediately preceding actions and contributes to the framework in terms of which the next action will be understood (Heritage 1984: 242).

The ‘next turn proof procedure’, moreover, is the most basic tool for validation of the analyst’s interpretation of a specific interaction (Hutchby & Woofit 1998). The next turn, quite simply, displays the interactant’s orientation to the previous turn. In this regard even a minimal utterance – i.e. turn – perhaps consisting of only one word or of

a sigh can indicate the speaker's understanding of the on-going interaction. This methodical procedure gives the analyst access to participants' *own understandings* just as they are revealed in actual interaction (Arminen 2005) and demands that data is collected in the form of tape- and video-recordings of live interactions.

Participant's actions are organised into sequences they develop and manage together to conclude their business at hand. In looking at sequences, i.e. sequential analysis, the analyst explores the way in which

particular courses of interaction are initiated and progressed and, as a part of this, how particular action opportunities are opened up and activated, or withheld from and occluded (Heritage 1997: 230)

This step-by-step sequential organisation of interaction, therefore, has a dual capacity of being both an integral feature of the social organisation of talk and at the same time it provides for an analytic resource for its investigation (Heath & Luff 2000). Empirically, this means displaying the way in which interactants "*build their context in and through their talk*" (Heritage 1997: 224). The task of the analyst is, then, to discover the orderliness of the talk, i.e. "*the machinery, the organized practices, the formal procedures, the ways in which the order is produced*" (ibid: 2, 3). According to Psathas (1995), a basic assumption of CA is that order is a produced, repeatable and recurrent orderliness produced by the interactants in situ. An imminent effort of this research has, therefore, been to document discoveries and to systematize findings by focusing on recurrent phenomena in interaction (Drew & Heritage 1992; Arminen 2005; Woofit 2005). Later on in this section, I elaborate on two sequential features from my study: Formulations and story telling.

I conclude this brief introduction to CA with Ten Have's assertion (2004) that CA writings may be read in two different ways as either searching for 'rules' of a general kind or as exploring how these 'rules' are applied in different cases. This implies that CA takes an interest in generic social practices that are 'context sensitive' but also 'context free'. Critics maintain that CA has developed into a "*'normal science' in the Kuhnian sense of the term, as a relatively 'fixed' conventional discipline that is after the formulation of law-like generalities*" (ten Have 2004: 25; Lynch & Bogen 1994). By contrast, EM studies emphasize the situated character of all interaction and, for instance, been critical towards CA's formalism and distinctive analyses which at times seem positivistic in its outlook. This outlook is "*at odds with EM's more interpretive*

stance and its focus on the ways in which members achieve the sense of any particular event or moment” (Wooffitt 2005: 73).

2.3.1 Institutional interaction and conversation analysis

Most of the early work in CA was focused on ‘ordinary conversation’. This term implies forms of interactions that are not confined to institutional settings (Heritage 1998). In contrast, studies of institutional settings emerging in the late 1970ties have made a major contribution to the sociological understanding of the way in which official activities in more restricted environments like institutional settings are accomplished in and through talk. These studies have been inspired by Goffman’s writings on the ways in which *”social interaction embodies a distinct moral and institutional order”* (Heritage 1997: 222). This ‘interaction order’ comprises specific interactional rights and obligations, which are connected to the identities and face of interactants in the setting. This order, moreover, mediates the businesses of the daily institutional practices and can, therefore, be seen to underlie all social operations. Drawing on Goffman’s idea of an ‘institutional order of interaction’ (Heritage 1997: 222) conversation analysts began to study *”the practices that make up this institution as a topic in its own right”* (ibid.) and show the way in which they were so to speak *“talked into being”* (Heritage 1984: 290).

The concept of ‘institutional talk’ was coined by Drew & Heritage (1992) and they claim that

interaction is institutional insofar as participants’ institutional and professional identities are somehow made relevant to the work activities to which they are engage (Drew and Heritage 1992: 4).

The implications of this description seem to be that even in institutional settings *”conversations may be non-institutional and institutional identities may be invoked in conversational settings outside of institutional settings”* (Sandlund 2004: 54). This point emphasizes the inductive analytic perspective of both EM and CA meaning that specific structures do not determine and shape actions. In both EM and CA, the aim is to describe how social order is an ongoing achievement and *”produced through actions of the participants themselves and their understanding of the institution”* (Sandlund 2004: 54). In the article about emotion work a story telling at the weekly conference in the palliative ward, I, for instance, demonstrate the way in which the participants orient towards to this institutional activity for decision-making (Nordentoft I).

Previous CA research has outlined some general characteristics of institutional talk. Drew & Heritage (1992) claim that institutional talk is characterised by being goal oriented in institutionally relevant ways and that there are

special and particular constraints on what both of the participants will treat as allowable contributions at hand”; finally institutional talk ”may be associated with inferential frameworks and procedures that are particular to specific institutional contexts” (Drew & Heritage 1992: 22).

Heritage (1997) has listed six characteristics in which the analyst can probe for the ’institutionality of interaction’. These characteristics are: Firstly, the turn-taking organisation which often, in the case of institutional settings, restricts one party to ask questions, the other to answer them and hereby indicates the institutional asymmetries. Peräkylä (1995) has, for instance, described turn taking practices within counselling contexts where these are designed to implement therapeutic processes. Gafaranga & Britten (2004) have studied formulations in general practitioner setting and found that they are primarily done by the general practitioner and that they, moreover, are designed differently in different phases of the consultation. With respect to my study, I discuss supervisors’ and moderators’ reformulations in Nordentoft III, IV and V.

Secondly, institutional interaction is also characterized by the overall structural organisation of the interaction. There will often be ’phase structure’ in that these practices normally are very ’task focused’ and previous research has displayed the way in which interactants orient towards these phases in, for instance, doctor consultations (Haakana 2001; Heath 1989; Robinson 2001). In my study, I, moreover, found that the weekly interdisciplinary conferences had similar characteristics (Nordentoft I).

The third and fourth point on Heritage’s list is the sequence organisation and turn design. These features display how particular courses of action are initiated and progressed – in short – the way in which the business at hand is managed within institutional contexts. Lexical choice, the fifth point, is described as a clear marker of the institutional context. Often speakers select descriptive terms fitted to the setting. Finally, interactional asymmetries can be examined in the exploration for the institutionality of interactions. In institutional settings there is *”a direct relationship between institutional roles and tasks on the one hand and discursive rights and obligations on the other”* (Heritage 1997: 237).

In my study I have applied the insights above from CA and institutional interaction. In the paragraphs below, I elaborate on two particular sequential phenomena I have found to be distinctive in the data relating to two core notions from Harvey Sacks (1995). Namely: Sequential analysis and membership categorization analysis (MCA). Firstly, I describe reformulations and story telling which are phenomena I write about in Nordentoft III, IV, V and Nordentoft I. Secondly, I introduce membership categorization analysis (MCA) in that I apply MCA in Nordentoft I and II.

2.3.2 (Re) Formulations

When supervisees in a supervisory group tell about their problems from practice the supervisor is an active listener, who from time to time reformulates, what has been said. According to Garfinkel and Sacks (1970: 351), conversationalists' practices of "*saying-in-so-many-words-what-we-are doing*" are called formulating. This means that formulations describe, explain, characterize, summarize, or otherwise what seems to be the 'gist' of the conversation. Formulations can, therefore, be seen as indexical expressions in that they clearly relate to previous statements one way or the other. Formulations are "*exhibitable for the telling*"(ibid) and available for the other interactants to report or comment on. Formulating is, then, an accountable phenomenon in that it is observable by other members. Moreover, it is a feature of the ongoing practical and sequential accomplishment of social interaction. In this regard I have been inspired by previous studies of formulations in health care (Gafaranga & Britten 2004) and psychotherapeutic settings (Davies 1986; Antaki, Barnes & Leudar 2005; Buttny 1996). The primary function of formulations is according to Davies (1986) to exhibit understanding and formulations include activities like explaining, summarizing and furnishing gists, or implications, i.e. e. 'upshots' meaning that the speaker "*makes explicit a presupposition left implicit*" (Gafaranga & Britten 2004: 153; Antaki et al 2005) of the talk so far. Like Davies (1986), I choose to call formulations for re-formulations since they imply a selection and thus a transformation of the original material being reformulated. With Buttny (1996), it can be said that 'the therapist', in my study, the supervisor, uses her professional skills by reformulating 'client's problems in a way that is suitable for further work in therapy' (Buttny 1996: 126). Reformulations can, therefore, be characterized as having a meta-communicative function: "*through which participants comments on the nature of the discourse in which they are engaged*". (Drew 1998: 32).

Reformulations are rare in everyday conversation, however, they are an integral part of institutional interaction (Gafaranga & Britten 2004) in which they are mostly done by questioners in the given setting (Heritage 1985) – such as, with respect to my study, the supervisor, the physician or the moderator at a conference. According to Davies (1986), the process of reformulation is a co-construction between supervisor and supervisee. This co-construction involves three stages: The definition of the problem, the documentation of the problem and finally pursuing consent from the client, in this case, the supervisees. Moreover, Davies found that the therapist keep persuading the client of her version of the problem until the clients accepts it. The client's consent is needed before the session can move on. Reformulations can also be seen as a sort of 'instant fixing' (Watson & Heritage 1979) and previous research (Buttny 1996) indicate that they exercise a certain conversational control of relevant topical agendas in the talk. Still, as mentioned, this control is achieved reciprocally between supervisors' interactional skills and participants' responses in the talk. In Nordentoft III, IV and V, supervisees' responses to the supervisors' reformulations, for instance, indicated if supervisees were ready to do emotion work in the supervision sessions

Footing

In the supervisors' documentation of problems they shifted 'footing' in the talk (Goffman 1981) from using personal statements from the participants in the documentation to general i.e. meta perspectives in the definition of the (therapeutic) problem. The concept of footing was introduced by Goffman (1981) to explore the nature of involvement and participation in social interaction. Goffman says that a change in footing implies

a change in the alignment we take up ourselves and the others present as expressed in the way we manage the production or reception of an utterance (Goffman 1981: 128).

The concept of 'footing' illustrates the fact that both speakers and listener are capable in the matter of seconds to shift positions during a conversation (Beck-Nielsen 2003). Goffman (1981) describes the way in which speakers, for example, may take up various footings in relation to their own utterances. By employing specific "production formats" (ibid: 145) they may "*convey distinctions between animator, author and principal of what is said*" (Clayman 1992: 165). The animator is the person who is presently speaking. The author originated the beliefs and sentiments and perhaps also selected and put the words together. Lastly the principal is the one

"whose viewpoint or position is currently being expressed in and through the utterance" (Clayman 1992: 165). These analytic concepts, then, differentiate between the speaker and the source. Goodwin is critical of this deconstruction of the speaker's role because

it provides a typology of participants rather than analysis of utterances are built through the participation of structurally different kinds of actions within ongoing courses of interaction (Goodwin 2006)

Still, I have found Goffman's terminology useful to pinpoint what the supervisors are doing with their reformulations. For instance, I demonstrate how the supervisors draw on statements of the supervisees in their reformulations as 'the source' so that the supervisees become authors whereas the supervisor can be said to be both animator and principal. The supervisors may, therefore, be speaking but they are not responsible for the documentation of the problem. The authors – the supervisees - are responsible. I, therefore, argue that 'footing' seems to support and maintain supervisor's neutrality in interaction just as Clayman (1992) has found it does for journalists in his studies. Clayman has explored the use of 'footing' in the discourse of news-interviews and in spite of the differences between the two institutional settings they still share the professional ideal of neutrality. Finally, the footing integrates moral aspects in the emotion talk in a rhetorical format and, therefore, seems to provide for a seemingly fruitful distance and allow for talk about emotions which can be difficult to talk about.

2.3.3 Story telling

My observations of the interdisciplinary conferences in the palliative ward showed that the interdisciplinary team frequently shared their experiences in the telling of stories about patients and relatives. This is nothing surprising in that humans have always created sense and meaning of events in the telling stories (Fineman 2003 a & b) and one would, therefore, naturally expect the palliative team to have a need to make sense of and to share their experiences of the dying processes they witness (Mattingly 1998).

EM and CA studies have produced a corpus of work in which the situated character of stories have been explored (Sacks 1995; Jefferson 1978; Goodwin 1992; Bülow 2004, Ochs 1992; 1997; Housley 2000). This work demonstrates the ways in which stories are an integral part of *"the manner through which topics (and therefore categories in talk) in conversation are sequentially managed"* (Housley 2000: 426). In this regard, Ochs (1992) has found that a story is characterised by usually dealing with some

noteworthy event, i.e. some sort of 'initiating event'. Maybe the teller finds something especially surprising, disturbing, and interesting making the story worth telling. Stories, then, often has a point to make which is a sort of moral evaluation of the event "*or a psychological stance related to a set of events*" (Ochs 1997: 193). Moreover, once the telling gets going often more than one story is told. Sacks calls this phenomenon for 'second stories'. According to Sacks, telling a second story is an efficient way to exhibit attention, understanding and also to be compassionate. A second story also often recontextualizes issues presented in the first story and, therefore, may initiate further discussion of the topic. Story telling, then, is a social activity involving different participant roles. In this respect, Bülow (2004) shows how adults in a patient schools share their experiences of illness through storytelling. Ochs et al (1992) has found that the telling routinely shifted from one family member to another around the dinner table in the evening in storytelling in families. Also Goodwin (1992) has produced some essential social and interactional insights about the importance of the non-verbal signs of the story telling such as body posture and gaze.

In her work, Jefferson (1978) has been especially focused on sequential aspects of story telling. According to Jefferson, stories are organized into story prefaces "*with which a teller projects a forthcoming story, a next turn in which a co participant aligns himself as the story recipient, a next in which the teller produces a story*" (Jefferson 1978: 219) called the story proper (Housley 2000: 427) and "*a next turn in which the story recipient talks by reference to the story*" (Jefferson 1978: 219). Finally, there is the story closing (Housley 2000: 427). Lepper summarizes the structure in this way: 'Preface-First-Then-Coda' (Lepper 2000: 101). By 'coda' she means a final part of the story "*which links the ending of the story to the preface and provides the opportunity for the reply which acknowledges the receipt of the story*" (Lepper 2000: 108).

Sacks' contribution to the study of story telling has been to reveal "*the underlying rules of production and hearing which he proposed underlies the recognizably of actions in the situated context*" (Lepper 2000: 102, Sacks 1995). These rules are also reflected in the manner in which we categorize the world surrounding us and the categories we employ in order to create coherence in story telling and other interactions. This implies that stories not only can be viewed as sequential components within talk: "*they are also means of category display*" (Housley 2000: 428). Thus stories are both sequential and categorical organized and the production of stories can

be seen as the *"reflexive, practical work of members accomplishing situated contingencies of social organisation and order"* (ibid.) Below I, therefore, introduce Sacks' (1995) work on membership categorisation analysis.

2.3.4 Membership categorization analysis

An important theme in Sacks' earlier work was how *"the organization of knowledge was used, relied on and displayed in interactions"* (ten Have 2004: 23; Sacks 1995). Sacks illuminated how much of this work was organized in terms of the ways in which people were described and put in certain categories. According to Sacks, membership categories are classifications or social types that may be used to describe persons and he contemplates that interactants routinely and pre-reflectively use and apply categories in talk. (Hester & Eglin 1997: 3). According to Johnson & Paoletti (2004) members use membership categories and thereby *"project different identity attributions"* (Johnson & Paoletti 2004: 193). Thus Baker (1997) asserts that: *"people achieve identities, realities and social order and social relationships through talk"* (Baker 1997: 164).

Membership categories can be linked interactionally together to form classes and collections – i.e. 'membership categorization devices' (MCDs) (Hester & Eglin 1997). MCD is defined by Sacks as:

any collection of membership categories (containing at least one category) which may be applied to some population (containing at least one member) so as to provide, by the use of some rules of application, for the pairing of at least a population member and a categorization device member. A device is then a collection plus rules of application (Hester & Eglin 1997: 4)

Moreover, categories are not just articulated or implied *"they also carry a number of associated properties 'category predicates' called: category bound activities"* – CBAs (ten Have 2004: 23). Related CBA's to the MCD: 'mother' could, for instance, be caring, feeding, raising and so on.

MCDs can be seen as members' resources for sense making in social interactions and this means that by tracing categories it is also possible to trace how social identities, social relationships and institutions are constructed (Baker 1997). The idea is that categorization rules underpin meaningful action and these rules – called the

'inferencing machine' by Sacks (Lepper 2000: 15) - represent a given cultural knowledge. On the one hand they are means through which we are able to collectively share perspectives of what is going on and thus make sense of events. (Mäkitalo 2003). On the other hand they can also be seen as constraints for perception, reasoning and remembering. Categorisation analysis studies how these categories are employed in talk and text and what the possible consequences this employment has for the interactions.

MCDs are regarded as "*in situ achievements of members' practical actions and practical reasoning*" (Hester 1997: 221). As Sacks puts it categories are not 'storehouses' of decontextualized meaning, it can be said that they

are 'collected' with others in their course of being used. In turn then this means that the 'collection' to which a category belongs is constituted through its use in a particular context; its recognizability is part of the phenomena itself (Hester 1997: 221).

Consequently, context is achieved in the interaction and evoked by the use of categories – not something that is externally imposed. Categories, then, get their specific meaning in specific contexts.

The selection and use of a certain category indicate that the 'matter' discussed is talked about in a specific manner. The choice of category, therefore, represents a form of evaluative stance taken 'towards' the issue that is characterized and described. Furthermore, categories don't come out of the blue. Categories are employed in institutions, in my study the hospital, and they are intrinsically activity bound (Sacks 1995). As such they are materialized and negotiated through text and talk and they are "*powerful discursive tools*" (Mäkitalo 2003: 498).

Research in institutional settings, including the research I present in this thesis, reveals that interactants orient – or do not orient - to specific identities or membership categories in-talk-in-interaction such as nurses, physicians and terminally ill patients (Psathas 1999; Nordentoft I; II). In Nordentoft II I, for instance, demonstrate the way in which the terminally ill patient, Iben, orients to the category of 'a troubled patient' in that she appears to be "*irritable, demanding and critical of palliative care staff*" (Li and Arber, 2006: 27). These orientations, then, seem to affect the social order in specific situations. MCA, therefore, has much offer interactional analyses of

institutional settings in the exploration of common sense structures, interactional dynamics and local power relations.

2.3.5 Summing up: Conversation analysis and institutional interaction

CA - like other forms of discourse analysis - focuses on the issues of meaning and context in interaction (Heritage 1997: 223). CA, however, is distinctive in developing this focus by linking both meaning and context to the idea of sequence and explores the way in which interactants orient to, evoke and shape contexts in and through talk (Heritage 1998). In this regard, institutional CA explores how official activities in institutional settings, like the palliative ward I conduct my study in, are accomplished in and through talk. CA offers EM a concrete linguistic methodological toolbox providing a *"set of sharp instruments to bring to the fore detailed features of the production of social order"* (ten Have 2004: 25) and is capable of, for instance, uncovering inductively the way in which specific power relations are manifested in interaction. In my study sequential phenomena such as, for instance, reformulations and story-telling have been prominent and, therefore, a main focus in the analyses since emotion work appears to be embedded in and through these phenomena. Finally, MCA draw the attention to and express indexicality in that membership categories *"point out the relevance of certain contextual aspects of whatever is talked about"* (Mäikitalo 2002: 15). According to Garfinkel & Sacks (1970), these expressions can be seen as essential in members' practical reasoning and actions and, therefore, explicate the local order of the specific setting.

Discursive psychology (DP) is a more recent discourse analytic approach that builds on the theoretical, methodological approach and findings from EM and CA in institutional settings. Increasingly, much of DP's work is also done in institutional settings (Hepburn & Wiggins 2005) and concerns it self with the way in which mental states – including emotions - are realized in interaction. DP has, therefore, inspired my analyses and in the paragraphs below I elaborate on the rationales of DP.

2.4 Discursive Psychology

Discursive psychology (DP) sees psychology as something displayed in interaction. According to Potter (2005) *"DP is an approach that treats psychology as an object in and for interaction"* (739). This implies that DP has moved the theoretical and analytical focus away *"from individual cognitive events and processes to situated interaction"* (Hepburn and Wiggins 2005: 595). Discourse in this sense, then, means

examining how text and talk are constructed to perform social actions. This approach to psychology is inspired by Wittgenstein's critique (1953) of a private language, Coulter's (1990) sociology of mind and finally Sacks' (1995) theories on interaction. DP studies in institutional settings shows how participants work up 'the psychological' and make psychological themes and identities relevant for various kinds of institutional business (Edwards & Potter 2001). Thus, in contrast to the traditional and more cognitive oriented paradigm in psychology, discourse is "*approached, not as the outcome of mental states and cognitive processes, but as a domain of action in its own right*" (Edwards & Potter 2001: 12). In DP, discourse is seen as being *constructed* and it studies the way "*that discourse itself is constructed*" by exploring language in interactions (Edwards & Potter 2001: 14). Specific words, stories are seen as being built in the interaction to perform particular actions. DP, then, asks how people categorize and formulate the world and hereby make some particulars relevant.

While much conversational analytic work has focused on sequential organization, DP takes a special interest in the rhetorical organization of talk i.e. "*the way versions are put together to counter alternatives*" (Potter 1997: 207). Also DP is anti-cognitivist, which means that it does not explain action by reference to underlying mental states. Potter & Molder refer to Wittgenstein (1953) when they argue that:

What we are calling 'mental states avowals' (i.e., description of one's thoughts and feelings) do not and could not obtain their meaning from 'referring to' privately experienced mental states (Potter & Molder 2005: 246)

DP, then, rejects the cognitivist notion that minds are revealed in what people say (te Molder & Potter 2005). Instead, DP insists on treating cognitive phenomena as parts of social practices. Still, some common sense uses would have that somebody's words may be taken to be expressions of a "*private realm of mental life*" (te Molder & Potter 2005: 244). However, DP sees these expressions as a practical base for doing things with words, "*whose investigation requires no commitment to mentalism on the analyst's part*" (ibid). With Coulter it can be said that this talk "*may be a rhetorically useful way of talking*" (ibid: 247) and DP's project is to explore

how, when and in the performance of what kinds of actions, do people talk as if they were in possession of a privately available mental life, which their words may either truthfully or falsely express? (ibid: 247)

In other words, how participants 'are doing' mental states in talk-in-interaction.

An important theme is how emotions are illuminated and handled in interaction (Edwards 1997, 1999; Locke & Edwards 2003). Edwards has dealt extensively with the various uses of emotion discourse in interpersonal relations and narrative accounts. He advocates for approaching social practice as discourse rather than mental expression in which 'mental states are talk's categories and concerns rather than its causes' (Edwards 1999: 288). Emotions are seen as worked up descriptively rather than illustrating the way things were prior to the description. So Edwards claims that specific stories are constructed "*on and for their occasions, including the ways links between emotions and scenarios can be discursively worked up and made relevant*" (Edwards 1999: 278). Narratives are ways of making sense of events and in their construction they are orienting to a normative and moral order, to "*responsibility and blame, intentionality and social evaluation*" (Edwards 1999: 279).

Edward's emphasizes the flexibility of emotion discourse and describes various rhetorical effects. Emotion categories can provide for a "*rational (sequentially understandable, in Garfinkel's sense) accountability*" (Edwards 1999: 277) or the opposite be worked up in contrast to rational thought and allow for "*temporary inflammations of the passions*" (ibid: 277). In the latter case the behaviour can then be described as "*spontaneous and sequentially incoherent (unjustified by events) and even to pathologize it*" (ibid: 277)

Within DP metaphorical expressions are seen as conceptual resources available for discursive deployment. Metaphors are capable of specifying emotion words in graphic and visual detail and this can according to Edwards and Potter manifest the validity of stories since metaphors seem to provide the speaker with a warrant of having been 'there' and knowing what he is talking about (Edwards 1999, Edwards and Potter 1992). In short metaphors can "*enable certain things to be said and not thought (...), such that the proliferation of metaphors may be motivated not only by their conceptual sense (...) but by what they say and do*" (Edwards 1997: 189).

2.4.1 Summing up: Discursive psychology

DP explores the ways in which cognitive phenomena are articulated in-interaction. In this respect emotions and how they are expressed and negotiated interactionally has been a major theme in DP. Edward's research (1997; 1999) on emotions in which he demonstrates, for instance, how stories and metaphors appear to be discursive resources allowing for emotion work has contributed to the growing interest in the

'emotional' arena both in everyday settings and workplaces in the past 20 years. In the paragraphs below, I elaborate more on interactionally inspired studies of emotions and emotion work in institutional settings.

2.5 Interactional research on emotions

The interactional perspective on emotions I work with in this dissertation is embedded in within a social-constructionist perspective. A social constructionist perspective on emotions is embedded within a larger constructionist programme in the social sciences which explore how different aspects of reality are "*constituted, embedded and maintained in social and cultural practices including language*" (Sandlund 2004: 65). In social constructionism, emotions are seen as culture specific and as emergent in social interaction rather than biologically fixed, as a result of evolution or individual characteristics. An interactional approach inspired by EM, CA and DP, then, provide at space for analyzing emotions on a social level, within interaction. This means that I do not anticipate to determine neither the origin of emotions nor their biological correlates (ibid).

There is a large body of CA, DP and EM inspired studies about emotions and emotion displays in both institutional and non-institutional settings. These studies have looked at the interactional construction and significance of emotion displays such as laughter (Osvaldsson 2004; Jefferson 1984), crying (Hepburn 2004), hysteria (Whalen and Zimmerman 1998), frustration, embarrassment and enjoyment (Sandlund 2004). Pudlinski (2005) and Ruusuvouri (2005) have looked at empathic and sympathetic emotive responses in different institutional settings.

In health care settings, Nikander (in press) has explored elderly care and unfolded how emotion categories are embedded in staff's ongoing narrations and descriptions at team meetings. Heath (1989) has explicated how the institutional setting affects the actions of the participants and visa versa. He researched the ways in which the organisation of diagnostic work informs the expression of unpleasant physical sensations and pains. In his analyses of medical consultations Heath shows that both the verbal and non-verbal aspects of patients' pain cries in the consultations appear to be tailored to fit the circumstances at hand. Lutfey & Maynard (1998) and Beach (2001) have looked into the delivering of news, mostly bad news, to cancer patients. Among others things Lutfey & Maynard found that the use of euphemisms and allusions keep the conversation going and help the doctor and the patient manage the

emotional process and talk about the fatal news. Their approach relates closely to Sudnow's perspective on death and dying processes. Sudnow shows in his ethnomethodological study: 'Passing On' from 1967 how these processes are "*defined and managed collaboratively through the interactions and mundane practices of hospital staff members*" (Lutfey and Maynard 1998: 322).

Coulter (1979, 1990) and Harré (1985) and Harré & Parrott (1996) have looked more into emotion concepts, logico-grammatical analysis and language games in talk. They emphasize the way in which we experience emotions is closely related to how we talk about them and how they are given embodiment in specific discourses. Due to the situated nature of emotions and emotional expressions, Harré & Parrott (1996) suggest that research on emotions in a specific setting must begin by exploring how different emotion concepts are used in the setting – otherwise there might be a divergence between what the researcher is looking for and what the participants are practicing in-talk-in-interaction (Sandlund 2004). Bendelow & Williams (1998) and Arlie Hochschild 1979; 1983) have examined emotions from a sociological perspective and have specifically looked at how emotions are expressed and managed at work.

To summarize, interactional approaches display how emotions are social phenomena that: "*need to be studied in the practical interactional contexts of attribution, discursive action and accounting*" (Nikander, in press). In this regard, we spend a majority of our lives at work. Moreover, my study deals with how emotions are managed at work. Below, I, therefore, elaborate on emotion research at work and 'emotion work' – in particular in health care settings.

2.5.1 Emotions at work and 'emotion work'

Fineman describes organizations as "*emotional arenas where feelings shape events and events shape feelings*¹⁰" (Fineman 2003a: 1). We meet people, must cooperate with colleagues and try to do serve our customers – whether we like them or not. We thrive or feel inadequate, we love and we hate – at work. In other words, there is no way around emotions at work. Still, research on emotions at work is still a fairly new discipline, which leaves much to be explored (Bendelow & Williams 1998). In this respect, Arlie Hochschild's work (1983) on flight attendants has been ground breaking. Hochschild demonstrated that flight attendants' work not only could be described in terms of the physical aspects of their job. She argued that the energy expended in the

¹⁰ Inspired by Fineman I make the following distinction between feeling, emotions and affect. I use 'feelings' for the private, subjective experience. 'Emotion' for the display. Finally, 'affect' is according to Fineman (2003a: 9) "*an all-encompassing expression for any emotional or emotionalized activity*".

managing of emotion must also be considered and called this for 'emotion work'. By the concept of 'emotion work' Hochschild refers to "*the act of trying to change in degree or quality an emotion or feeling*" (Hochschild 1979: 561) which, according to Hochschild, is essential for the smooth regulation of the daily practice in organizations that are engaged in working with people like, for instance, the caring sector (Hochschild 1983). She was inspired by the work of Goffman (1990) and his theories on 'impression management'. According to Zapf (2002), "*impressions include the display of normatively appropriate emotions following certain display rules*" (238).

So Hochschild's conception of emotion work articulates the fact that not only are people expected to work in their tasks and spend mental as well as physical energy – they are also expected to manage emotions in a specific manner according to certain 'feeling rules' as part of their job. 'Feeling rules' can be said to be social norms relating to feeling and display of emotion. These feeling-rules may change depending on the occupational and professional norms and they comprise strong messages about how one should feel and act (Hunter 2004). In this light, emotions and feeling rules can be seen as negotiable social products that are routinely managed.

Since Hochschild's seminal study on flight attendants, the concept of emotion work has become an umbrella term used by many scholars in a variety of ways and settings to explain different kinds of emotion work (Wingaard & Willhenganz 2006). Most of these studies, however, share one thing: they build on Hochschild's terminology and findings from 1983. These researchers talk about 'emotional labour' and not 'emotional work'. As a sociologist Hochschild differentiated between

emotional labour as the exchange value of work which is sold for a wage and emotion work or emotion management, which refers to the private context where they have use value (Zapf 2002: 238).

I follow Zapf in using the term 'emotion work' to be compatible with other fields of work and organizational psychology where this term is preferred.

Examples of studies inspired by Hochschild's ideas are, for instance, Waldron & Crone (1991) who have explored emotion work in state departments of corrections and rehabilitation. Moreover, Seymour & Sandiford (2005) have examined how emotion rules are learned by service workers through an ethnographic study of employees in a chain of public houses. Finally, Tracy (2000) has explored emotion work in an ethnographic study on a cruise ship.

Some researchers are critical towards what they see as Hochschild's negative approach to emotion work. According to them, Hochschild's (1983) main concern appears to be that the work situation makes it difficult for the employee to be authentic and her 'true self'. For this reason the employee may have to deal with issues of cynicism, low self esteem and perhaps even burn out (Sypher & Sypher 2000; Kruml & Geddes 2000). They claim that Hochschild seems to ignore situations where "*individuals spontaneously experience and express the same emotion*" (Kruml & Geddes 2000: 12) and situations producing favourable results such as increased satisfaction and enhanced self-esteem. They have, therefore, looked into positive emotion work and operate with a broader definition of the concept in talking about the management of emotions (Sypher & Sypher 2000; Kruml & Geddes 2000). Sypher and Sypher (2000) has looked at emotional labour at the emergency communication centre in the Midwest in USA and Kruml and Geddes have made a larger survey in companies where service employees worked in jobs requiring emotional work according to Hochschild's (1983) job-based classification.

Also health care settings have been on of the prime sights for research on emotion work. Treweek (1996) has looked at care assistant's work and concludes that emotion work can be used to better a problematic situation/emotion – or the opposite to support positive emotions. MacRae (1998) have researched elderly care and she concludes that emotional work can be both self and /other-directed which means that it may concern both a carer and the patient who is cared for. Henderson (2001) has looked at emotion work in nursing and Hunter (2004) in midwifery. Interestingly enough, Hunter - unlike most studies - locates the key source of emotion work in conflicting ideologies of the midwifery practice.

Finally, there is a body of research on emotion work within oncology and palliative contexts. Katz & Geneway (2002) and Thomas, Morris and Harman (2002) have explored emotion work in cancer contexts by both formal and informal caregivers. Similar to Mac Rae (1998) Thomas et al (2002) describe how emotion work is both self- and other directed. Frogatt (1995, 1998) has written a doctoral dissertation and later an article on hospice nurses and their management of emotions. One of her major findings is that the strategies these nurses use can be identified both practically in their work but also metaphorically in the language they use. Goodman's study (2001) is inspired by Frogatt's work. Goodman discusses whether the use of metaphor can offer insights into nurses' experiences of their work and she concludes, like Frogatt, that nurses do emotion work in/and through metaphorical language.

James (1992) has also written about hospice nurses. She pursues a gender perspective and discusses the meaning of 'care' from a historical and cultural perspective. James, for instance, refers to the dual nature of 'care' since it involves both 'caring for' and 'caring about' as a part of a woman's activity and identity in a way that differentiates them from men. This conceptual history creates a dilemma and is a source of emotion work for many nurses since institutional settings emphasize illness and cure rather than care. Zimmerman & Applegate (1991) have examined comforting strategies in responding to another team member who appeared to be emotionally distressed in hospice teams. They evaluate this strategy very positively. Staff members reported the comforting communication to be a significant predictor of team members' satisfaction with team communication – and – quite interesting – task effectiveness.

There are very few studies on emotion work from an interactional perspective based on natural data on face-to face-interaction. All of the studies above are based on data that is retrieved from interviews, questionnaires or ethnographic observations. I have, therefore, chosen to include Frith's & Kitzinger's (1998) interactional study of young women and their talk about past emotional experiences even though their study does not deal with emotion work *at work*. Also Frith & Kitzinger are critical towards most existing research on emotion work since they claim it:

takes self-report data (i.e. data in which social participants talk about doing what analysts call 'emotion work') as evidence for actual behaviour, which analysts then label 'emotion work' (Frith & Kitzinger 1998: 300)

According to Frith & Kitzinger looking at emotion work only as evidence for at scientific theory is overlooking the functions of the talk "*as talk grounded in a particular context*" (ibid: 300). The focus of an interactional approach, then, becomes to look at how emotional displays are interactively managed and discursively negotiated to serve the interests of the participants. In the young women's talk, Frith & Kitzinger demonstrate that they also are attending:

to the expectations and responses of those with whom they are talking, managing their identities, and justifying and excusing, and otherwise accounting for their behaviour in socially plausible ways (300).

They conclude that interactional emotion work seems to be a resource for processing past emotional experiences.

Li & Arber (2006), Li (2004) have also made interactional studies of the ways in which nurses manage emotional issues in palliative care settings. Li & Arber (2006) have studied three palliative caring settings and they show how emotion talk is used in the construction of dying the patients' moral identities as being either credible or troubled. These identities are seen as a co-production being negotiated between the staff and the patients. As mentioned in the introduction to the article, the nurses seem to prove their professionalism and their ability to stay in control through emotion talk which is done in the production of atrocity stories and extreme case formulations. One of the main conclusions of Li & Arber's study is that displaying a nice professional façade is important for the nurses and that it involves trying to hide undesirable feelings and to

cultivate and sustain good impressions of themselves in settings with terminally ill people. To lose self-control or composure might reflect badly on their personal image and the image of the organizations in which they work (41).

Li (2004) elaborates on this 'nice-ness' and analyses emotion work as a project for the production of particular kinds of nice-ness which in turn require particular types of emotional work. Li argues that as a point of departure communication training should focus on nurses' own interactional skills which are readily available and can be improved for their own professional benefits.

Lastly, Arber (in press) has focused on 'pain talk' at palliative team meetings. Along with previous findings in Li's & Arber's study from 2006, she finds that the specialist care nurses work hard at maintaining her reputation in the team which seems to be dependant on "*expertise and competency in managing difficult and complex symptoms*" (Arber, in press). Arber, therefore, finds that the nurses use rhetorical strategies such as contrastive rhetoric, telling atrocity stories, veiled criticism and neutralism as a platform for building a reputation in managing pain.

2.5.2 Summing up: Emotion work

To sum up, it can be noted how vast and differentiated interactional research on emotion work is. To begin with there is neither a mutual consensus about what term should be used, i.e. emotion work or labour/labor, nor what the concept implies. Is it self-directed/other directed, does it primarily focus on the problematic aspects of work

for the employee– or is emotion work a good thing? Moreover, research on emotion work has been done both in private companies and the public service sector where the working conditions are very different. Health care contexts have been a prime sight for exploring emotion work. Still, there are very few interactional studies of palliative care settings based on natural data and applying EM and CA in the analyses. In the dissertation I have, therefore, been very inspired by and build on the work of Li & Arber (2006) and their study of how palliative staff members apply interactional resources when they do emotion work. However, I am not as much concerned with whether or not emotion is good or bad, whether we keep them inside or let them out. Given my theoretical point of departure, I hold a different perspective on the study of emotion work. In my book, we cannot *not* express emotions we negotiate them all the time. The interesting question, therefore, becomes the ways in which they are initiated and produced in specific situations and settings – in this case in supervisions sessions and at interdisciplinary conferences in a palliative care setting. Also I do not build on Hochschild's terminology and operate with predefined structural terms such as 'feeling rules'. I research inductively how emotions are negotiated interactionally and I have, therefore, coined the following definition of emotion work I apply in my analyses. I see emotion work as talking about emotions, 'emotion talk, the expression of emotions, 'emotion displays', and the interactive work leading up to or following these. In the present case, emotion talk is defined as talk about one's previous or current emotional state. Also, emotion displays are conceived as the participants' non-verbal indications of being emotionally moved indicated by their tone of voice, laughter, crying, and so forth.

2.6 Summing up: Theoretical and methodological perspectives

This dissertation explores the language game for emotion work in CS and how supervisees proceed and do emotion work after CS in their daily practice: a palliative outpatient ward. Until now, the CS intervention has been relatively unexplored and my study, therefore, provides new knowledge into the ways in which emotion work is managed in and after CS. In the analyses, I operate within an ethnomethodological frame of reference in wanting to discover the local order of the palliative setting and CS. Furthermore I draw on CA and DP in that these theoretical approaches offer specific insights that are relevant to my study. Previous EM, CA and DP studies have looked at the ways in which emotions are handled interactionally both in- and outside health care settings including a small body of research in palliative settings. However, none of these studies have uncovered how emotion work is done in CS – and

moreover, of CS in a palliative setting. My study, therefore, fills a gap in interactional research of institutional settings in that it investigates the interactional management of emotions in both a palliative setting and in CS.

PART TWO: Clinical supervision in a palliative outpatient ward

3 The empirical study

3.1 Methodological approach

In wanting to study the 'local order' of the setting and how supervisees proceed in their daily practice after CS, an ethnomethodological perspective is confronted with a genuine methodological problem: How can something invisible like the 'local order' be studied? Members of a given society have a practical more than a theoretical interest in their constitutive work. Consequently, they take common sense for granted as a resource they utilize in their daily lives. Inspired by one of the methodological strategies of EM this project, therefore, conducts a close study of sense-making situations in which the sense making has been especially noticeable in order to direct a focus at the ordinary. Such situations are those

in which sharp discrepancies, between on the one hand existing expectations and/or competencies, and on the other practical behavioural and/or interpretative tasks necessitate extraordinary sense making efforts by members (ten Have 2004: 40).

This means that, for instance, patients who are challenging the routines and competences of the team will be included in the project for a closer analytic study of why and how these patients are challenging.

Moreover, I have also been inspired the action research tradition (AR) as it is represented by Argyris (1985). EM and AR share a common interest in wanting to study the common sense of a given social context. However, AR takes the purpose of studying this context further in stating, that social science has an important role in creating liberating alternatives for the participants involved in the study. Thus the purpose becomes not only to unfold a knowledge on the common sense but also knowledge on the variables in changing the status quo and in the science of intervention – and ultimately knowledge on a research methodology "that will make change possible and simultaneously produce knowledge that meets rigorous tests of disconfirmability" (Argyris et al 1985: xii). Put in another way it can be said that traditional EM along with other traditional modes of scientific research aims at describing reality, as it exists and not changing it. In AR it is believed that it is

important to understand the world if the aim is to change it. But Argyris also says that it is not possible to get a true picture of the "resiliency of defensive routines by just watching and waiting"(Ibid: xii). Consequently, it becomes necessary to change the world in order to understand it.

However, AR has been criticized for abandoning the research-perspective in favour of political perspectives so that 'the cause' and the solidarity with the participants supersede the research bearing consequences for the quality of the scientific work that is produced (Clausen & Lorentzen 1992). In this regard, EM and HS provides a theoretical platform which, in my opinion, appears to be absent in AR studies in that they focus more on the processes of change than explicating theoretically the ways in which they are constructed. This project, therefore, combines essential aspects from the hybrid studies tradition and EM. On the one hand the purpose is to uncover more traditional scientific knowledge coming from the introduction by supervision. How does supervision affect 'the local order' and emotion work in members' practices? This is done on the basis of participant observation, informal interviews with participants, analyses of video- and audio-recordings of practices and collection of written documents. On the other hand the project is also an intervention project where specific changes are instigated in the setting in collaboration with staff members. For hybrid study, it is, similarly to the AR tradition, essential that the practical and theoretical outcomes of the research can be said to be grounded in the interest and perspectives of those people who are affected by the issues the research focuses on - and not primarily grounded in the interest of the researcher - it can be argued, that this kind of research is an better and more realistic kind of social research with a dual capacity: Firstly, it can provide scientific results and secondly these results can be said to affect and be integrated in the research area at the same time.

3.2 Gaining Access to the Field of Study

The choice of a palliative setting for my study of clinical supervision was accidental. I was looking out for a ward wanting to participate in my project when I by chance met the clinical head nurse of the palliative ward on the train. A couple of weeks later a meeting was set up between her, the ward's head physician and psychologist to discuss my project. They were interested. I, therefore, proceeded to get consent from firstly, the administrative head physician and - nurse and secondly, I met twice with the palliative team members to present my project and get their consent to participate.

3.3 Selection of supervisors

Initially, I intended to ask educated supervisors at the hospital in which the palliative ward was situated to supervise the group. However, the palliative staff preferred supervisors from outside the hospital. I, therefore, applied for and got external funding for two supervisors. My selection of the two supervisors for the project was based on the following parameters:

- They were both experienced supervisors
- They both had supervised interdisciplinary supervision groups before
- They knew each other and had collaborated before

3.4 The data

The empirical part of the project lasted exactly fifteen months from the first contact with the ward to the last evaluation with the supervisors. To capture the local order and routines of the team and supervision I applied not only one but several qualitative methods and collected data before, during and after supervision. The data consisted of:

- 1) Video observation of supervision group sessions (21 hours)
- 2) Video observation of interdisciplinary conferences (20 hours)
- 3) Participant observations
 - Of members' activities in the ward
 - Of supervision group sessions and weekly interdisciplinary conferences in the palliative ward.
 - After conferences in the ward both before and after supervision was introduced I observed interactions between the contact person of the patient being discussed at the conference and the patient – eight in total (four patients before and four after). These interactions were audio-taped on a hard disk recorder. In total I have 32 recordings of consultations with these patients. Moreover, I made 10 interviews with patients: 6 before and 4 after CS.
- 4) Qualitative individual interviews – formal and informal – with members of the team and with patients.
- 5) Written sources such as physicians' and nurses' reports and written reflections from the members of the supervision group.

3.4.1 Video observation

I used one stationary video camera through out the entire project. Video is a valuable analytic tool when you want to study learning and work processes in complex work

settings for a number of reasons. By doing this kind of direct observation video provides:

a shared resource to overcome gaps between what people say and what they in fact do. Video observation provides optimal data when we are interested in what "really" happened rather than accounts of what happened (Jordan & Henderson: 50).

It replaces the bias of the researcher with the bias of the machine and it is essentially passive but constant. Unlike participant observation with field notes highlighting some events more than others, the video machine takes it all in from where it has been set up. So there are of course limitations when using video, the method is –like other methods – an expression of a certain 'point –of-view' – on reality (Arendt Rasmussen 1997). The videotape can be said to be a transformation of the reality and in a transformation certain information is always lost, it becomes less rich and 'objective'. However, I agree with Jordan and Henderson in saying that video still loses less than other methods and no other method can catch the complexity of interaction data like a video. Even trained observers cannot possibly keep track of the multitude of overlapping activities taking place in interactions. Ideally speaking, I should have used more than one video camera to get interactions from more than one perspective. However, it was not possible for economical reasons. I, therefore, chose to sit opposite the camera when I was recording in order to catch events in the blind angle of the video camera.

At the first meeting with the team I told them that my plan was to video tape the interactions at conferences and supervision sessions and they did not object. However, I did not make a pilot recording of one of the staff meetings until after a couple of weeks when the team had gotten used to my presence. From then on, I videotaped as much as I could in collaboration with the team providing I had consents from patients. Before each patient was brought up the moderator would, for instance, ask if I had an informed consent from the patient. If not, we would discuss the probability of getting this **consent**¹¹ and then I would either turn the camera on or off. There was only one conference I did not videotape. Interestingly enough, the team members present at this conference asked me where the video camera was – just like they would ask for a missing team member. This remark seemed to indicate that they were aware of the video camera and that they expected to be video taped as a natural part of 'doing a conference'.

¹¹ Please read more about my ethical considerations on page 52.

Lastly, I had two video review meetings with the team in which we watched and discussed some of the videos I had recorded. Moreover, I planned the last meeting together with two of the team members. These meetings appeared to ‘de-mystify’ the video recordings. Watching recordings together with the team made them more available and less ‘secret’ than they would have been if they had been kept in a locked cupboard and only watched by co-researchers and myself.

3.5 Application of a hybrid studies design

The hybrid studies design (HS) inspired design was applied through meetings with the team and my active role as a supervisor and vulgarly competent researcher before, in between, and after supervision session and conferences. In the beginning of my field work, however, I anticipated to put my knowledge as a former oncological nurse on stand-by in exploring questions like ‘What is going on here?’ (Agar 1986; Silverman 2001) ‘How do the team members do palliative care and treatment?’ On average, I spent about three or four days in the ward per week during the ten months of field study. When two of the nurses had their day off I was using the desk of the nurse who was absent. I, therefore, spent a lot of time in the nurses’ office and whenever a nurse came back from a consultation or had had a meeting or conversation with somebody they often unloaded their initial reactions and experiences on me. I also spent a lot of time in the coffee/lunch room, drinking coffee and just chatting to team members. After a month of fieldwork I increasingly used my professional skills as a certified clinical supervisor in my fieldwork. With my supervisory background in systemic supervision¹² I am critical towards the idea of instructing participants as it suggested researchers do in the hybrid studies tradition. I do, however, believe that it is possible to ask questions in order to inspire participants to reflect, search for and find possible answers (Andersen 1996). At the half-way meeting I had with the team, for instance, questioned why they talked about how busy the conferences were. My observations of the conferences so far, i.e. 14 conferences, indicated that there generally was no more than one or two patients scheduled for discussion. This question made the team reconsider the purpose of the conferences and the ways in which they could use this precious time once a week.

¹² For more information on systemic thinking please consult Bateson & Bateson 1990; Ølgaard 1991; Maturana & Varela 1987

3.5.1 Meetings with the interdisciplinary team

The overall and more general purpose of the project was formulated by me and was revised along the way after the dialogic meetings with the team. The practical frame of the empirical part of the project was – as mentioned - discussed at several meetings with the staff. These meetings were conducted in an open atmosphere where both the theoretical, practical and ethical frame of the project was discussed. The main issues at the initial meetings were:

- A collaboration agreement between the ward and me.
- An election of two people who should be contact persons between the ward and me in case there was anything the team felt uncomfortable with.
- Who should participate in the supervision group?
- Which patients could enter the project and how should they be informed?

After the meetings I met specific needs and wishes of the team without changing the core issues reflected in the purpose of the project. These wishes were: All team members should participate in the supervision group. Also a time-schedule for the entire empirical part of the project was outlined, including two meetings with the team during the process. The two last meetings were video-review sessions in which the team members watched video-recordings of episodes from the interdisciplinary conferences. Afterwards, we talked their impressions and the implications for future improvements of the communication at the conferences. Finally, there was one last evaluation meeting when the empirical part of the project was over. If any unforeseen problems arose during the process the team had a weekly meeting, in which they could be discussed. The supervisors were introduced at one of these meetings.

3.5.2 Meetings with the supervisors

I met four times with both supervisors. At the first meeting we discussed the project – purposes, ethical issues and practicalities such as the role of the supervisor at the conference and my role in the project. The supervisors were in charge of supervision sessions. I observed the sessions and afterwards we talked/mailed and clarified how the work with the group was getting along. Moreover, Karen, the supervisor of the conferences, and I often had a 'debriefing' meetings after the conferences. The second meeting was a half way evaluation of our experiences so far. At the third meeting the supervisors had a look at some of the videotapes. They both found the supervision group to be a challenge and they wanted to have a look at the interaction of the group to see if there was any thing they could do better/differently. At the fourth meeting we evaluated both the supervision group and supervision of the conferences.

3.6 Research design

The empirical design is divided into three parts before, during and after CS. I started observing the palliative team members' every day practices and the way in which they did emotion work before I instigated CS. During this time I recorded four conferences, followed four patients that particularly attracted the team members' attention and made interviews with these patients and their contact person from the team. Nordentoft I and II are based on data from this part of the study. Six weeks after CS had terminated I, then, re-entered the ward and repeated the first stage of the study. The six weeks gave the team members some peace and quiet and a chance to adapt to their normal practices. Nordentoft IV and V are partly based on the data I collected in May. In these articles, I discuss some of the changes at the conferences after supervision had terminated.

CS was instigated in two ways. Firstly, a supervision group was established counting, as mentioned, all team members. Secondly, the conference was moderated, by one of the supervisors supervising the group 14 times in order to increase the impact of the 'supervisory language game'. Moreover, this fact increased the continuity in that one of the supervisors was actually in the ward once a week working with the team members. The supervision of the conference started two weeks after the supervision group in order not to start two activities at the same time. Nordentoft III looks into the 'supervisory language game' as it was practiced in the supervision sessions. Nordentoft IV and V contain findings based on analyses of the video recordings of these sessions. To give the reader an overview of the empirical events of the study I have listed the events in the chronological table in appendix 1.

3.7 Process of analysis

The process of analysis is according to Hammersley & Atkinson (1995) not a distinct phase of a project but an ongoing process throughout the course of a study from the very first day you enter the field of study. In fact, they claim that it starts before you even enter the field of study in the formulation of research problems. Formally, it starts when you start writing in your field logbook – and informally it is "*embodied in the ethnographer's ideas and hunches*" (Hammersley & Atkinson 1995: 205). It is, therefore, a complex task to account for the specifics of the analytic process. As a field worker you often need and rely on intuition to proceed and get through the first chaotic part of the analytic process. The case is, more often than not, that you have to

handle a huge amount of data. It is also frequently the case that it is not possible within your time limits to transcribe all of the data – or go through it as thoroughly as you would ideally wish to do. Due to the inductive approach I had to the study of the palliative ward and supervision I had collected so much data that I realized by the end of the empirical part of the study that I could not transcribe or include all of the data in my study. Ideally speaking, I should have engaged in analyses of data during my field study. However, as Lawton (2001) puts it fieldwork is *"a very demanding activity"* and *"the processing of data is equally time consuming"* (Lawton 2001: 701). Like me, Lawton made a field study in a palliative ward and she also refers to the *"highly emotive nature of the research"* which makes it difficult to distance you from the data and process them as you go along. Therefore, neither Lawton nor I have made any deeper analyses during the field study.

When my field study was over I had, therefore, not found a specific focus or theme for the project within my overall purpose of finding out how supervisees proceed after supervision. Furthermore, I had to spend the summer away from the palliative ward before I was able to look at the data from a more distanced – i.e. detached - perspective. During that time, I listened to all of the tapes – both audio- and videotapes and took notes on content, form and temporal aspects (Sandlund 2004; Silverman 2001). My cardinal focus on 'emotion work' is based on several arguments. Firstly, the team members talked about the interpersonal relations of the team a majority of the time in the CS sessions. The nature of these relationships appeared to be illuminated in frequent emotion talk and displays with regard to the ways in which team members felt about their job and colleagues. Secondly, palliative settings are emotional settings by nature in that their services pinpoint issues of life and death. I wondered how the team members managed this emotional aspect of their practice. Last but not least, my motivation to explore the emotional topic was increased by critics' conception of CS as an emotional outlet. Here was my chance to explore how emotion work was in fact done in CS - something nobody had explored prior to my study - and at the same time critically discuss this critical conception! To conclude, I used my ethnographic observations as a point of departure for the microanalyses of how emotion work was done in the two activities under investigation: The interdisciplinary conference and clinical group supervision.

Then followed the long and tedious process of analysing the data. I narrowed my focus to look only at the conferences – before, during and after supervision. I went

through the video data again and made a complete registration of the minute-by-minute actions on all of the video recordings. Who said what and when? Initially, I practiced what is referred to as 'unmotivated looking' (Psathas 1995) in exploring and coding when and how interaction became emotional. Examples of my initial codings are: Metaphors, pauses, contrasts, upgradings, interaction between supervisors and their monologues when they did not get any response from the group, incomplete sentences and when participants made word searches when they did not know the way in which to express themselves. I developed a definition of emotion work and used it as a point of departure for exploring when and why talk became emotional¹³. Furthermore, I was inspired by Pommerantz' & Fehr's directions (1997: 71-74) and also Sandlund (2004) in doing interaction analysis. They suggest that a sequence should first be selected and the actions in the sequence characterised. Second interactants' packaging of actions should be considered including ways in which their selection of words initiates certain interpretations of the actions performed and of ways in which topics are talked about. The options the speaker's specific packaging offers the recipient should then be studied. Finally, timing and taking of turns should be looked at to see how they provide for certain options and interpretations and how a specific turn has been obtained by the current speaker. Does the previous speaker select the next speaker or has the speaker selected himself to speak – and why?

Later on in the analytic process, my approach became increasingly abductive (Alvesson & Skjöldberg 1994). I studied literature and research on emotion work, compared and applied previous findings in my analyses. As the analyses progressed two essential formats for doing emotion work evolved in the coding process: Storytelling and reformulations. At conferences emotional talk and expression appeared to be embedded in the storytelling. From the beginning of my participant observation, I had noticed how the team told many stories and used metaphors in their story telling. Using this observation as my point of departure, I began exploring when and how the stories were told at conferences without supervision, when they appeared to get emotional and why. What were the stories about, which team members responded to the story telling and how did they respond? Due to my methodological approach I specifically, as mentioned, collected data about patients who were challenging routines of the team. Interactions with and about these patients are described in Nordentoft I and II.

¹³ Please see page 41.

In the supervision sessions, supervisors' reformulations seemed to illuminate the potentially implicit and explicit emotional topics in what supervisees uttered. The next analytic move was to look at how and emotion talk or displays were prominent in supervision sessions. I, then, coded the registrations I had made and transcribed the relevant passages after the coding. Finally, I looked at the conferences after supervision. I coded them looking for emotion talk and displays – but also stories and reformulations or other relevant interactional elements and transcribed a vast majority of these conferences. After having looked more into supervisors' roles at supervision sessions and conferences, I also found it relevant to research how/if moderator's role at conferences after supervision had changed. Moderators' handling of their role as a moderator was, then another analytic focus in my late analyses. Nordentoft III, IV and V revolve around reformulations and emotion work in and after supervision was over.

4 Ethical considerations

4.1 Formal Consents

All participants in the project were informed about the project in writing and orally. Furthermore, they were asked to sign a written consent that they have been informed about the purpose and the methods of the project. Both patients and team members were informed that participation was voluntary and that they could at any time exit from the project without any consequences involved. Furthermore, the audio- and videotapes would only be used for analyses in my research-project. If I wished to publish elsewhere or use the tapes in teaching-sessions, I would seek the written consent from the participants being audio- or videotaped. Lastly, the data-supervision-board has given its consent to the project. Following their rules I delete all of the data which has not been anonymized, at the end of my ph.d -time.

4.2 Patients

Two kinds of patients entered the project: admitted patients attended by the palliative ward and outpatients, who had regular consultations at the palliative ward. Patients who were candidates for the conference were included in the study. I asked the team which patients they considered to possible candidates and contacted these patients.

However, it was not a straightforward situation. Some conference patients were not included in the project for ethical reasons. An example of such a situation happened about one month after I had started my fieldwork. The psychologist contacted me and said:

I have two candidates for the next conference. The first patient is about to be admitted to psychiatric hospital because she wants to commit suicide and the second patient has become psychotic

Naturally, neither of these patients was included. Conference patients were by nature characterized by being demanding in one sense or another. Only three or four out of more than one hundred patients got their situation brought up at each of the weekly conferences. The psychologist's remark, then, demonstrates how some of the most challenging and emotionally demanding conference patients cannot be included in the project for ethical reasons. In other words, only patients with a certain mental clarity have entered the study and this clarity was assessed by the team not me. The exclusion of particular vulnerable patients from the study, moreover, illustrates one of the problems I faced in catching 'the lived order' of the palliative ward. Later on in the paragraphs below, I return to and elaborate on this challenge.

Interactions with patients were not videotaped for ethical reasons. Most patients were visibly weak and advised by the team I did not want to illuminate and expose this weakness by asking their permission to video tape interactions with them. Also this might take away focus from the purpose of my project.

4.2.1 Patient Information

During the first month of my fieldwork I developed the written information for patients in collaboration with the clinical nurse specialist of the ward¹⁴. She helped me condense the information from patients' perspectives. All in all, I made about ten drafts before conducting a pilot test on two patients of both written and oral information. After this test I, then, made the final adjustments.

An example of an adjustment is cutting out the description of the project's time limits, when the empirical part of the study started and ended. I made this adjustment after one of the patients in the pilot study, a middle-aged woman who had cancer declined to participate. She expressed that she did not have the energy to see so far ahead in the

¹⁴ Please see appendix 4.

future. Her response made me think that she possibly did not know if she was going to be around that long. Her response, therefore, appeared to illuminate the dilemma between constructing specific and detailed information versus overloading patients with unnecessary information. Consequently, I decided to take out this piece of information in writing and instead give it orally.

Another adjustment I made was to call CS communication education. Few patients know about CS and instead of having to use their time and effort to explain what CS is and how it is practiced I decided, advised by the head nurse in the ward, to call it communication education in the written material. I considered this rewriting acceptable since my focus is on the way in which communication, i.e. interaction, takes place in CS. When I informed patients orally I explained that 'this education' is called CS.

All patients were informed orally before I handed out the written information. I asked them to read the written information and discuss it at home with their wife/children before they made their decision to participate. After a day or two I consulted admitted patients to get their response. I phoned the outpatients and told them about my project before mailing the information to them. I informed them that I would be at the ward when they came for their next consultation to provide any additional information they needed, to answer their questions and to discuss whether they wished to enter the project.

In practice, it was impossible for me to inform all candidates for conference discussions. I was at the ward most days, however, I also had other obligations during my field study. Consequently, I asked contact nurses for these patients if they would inform them for me in case I was occupied with other professional tasks outside the ward. I emphasized to the nurses that they remained as neutral as possible when they delivered the information about the project by stressing to the patients that participation was voluntary and they could exit the project at any time without consequences. One of the physicians asserted that it would not be a problem to get patients' consent: "*Our patients will do anything to make us happy*" he said. He was probably referring to the fact that most patients were very satisfied with the care they received and perhaps, therefore, would say 'yes' as favour to the team. This decision was, therefore, not without ethical considerations in that my request might incline patients to say 'yes' rather than 'no' in order not to disappoint their contact nurse. In

reality none of the patients team members asked declined an invitation to be included in my project.

4.3 The problem with informed consent in an inductive field study

Achieving informed consents in an inductive field study seems to be almost impossible. Given the nature of the study there should be no way of foreseeing what is going to be the main topic or outcome of the research. Lawton (2001) and de Raeve (1994) have attracted attention to this fact in their articles about ethical problems in palliative research. De Raeve is quite radical in her line of thinking in that she questions whether it is at all ethical to conduct research in such a sensitive setting. In addition, she asks if dying patients should ever be subjects for a scientific study. She is critical towards the notion that the anticipated research outcomes are "*undeniable good*" and questions the extent of the moral scrutiny which is practiced. In this respect, De Rave claims that there historically has tended to be a view that is okay to do research on the most vulnerable and disadvantaged people in society. However, she thinks that frequently these research subjects in fact become "*means to an end*". Hereby she means that it is "*the completion of the research not the care of the individual*" which seems to be the researcher's primary motivation. The problem de Raeve is raising is whether the free will of these vulnerable patients is compromised because they of their dependency and illness? In this regard she raises the issue of the seductiveness of this kind of research in which it can be difficult to pinpoint what the role of the researcher actually is. Is the researcher a nurse, a friend, a visitor? Role confusion has profound implications for consent (Dickson, Swift, James, Kippen & Liamputtong 2006)

Normally, I got the consents from patients at our second or third meeting. I, therefore, did not have a close relationship with patients at the time I got the consent. Later on in the course of events, I got more close to some patients than others. Also I found that they were happy to talk to me. Several of them said that they had nothing better to do. They were waiting a lot. Waiting for examinations. Waiting for visits from relatives and so on. I usually made interviews in the morning when visitors were not allowed and offered time to listen to their story. De Raeve describes this situation as "*a godsend for anyone who happens to feel lonely or worried*" (de Raeve 1994: 303). Listening like I did can be seen as being similar to what a therapist or counsellor does with the exception that the researcher interprets what is being said. In palliative research you are also faced with an additional problem I have experienced several

times. The patients die – and thus there is no way to renegotiate the informed consent. Lawton also talks about the dilemma of becoming so much a participant – i.e. vulgarly competent – that patients and staff forget that you in fact are a researcher and therefore are obliged to look at events as possible data. This situation might result in participants sharing confidential issues which are not meant for research purposes.

Participant observations of consultations with admitted patients, moreover, initiated some ethical reflections. As I have mentioned I always informed patients of my professional identity, the purpose of my presence and asked their permission to observe the consultation. Ideally speaking, these patients should be given more time to make up their mind. However, this was not possible if I had to catch 'the local order' and daily routines of the ward. The team consulted too many patients. Furthermore, a large number of these patients were acute. I, therefore, contemplated that it was okay to do what I was doing as long as I used my impressions as background knowledge of the ward's practices and not included these consultations in more detailed analyses within the patient's consent.

To summarize, there are no simple answers to this complex dilemma of wanting to catch the 'real' reality on the one hand and protecting the integrity of participants on the other. Therefore - to quote Lawton:

A particular responsibility is thus placed on a researcher to use the data collected during such a study in a very careful and selective manner. Ultimately, it is his or her discretion and integrity that are at stake (Lawton 2001: 703)

4.3.1 The problem of conference patients

- Natural or un-natural data?

My theoretical framework requires that I retrieve natural data in order to catch 'the lived order' in the setting, however, exactly this point has taken much consideration and planning with respect to getting informed consent from patients who were brought up for discussion at conferences *prior* to these conferences. Frequently, conference patients were not chosen until the day before the conference before supervision was instigated in the ward. Interestingly enough, this changed at the conferences after supervision was over in which more conference patients were announced - on the intra net and not a piece of paper on the white board like before supervision - a few days before the conference. Before supervision this late decision on conference patients

represented an ethical obstacle since it was impossible to get informed consent from these patients in such a short amount of time.

Together with the team I came up with a 'two-step solution' to this problem. Firstly, the team was encouraged to consider well in advance possible candidates for conferences and tell me the names of these candidates so that I could contact these patients and get their consent. Also this strategy gave team members opportunity to think about possible contributions they wanted to make to the discussion about a particular patient. Still, practice can be chaotic and it is not possible to always predict what comes up. Moreover, the acute discussions proved to be more emotional at times than the discussion which were planned ahead of time. These situations warranted the second solution to the problem of getting consent. A strategy I only used a few times. I videotaped the conference and sought consent from the patient after the conference. If I did not get the consent I deleted the videotape, however, this only happened once. This solution can be said to be an ethical compromise. Together with the team, I decided that the compromise was bearable since I did not use data without having retrieved the consent. The inclusion of patients was, therefore, a balance between ethical and practical considerations.

I believe my situation is not unique, however, the challenge it reflects seems silenced in the ethical debates of health care research in which the ideal is that if patients are to be mentioned by name and their situation is talked about they have a right to be informed and asked if this is okay *in advance and following the right procedures*. Still, it is impossible to always plan ahead what and whom the talk is about – life is more complex and chaotic than that. The point I wish to make here, is that health care research will never be able to catch 'lived order' if consents must be obtained before including data in the study. I, therefore, argue that this dilemma calls for a discussion of the way in which ethical standards can be adjusted to social research in health care settings where acute patients is a common feature of practice!

4.4 Ethical considerations with respect to the team

4.4.1 Additional consent

Using video calls for some ethical considerations since participants are easily recognized. From the start, I emphasized to the team that the video was primarily for research purposes and that only my supervisor, close colleagues and me working to

explore the purposes of my project would watch the video, listen to, or read any part of my data. On two occasions I have, therefore, in writing sought written consent from the team to use the data in different contexts. Firstly, to show video at a research seminar and secondly, to use data for a chapter to an anthology about supervision (article V in the dissertation)

4.4.2 Anonymity

All participants and places have been anonymized. This means that all participants have been given new names. All names of places have been altered. I do not present any factual information such as figures, numbers, names of people and places (which are, of course, anonymized) unless it is absolutely necessary to comprehend or prove a specific point. Denmark is a small place and this fact makes it even more prominent to disclose any personal or factual information. In the beginning the palliative ward did not want to be anonymous¹⁵. After a while, however, I decided to inform the team members that I would anonymize all the data for ethical reasons.

4.4.3 Ethics and the emotional topic

Emotion work did not become the main topic until the fieldwork was over and I had started my analyses. Six months later I visited the ward and my focus did not appear to be a big surprise for team. Everybody involved in the project were aware of the emotional nature of the course of events during the supervision period. During the visit I also told the team that I would be glad to tell them more about my analyses and to cooperate with them and integrate their responses in the process. However, they never contacted me. My impression is that ward got what it wanted from my project during the intervention phase and did not have time or effort to spend on meetings after supervision.

5 Issues of reliability, validity and generalizability

The aim of social science is to produce descriptions of the social world that surrounds us. Descriptions are traditionally called scientific if they in some controllable way can be seen to correspond with the world they claim to describe. This is where concepts like validity and reliability are of major importance since they capture the objectivity and credibility of social scientific research (Peräkylä 1997). However, qualitative research inspired by post-modern and post structuralist directions either reject or call for a re-evaluation of these criteria for adequacy of research. These approaches stress

¹⁵ Please consult appendix 2.

that validity is always constructed within specific interpretive traditions and ideological positions. They do not, therefore, look for or believe in universalistic criteria. According to Atkinson, Coffey & Delamont (2003), the general position of what they call 'the avant garde' "*reflects a thoroughgoing scepticism concerning authority and legitimacy of more conventional notions of methodology, epistemology, and research practice*" (Atkinson et al 2003: 12). I do not consider myself to be one of the 'avant garde' people, however, I do think that they have raised issues of major importance when they draw attention to the contextual nature of research practice and the personal, political and ideological processes affecting the outcome.

Still, I agree with Atkinson et al (2003) when they assert that "*questions raised in 'classic' methodological papers and studies remain important ones*" (ibid: 16). So the challenge for validating social research seems to be how to incorporate and allow for "*rigor and subjectivity as well as creativity into the scientific process*" (Whittemore, Chase & Mandle 2001: 522). According to Peräkylä (1997) enhancing credibility and objectivity of research is very concrete process of asking 'classic' questions. In the following paragraphs I therefore anticipate to qualify my findings by asking the classic questions with a touch of creativity – I hope?!

5.1 Reliability

Reliability has to do with the degree to which the researcher or other researchers might obtain the same results if she went through the same research process again. Working with audio- and videotape recordings as I have done in my study eliminates some of the problems ethnographers have with unspecified field notes other researchers would have a difficult time understanding. Given that the quality of the recordings is good enough, as is the case with my recording, the researcher (I) enhances the reliability of her (my) research since Moreover, these recordings are also publically accessible representations of the social interaction that took place in the field of study. In my study I, for instance, presented data at data sessions with other researchers at the two universities I have been affiliated with to qualify and deepen the analyses.

Although recordings possess an intrinsic strength, Peräkylä (1997) points out that the researcher need to pay attention to the inclusiveness of this kind of data. There are three important aspects they do not capture and I have anticipated overcoming these weaknesses in my data collection as I have shown in the paragraphs on data

collection: Long span temporal processes, ambulatory events and impact of texts and other 'non-conversational' modalities of interaction.

Conversation analytic inspired studies are focused on the sequential organisation of interaction. However, social worlds are also organized in terms of longer temporal processes as it is illustrated very nicely in two famous studies in a similar setting to mine. Here I am thinking of Glaser's and Strauss' (1968), and Sudnow's (1967) studies of dying patients' trajectories in a hospital setting. I have, therefore, used a longitudinal design and made both audio- and video recordings during the ten months I spent in the palliative ward. Having these recording has given me the opportunity to go back and forth in my data to trace re-concurrent patterns. Secondly, each event in a hospital setting demands a variety of data collecting methods if one is to capture everything that goes on. In this case my ethnographic observations of daily routines contextualized the recordings I made of specific activities. Finally, written documents I collected throughout the study have made my understanding and descriptions of the activities in the ward more complete.

5.2 Validity

Validity has to do with the researcher's ability to demonstrate consistently and transparently how he has produced answers to the research questions he has posed.

5.2.1 Ecological validity

I argue that my study possesses a relatively high ecological validity. Ecological validity refers to "*whether data gathered under controlled conditions are commensurate with routine problem solving and language use in natural settings*" (Cicourel 1996: 221)¹⁶. This kind of validity refers the ability of the experiment to tell us how real people operate in the real world. I have not installed anything unusual in the field of study. CS is a common practice in hospitals in Denmark and the head nurse at the palliative ward was planning to get it implemented in the ward when I introduced my project. I planned the empirical part and hired the supervisors. Still the supervisors practiced supervision just as they would have done it in a 'real-life situation'. They used the same techniques they normally use in CS. I, therefore, claim

¹⁶ Cicourel, Aaron V. (1996): Ecological validity and 'white room effects'. The interaction of cognitive and cultural models in the pragmatic analysis of elicited narratives from children. *Pragmatics and Cognition*, 4(2), 221-264.

that what went on in the ten supervision sessions was indicative of 'the local order' with respect to the 'supervisory language game'.

In spite of these considerations, there are two drawbacks with respect to the ecological validity. Firstly, I had to hire outside supervisors. Normally a ward would recruit supervisors locally if they wanted supervision. Secondly, I – as the researcher responsible for the project - negotiated the collaboration agreement with the ward. In a real life situation clinical supervisors make their own way into the ward they are going to supervise in. As it happened I introduced the supervisors – they did not introduce themselves.

Paradoxically, the validity of my claims possibly would have been improved if the same team member had moderated the conferences both before and after CS. Due to the ecological validity of my study and the natural course of events before, during and after the supervisory sessions in the palliative ward, the psychologist who moderated conferences before CS resigned from his job just when the CS was finished. Different team members, therefore, moderated conferences before and after supervision. Consequently, it can be seen how ecological validity not necessarily adds to the overall validity of the study. In hindsight, I might have asked three different people to moderate both before and after CS to make sure that there would be at least one of these moderators who would be the same before and after CS. It would also have improved the validity of my study if I had video recorded more than four conferences after supervision and analysed consultations with patients before and after CS to explore possible changes in how team members communicated emotions in this activity.

5.2.2 Transparency

Validity also has to do with the transparency of claims and how the researcher gets to them. In this regard I have integrated the following considerations in my analyses. Firstly, I have enhanced transparency of my analytic claims by structuring my analyses consistently in a bottom up and hopefully logical manner. The consistency is illustrated in, for instance, similar analyses of the way in which supervisors reformulated emotional topics during supervision and of how moderators reformulated after supervision. Secondly, I have validated my analyses 'through next turn' inspired by Sacks (1995) and the conversation analytic tradition. Researchers within this tradition have pointed out that "*talk-in-interaction has an inherent methodological resource*" (Peräkylä 1997: 291) namely that the speaker will display his understanding

of the previous turn in this talk. This means that people engaged in a conversation will display to each other their interpretations of the talk at hand. Moreover, this interpretation is also available to the analyst.

5.2.3 Institutional character of the interaction

The fact that interaction takes place in an institution does not per se mean that the talk is institutional. The researcher has to show inductively how participants orient towards the institutional setting since the point is that *"institutional roles, tasks and arrangements may or may not be present at particular moments in particular interactions"* (Peräkylä 1997: 294). There is always a danger of importing the institutional context – a danger the true inductive researcher at all costs must try to avoid! Schegloff (1991; 1992) has outlined two basic criteria: The relevancy of categorization and the procedural consequentiality of context

In the first instance, the parties in the talk display what part of a given context and identities of the people present are evoked. In Nordentoft I, I, for instance, show how the team orients towards Martin as belonging to the category of 'terminally ill patient' and how they collaboratively develop the category attributions to this specific category. In the articles about supervision (Nordentoft III, IV, V) I show how the interactants orient towards specific roles and relations in the talk. The supervisor and the moderator reformulate and invite the rest of the group to emotion work – and the participants on the other hand orient towards their role by accounting for their actions as you would expect supervisees and participants at a conference to do in institutional settings.

In the second instance, Schegloff argues that it is not good enough to say that a specific context is oriented to in general. He says that it has to be shown how the specific details are consequential for specifiable aspects of the interaction where the goal is to make a *"direct procedural connection"* between the context *"and what actually happens in the talk"* (Schegloff 1991: 17). This means that the researcher has to focus on phenomena such as lexical choice, turn design, sequence organisation and overall organisation (Heritage 1997). In my analyses, I have, for instance, looked at the use of metaphors and shown how they in the specific institutional contexts seem to allow for emotion work. I have also shown how the constructions of reformulations seem to affect the overall sequential organisation in the institutional setting, which potentially is loaded with unspoken emotions. It is clear that it is the supervisor – or the moderator – who reformulates – or to put it in sports metaphoric language – gives

the ball up. Next, it is up to the other participants to provide a proper response to the reformulation before the talk can proceed.

5.2.4 Deviant cases

Finally, an important method for validating findings in conversation analytic research is to search for and examine deviant cases in the material. Deviant cases are, according to Peräkylä, cases “‘*where things go differently*’ – most typically, cases where an element of the suggested pattern is not associated with the other expected elements” (Peräkylä 1997: 292). Sometimes, as is the case with my study, deviant cases can also exhibit participants’ orientations to the same normative structures that produce the observed regularities. My study includes six deviant cases in which the palliative team orients towards the normative pattern of telling stories and applying metaphors in the talk at the conferences. At the same time, they also deviate from the normative pattern by including additional interactional features in an identifiable and specific kind of story telling which appear to intensify the emotional nature of decision-making at conferences.

5.3 Generalizability

A discussion of generalizability means a discussion of whether results from scientific work can be transferred to and applicable in other contexts. The traditional conception of generalizability reflects an assertion that specific values can be enduring and context free (Lincoln & Guba 2000). However, qualitative research has moved beyond this position and now recognizes the contextual impact on social scientific research. Questions about generalizability, therefore, have to be reformulated and operationalized differently. I, therefore, question if findings from a small study like mine can be generalized? If so – how can this be done?

Off hand, it is likely to conclude that case studies cannot be generalized in terms of the traditional understanding. However, I still claim that there are *aspects* of my study which can be generalized to take place in other *similar settings* due to the ecological validity I have argued for previously. Moreover, I have used and build my analyses on similar findings of research in similar institutional settings. Here I am thinking of the literature on reformulations (Davies 1986; Buttny 1996; Antaki, Barnes & Leudar 2005) and metaphors (Frogatt 1995; 1998; Li & Arber 2006) that are based on research in health care and therapeutic settings. I, therefore, argue that it is likely that my results are applicable in other similar health care settings where CS might be

instigated. What I am arguing here in the terminology of Lincoln & Guba (2000) is that if there is a 'fit' – a similarity between my hopefully 'thick descriptions' of the palliative ward and clinical supervision practice *and* other settings – i.e. the source (my context) and target cases (other contexts) – then the possibility of a generalizability exists.

Peräkylä (1997: 297) claims that there is another route one can take when wanting to discuss generalizability with respect to qualitative data. Peräkylä claims that the word 'possibility' is the key to this. He explains: "*Social practices that are possible, i.e. possibilities of language use*" these themes are the central objects for interaction research. Following this line of thought, he makes the point that "*...the possibility of various practices can be considered generalizable even if the practices are not actualized in similar ways across different settings*". He exemplifies this type of generalization from his own research in which he argues for the generalizability of the description of questioning techniques he has found in his dissertation on AIDS counselling. A questioning technique that is possible across a wide variety of settings. In this study, he shows in details the ways in which these practices are actualized – similar to how I have analyzed the supervisors' reformulations. Peräkylä, therefore, argues that his results are not generalizable as mere descriptions of what

other counsellors or other professionals would do with their clients; but they were generalizable as descriptions of what any counsellor or other professional with his or her clients can do given that he or she has the same array of interactional competencies as the participants of the AIDS counselling sessions have (Peräkylä 2005: 297)

Inspired by Peräkylä, the same thing could possibly be true with respect to my study. This implies that my descriptions are generalizable as descriptions of what any supervisor or other professional with his or her supervisees or colleagues can do given that he or she has the same array of interactional competencies as the participants of the supervisory sessions have!

6 Summary of the studies

In the paragraphs below, I describe the background for the five articles I present in part three. These insights, then, provide information supplementing the interactional analyses in the articles.

6.1 Article I: ‘It will tear your heart apart’: Emotion work and story telling at interdisciplinary conferences in a palliative outpatient ward

The first article addresses the emotional nature of the palliative setting and the ways in which the interdisciplinary team collaboratively appear to manage this aspect in talk-interaction. From the very beginning of field-work I observed that the ‘members practices’ in the palliative ward was emotional in that it encompassed dealing with life and death, patients, relatives and colleagues from other disciplines on a daily basis within a limited amount of time adding to the emotional and professional pressure on the team. I was also often emotionally affected by what I experienced. In fact, I consider managing this emotional side of the project one of the main issues for me in becoming a vulgarly competent researcher. I, therefore, wondered how the team managed the emotional nature of their work and explored this question in my observations of the activities in the ward and in informal interviews with the team members.

Davison (2005) describes the palliative environment as “*an uncertain dynamic environment with a certain conclusion*” and he continues “*prior to arriving at that certain conclusion it is the uncertainty that directs all attempts to provide care*” (Davison 2005: 208) in order give patients and their relatives the experience of ‘a good death’ (McNamara 1995). The ambition of the interdisciplinary team¹⁷ in the palliative outpatient ward was to provide a holistic care¹⁸ that enhanced the quality of life for the patient and his family by attending to most of their needs in the terminal stage of life (Li 2004; WHO 1990). The team in the palliative ward counselled both

¹⁷ Interdisciplinary teams are teams, where the members continue to work from their particular professional orientations but undertake some joint collaborative work (Opie 1997). The team counted 13 members and consisted of physicians, nurses, one psychologist, a physiotherapist, a dietician, a secretary and social worker.

¹⁸ Holistic care implies that all of the patients possible needs - physical, mental and spiritual- are taken care of by the interdisciplinary team

patients and relatives at the hospital and in their homes, co-operated with other hospitals, the hospital vicar the general practitioner and the home care.

Often the palliative ward also took care of patients the other wards have given up on. For these patients the palliative ward became nearly their second home, a place where they could feel safe and where they knew the team would listen and attend to their needs. Still, the literature on hospice and palliative care describes the way in which palliative staff members often are frustrated by the lacking recognition by mainstream medicine and *“frustrated in their attempts to validate their ‘caring rather than curing’ approach to terminal illness”* (McNamara et al 1995: 241). In the palliative outpatient ward, several team members expressed that they did not feel that they got enough recognition for their work neither from their fellow colleagues, the organization or the other wards. Because most palliative patients are defined by the fact that they cannot be cured they potentially have a low prestige in the hospital system – especially among physicians – who may believe that the most rewarding duty of a physician is to cure his patients. This lacking recognition could be evident in daily challenges in the co-operation between the palliative ward and other wards. The palliative ward, for instance, was confronted with many prejudices about and resistance towards the palliative treatment of pain like, for instance, the prejudice about making drug-addicts out of patients from the treatment with morphine. Being a pioneer, therefore, seemed to be a two-edged sword. On the one hand, it was not much fun not to get recognized by the organization for what you were doing on the other hand I observed that the recognition the ward got from most patients was explicit and exceptional. In fact, this recognition in many respects seemed to make up for the recognition the ward lacked from the organization and infused the palliative ambition of providing a good death for patients.

I, for instance, observed that the ambition of achieving a 'good death' for patients and their relatives did not stop when the patient was dead. Especially patients with 'problematic' home conditions appeared to get the emotion talk going both before and after they had died. 'Problematic conditions' could be, for instance, that the wife or husband was away a lot from home, conflicts with children, wives or husbands. The nature of these challenges seemed to be indicative of the ward's normative pattern for how one should behave – live and die – when belonging to the membership categories of 'terminally ill', 'wife to terminally ill patient' and 'family with at terminally ill patient'. Consequently, my study support findings of other studies within palliative

settings in pointing towards the ideals of what a 'good death' is supposed to be like in these settings (McNamara et al 1995; Kristjanson 2001).

The team, then, conceived care of the dying as important, rewarding and satisfying. It appeared to give them a sense of both professional but also personal and existential form of meaning. One nurse even told that working with palliation made her feel privileged and in a sense gave her life meaning when she was off work. Exactly these aspects of palliative care are highlighted by the literature in describing how terminal care can provide a sense of interconnectedness, of mutual nurturing and of "*being close to patients and sharing a part of one's self; having the chance to make a difference in peoples lives*" (Vachon 2005: 997).

Several of the palliative team members, however, experienced that they could not talk openly about the nature of their profession when they were off work. The openness towards the dying process in palliative care appeared to contrast with societal and attitudes towards death and dying which generally are marked by apprehension, fear and avoidance (Lyth 1988). This sensitive nature of the team's work in dealing with frail, ill and frightened patients and their families who are vulnerable and perhaps unwilling to thrust into the "*final act of parting*" (McNamara, Waddell & Colvin 1995: 241) has been described as adding to the stress to palliative teams. I, therefore, argue that an emotional dimension is added to the cooperation and interaction in palliative teams. The weekly conferences in the palliative outpatient ward were, for example, not only used for clinical decision-making (Drew and Heritage 1992; Arminen 2005). I also observed that they were used as a forum in which the team members displayed empathy and sympathy and shared their experiences and in the telling of stories and second stories (Sacks 1995 April 24: 764-772; Ruusuvouri 2005; Bülow 2004). My initial observations align with the findings of previous studies maintaining that patients who are especially at risk of not getting 'a good death' affect palliative team members emotionally and that they respond to this emotional stress by telling stories about these patients over and over again until they die "*in order to consolidate the lack of control*" (McNamara, Waddell & Colvin 1995: 238). I, for instance, observed that the team had a difficult time closing the talk about these patients and that the sharing became increasingly intense, collaborative and emotional. This kind of emotion work remained unchanged in my data through out the course of the project and in the article I analyse data from one of the conferences towards the end of the period of supervision. The last three conferences the supervisor no longer moderated the conference she merely assisted the team member who were assigned to

write key-words down on the flip-over chart the ward had bought to increase the focus of the talk at the conferences.

Former research in palliative settings has mainly focused on nurses (Kristjanson et al 2001; Costello 2006; McNamara et al 1995). Until this article the interactional management of emotions in palliative team-talk and the ways in which emotions have an impact on decision-making in this setting remains unexplored. The first article in the dissertation, therefore, contributes to the existing research into palliative care by adding analytical and empirical observations about the interactional and collaborative management of emotions and decision-making. In the article, I explore the following questions:

- What can the interactional dynamics of story telling tell us about emotion work at team conferences in a palliative setting?
- How do the team members respond to the stories and how do they appear to affect the decision-making in this setting?

The findings are derived from a single case analysis of a conference in which the team is talking about a terminally ill patient. The analyses demonstrate that the team collaboratively does emotion work in a sequential pattern where the telling of an atrocity story is followed by a grim future scenario, then a sympathetic second story and ended with a suggestion for future medical actions. In the telling the filling of category attributions to the membership category: Patient, in the course of the telling is constructing and intensifying the patient's tragic character and risk of dying a bad death. The patient is not only ill, he is also both young and terminally ill. Moreover, he is primary caretaker of two younger children. Together with these features the use of extreme case formulations and metaphors in the telling seem to warrant emotion talk, call for certain actions and, therefore, provide for emotion work at the conference.

6.2 Article II: Negotiating field roles in qualitative health research

Critics within palliation claim that the back side of wanting to make a difference for patients and their families in order to fulfil the idealistic notions of palliative care seems to be that palliative staffs have a tendency to suffer from a "*vener of niceness*"(Aranda 2001: 572). Aranda argues that this 'niceness' seems to inhibit palliative staffs from challenging and developing care because

When you work in a context that provides you with a positive feed-back about your work every day, it is easy to develop a self-satisfied and warm fuzzy feeling about what you do (ibid: 576).

Li (2004), however, asserts that this ‘symbiotic niceness’ - as she calls the niceness existing between patients and their caretakers – represents a core component of professional and patient identity in palliative care “*which works to maintain social orderliness as well as to advance personal, professional and organisational aspirations*” (Li 2004: 2571). During fieldwork I, therefore, took a special interest in patients who appeared to challenge the palliative culture of ‘niceness’ in that they illuminated the way in which things were supposed to be done. According to Li and Arber (2006), palliative nurses categorize these patients as ‘troubled patients’ in that they are

dying from a terminal disease, which makes them difficult. Such patients are presented as irritable, demanding and critical of palliative care staff (Li and Arber, 2006: 27).

In the beginning of my fieldwork, the palliative ward treated a terminally ill patient called Iben. Iben was critical and demanding of the services of the palliative team and she, therefore, appeared to be categorized as ‘a troubled patient’. In article II, I address a case study of interactions between her and myself in that she did not only seem to challenge the MCD’s of the team members but also my position as a researcher in the field of study by recruiting me as a confidant and insider into a dialogue about the repercussions of my influence on the previous consultation of which I had made a sound recording. Iben, then, attracted my attention to the ways in which participants’ roles in the field of study are constantly and interactively negotiated.

Iben illuminated my outsider-position in her talk in spite of the fact that I had chosen to wear a white uniform and not my own clothes when I was in the ward in order to downplay my ‘difference’ when observing the interactions with patients. At the same time I was aware of the risk of going native being a former oncological nurse. Still, I considered my choice to be beneficial both for the team, the patients and me because the uniform did not attract attention my presence in the same manner as wearing normal clothes would have done. It might have confused the patients and made them think that I was, for instance, a psychologist or a social worker and I would have to do more explaining about my project and presence, and this might shift the focus in the wrong direction – away from the normal practices.

The purpose of this article, then, is to look at ethnographic work as a dynamic process of negotiation affected by ethnographic tensions such as engagement, strangeness, distance and familiarity. I argue that previous research does not capture and lacks an exploration of the ways in which the traditional bipolar constructions of ‘insider/outsider’ relationships are constructed interactively. The research questions are:

- How can the interactional dynamics of insider/outsider relationships be described?
- How does the patient appear to recruit the researcher as an insider and a confidant in the field of study and how does the researcher respond?
- How do participants orient to the institutional context in-talk in-interaction?
- What can the interactional dynamics of insider/outsider relationships tell us about the normativity of the setting?

In the article, I assert that the negotiation of roles and relationships in ethnographic work can be understood and explained in more detail by looking at the reflexive relationship between micro-level interactions and their normative and institutional underpinnings from an EM approach. This approach illuminates the way in which participants – in this case the team members including the researcher - orient to a different exogenous set of normative values, categories and expectations which affect their positions as insiders or outsiders in-talk-in-interaction. The analyses, for example, demonstrate different ways in which the patient, Iben, orients to – and is treated as – a ‘troubled patient’ in her talk. The detailed analyses of the interactions between the researcher and the patient reveal how she appears to challenge the researcher’s position by inviting her to a morally dubious conversation resembling gossip. Furthermore, the physician, for instance, gets frustrated because Iben does not want to talk about her death - where and how she wants to die - and, therefore, she makes it difficult for him to fulfil his professional and also the palliative ideal of ‘a good death’.

With Psathas (1999) I claim that by “*understanding how ‘categorization work’ is ongoing we can also understand how organizational context is invoked and made relevant by the parties since organizational identities are involved*” (Psathas 1999: 142). These identities and roles establish structural relationships between people implying certain roles and asymmetries, i.e. power configurations explicit in, for instance, researcher/participant and physician/patient relationships. Looking at the

interactional constructions of these relationships are seen as crucial in that *“our role in the setting is inherently connected with what we ‘find out’”* (Allen 2004: 16). Relationships between the researcher and the researched, then, have a profound impact on the outcome of a scientific study. In this regard I argue that an EM informed perspective explicates the social conditions of the produced knowledge.

6.3 Article III: Reformulations and reflection on emotions in clinical supervision

As we enter new practices or social situations - like CS - we need to learn the forms of talk, i.e. the language games, and the ways of acting relevant to those practices – in fact that is what the practices are made up of (Peräkylä & Vehviläinen 2003). In this regard, CS is described as a reflective practice in which the supervisees have an opportunity to talk about and reflect on a situation or a problem from their every day practice. (Lund-Jacobsen & Holmgren 1996). Previous literature emphasize that being supervised means that you do not only learn more about your own practice you also learn a new ways of interacting (Pedersen & Lykke 2007). After CS was over, the physiotherapist, for instance, stated that she felt as if she had learned a new language. *“I feel like I have a new platform to stand on”* she said.

In the third article, I investigate the supervision intervention from a particular perspective. Given my theoretical focus I avoid theorized accounts and generalizations about the nature of reflection (Garfinkel 1967). Instead, I inductively explore the methodological production of CS and explore how it is constituted and accomplished as being a reflective practice in and through talk. In the analyses, I, therefore, focus on the supervisors and their utterances in that I consider them to be role models for how CS ideally speaking should be practiced. Furthermore, I combine the investigation of CS as a reflective practice with an exploration of the ways in which reflection on emotions are done in CS in posing the research questions below:

- How can CS be seen as a 'language game' for doing emotion work?
- How can the interactional dynamics of this language game be described?

Due to space and time limits, I primarily draw on data from the supervisory sessions in the analyses. Moreover, I found that the language game for emotion work was conducted similarly in the supervision of the conferences. In the article I supplement previous research on client's narratives in therapeutic settings with what the therapist,

here the supervisor, makes relevant in her reformulations from supervisees accounts and how she rhetorically moves into and legitimizes her professional version, i.e. ‘the therapist’s version’ (Buttney 1996), in this case, the emotional discourse. I argue that my findings are capable of illuminating pre-defined models of the ways in which professional are supposed to act in specific settings such as, for instance, CS. These models are called “*stocks of interactional knowledge*” (SIK) by Peräkylä & Vehviläinen (2003). In the paragraphs below, I intend to provide the reader with additional contextual information about the work of the supervision group as a frame of reference for articles III, IV and V.

6.3.1 The organization of clinical supervision

The supervision group met ten times: First time for three hours and thereafter two hours each time¹⁹. All team members participated and I was present as an observer. Because the group was a big group with twelve participants two supervisors, Karen and Grete, supervised the group.

CS took place during the normal working hours at the end of the day in the same room, where the weekly interdisciplinary conferences are held. Furthermore, most of the team was dressed in their uniforms and not private clothes. Considering these facts the tables were moved out of the room and the members were sitting in a circle in order to create a different atmosphere than usual. However, the physical surroundings possibly affected the supervisees’ sense making of the supervision sessions in that they oriented to the similarity of the two activities. Moreover, the first two supervision sessions also revolved around problematic patients – just like the weekly conferences. During the fourth session most of the supervisees expressed that the supervision sessions reminded them a lot of the weekly conferences. Moreover, it came out that they would rather talk about the interpersonal relations of the team and how they collaborated in their daily practice. Later on in this session, several team members expressed that they felt insecure and lonely in the team. From the fourth session, then, CS moved into a different phase in which the focus was changed from the relationship between the therapist and the client/patient to the relationship between the therapists – i.e. professionals of the team.

The talk in the next supervision sessions revealed that the social and cultural history of the palliative team had been a challenge to all team members. Most of the team

¹⁹ A brief summation of events in each session can be seen in appendix 3.

members had, for instance, been employed during last three years in which the ward had expanded extensively. On top of that the ward had been moved to another part of the hospital. A few years prior to my study, there was only two nurses and two physicians and they just had a couple of small consultation rooms to operate in. Since then, the rest of the team had been employed on different conditions. The physiotherapist, social worker and dietician were employed part time and did not have offices in the ward. Also the two younger physicians did not have offices in the ward because they alternated working two days pr. week in the ward. Lastly, two of the nurses had one-day pr. week off. The supervision sessions displayed that these conditions had been a challenge for the palliative team members in creating a 'team spirit' and a healthy working climate.

The change of focus also changed the structure of the sessions. From the fourth session the main structure of the supervision sessions was 'the round'. A 'round' was simply is - as the word indicates - a round in which everybody's opinion one by one was heard. During the round, one of the supervisors interviewed each member briefly. She then re-formulated what she had heard to assess what the supervisee was saying. Often the supervisor would combine or compare this new information with what had been said previously and question the nature of the difference between these statements. In this process, the supervisors were active listeners who from time to time reformulated supervisees' utterances. Supervisors also used a blackboard to write down and sometimes organize key words in supervisees' talk. Finally, they occasionally introduced breaks for reflection after the initial presentation of patients – at the conferences - or problems/compliments expressed in the supervision sessions. In these breaks, supervisees were invited to reflect on what they had heard for a few minutes in silence. After the break, there was a new round during which the reflections of all supervisees were heard. The supervisors took turns being the primary supervisor. The other supervisor came with follow up questions and clarifications, when it was called for. The exploration of supervisors' reformulations drew my attention to how they seemed to illuminate emotional themes in the interaction for the next four sessions.

A manifest feature of the supervisory language game for emotion work, then, appeared to be supervisors' reformulations of supervisees' utterances. The supervisors demonstrated their professional expertise in the talk about emotions during CS by creating a focus on emotional aspects in the supervisees' statements. They transformed supervisees' utterances from being potentially implicit to explicit

emotionally loaded (Buttny 1996). In this process, the supervisors shifted perspective i.e. 'footing' and elaborated on metaphors introduced by the supervisees. This 'footing', moreover, integrated moral aspects in the reformulation by indicating that it should be allowed to talk about and feel something.

In article III, I, then, demonstrate the ways in which emotional topics were illuminated in the talk and I, moreover, illustrate how the supervisees failed to respond to the supervisors' invitation to do emotion work on several occasions and how the two supervisors handled these incidents. One reason for this lacking response could be the supervisor's inaccurate documentations in these reformulations as I exemplify of in the analysis of the first extract in the article. Perhaps the difference between what the supervisees had actually said and what the supervisors re-formulated was too big in order for them to accept or recognize the reformulation and do emotion work. Still, supplementary analyses from the supervision sessions and informal interviews with the team members indicate that there may be several other explanations for supervisees' lacking responses and hesitance to do emotion work.

6.3.2 Insecurity and loneliness

One of the nurses, for example, stated that the team had not had a culture for expressing emotions. Apparently, the supervisees were afraid of getting "undressed" and exposed emotionally as the social worker phrased it in her commentary in the talk about whether to engage in talk about the interpersonal relations of the team. In article III, I demonstrate the way in which one of the supervisors, Karen, integrates this comment in her reformulation and appear to invite the supervisees to do emotion work. The supervisees started to do emotion work half way in the supervision sessions and it became more apparent why several of the supervisees were reluctant to speak up in the group. Several supervisees, for instance, kept returning to a feeling of insecurity for various reasons. To begin with one of the nurses attracted attention to an unspoken rule which seemed to dictate that the nurses generally did not ask each other for help - only in special cases. She, therefore, often felt insecure in that she did not know if she was doing things 'the right way' and moreover, she did not feel she could ask for help if she needed it. This fact increased the stress she sometimes felt even more. Furthermore, several of the supervisees mentioned that they did not like – or even understand – the tough language which was frequently used in the ward. Several of the supervisees characterised this language as being ironic and very direct at times and it, therefore, made several team members feel insecure and reluctant to speak up at conferences. In article III, I present an example in which the supervisee Vera talks

about her insecurity and lacking understanding of what the meaning is in what is being said. In the analysis of this example, I demonstrate the way in which the supervisor assists Vera in formulating and practicing how she can handle the next situation in which she is confronted with a colleague's tough language. In this situation, Vera displays her understanding of the supervisory language game in that she shows how she will precede in future interactions.

The supervision sessions were filled stories and second stories (Sacks 1995) about the loneliness a majority of the supervisees experienced in their daily work. Ironically, the experience of loneliness, in a sense, became a collective experience and thereby in a sense created a space in which the loneliness was dissolved. In their stories, the supervisees used forceful metaphors like such as: To be an ice flake in a big ocean, to be swimming in an ocean looking for the shore, a flower living in the dark. These expressions seem to concur with what Jones (2003; 2005) has described in her studies of CS for palliative care nurses in which she illuminates the feelings of isolation and moreover, a search for meaning work with terminally ill patients might lead to. Severinsson (1995b) describes that loneliness can be explained as "*a lack of trust and lack of ability to relate to oneself and to others*"(6). The nurse, Julie, attracted attention to the irony of the ward's ambition to provide a holistic care for patients but not for the employees. In this respect, another nurse questioned why the 'competent' palliative team members capable of analysing and dealing with the pain and discomfort of patients were unable and, in a sense, 'incompetent' of facing and handling their own pain. She said: "*Why can we not make a pain history and initiate treatment on ourselves*"? The supervisors displayed their recognition of the supervisees' statements by reformulating, elaborating on and thereby confirming their statements similar to what I have shown in article III.

During the eight supervision, session three of the nurses were able to talk about and discuss their mutual expectations to each other – and also when these expectations had not been met in the past. In this talk, they kept returning to the way in which they missed to be recognized for what they doing and accomplishing in the daily work from their colleagues. It appeared like this message was heard by some of these colleagues during the last three sessions in which several supervisees paid compliments to the other colleagues/supervisees in that they explicitly recognized and verbally appreciated them as colleagues. The psychologist, for instance, said that he was grateful for having such good colleagues and one of the nurses said that she cared about all of her colleagues and that she really wanted to make it work between them.

After these compliments, the supervisors conducted 'a round' in which each team member was asked to respond on the compliment and express the way in which it made him or her feel – or think. Moreover, the supervisors explained why they made these rounds in saying that they were thinking that part of the reason why so many expressed a feeling of loneliness was caused by a lacking response from the other team members. In the last sessions the supervisees, then, seemed to improve the troubled atmosphere in the team by explicitly showing each other collegial respect and care. With Severinsson (1995b) it can be said that *“the ability to establish a relationship is dependent on levels of self-respect and self-confidence as well as respect for others”* (6).

6.3.3 Summing up: Clinical supervision

The supervisees' hesitance to do emotion work in the beginning of the supervision sessions can be seen as being partly indicative of how collaborative teamwork in palliative settings is often not without conflicts and challenges for a complex number of reasons ranging from organisational to personal (Larson 1993; Vachon 1986, 1987; Arber, in press; Li and Arber 2006; Payne, Seymour, & Ingleton 2004; Reese & Sontag 2001). According to Reese & Sontag, it is a challenge *“to cross cultural boundaries between professions, to adapt differences in values and theoretical perspectives, and to relate with respect and appreciation for colleagues expertise”* (Reese & Sontag 2001: 173). Still, the expertise of each team member cannot be fully realized the team is not capable of fulfilling the ambition of giving patients a holistic care. The work of the supervision group was, then, not only difficult for supervisees but also supervisors and in that it was hard work to build a room for mutual trust and confirmation. In this regard, I align with previous research and experienced supervisors who maintain that inter/multi-disciplinary supervision represents a professional challenge for supervisors in that it demands a constant coordination of different professionals' new understandings and modes of action (Pedersen & Lykke 2007; Hyrkas & Appelquist-Schmidlechner 2003). According to Vachon, the statement of Mount and Voyer²⁰ sums up the difficult and demanding process of working in a palliative team: *“Team's just don't happen. They slowly and painfully evolve. The process is never complete”* (Vachon 1986: 75). In the articles of this dissertation I have not fully explicated the ways in which these challenges were dealt with in the supervision group. This topic is certainly important to investigate in future research into inter/multi-disciplinary CS.

²⁰P. 466 in: Mount, B. & Voyer, J.: Staff stress in palliative/hospice care. In I. Ajemian and B. Mount (eds.): *The RVH Manual on Palliative/hospice Care*, 457-488. New York: ARNO Press.

6.4 Article IV and V: ‘Changes in emotion work at interdisciplinary conferences after clinical supervision in a palliative outpatient ward’ and ‘Sprogspil om følelser i sundhedsprofessionel supervision’

The fourth and fifth article looks at the changes of the interdisciplinary conferences after CS and address the following research question:

- How do the supervisees proceed and do emotion work in their daily practice after CS – here exemplified by the weekly interdisciplinary conference?

The fifth article is a popular version combining the findings of article III and IV in that it is being printed in a new anthology about the perspectives and methods of CS as it is practiced in Denmark. Moreover, the fifth article also presents some examples of the ways in which the team members appear to recognize and confirm each other’s emotion work at the conferences after CS – something I did not observe to happen at conferences before CS.

In the articles, I conclude that the supervisees appear to have learned important features of the supervisory language game in that they seem to adapt these features in their organization of the conferences after CS. Both article IV and V takes their points of departure in conceiving reformulations as a main interactional feature of the supervisory language game for emotion work. Furthermore, these articles display how the reformulations appear to be institutionalized after CS has terminated in the ward. Clearly the supervisors became role models for the way in which moderators at these conferences reformulated emotional topics. Interestingly enough, the other team members also began to reformulate and initiate talks about potentially emotional topics. This institutionalisation and, moreover, construction of moderator’s reformulations together with moderators’ elaboration of team members metaphors seem to legitimize emotion work as a business in its own right by providing space for talking about and recognising emotions and specific actions taken by the team members. Ethical considerations, for instance, were stimulated through breaks for reflection followed by another main feature for the supervisory language game: ‘The round’, during which all team members were heard. In the round, team members who did not normally speak up was heard and brought in new emotional perspectives on the care and treatment of patients. Lastly, the use of a flip-over chart to write down keywords in the talk seemed to be a point of reference which focused and enhanced emotion work at the conferences.

To summarize, there were striking similarities between the ways in which the supervision group, CS of the conference and conferences after CS were organized and how emotions were introduced as topic. I assert that the ‘new’ language game for emotion work at the conferences appeared to enable the team members to evaluate and to adjust their actions differently than before CS. The analyses in the articles demonstrate how the interactional features of the supervisory language game, i.e. the round, the break for reflection, the reformulation initiated professional, moral and ethical discussions on how qualified care could be characterised in the specific context. Whose needs should be taken care of and how this could be done? These features, then, appeared to illuminate a dual aspect of care in the sense that it serves the needs not only of patients but also team members. I, therefore, believe that this recognition captures one of the great challenges in palliative care namely to separate the carer’s own needs from patients. The articles conclude that CS seems to enhance professional development and may prevent stress and burnout in palliative care.

7 Discussion and perspectives

In this last chapter of the dissertation I start by discussing significant aspects of my findings followed by a conclusion and, finally, a listing of perspectives for future practice of and research on CS.

7.1 Discussion

My analyses of the activities in the palliative ward demonstrate the way in which the team members work hard to give the patients a good death and fulfil the palliative ideal of providing holistic care. These professional ambitions, however, sometimes collide with respecting patients’ own agendas and autonomy as I have demonstrated in Nordentoft 2007c and appear to cause emotion work. In this regard McNamara (2004)²¹ asserts that the ‘good death ideology’ has become increasingly inappropriate in “*the current climate of patient autonomy and consumers choice*” (929) and transformed into ‘a good enough death’. The palliative staffs are faced with a challenge of balancing the character of their professional care for terminally ill patients both with respect to social, psychological and physical needs. In other words, when to and when not to intervene in order not to violate the patient’s autonomy. This apparent tension between acting and not acting appears to be evident in the

²¹ McNamara’s article is based on recent anthropological studies in palliative care settings.

interactions with patients but also underpins the good death. This challenge, moreover, illustrates the complex interplay of decision-making which is premised on the staff's *"skill at identifying opportunities for communication"* (ibid: 933). Some palliative staff members respond to this challenge, according to McNamara, by adopting a compromised stance and focus on the physical care and treatment adjusting to the principle *"that people die very much as they have lived"* (ibid: 930). However, what seems to be a compromise *"informed by ethical practice masks a return to routine medical practices and a hierarchy of care which prioritises the physical management of symptoms"* (ibid: 929).

In the light of these tendencies within the last decade, I would, therefore, argue, that it becomes even prominent to create reflective spaces like CS for staff working in palliative care. In CS, the palliative staffs get a chance to talk about, work out and specify the nature of their ambitions and patients and, moreover, how to implement them in practice (Kristjanson et al 2001). If not, there is a risk that they withdraw from patients, do not get as involved as they would have and legitimize their withdrawal with patients ability to make the right decisions themselves – i.e. their autonomy. In Nordentoft I, I, furthermore, draw attention to the way in which emotional aspects are added to the cooperation in palliative team in that they often cannot discuss the nature of their work outside work.

In this respect, I suggest, along with several other researchers (Jones 2003; 2005; Kristjanson et al 2001), that inter/multidisciplinary supervision is a setting in which the palliative staff can share and separate their own emotional involvement from the professional affiliation to patients and thereby qualify and balance the care of terminally ill patients. Furthermore, these talks may strengthen the interpersonal ties, the social cohesion and create trust among the team members. Trust is seen as having a major impact on professional developments in both inter/multi-disciplinary teams and supervisory groups (Davison 2004, Severinsson 1995; 1995b; Kristjanson et al 2001). According to Davison (2004), these factors help create a mutual language and responsibility in the team which may, moreover, assert the importance of creating a commonly understood language which, for instance, may improve communication on ethical issues and meaning in practice (Reese & Sontag 2001). However, my analyses also reveal along with previous research that inter/multi-disciplinary supervision is not an uncomplicated process neither for supervisees (Hyrkäs & Appelqvist-Schmidlechner & Paunonen-Ilmonen 2002; Hyrkas & Paunonen-Ilmonen 2001) nor supervisors (Hyrkas & Appelquist-Schmidlechner 2003). Inspired by Yegdich's

research (1998; 1999; 2000), I propose that the shift of focus from the relationship between the therapist and client, i.e. patient, to the relationship between therapist's, as is the case in my study, represent a new and different challenge for supervisors which potentially affected the building of trust between the supervisees and supervisors

In this regard, Kilminster and Jolly (2000) claim the single most important factor of the success of a supervisory process is the relationship between supervisor and supervisee. Unfortunately, there are no recipes for the way in which trustful relationships can be built. Instead, I maintain it becomes important to study and to discuss incidents in CS in which trust appears to be challenged. What happens, when and why? And, moreover, how do respectively the supervisor and supervisees respond to these challenges. My observations, for instance, show that there were many longer pauses at the time where the supervisors invited the supervisees to talk about their interpersonal relations. Moreover, I have shown the way in which the supervisors in their reformulations appeared control the topical agenda and to introduce a *new* normativity in which it was only natural that one should be able to/allowed to speak up and say how one feels. These statements are in principle impossible to disagree with and yet, I would argue that supervisors also need to pay respect to the individual supervisee and not put pressure on him or her to do so if he or she seems to be insecure or do not know what to say. In this regard, 'the round' can be seen not only as a feature of CS that enhances democratic dialogue but also a feature putting a certain pressure on the individual supervisee to express his/her emotions. With Yegdich, I believe that supervisees need to feel 'a freedom' from being 'therapized' in CS (Yegdich 1999: 1273). On the other hand there is a need for a space in which health care workers can talk about their work related emotions, however, CS should aim at being a 'trustful' rather than a 'confessional' practice (Clouder & Sellars 2004). Future interactional research into the CS intervention itself is, therefore, called for and I suggest that this research should/could explore more in detail the way in which emotion work is done in inter/multi-disciplinary supervision.

7.2 Conclusion

This dissertation has primarily brought together two areas of inquiry: Clinical supervision and emotion work. However, in working with the dissertation the palliative setting increasingly has become a third and prominent theme in the dissertation. This study, then, contributes to previous research into interactional analyses of emotion work in palliative settings (Li & Arber 2006; Li 2004) of CS in

palliative settings (Jones 2003; 2005; Feld & Heyse-Moore (2006) and lastly, of CS of multi/interdisciplinary groups (Hyrkäs & Appelqvist-Schmidlechner & Paunonen-Ilmonen 2002; Hyrkas & Appelqvist-Schmidlechner 2003; Hyrkas & Paunonen-Ilmonen 2001; Østergård 1995).

The interactional investigation of the language game for emotion work at interdisciplinary conferences without supervision and in supervision sessions provides knowledge into how emotions are realized and made relevant by participants in interaction. This inductive perspective contrasts with theoretical constructs and predefined terms like Hochschild's terminology for emotion work and oppose the import of this terminology into the data as explanatory frameworks without grounding in the data. Rather, this study has revealed that emotion work is a social organized phenomena and *"made visible as a consequential event through systematic practices that are lodged within the processes of situated interaction"* (Goodwin & Goodwin 2000: 48). The analyses have shown the fruitfulness in operating with an open definition of emotion work by looking at emotions as interactionally constructed and not only focusing on emotion displays and emotion talk, in which it appears to be more clear cut whether people in fact get emotional, but also on interactional phenomena leading up to or following emotion displays and/or emotion talk. In this respect, I have mainly focused on emotion talk and interactional features leading up to this talk in the dissertation. Here, the exploration of membership categories, atrocity stories, the construction of reformulations and metaphors in the sequential organization of talk as interactional resources illustrating speakers' orientation to emotion work in the talk. The exploration of the discursive dynamic of emotion work in the specific setting, then, contribute to previous DP studies in which rhetorical aspects of emotion work in calling for specific attitudes to and actions with regard to the practices in question are illuminated. Furthermore, the analyses reveal how emotion work is used to emphasize professional accountability, to demonstrate sympathy and empathy in talk and, therefore, appears to be both self- and other-directed. Still, I find that that further investigation into emotion displays are called for in future research into CS²².

In the process of analysis, I found it difficult – just like Sandlund (2004) to label the phenomena I observed. According to Sandlund, it is not unproblematic to apply emotion terms we use in everyday language in emotion research. She, for instance,

²² Please consult the next paragraph on the perspectives of the study.

questions how we distinguish between displays of fear, anxiety and shyness – and moreover between enjoyment and exhilaration? Sandlund asserts that there is

No be-all and end-all method of proving a strict correlation between psychological changes, feeling experiences and outer behaviour. They just capture different aspect of what emotions are, do, and feel like, and no contribution is less important in understanding the full extent of what emotions are and do (Sandlund 2004: 317)

To conclude CS has suffered from being an umbrella term applying many different theories and methods. My project has been to uncover the interactional features of the supervisory language game for emotion work and de-mystify what in fact happens in CS. In the articles II, III and IV I demonstrate the nature of the supervisory language game and the basic interactional features it contains. However, as my previous discussion demonstrates there is still much to be explored to achieve this goal. Below I, therefore, list perspectives for future research.

7.3 Perspectives

7.3.1 Supervisees' motivation

After CS had terminated in the palliative outpatient ward, most members of the interdisciplinary team evaluated CS in positive terms. However, nobody responded positively when asked if they would pursue CS in the future. One nurse explained her position in this way: *"It takes time away from patients!"*

Her remark captures one of the great challenges CS is struggling with (Hyrkas 2006). Apparently this nurse – along with many others – has not been exposed to the benefits of CS on her every day practice. Or – could it be that it is not the research but CS itself which has a problem with its purpose and methods which needs attention in future research? Lastly, CS cannot be looked at independently of the context where it is practiced. In this respect it is interesting to note that CS has established itself as a practice at the same time as the health sector has become increasingly affected by a management culture and evidence based practice, where ideas of rationality, efficiency and neutrality are illuminated (Arber, in press; Nikander, in press). The nurse's evaluative remark draws attention to how time and what the time is used for has become an important factor CS is facing when it has to account for its relevance. Her response clearly indicate that she is very busy and does not have time for CS and,

most importantly, she feels it takes away time from patients. The question, then, seems to be: What would motivate her? In this respect, it would be interesting to make a study looking into why health care staff members do not want to be supervised. In other words, a study that uncovered and provided an outside perspective on CS clarifying the way in which supervisors account for purpose and methods in CS.

The present study reveals that CS can be seen as a method that improves supervisees' communicative competences at interdisciplinary conferences. Much of the previous research has focused on the subjective well being of supervisees after having received CS. My results indicate that CS also stimulates collective learning processes in that it enhances team members' collective questioning of their practices. I argue that this perspective might motivate future supervisees who potentially are afraid of being undressed emotionally – just like supervisors often experience supervisees articulate their scepticisms with regard to CS.

My findings indicate that it would be fruitful to introduce CS in supervisees' every day practices by having for instance meetings and conferences supervised in the wards by professional supervisors. In fact this introduction might motivate future supervisees and make them experience how the supervisory language game works. To explain the nurse I quoted initially *why* she has to spend her precious time on CS, the research into CS also has to demonstrate the way in which CS positively may affect her care of patients. In this respect, my findings show how a more holistic care and treatment of patients can be increased by improving interdisciplinary cooperation, looking at care giving as emotion work by explicitly addressing emotional topics and making emotion work a business in its own right.

7.3.2 Research on the supervisory relationship

As mentioned in the discussion more research is called for looking into the ways in which supervisors 'do' CS. In this regard, my findings also point to some interesting sub themes like, for instance: Who is supervising whom? The two supervisors in my project were former nurses and they in this project they were supervising both males, females, academics and non-academics. I have not discussed the group dynamics or gender issues in this dissertation, however, the supervision sessions revealed that the male academics and the most educated nurses were challenging the supervisors' agenda more than the other supervisees. I, therefore, consider an exploration of the roles and relationships between supervisor and supervisees to be important aspects to

investigate in future research. These insights can be used in preparing future supervisors for the challenges of multi/inter-disciplinary supervision.

7.3.3 Research on the supervision session

My preliminary analyses of the supervision sessions suggest that primary *talk* about emotions appear to function as ‘emotional massage’ and precede both positive and negative emotional *displays* like laughter and crying. Most of the laughter and crying episodes seemed to ‘unite the group’ and give them mental space different from their every day practice. These episodes appeared to be a point of departure for talks about insecurities and frustrations both at the individual but also at the collective level in the organization. CS, therefore, can be seen as a context in which the members of the supervision group are using laughter and crying as interactional resources to do emotion work. It would be interesting to dive deeper into these preliminary findings and explore when and how laughter and crying episodes occur and what their interactional impact is.

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9 Dansk resumé af ph.d.-afhandlingen: ‘At gøre emotionelt arbejde’. Sundhedsprofessionel supervision i en palliativ afdeling

Forskning indenfor det sociale og sundhedsmæssige felt viser, at det professionelle ideal om at være rationel og neutral stadig har stor betydning for den professionelle rygte og position (Nikander in press; Arber, in press)²³. Ledelsen på hospitalerne forventer desuden en professionel praksis, der baserer sig på en på *"nøgternt og videnskabeligt grundlag"* (Larsen 1999: 15) gennem introduktionen af en evidens baseret praksis i løbet af det sidste årti, hvor undvigelser fra dette videnskabelige grundlag ofte betragtes som *"et brud på en sund professionel praksis"* (Nikander, in press). Følelser associeres tilsyneladende med det irrationelle *"det indre, muligvis det ukloge og det kaotiske"* (ibid) og ifølge Nikander giver det sig fx udtryk i en agenda, som søger at undgå, at institutionelle beslutninger ‘forurenes’ af følelser.

Disse tendenser kan muligvis forklare behovet for, etableringen og populariteten af en ny praksis som sundhedsprofessionel supervision (SPS). SPS er blevet en almindelig praksis indenfor sundhedsvæsenet, hvor det er muligt for de ansatte at udtrykke deres følelser og reflektere over praksis (Lund-Jacobsen & Holmgren, 1996; Arvidsson, 2000). Tidligere forskning i SPS fremhæver, at følelser er et centralt tema i SPS og, de ser SPS som et forum, hvor deltagernes refleksivitet og professionelle modenhed kan vokse (Teslo 2000, p. 34-36; Gadgil, 1997; Iskov, 1997; Arvidsson, 2000). Nogle forskere beskriver også, hvordan SPS kan forbedre kommunikationen og samarbejdet i multi/interdisciplinary teams²⁴ (Hyrkäs & Appelqvist-Schmidlechner, 2003, Aranda 2004; Palsson, Hallberg, & Norberg, 1994). Kritikere ser dog SPS blot som ‘en følelsesmæssig ventil’, hvor de ansatte kan tale om og få aflastning for de følelsesmæssige spændinger, der er forbundet med deres arbejde (Lind 2000). Indtil denne afhandling er det dog ikke blevet udforsket, hvordan emotionelt arbejde gøres interaktionelt i SPS og i supervisanernes praksis efter supervisionen. Tidligere forskning baserer sig hovedsagelig på interview-personernes post-hoc forklaringer på interaktionelle begivenheder i supervision. I den forbindelse ønsker jeg at pointere, at disse beskrivelser blot er et udtryk for rekonstruktioner af den supervisoriske praksis. De giver ikke *"troværdig empirisk evidens for specifikke handlinger og deres præcise placering i en sekvens med handlinger"* (Sandlund 2004: 316). Denne afhandling er derfor med til at udfylde en mangel i udforskningen af SPS, da jeg ser på selve

²³ Referencerne i resuméet og det engelske summary kan findes i referencelisten til afhandlingen.

²⁴ Multidisciplinære teams er teams, hvor team medlemmerne arbejder parallelt med udgangspunkt i deres respektive professioner. I interdisciplinære teams er teams er der en vis grad af samarbejde mellem team medlemmerne og dermed de forskellige professioner (Opie 1997).

supervisions-interventionen som en diskursiv praksis, og desuden ønsker at forbinde denne udforskning med at se på, hvordan supervisanterne interagerer og gør emotionelt arbejde i deres daglige praksis efter SPS i den palliative afdeling²⁵, hvor jeg indhentede min empiri. Dette udgangspunkt betyder også, at det formålet med afhandlingen ikke er at evaluere en slags supervision frem for en anden. I afhandlingen ser jeg på supervision som en lingvistisk praksis. Inspireret af Wittgenstein (1953) betragter jeg det som 'et sprogspil' og udforsker induktivt, hvad der karakteriserer dette 'sprogspil' for 'at gøre' emotionelt arbejde. Mine forskningsspørgsmål er:

- Hvordan kan SPS ses som 'et sprogspil' for at gøre emotionelt arbejde?
- Hvordan fortsætter supervisanterne og gør emotionelt arbejde i deres daglige praksis efter SPS – her eksemplificeret ved den ugentlig tværfaglige konference?

Begrebet 'emotionelt arbejde' refererer til, hvordan følelser håndteres i en arbejdsmæssig sammenhæng (Hochschild 1983). I den forbindelse understreger forskere i palliativ pleje og behandling arbejdets emotionelle karakter i og med at det indbefatter at personalet arbejder med liv og død, patienter og pårørende hver dag indenfor et begrænset tidsrum. Disse faktorer anses for at være med til at øge det emotionelle og professionelle pres på plejepersonalet. (Li & Arber 2006; Payne, Seymor, & Ingleton 2004; Vachon 1986; 1987). Desuden vokser interdisciplinært samarbejde i dette fagområde for at øge kvaliteten af den pleje patienterne får og kunne opfylde de fleste af deres behov i den terminale fase (Li 2004; James 1992). Denne ambition fordrer et intenst samarbejde mellem forskellige professionelle og flere forskere peger på, at dette samarbejde ikke er uden problemer, (Payne et al, 2004; Vachon 1986; 1987) hvilket også er et argument for at udforske emotionelt arbejde i indenfor en palliativ sammenhæng.

I afhandlingen er jeg inspireret af diskursiv psykologi (DP) (Edwards 1997; 1999) og etnometodologi (EM) (Garfinkel 1967), da disse teoretiske retninger ser følelser som noget, der forhandles og gøres relevante i en social sammenhæng i modsætning til psykologiske og kognitive tilgange, som udforsker indre mentale processer. Både DP og EM beskæftiger sig således med, hvordan mennesker skaber mening og social orden gennem deres tale og interaktion (Jørgensen & Phillips 1999). DP ser især på, hvordan 'psykologi' og 'virkelighed' er diskursivt produceret, håndteret og gøres

²⁵ At palliere betyder 'at lindre' for smerter eller ubehag, som er fremkommet i forbindelse med lidelser, der ikke kan kureres. De fleste patienter i palliative afdelinger oftest terminalt syge cancerpatienter.

relevant af deltagerne i og gennem interaktion (Hepburn & Wiggins, 2005). Det betyder, at det udforskes, hvordan folk taler eller skriver om psykologiske temaer. I denne sammenhæng står følelser og, hvordan disse kommunikeres i interaktion centralt indenfor DP (Edwards 1999). For både EM og DP gælder det, at den metodiske tilgang i analyserne af data er induktiv og, at de benytter sig af konversationsanalytiske værktøjer ud fra en betragtning om, at al social handling og interaktion er et udtryk for organiserede mønstre, hvor deltagerne konstant tilpasser sig og skaber forståelse afhængig af de lokale omstændigheder. I afhandlingen definerer jeg 'emotionelt arbejde' som tale om følelser, følelsesudtryk og interaktivt arbejde, der leder frem til eller kommer efter tale om følelser og følelsesudtryk.

Jeg er endvidere inspireret af en nyere udvikling indenfor EM som kaldes 'hybrid studies' (HS) (Crabtree 2004; Garfinkel 2002; Lindwall & Lymer 2005). HS beskrives som anvendelsesorienteret og praktisk forskning, der er lavet af 'outsidere' der også er 'insiders'. Traditionel EM ønsker ligesom andre traditionelle former for forskning at beskrive virkeligheden, som den eksisterer og ikke at forandre den. HS, derimod, henvender sig direkte til praktikere i et specialiseret område og tanken er, at erkendelserne fra EM forskningen kan bruges til at udvikle de professionelles praksis. Jeg brugte således mine kompetencer som tidligere onkologisk sygeplejerske og integrerede idealerne fra HS gennem jævnlige møder med det palliative team i den empiriske del af projektet.

Data er indsamlet før, under og efter introduktionen af supervision og består af 21 timers video-optagelse af supervisionsgruppen og 20 timer af den tværfaglige konference. Supervision blev introduceret på to måder: Dels gennem etableringen af en supervisionsgruppe, hvor hele personalet i afdelingen deltog. Dels gennem supervision af den ugentlige konference, hvilket betød, at en af supervisorerne fra supervisionsgruppen var mødeleder på den ugentlige konference i alt 14 gange. Desuden lavede jeg etnografiske observationer i afdelingen mellem konferencerne og supervisionsseancerne, hvor jeg også interviewede de ansatte og patienterne i afdelingen. Endeligt indsamlede jeg skriftlige kilder så som læge- og sygeplejersjournaler og skriftlige refleksioner fra deltagerne i supervisionsgruppen. Mine fund er hovedsageligt baseret på videooptagelser af 6 konferencer uden/før SPS, de 10 supervisionsseancer og 4 konferencer 6 uger efter supervisionen var afsluttet.

De 5 artikler i afhandlingen præsenterer mine fund og hvordan emotionelt arbejde gøres i de to institutionelle kontekster jeg har primært har undersøgt: Den tværfaglige konference og supervisionsgruppen. I artiklerne viser jeg hvordan emotionelt arbejde udvikler sig til at blive 'a business in its own right' (Li & Arber 2006) og en vigtig del af samtalen på konferencerne både før og efter SPS blev introduceret i afdelingen. Den første artikel: "*Det kommer til at rive i hjertet*"/"*It will tear your heart apart*" – *emotionelt arbejde og historiefortælling på en interdisciplinær konference i en palliativ afdeling*" beskriver, hvordan emotionelt arbejde gøres i samtalen om en ung døende patient på en konference uden supervision. Tidligere forskning indenfor palliation har ikke undersøgt, hvordan palliative teams gør emotionelt arbejde interaktionelt og, hvilken rolle følelser spiller for beslutningsprocesser på team konferencer. Den første artikel i afhandlingen bidrager således til den eksisterende forskning ved at tilføje analytiske og empiriske observationer om den interaktionelle og fælles håndtering af følelser og beslutningsprocesser. Artiklen illustrerer det emotionelle arbejde, som idealet om at give patienter og pårørende 'en god død' afstedkommer. Analyserne demonstrerer, at dette arbejde organiseres interaktivt i et specifikt sekventielt mønster. Dette mønster er karakteriseret af bestemte interaktionelle træk så som rædselshistorier (atrociti stories), opfølgende historier (second stories), metaforer, orienteringen mod bestemte medlemskategorier så som at patienten er 'ung og døende' og ved endvidere at komme med tilføjelser til denne kategori gennem samtalen. Fx oplyses det, at patienten ikke blot er ung og døende men også far til mindreårige børn. Disse interaktionelle træk synes at påvirke teamets beslutningsproces, da de intensificerer patientens tragiske situation og derfor fordrer specifikke fremtidige handlinger. Artiklen konkluderer, at disse erkendelser kan være med til at kvalificere pleje og behandling af terminalt syge patienter og desuden pege på, hvordan støttende team strategier kan udvikles for at forebygge udbrændthed indenfor det palliative område.

Den anden artikel: "*Forhandling af felt-roller i kvalitativ sundhedsforskning*" er en metodologisk artikel om den interaktionelle konstruktion af insider/outsider relationer i det felt, forskeren studerer. Den belyser, hvordan roller og relationer i sundhedsforskning konstant forhandles, er interaktionelt konstruerede og reflektivt situerede. Artiklen tager sit afsæt i et case studie af interaktioner mellem forskeren og en terminalt syg patient. Analysen af disse interaktioner peger på, at patienten udfordrer forskerens position i feltet ved at forsøge at rekruttere hende som en fortrolig og 'insider'/allieret gennem en dialog om forskerens påvirkning af den tidligere konsultation. Supplerende data så som etnografiske observationer af den

interdisciplinære konference og interviews med personalet og med patienten illustrerer, hvordan denne tilsyneladende usædvanlige situation lader til at være en naturlig del af feltet. Disse data viser, at den samme patient også udfordrer de andre team medlemmers professionelle identiteter og, at det virker som om hun orienterer sig mod medlemskategorien 'en vanskelig patient'. Analyserne indikerer, at patienten bruger sine interaktionelle ressourcer som tidligere lærer til at kontrollere det eneste hun kan kontrollere: Hvem hun snakker med og hvordan - både i forhold til det palliative team og forskeren. Det konkluderes, at udforskningen af den konkrete samtales refleksivitet kan eksponere normativiteten i den givne sociale sammenhæng.

De næste tre artikler handler om refleksion og emotionelt arbejde i og efter SPS. Den tredje artikel "*Reformuleringer og refleksion over følelser i sundhedsprofessionel supervision*" udforsker, hvordan refleksion over følelser praktiseres i supervision. Jeg analyserer supervisorernes konstruktioner af reformuleringer og hvordan disse inviterer deltagerne til emotionelt arbejde. Mine fund demonstrerer, hvordan supervisorerne dokumenterer problemer i deltagernes tale ved at fremdrage potentielt emotionelle og metaforiske elementer, hvorefter de bliver reformuleret til supervisors generelle opfattelse af, hvori det 'reelle problem' består gennem at inddrage såvel normative som morale aspekter i reformuleringen. Henimod slutningen af supervisions-seancerne ses det endvidere, hvordan deltagerne reproducerer interaktionelle elementer af dette 'sprogspil'. De næste to artikler: "*Forandringer i emotionelt arbejde på interdisciplinære konferencer efter sundhedsprofessionel supervision i en palliative afdeling ward*" og "*Sprogspil om følelser i sundhedsprofessionel supervision*" belyser desuden, hvordan supervisorernes konstruktion af reformuleringer overføres til deltagernes ugentlige konferencer. Jeg viser, hvordan mødeledernes på disse konferencer dokumenterer problemer i team medlemmernes snak og fremhæver potentielt emotionelle aspekter på samme vis som supervisorerne gjorde det under supervisionen. Disse artikler konkluderer, at reformuleringer bliver institutionaliserede efter supervisionen og tilsyneladende legitimerer emotionelt arbejde som en selvstændig aktivitet, da de giver plads til at tale om og anerkende personalets følelser og dermed også deres konkrete handlinger. Supervisorerne bliver tilsyneladende rolle modeller for deltagerne i supervisionsgruppen og at det 'supervisoriske sprogspil' lader til at befordre deltagernes refleksivitet i og med at de kollektivt sætter spørgsmålstejn ved deres praksis ved at 'gøre meta-perspektiver' på processen af deres arbejde. Jeg ser, at disse handlinger kan være med til at påvirke ikke blot beslutninger om pleje og behandling af patienter med også de interpersonelle relationer imellem team medlemmerne.

I analyserne har jeg vist at deltagerne i supervisionsgruppen bruger og integrerer interaktionelle ressourcer fra det supervisoriske sprogspil på de interdisciplinære konferencer efter supervision. Dette sprogspil virker til at have introduceret og legitimeret emotionelt arbejde. Det er derfor rimeligt at drage den konklusion, at deltagerne har lært noget. Med mit teoretiske afsæt definerer jeg læring som observerede ændringer i interaktionen på konferencerne. Nye sprogspil giver muligheder for udvikling af nye begreber indenfor bestemte kategorier som fx emotionelt arbejde. Mit studie af SPS har vist at supervision kan ses som en metode, der kan udvikle deltagernes kommunikative kompetencer på de interdisciplinære konferencer. En del af den tidligere forskning indenfor SPS har fokuseret på deltagernes subjektive velbefindende efter supervisionen. Mine resultater peger på, at supervision også kan stimulere kollektive læringsprocesser, da den udvikler deltagernes kollektive udforskning af deres praksis efter supervision.

10 English summary of the ph.d. - dissertation

Even though emotions are an important part of institutional practice affecting decisions on treatment and care of patients, there appears to be an agenda of avoidance whereby institutional decision-making is not 'contaminated' by emotions (Nikander, in press). Emotional perspectives seem to have been neglected for reasons of being non-rational and threatening the professional ideal of neutrality (Arber, in press; Nikander, in press). Moreover, hospital managements expect a professional practice that relies on an "*sober scientific basis*" are (Larsen 1999: 15) with the introduction of an 'evidence based practice' during the past decade in which departures from this 'objective scientific basis' often is treated as "*a breach of sound professional practice*" (Nikander, in press). Emotions appear to be associated with the irrational "*the internal, the potentially unwise and the chaotic*"(ibid).

These tendencies possibly explain the need for, establishment and success of a new practice like clinical supervision (CS). CS has become a common practice within the health sector in which it is possible for the employees to express their emotions and reflect on practice (Lund-Jacobsen & Holmgren, 1996; Arvidsson, 2000). Former researchers into CS assert that emotions are a prominent theme in CS, and they see CS as a forum where competences like reflexivity and professional maturity grow (Teslo 2000, p. 34-36; Gadgil, 1997; Iskov, 1997; Arvidsson, 2000). Moreover, a few researchers describe CS as a way of improving communication and collaboration in multi/interdisciplinary²⁶ teams (Hyrkäs & Appelqvist-Schmidlechner, 2003, Aranda 2004; Palsson, Hallberg, & Norberg, 1994). Still, some critics see CS as no more than an 'emotional outlet' in which the employees can talk about and get relief from the emotional tensions connected to their job (Lind 2000). However, until this dissertation it has not been uncovered how emotion work is done interactionally in CS and in supervisees' practices after supervision. Previous research has to a large extent been based on interviewees' post-hoc sense making of interactional events in supervisory sessions. In this regard, it is important to remember that these accounts are just that: Constructions according to hindsight. They do not "*yield reliable empirical evidence as to the particular actions and their precise location in a sequence of actions*"

²⁶ Multidisciplinary teams are teams in which members work parallel to each other out of their respective disciplinary bases. Interdisciplinary teams are teams where the members continue to work from their particular professional orientations but undertake some joint collaborative work (Opie 1997).

(Sandlund 2004: 316). My study, therefore, fills a gap in research on CS in that I look at the CS intervention itself as a discursive activity and, moreover, anticipate to link this exploration with the ways in which supervisees proceed in their daily practice after CS. Finally, this point of departure implies that my purpose with this dissertation is not to evaluate a particular kind of CS over another. In the dissertation, I look at CS as a linguistic practice. Inspired by Wittgenstein (1953), I call it a 'language game' and I explore inductively what characterizes this 'language game' for doing emotion work. My research questions are:

- How can CS be seen as a 'language game' for doing emotion work?
- How do the supervisees proceed and do emotion work in their daily practice after CS – here exemplified by the weekly interdisciplinary conference?

The concept of 'emotion work' refers to the management of emotions at work (Hochschild 1983). In this respect, researchers in palliative settings²⁷ emphasize the emotional nature of the work in palliative care since it encompasses dealing with life and death, patients and relatives on a daily basis within a limited amount of time. These are all considered to be factors adding to the emotional and professional pressure on the staff (Li & Arber 2006; Payne, Seymor, & Ingleton 2004; Vachon 1986; 1987). Moreover interdisciplinary teamwork is growing in this setting in order to enhance the quality of care for patients by being able to fulfil most of their needs in the terminal stage of life (Li 2004; James 1992). This ambition calls for an intense collaboration between the different professionals and several researchers (Payne et al, 2004; Vachon 1986; 1987) have found that this cooperation is often not without tensions, which makes it even more important to explore and improve emotion work in this specific setting.

In the dissertation, I investigate emotions in social situations, and how they are collaboratively and discursively managed inspired by discursive psychology (DP) and ethnomethodology (EM) (Edwards 1997; 1999; 1999; Edwards and Potter, 1992; Garfinkel 1967. Moreover, I draw on the method of conversation analysis (CA) in that CA offers EM and DP a concrete linguistic methodological toolbox in the analyses of social interaction in an institutional setting (Drew & Heritage 1992; Heritage 1997). This theoretical and methodological approach has challenged more psychological and cognitive perspectives on emotions by claiming that since we do not have access to peoples' thoughts and inner feelings, there is no point in looking inward to explore

²⁷ To palliate means to relieve from pain or discomfort based on an illness, which cannot be cured. Most patients in palliative wards are terminally ill cancer patients.

internal mental states. Rather, emotions within discursive psychology are seen as social phenomena that have to be studied in the specific practical contexts. This focus on discursive dimensions has its roots in ethnomethodological studies of work (EM) seeking to uncover the dynamic properties of social life, dealing with members' sense making activities and their cooperation as they negotiate and create social order. In the dissertation, I, therefore, define emotion work as consisting of talk about emotions, or 'emotion talk', and the expression of emotions, or 'emotion displays' and the interactive work leading up to or following these and I explore how emotion work is done in two institutional settings: The interdisciplinary conferences and in a palliative outpatient ward and in a supervision group consisting of all the team members in the palliative ward.

Within EM I am inspired by a more recent development called 'hybrid studies' (HS) (Crabtree 2004; Garfinkel 2002; Lindwall & Lymer 2005). HS can be described as applied and practical research done by outsiders who are also insiders. Traditional EM along with other traditional modes of scientific research aims at describing reality, as it exists and not changing it. HS, however, directly address practitioners in a speciality area and the research is seen as being capable of providing instructions that are usable to these practitioners. The idea is that the insights of EM research could and should be aimed at the development of the members' practice. I, therefore, used my competences as a former oncological nurse and applied a HS design through meetings with the palliative team throughout the data collection.

Data was collected before, during and after supervision was introduced and consists of 21 hours of video observation of the supervision group sessions and 20 hours of the interdisciplinary conference. CS was introduced in two ways: Firstly, I established a supervision group in which all team members participated. Secondly, the weekly conferences were moderated 14 times by one of the two supervisors supervising the group. I, moreover, observed of members' activities in the ward in between the conferences and supervision session and made qualitative individual interviews – formal and informal – with members of the staff and with the patients. Finally, I collected written sources such as physicians' and nurses' reports and written reflections from the members of the supervision group. My findings derive mainly from video recordings of 6 conferences without CS, 10 supervisory sessions and 4 interdisciplinary conferences 6 weeks after supervision had terminated in the ward.

The five articles of the dissertation present my findings and how I have found emotion work is done in the two clinical settings I have investigated. In the articles, I show how emotion work is 'a business in its own right' (Li & Arber 2006) and an important feature in talk and in maintenance of accountability at interdisciplinary conferences in a palliative outpatient ward both before and after the instigation of supervision. The first article "*It will tear your heart apart*" - *Emotion work and storytelling at an interdisciplinary²⁸ conference in a palliative outpatient ward*" describes how emotion work is done in the talk about a younger dying patient at an interdisciplinary conference without CS. Previous research within palliation has not explored the interactional management of emotions in palliative team-talk and the ways in which emotions have an impact on decision-making in this setting. This article, therefore, contributes to the existing research into palliative care by adding analytical and empirical observations about the interactional and collaborative management of emotions and decision-making. The article reveals the emotion work entailed in the team's orientation to the palliative ambition of achieving 'a good death' for patients and their relatives. The analysis demonstrates particular ways of interactively organizing emotion work in a specific sequential pattern. This pattern is characterized by specific interactional features such as atrocity and second stories, extreme case formulations, metaphors and the choice and elaboration of specific categories and category attributions. The patient is, for instance, not only terminally ill. He is also young and the father of younger children. These interactional features, then seem to affect the team's decision-making process at the conferences in that they intensify patients' tragic situations and, therefore, warrant specific future actions. The article concludes that these insights may qualify the care and treatment of terminally ill patients and moreover, guide the way in which supportive team strategies can be developed to prevent burn out in palliative care.

The second article: "*Negotiating field roles in qualitative health research*" is a methodological article about the interactional construction of insider/outsider relationships in the field of study. It illuminates the ways in which roles and relationships in health research are constantly negotiated, interactionally constructed and reflexively situated. The article takes as a point of departure an interaction between the researcher and a terminally ill patient. The analysis of this interaction reveals that latter seems to challenge the researcher's position in the field of study by

recruiting her as a confidant and insider into a dialogue about the repercussions of the researcher's influence on the previous consultation. Supplementary data such as ethnographic observations, videotape recordings of the interdisciplinary conference and interviews with the palliative team and the patient display how this apparently unusual situation appears to be 'part' and 'parcel' of the setting. These data show how the same patient also challenges the professional identities of and relationships with the team members and seems to orient towards the membership category: 'a troubled patient'. The analyses indicate that the patient seems to use her interactional resources as a former teacher to control the only thing she can control: Whom she talks to and how both with regard to staff and the researcher. The exploration of the reflexivity of the talk, therefore, seems to expose the normativity of the setting.

The next three articles are about reflection and emotion work in and after CS. The third article: "*Reformulations and reflection on emotions in clinical supervision*" explores inductively how reflection on emotions is practiced in supervision. I analyse the construction of supervisors' reformulations and how these reformulations invite the participants to do emotion work. My findings show how supervisors document problems in supervisees talk by focalizing potentially emotional and metaphorical elements where after they are reformulated into the supervisors' version and more general assessment of 'the real problem' by injecting normative as well as moral aspects into the talk. Towards the end of the supervisory sessions it can be seen how supervisees reproduce interactional elements of this 'language game'. Moreover, the next two articles "*Changes in emotion work at interdisciplinary conferences after clinical supervision in a palliative outpatient ward*" and "*Sprogspil om følelser i sundhedsprofessionel supervision*" describe how supervisors' construction of reformulations is transferred to participants' weekly interdisciplinary conferences. I show how conference moderators reformulate and focalize potentially emotional aspects in team members talk similar to how supervisors reformulated during supervision. These articles conclude that reformulations are institutionalized after supervision and seem to legitimize emotion work as a business in its own right by providing space for talking about and recognizing emotions and consequently specific actions taken by staff members. Finally, I argue that supervisors become role models for the supervisees and that the 'supervisory language game' seems capable of enhancing supervisees reflexivity in that they collectively question emotional aspects of their practices by 'doing meta-perspectives' on the process of their work. These actions, I assert, may affect not only decisions about care and treatments of patients but also interpersonal relations among team members.

In my analyses, I have shown that the supervisees use and apply interactional resources from the supervisory language game at the interdisciplinary conferences after supervision. This language game seems to have introduced and legitimized emotion work. Consequently, it is reasonable to draw the conclusion that the supervisees have learned something. From my theoretical point of reference, I see learning as observed changes in-interaction at the conferences. New language games provide opportunities to develop new concepts in a variety of categories and enable the use of these to evaluate and adjust actions in specific contexts like the contexts I have investigated. To conclude, the present study reveals that CS can be seen as a method improving supervisees' communicative competences at interdisciplinary conferences. Much of the previous research has focused on the subjective well being of supervisees after having received CS. My results indicate that CS also stimulates collective learning processes in that it enhances team members collective questioning of their practices.

Appendices

Appendix 1: Cronological table of empirical events

Appendix 2: Cooperation agreement with the palliative outpatient ward

Appendix 3: Table of events in the clinical supervision group

Appendix 4: Patient information

Appendix 5: List of video- sound clips on the DVD for the comitee

Appendix 1

Chronological tables of empirical events

2004: Negotiations with the field of study before the datacollection

April	May	June	July	August
4/5: Informal meeting with the head nurse 4/9: Written information sent to the ward 4/21: Meeting with head physician, nurse and psychologist of the palliative ward to get their consent to proceed and meet with the rest of the team.	5/28: Introductory meeting with all team members in the palliative ward	6/14: Meeting with the management to get their written consent	7/30: Meeting with the ward to get the collaboration agreement signed	8/6: First meeting with the two supervisors 8/9: Meeting with the daily administrators of the ward to plan the chronology of events, i.e. meetings, supervision sessions, conferences

2004 Data-collection before supervision

August	September	October
8/16: The field study and data collection begins	2 conferences are recorded on video	2 conferences are recorded on video 10/8: The 2 supervisors are introduced at a weekly staff meeting

Appendix 1

2004/5: Data-collection during supervision

November	December	January	February	March
11/1 + 14 + 28 First 3 supervision sessions.	12/13 4th supervision session	1/2 + 16 + 31 3supervision sessions	2/14 + 28 2supervision sessions	3/14 Last supervision session
11/30: Supervision of the conference begins	12/7+14+ 21 Conferences moderated by a supervisor	1/31 A spontaneous meeting with supervisors before the session 1/31 in which they watched some of the video recordings of the supervision sessions	2/1 + 8 + 14 + 21 4 conferences with a supervisor as moderator	3/1 + 8 2 supervised conferences
	12/14 Half way meeting with supervisors			
	12/20 Half way project and video feed back meeting with the team	1/4 + 11 + 18 + 25 4 conferences with a supervisor as moderator		

2005: Data-collection and evaluations after supervision

April	May	June
4/18: Video feed-back and evaluation meeting with the palliative team	Participant observations, patient interviews and video recording of 4 conferences without supervision	6/9 Evaluation meeting with supervisors

Appendix 2

Samarbejdsaftale mellem palliativ afdeling og ph.d.-stipendiat Helle Merete Nordentoft

Aftalen omfatter rammerne for samarbejdet mellem de to parter om den empiriske undersøgelse i forbindelse med Ph.d. projektet ”Dialogiske Møder”.

Ph.d.-projektets formål

Formålet med projektet er at udforske, hvordan dialogiske ressourcer, som skabes i en tværfaglig vejledningsgruppe, overføres og anvendes i andre interaktioner. Det drejer sig om

- * en tværfaglig patientkonference
- * interaktionen med patienterne

Centrale spørgsmål

- * Hvordan konstrueres dialogiske ressourcer og hvordan kan disse beskrives?
- * Kan der spores forbindelser mellem dialogen i den faglige vejledningsgruppe, på konferencen og dialogen - såvel den mundtlige som den skriftlige - omkring og med patienterne, og i så fald hvilke og hvordan?

Sagt på en anden måde, undersøges det, hvordan personalets erfaringer med faglig vejledning kan få betydning for dialogen på den tværfaglige patientkonference og evt. bidrage til en kollektiv faglig erfaringsdannelse. Og videre hvilken betydning erfaringerne og erkendelserne fra faglig vejledning kan få for praksis og patienternes oplevelse af kontakten og dialogen med plejepersonalet.

Ansvarlig

- Projektet gennemføres af: Ph.d.-stipendiat Helle Merete Nordentoft Jakobsen,
- Institut for Sprog og Kommunikation, Syddansk Universitet i Odense
- Faglig vejledere er: Lektor Dennis Day, Institut for Sprog og Kommunikation, Syddansk Universitet i Odense, Lektor Betina Dybbroe, Institut for Uddannelsesforskning, Roskilde Universitetscenter.

Metode

Dataindsamlingen vil ske gennem:

- Videoobservation før og efter introduktionen af faglig vejledning af den tværfaglig patientkonference
- Videoobservation af vejledningsgruppen
- Deltagerobservation af personalets omgang og dialog med patienter og kolleger
- Kvalitative interviews med patienter og personale

Appendix 2

- Indhentning af personalets skriftlige refleksioner efter vejledning
- Læsning af sygepleje- og lægejournaler med henblik på at se forbindelser mellem den mundtlige og skriftlige dialog omkring patienterne.

Projektet er dialogisk orienteret, hvilket betyder, at indsamlingen af data vil foregå i en afklarende dialog med det personale, som deltager i projektet. Dette betyder, at der har været afholdt møder inden starten på den empiriske undersøgelse, hvor personalet har haft indflydelse på, hvordan denne afvikles. I undersøgelsesforløbet afholdes der 2 møder: et midtvejs i vejledningsforløbet og et afsluttende og evaluerende møde. Formålet med disse møder er dels at præsentere foreløbige resultater, få personalets respons på disse og diskutere deres oplevelser og potentielle udviklingsmuligheder i projektet. Der vælges også 2 personalemedlemmer, som i forløbet kan fungere som kontaktpersoner mellem Helle Merete Nordentoft Jakobsen og personalet.

Etiske overvejelser og retningslinier

Personale

Plejepersonalet informeres grundigt om projektets formål skriftligt og mundtligt og garanteres anonymitet og fortrolig omgang med de informationer jeg kommer i besiddelse af. Enhver, som deltager, har til hver en tid ret til at gennemse lyd og videodata og kan forlange at særlige segmenter udelades, hvis de indeholder materiale, som man mener kan volde skade. Det er naturligvis frivilligt at deltage, og et samtykke til deltagelse kan til enhver tid trækkes tilbage

Ellers består projektets etiske retningslinjer af fire hovedprincipper:

1. *Respekt for projektets deltagere.* Ved at give forskere adgang til at optage deltager- interaktioner, samt ved at give tilladelse til, at datamaterialet efterfølgende kan analyseres, har deltagerne bidraget væsentligt til videnskabelig forskning. Det er derfor vigtigt, at både deltagere og brugere af data anerkender dette bidrag. Det vil være uetisk at tilbagebetale denne velvilje med nogen form for offentlig kritik af disse personer. Især bør kommentarer om deltagerne ikke indeholde nogen form for sammenligninger mellem deltagerne, der inddrager personlighed, som så som intelligens, evner til at udtrykke sig, sociale evner, eller fysisk fremtoning.
2. *Fortrolighed.* Når deltagere giver tilladelse til anvendelse af data, forventer de ofte, at disse data analyseres af en forsker, der ikke kender dem personligt. Sker det, at en forsker opdager, at han/hun er personligt bekendt med en deltager, skal forskeren afgøre, om det vil være mest korrekt at erklære sig inhabil, eftersom en personlig forbindelse kan påvirke forskningens fortrolighed. I sådanne tilfælde har en forsker tre valgmuligheder: (1) afstå fra at bruge opgældende data, (2) kontakte og indhente tilladelse fra den pågældende deltager til brug af hans/hendes data, eller (3) kontakte vejlederen og klarlægge vilkårene for brugen af pågældende data. Bemærk at disse regler ikke gælder brug af data, hvor personligheden er udvisket, eller tekstsøgninger på tværs af data, hvor identiteten på deltagerne ikke er genstand for analyse.
3. *Respekt for grupper.* Data leveres af individuelle deltagere. Dog er alle deltagere også medlemmer af sociale grupper. Mange af disse grupper har udviklet en velbegrundet sensitivitet overfor kritik fra det øvrige samfund. Generelt bør man ved analyse af disse data undgå at drage paralleller imellem

Appendix 2

grupperne, der involverer grundlæggende værdier og socialt identificerende træk

4. *Accept af professional evaluering.* Det kan ofte være svært for forskere, at afgøre om deres analyser krænker de to ovenstående principper. Derfor vil forskeren – jeg - referere til en udenforstående evaluerings komité, som i mit tilfælde er mine 2 vejledere, som vil bistå med gennemgang af de fortolkninger, som er bestemt til offentlig fremlæggelse både skriftlig og mundtlig.

Palliativ afdeling

Palliativ afdeling fremtræder efter ønske ikke anonym i projektet

Patienter

Ifølge lov om patienters retsstilling paragraf 19 stk 2 skal alle patienter, som er med i projektet, give informeret samtykke. Dette betyder, at de patienter, som indgår i undersøgelsen må skrive under på, at de er blevet informeret mundtligt og skriftligt om formål og indhold i projektet og giver deres tilladelse til, at jeg må indhente de oplysninger jeg finder nødvendige om deres pleje og behandling gennem de dataindsamlingsmetoder, som er skitseret under afsnittet om metode.

Den Videnskabetiske Komité og Datatilsynet

Den regionale Videnskabetiske Komité har vurderet projektet. Projektet kræver ikke en tilladelse fra dem, da der ikke er tale om biomedicinske forsøg med patienter.

Der er indhentet tilladelse fra Datatilsynet efter lov om behandling af personoplysninger. Ifølge aftale med Datatilsynet skal alle oplysninger slettes, anonymiseres eller tilintetgøres, således at det ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen, senest ved projektes afslutning.

Vilkår

Helle Merete Nordentoft Jakobsen har adgang til de oplysninger, som er relevante for projektet, herunder informationer i læge- og sygeplejelogbøger om konkrete patientforløb samt deltagelse i relevante mødefora. Det er som nævnt en forudsætning, at oplysningerne anonymiseres, dvs. at såvel personfølsomme oplysninger i patientforløb som interviews er anonyme.

Undersøgelsens resultater

Undersøgelsens resultater anvendes frit af Helle Merete Nordentoft Jakobsen i det videre forskningsprojekt. I tilfælde af ønsket om brug af data og resultater i forbindelse med anden publikation og undervisning søges deltagernes skriftlige tilladelse

Tidsramme

Undersøgelsen falder i to dele: Første del, hvor data indsamles inden faglig vejledning introduceres i afdelingen og anden del, hvor faglig vejledning introduceres i form af en vejledningsgruppe, og hvor den tværfaglige konference nu ledes af en uddannet faglig vejleder. Første del varer fra 16. august til midt i oktober 2004. Anden del varer fra midt i oktober 2004 til midt i marts 2005. Dvs. hele undersøgelsesforløbet varer i alt ca. 8 måneder.

Appendix 2

Tillæg til samarbejdsaftale mellem palliativ afdeling og ph.d.-stipendiat Helle Merete Nordentoft

Dette tillæg til den oprindelige samarbejdsaftale er lavet, da tidsrammen for undersøgelsen er ændret, så den udvides med yderligere 2 måneder.

Tidsramme

Undersøgelsen falder i tre dele: Første del, hvor data indsamles inden faglig vejledning introduceres i afdelingen og anden del, hvor faglig vejledning introduceres i form af en vejledningsgruppe, og hvor den tværfaglige konference nu ledes af en uddannet faglig vejleder. Første del varer fra 16. august til midt i oktober 2004. Anden del varer fra midt i oktober 2004 til midt i marts 2005. I tredje del af projektet observeres dagligdagen efter vejledningen er slut, og der indsamles data som i den første del af projektet. Tredje del finder sted i maj måned 2005.

Dvs. hele undersøgelsesforløbet varer 9 1/2 måned.

Den 18/3 2005

Appendix 3

Table of events in the 10 supervision sessions

1	Contract work for the group in which issues of confidentiality, participants, pauses and so on were discussed.
2 + 3	Traditional CS in which two patients were discussed
4	Change of focus from talk about patients to talk about how the team could talk about their cooperation problems.
5+6	The round was the main feature. There appeared to be two intertwined themes in the talk. Firstly: Talk about how the team could talk about their cooperation issues. Secondly: Stories about the ways in which team members had been employed and how they experienced their work.
7	Division of the group: The head nurse told her story to the nurses in one group and the rest of the team members met in a different room. This group discussed the way in which the feed-back culture in the ward could be improved.
8	The two sub-groups from the 7th session gave a resumé of the last session in which they were divided.
9+10	The head physician had been absent for three sessions. In the ninth session each team member, therefore gave a resumé of what had made an impression on him/her during the last three sessions. The main theme for the last two sessions was the future and the way in which the supervisees could/would better their cooperation. The last session were used to evaluate the all of the sessions.

Appendix 4

Patient-information

Kære patient i palliativ afdeling

Mit navn er Helle Merete Nordentoft.

Jeg er sygeplejerske og har en uddannelse i kommunikation fra universitet.

Personalet i palliativ afdeling ønsker at styrke Deres og andre patienters behandling og omsorg. Derfor får personalet nu undervisning i kommunikation, Jeg henvender mig til Dem, fordi jeg ønsker at lave en undersøgelse af, om undervisningen kan få betydning for, hvordan personalet taler med patienterne og med hinanden.

Hvad betyder undersøgelsen for Dem?

Undersøgelsen vil ikke belaste Deres tid og overskud. Måske spørger jeg Dem, om De vil interviewes af mig. Ellers følger jeg personalet i deres arbejde og samtalerne med patienterne.

Hvis de giver Deres tilladelse, vil jeg muligvis gerne optage nogle af de samtaler De har med personalet på en båndoptager. Samtalerne båndoptages for at få den præcise ordlyd, og for bedre at kunne huske hele situationen omkring samtalerne. Jeg vil også læse i Deres sygepleje- og lægejournal for at få informationer om Deres behandlingsforløb i palliativ afdeling

Personalet i palliativ afdeling holder konference en gang om ugen, for at finde de bedste løsninger på Deres og andre patienters behov. Jeg ønsker at optage konferencerne på video *før* og *efter* personalet har fået undervisning i kommunikation for at se på, om undervisningen har betydning for, hvordan personalet taler med hinanden

Jeg har tavshedspligt og alle oplysninger vil blive behandlet fortroligt. Når undersøgelsen er slut slettes alle bånd, der ikke er anonyme. Alle oplysninger sløres inden undersøgelsen offentliggøres. Det er frivilligt om De vil deltage, og de kan vælge at udgå af undersøgelsen når som helst uden begrundelse. Det gælder også, selvom De har skrevet under på at ville deltage. De er naturligvis altid velkommen til at stille uddybende spørgsmål til mig

Med venlig hilsen

Ph.d-studerende og projektansvarlig: Helle Merete Nordentoft

ERKLÆRING OM SAMTYKKE

Hvis de vil deltage i undersøgelsen bedes De skrive under nedenfor

Jeg erklærer hermed, at jeg er blevet informeret mundtligt og skriftligt om formål og indhold i ovenstående undersøgelse. Jeg giver min tilladelse til, at Helle Merete Nordentoft må få adgang til informationer om min behandling i palliativ afdeling gennem:

- * samtaler, som jeg har med personalet, der optages på en båndoptager.
- * læsning om min behandling og pleje i sygepleje- og lægejournal.
- * observation og videoptagelse af konferencen, hvor min behandling i palliativ afdeling bliver diskuteret.

Dato:

Underskrift:

Appendix 5

Video- and sound-clips on the DVD

Confidential material for the comitee!

Article I: Chapter 1/klip 1

Article II: Chapter 9/klip 8

Article III: Chapter 2, 3, 4/klip 2, 3, 4

Article IV: Chapter 3, 5, 6/klip 3, 5a and 5b

Article V: Chapter 2, 3, 5, 6, 7, 8/klip 2, 3, 5a, 5b, 6, 7

PART THREE: The articles

Article I

“It will tear your heart apart”. Emotion work and story-telling at an interdisciplinary conference in a palliative outpatient ward.

Article II

Negotiating field roles in qualitative health research.

Article III

Reformuleringer og refleksion over følelser i sundhedsprofessionel supervision

Article IV

Changes in emotion work at interdisciplinary conferences after clinical supervision in a palliative outpatient ward.

Article V

Sprogspil om følelser i sundhedsprofessionel supervision

Article I

Submitted to 'Health'

'It will tear your heart apart'

Emotion work and story-telling

at an interdisciplinary¹ conference in a palliative outpatient ward

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University of Southern Denmark

Abstract

This article investigates the way in which an interdisciplinary team in a palliative outpatient ward negotiates emotionally demanding aspects of their practice at their weekly conferences. In a deviant case analysis, the article illuminates the way in which emotion work is involved in the team's orientation to the palliative ambition of achieving 'a good death' for patients and their relatives as well as what this emotion work may entail for decision-making at the conferences. The analysis demonstrates particular ways of interactively organizing emotion work in a specific sequential pattern. This pattern is characterized by specific interactional features such as atrocity and second stories, extreme case formulations, metaphors and the choice and elaboration of specific categories and category attributions. These interactional features seem to affect the team's decision-making process at the conferences in that they intensify patients' tragic situations and, therefore, warrant specific future actions. The article concludes that these insights may qualify the care and treatment of terminally ill patients and moreover, guide the way in which supportive team strategies can be developed to prevent burn out in palliative care.

Key words

Interdisciplinary palliative team, decision-making, emotion work, storytelling, membership categorization analysis,

Introduction

Working with dying patients can be stressful. Palliative team members witness the

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process of dying; they care for patients and their relatives; they deal with patients' problems – physical, psychological and social – associated with terminal illness and death while they constantly work to maintain the dignity of all the parties involved in the process (McNamara, Waddell and Colvin, 1995). The palliative care setting has, therefore, been one of the prime sights for developing holistic care to give patients a 'good death' through the input of professional knowledge from different disciplines (James, 1992; Li 2004; McNamara et al, 1995; McNamara, 1994; 2004; Costello 2006; Kristjanson, McPhee, Pickstock 2001; Frogatt, 1995). Death and the dying process within a palliative setting can be seen as a series of social events including both patients and their relations such as friends, relatives and professionals (Sudnow, 1967; Glaser and Strauss, 1968). The death is defined as 'good' if 'there is an awareness, acceptance and preparation for death by all those concerned' (McNamara et al, 1995: 222). McNamara et al (1995) have conducted an ethnographic study of hospice nurses in Australia of the way in which they develop shared strategies and logic to manage their work. They find that threats to the goal of achieving a 'good death' for patients and their relatives represent a major challenge for these nurses. These threats can be, for instance, lacking organisational support, team-conflicts and patients who do not comply with the palliative care and treatment. McNamara et al describe the way in which this 'non-compliance is problematic; it is often a topic of discussion at team clinical meetings and manifests as a kind of 'collective' stress, draining the resources of the workers and the organisation' (McNamara et al, 1995: 231). Kristjanson et al (2001) assert that the palliative nurses they have studied may even feel that they have failed 'if the person whom they were caring experienced a traumatic death' (129). Sometimes this stress is not over until the patient dies and during this process 'the patient's story is told and retold by nurses in order to consolidate the lack of control' (McNamara et al, 1995: 238).

Previous studies maintain that the palliative staff's handling of these experiences at work is confined to their work setting (McNamara et al, 1995; Vachon, 1986; 1987; Payne, Seymour and Ingleton, 2004). These studies argue that the palliative agenda emphasizing 'care' rather than 'cure' differentiates and appear to separate palliative care from traditional medical treatment. Furthermore, palliative staff members experience that they cannot talk openly about the nature of their profession when they are off work. The openness towards the dying process contrasts with societal and attitudes towards death and dying which generally are marked by apprehension, fear and avoidance (Lyth, 1988). The institutionalisation of death and dying processes implying that deaths mostly take place in institutional settings like, for instance, nursing homes

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and hospitals has potentially accentuated these feelings in modern societies (McNamara, 1994). A physician in my study, for instance, tells how people lose their appetite and changes the subject when she starts talking about palliation outside work.

Drawing on the observations above I, therefore, argue that an emotional dimension is added to the cooperation and interaction in palliative teams. Vachon (1986; 1987), Larson (1993) Payne et al (2004) and Zimmerman and Applegate (1992) support this assumption in their work. Moreover, these researchers all maintain that a good team communication is essential in assisting staff to talk about, anticipate and cope with difficult deaths. It has not, however, been explored how interdisciplinary teams interactionally do emotion work at their conferences and handle stressors representing threats to the palliative ideal of a good death. Until now it mainly been investigated the ways in which palliative nurses interactionally do emotion work. Li (2004) and Li and Arber (2006), for instance, demonstrate the way in which palliative nurses display their ability to stay in control through emotion talk in the production of atrocity storiesⁱⁱ and extreme case formulationsⁱⁱⁱ. Hence, I investigate the following questions in the article,:

- How does a palliative team talk about a patient who is at risk of getting ‘a bad death’?
- What can the interactional dynamics of story telling tell us about emotion work at team conferences in a palliative setting?
- How do the team members respond to the stories and how do they appear to affect the decision-making in this setting?

Method

In researching the questions above, I have carried out microanalyses of talk-in-action at interdisciplinary conferences in a palliative outpatient ward using the methods of discursive psychology (DP) (Edwards, 1997) conversation analysis (Drew and Heritage, 1992; Arminen, 2005; Pommerantz and Fehr, 1997) and ethnomethodology (EM) (Garfinkel, 1967). To get proper insights into social action and interaction I consider it necessary to examine the talk – be it written, oral or non-verbal – in the specific setting under study since talk ‘is at the heart of human existence’ (Zimmerman and Boden, 1991: 3). The problem with much research in health settings is, as Sacks (1995) puts it, that it misses the interactional ‘what’ of the practice. Too often this research deals in theoretical abstractions like, for instance, ‘a good death’ without demonstrating how it is constructed in-interaction. EM’s and CA’s contributions, then, become to provide the missing interactional ‘what’ of institutional

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practice and document the social processes by which social life – in this case the ideals of ‘a good death’ - is constituted rather than treating social phenomena as given objects in the world.

Membership categorisation analysis (MCA) is an important tool for exploring interaction (Hester and Eglin, 1997). MCA reveals the way in which categories are employed in talk and text and what the possible consequences this employment has for the interactions – in this case – the weekly interdisciplinary conference in the palliative out-patient ward under investigation. The selection and use of a certain membership category (MCD) indicate that the ‘matter’ discussed is talked about in a specific manner which ‘project different identity attributions’ (Johnson and Paoletti, 2004: 193) such as, for instance, ‘terminally ill patient’ or ‘absent wife’. So in the choice of category represents a form of evaluative stance taken ‘towards’ the issue that is characterized and described. MCD’s can be seen as members’ resources for sense making in social interactions and this means that by tracing categories it is also possible to trace how social identities, social relationships and institutions are constructed (Baker, 1997).

Emotion work

Using EM and MCD I, then, investigate the way in which particular categorizations of people and their activities in stories invite to emotion work and moreover the way in which they potentially affect decision-making in these activities. The sociologist Arlie Hochschild originally coined the concept of ‘emotion work’ in her seminal study of flight attendants and their management of emotions to accomplish paid work (Hochschild, 1983; 1979). Hochschild maintained that their work could not only be described in terms of the physical aspects of their job but also in the energy expended in the managing of emotion. By the concept of ‘emotion work’ Hochschild refers to ‘the act of trying to change in degree or quality an emotion or feeling’ (Hochschild, 1979: 561) which, according to Hochschild, is essential for the smooth regulation of the daily practice in organizations that are engaged in working with people – like for instance the caring sector (Hochschild, 1983). Hochschild was inspired by the work of Goffman (1990) and his theories on ‘impression management’ and according to Zapf (2002) ‘impressions include the display of normatively appropriate emotions following certain display rules’ (238). So the concept of emotion work articulates the fact that not only are people expected to work in their tasks and spend mental as well as physical energy – they are also expected to manage emotions in a specific manner according to certain ‘feeling rules’ as part of their job.

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In my work, I take my point of departure in Hochschild's framework for studying emotion work, however, I do not draw on her terminology in my analyses. The EM approach I follow is conducted inductively and refrains from applying prefixed theories in order not to obscure local orders. Garfinkel argues that a sociology based on accounts or concepts burrs 'the fundamental role of enacted practices in the constitution of social phenomena' (Rawls, 2002: 21). Moreover, I maintain an agnostic position with regard to contemplating what goes on in peoples' minds. Rather, I anticipate to demonstrate and to explicate the ways in which emotions are realized through interaction. Consequently, I explore emotions in social situations, and how they are collaboratively and discursively managed in distinction from individual psychological and cognitive approaches to emotions. In this regard, EM and DP have challenged the more psychological and cognitive perspectives on emotions by claiming that since we do not have access to peoples' thoughts and inner feelings, there is no point in looking inward to explore internal mental states to see how they may affect interaction. This perspective sees emotions as revealing themselves descriptively and interactionally, using conceptual resources such as story telling and metaphors in the talk rather than illustrating inner mental states prior to the description (Edwards, 1997; 1999; Edwards and Potter, 1992). The question, then, is how emotions are initiated and produced in specific situations and settings, and the way in which they affect the organization of this specific activity, here, the conferences in a palliative care setting. I, therefore, define emotion work as talk about emotions. In the first place, this can be team members' talk about their own previous or current emotional state and/or talk about the emotional states of patients and/or their relatives. Secondly, emotion work can also be the expression of emotions, emotion displays, which are team members' non-verbal indications of being emotionally moved, indicated by their tone of voice, laughter, crying, and so forth. Thirdly, I also characterize the interactive work leading up to or following emotion talk or display as emotion work. This interactive work can, for instance, be performed through the telling of stories, the use of metaphors or the construction of reformulations.

The data

The data are derived from my ph.d. - project in which I research the impact of clinical supervision on emotion work in a palliative outpatient ward^{iv}. In researching the questions above, I have made ethnographic observations, reading of medical and nurses' journals, video recordings of clinical supervisory sessions, interdisciplinary team conferences and sound recordings of consultations with patients before, during

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and after CS was introduced^v. The data were transcribed according to conventions devised by Atkinson and Heritage (1984)^{vi}. In the analyses I drew upon directions for doing interaction analysis laid down by conversation analysis (CA) with the aim of describing ‘the structure and dynamics of the situated talk-in-interaction and how it evolves as a moment-by-moment achievement by the participants’ (Ruusurvuori, 2005: 207). In this kind of analysis, the task is to uncover participants’ own orientations ‘as observable in their interaction and show how these orientations are consequential for the interaction’ (ibid: 207).

An important method for validating findings in conversation analytic research is to search for and examine deviant cases in the material. Deviant cases are, according to Peräkylä, cases ‘where things go differently’ – most typically, cases where an element of the suggested pattern is not associated with the other expected elements’ (Peräkylä 1997: 292). Sometimes, as is the case with my study, deviant cases can also exhibit participants’ orientations to the same normative structures that produce the observed regularities. I observed six deviant cases in the data of talk about patients in which the palliative team oriented towards the normative pattern of telling stories and applying metaphors in the talk at the conferences. However, these talks also deviated from the normative pattern by including additional interactional features in an identifiable and specific kind of story telling which appear to intensify the emotional nature of decision-making at conferences. Typically, the pattern consisted of the telling of an atrocity story, followed by outlining a grim future scenario in which the team imagined possible future events. This worst-case scenario was followed by a sympathetic second story and a suggestion for future actions with regard to the care and treatment of the patient. Frequently, it was also difficult for the team to close the discussion about such patients. The team members kept supplying additional tragic information about the patient and his/her situation.

A single case analysis

In the article, I have chosen to demonstrate this interactional pattern in a single case analysis. Studies inspired by conversation analysis are not primarily interested in describing empirical patterns of interactions but rather to get a theoretical grasp of the endogenous logic of interaction - i.e. the principles guiding interactions. ‘The purpose of generalization, therefore, is to see whether and how some a priori rule or principle is oriented to by participants in various instances of natural interaction’ (ten Have, 2005: 136). It is a complex task to generalize and quantify results from interactional studies. Quantification requires analytic defensible notions of denominators, the set of

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types of occurrences whose presence should count as events and lastly the domain or universe being characterized (Schegloff, 1993: 103). Moreover, the character of and activity and its environment are seen as reflexively related in EM (Garfinkel, 1967). What, for instance, 'not doing anything' means – i.e. not responding verbally – when it would be appropriate in the talk varies depending on the circumstances. Or – as I shall illustrate in the analyses – what it means to be ignored when you try to take the floor several times. It is not, then, the non-occurrence per se – or the ignorance - that is interesting but rather how participants orient to it. All of this requires – according to ten Have (2005) single case analyses. Single case analyses reveal the details of actually occurring conversation that ideally speaking can – in the words of Sacks 'yield the technology of conversation' (Sacks 1984). This technology is evident 'in a set of formulated 'rules' or 'principles' which participants are demonstrably oriented to in their natural interactions' (ten Have, 2005: 135). Single case analyses, then, are capable of exposing these principles so they can be tested with comparable other instances.

Ethical considerations

The Danish data supervision board has given its consent to the project, and all participants, patients and team members, along with places have been rendered anonymous. Furthermore, all participants signed a written consent in which they were also informed that they could refuse to participate and withdraw from the study at any time without consequences of any kind. Despite this, achieving informed consent in an inductive field study is a negotiable matter (Li and Arber, 2006)^{vii}. Given the nature of the study it ought not to be possible to predict what is going to be the main topic or outcome of the research. Throughout the study I, therefore, informed participants of significant developments in the study.

The interdisciplinary conference

The interdisciplinary team in the palliative outpatient ward used the weekly conferences to discuss pressing issues involved in the caring for the patients and their families. The team counted 13 members and consisted of physicians, nurses, one psychologist, a physiotherapist, a dietician, a secretary and social worker. The team oriented to the institutional setting and their discussions revolve around issues that are presented as relevant for clinical decision-making (Drew and Heritage, 1992; Arminen, 2005). Practicalities as well as more complex issues like communication with the patient and his relatives and the way in which the team's resources can prepare the patient and his relatives for the terminal phase of the illness were brought

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up for discussion. Furthermore, actions taken by individual team members were accounted for and evaluated. Primarily medical and more factual issues such as the medical treatment of the patients were brought up for discussion. Still my study indicated that the interdisciplinary conferences not merely served as an institutional forum for decision-making. They were also used to share experiences and emotions with regard to patients who were at risk of not getting a good death. As I intend to demonstrate in the analyses below, the team members, for instance, displayed empathy and sympathy in the telling of stories and second stories (Sacks, 1995 April 24: 764-772; Ruusuvouri, 2005; Bülow, 2004) This sharing became increasingly intense and collaborative the more the patient was at risk of getting or has experienced a 'bad death' for various reasons listed in the table below.

Threats to 'a good death'

Sudden death	Sudden deaths do not allow for staff or relatives to prepare and be ready for death. Patients with particular cancer diseases are more at risk of a sudden death. Patients with, for instance, cancer of the prostate gland may get a spinal cord syndrome where they become paralyzed and may die. Also an aorta-aneurism can rupture anytime and cause sudden death.
Family conflicts	Domestic fights between husband and wife or between parents and grown up children appeared to disturb the dying process and were the topic of the talk at many conferences.
Controlling and demanding wives	Some wives did not let their husbands – the patient - speak up first at consultations. Especially wives who were former nurses were not inclined to do so. These wives made it harder to access the patient and his potential needs. Also some wives would call the ward and make specific demands which were seen as being inappropriate.
Younger children	Parents dying from their younger children represented an immense threat to a good death. In these cases the team told stories over and over

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	about the relationship between the patient and his children.
Absent wives with younger children	Patients with working wives, who did not take the leave of absence they were entitled to, gave these patients responsibility of the household and the children – at a time where they also had to manage their terminal illness and pains. According to the team this potentially stressed the patients and made their pains worse.
Uncontrollable pain	It was stressful for the team to witness patients dying in pain they could not control.
Physical deterioration	Many stories were told – sometimes in a black humoristic tone - about cancer patients who experienced a physical deterioration.
Lacking openness	If patients did not want to talk about how she/he felt how/ and wanted to die the team often discussed why this could be and the way in which they could assist these patients in getting a good death.
Loneliness	The team acted almost like a family and talked frequently with/about patients who did not have a social network

In these situations, the story-telling pattern deviated from the normal pattern. My analyses of the talk in the six deviant cases revealed a sequential pattern in which the team collaboratively developed tragic aspects of these patients and their fatal situations by means of an identifiable and specific kind of story telling. Below, I exemplify this story-telling pattern in a single case analysis of a conference in which the team is discussing the situation of and their potential actions with regard to a young and terminally ill cancer patient called Martin. Using the notion of story telling as a point of departure it is my claim that an analysis the five distinct features, atrocity stories, second stories, the use of metaphors, extreme-case formulations and categorical descriptions of people and their activities, of this sequential pattern will help us understand how and why emotion displays and emotion talk are made relevant. Furthermore, these expressions appear to pinpoint the way in which the palliative team orient to and define the palliative ideal of a good death. Lastly, I

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demonstrate how the team's emotion talk and displays seem to legitimize their past or future actions. Thus, I argue that their emotion work appears to be tailored to fit the concrete circumstances at hand.

Martin's case

Martin was a terminally ill patient with cancer in his forties with a wife and three younger children. Because Martin's wife had a job where she travelled a lot he had to take care of the home and children. In the first part of the conference, the discussion revolves around Martin, his needs, how to take care of them and how to balance giving hope with being realistic in the information. However, this perspective shifts at the end of conference as demonstrated in the extracts below. Here the team members' perspective and their potential needs are also brought up for discussion. The physician Lars, the psychologist Victor and the nurse Eva participate in the talk and the physiotherapist Sara moderates the conference.

An atrocity story

We enter the conference when Sara is about to close the discussion about Martin. Then Lars takes the floor and tells an atrocity story about an 'awful' experience he had with a former patient suffering from the same cancer and as Martin^{viii}.

English

- Com: Sara leans forward
1. °So°
2. Pause: (2.5)
3. Sara: °this was Martin°
4. Pause: (2.0)
5. Sara: for today
6. Pause: (0.6)
7. Lars: °This is going to take its toll this is°
8. Sara: Yes
9. Pause: (0.7)
10. Sara: °Yes°
11. Pause (0.7)
- Com: Lars is closing the medical journal in front of him
12. Lars: Also the other guy we had (0.4)° don't you
13. Remember° we had one who was about the same age where he
14. got spinal cord compression equivalent to C2↑ (1.1) he
15. suddenly collapsed (0.2) and became paralyzed↑ (0.7)
- Com: Lars is snapping his fingers. Sara is overlapping the snapping
16. Sara: [(xx)]
17. Lars: Like that↑
18. Sara: (xxx)
19. Pause: (0.9)
20. Lars: And then we had to give him something so he did not suffocate
21. it was so awful (1.0)
22. then he was (X) °in just 5 minutes° (0.2)
23. Sara: °It was° (xxx)
24. Pause: (1.5)
25. Lars: It wa:s

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- Danish
1. Sara: °så°
°So°
 2. Pause: (2.5)
 3. Sara: °det var Martin°
 4. Pause: (2.0)
 5. Sara: i dag
for today
 6. Pause: (0.6)
 7. Lars: °Det trækker søm ud det her°
 8. Sara: Ja
Yes
 9. Pause: (0.7)
 10. Sara: °Ja°
°Yes°
 11. Pause (0.7)
 12. Lars: Der var også ham den anden vi havde (0.4) °kan I ikke
13. huske° vi havde en der var der var på samme alder hvor
han
 14. fik tværsnitssyndrom svarende til C2↑ (1.1) han brast
 15. pludselig sammen (0.2) og blev lam↑ (0.7)
 16. Sara: [(xx)]
 17. Lars: Sådan↑
 18. Sara: (xxx)
 19. Pause: (0.9)
 20. Lars: Og så måtte vi give ham noget så han ikke blev kvalt det
21. var så forfærdeligt (1.0)
 22. så blev han (x) °i løbet af 5 minutter°
 23. Sara: °det var° (xxx)
 24. Pause: (1.5)
 25. Lars: Det va:r

From line 1 to 12 Sara appears to be initiating a closing relevant environment for the talk about Martin (Robinson, 2001) when Lars takes the floor with an evaluative statement about the future prospects of Martin's condition (7) and closes the medical journal in front of him, probably Martin's. Hereby Lars appears to align with Sara's effort to close the discussion about Martin. However, having taken a deep breath Lars re-opens the discussion from a new perspective with a question to the other team members in which he relates an experience the team had with a former patient to the present situation (12-25). The initiating event for Lars' story appears to be the previous discussion about Martin and Martin's situation is noteworthy since this patient reminds him of Martin (Ochs, 1997). As it can be seen from his story, there are also several similarities between the two patients. They are both young males terminally ill with the same cancer disease. The atrocity story he tells about the former patient (12-22), moreover, seems to be linked to his evaluative statement by the concept of time in that it appears unpack what Lars means by 'taking it's toll' with respect to Martin's future prospects (7). Lars' story, therefore, seems to invite the team to recapitulate the past experience and moreover, he appears to set up an analogy inferring that what happened with the former patient could also happen to Martin. Lars' experience, then, can be seen as a possible future scenario of and preparation for how Martin's situation might develop (Ochs, 1994). But how is the potential

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emotional nature of this topic unfolded in the structure and the use of categories in the Lars' story? The past experience, then, appears to be projected as something, which could also happen to Martin in the future

Lars projects his story in a preface when he says: 'Also the other guy we had (0.4) don't you remember' (12) (Jefferson, 1978: 219). Here Lars invites the conference participants to recall the situation he presents in his story, a situation which appears to be an 'eye witness account' of a personal experience (Webb and Stimson, 1976). He does not wait for one of the others to position him or herself as a listener he just continues to tell his story. The temporal order in Lars' story is marked by the chronological order of events in the story (Lepper, 2000). First: The patient got: 'spinal cord compression equivalent to C2' (14) and Then: 'He suddenly collapsed and became paralyzed' (15) and 'we had to give him something so he did not suffocate' (20). Lars evaluates his story in the coda (21): 'it was so awful' (ibid: 108). The fragmented repetition of the coda (25) potentially enforces the emotional nature of the coda. On the other hand the repetition could be caused by the fact that nobody, except Sara, responds to his story verbally right away or that he is not getting the response he is looking for. There are two pauses, a shorter (19) and a longer (24), where nobody takes the floor. Seen from this perspective, the coda could be Lars' snapping of his fingers just after line 15. Also the use of such a non-verbal effect initiate attention and involvement on the part of the listeners as could be expected in a 'closing' or a 'coda'. The dramatic quality of the atrocity story and the intensifying of the situation may also call for more response from the listeners and could support the interpretation of the fact that the coda is in line 17 and not 20, 21. Lars does not, however, get a response right away. Instead there is a longer pause (24) before the psychologist Victor takes the floor.

Lars describes the patient in the analogous story as collapsing and being paralyzed (15) and later on nearly suffocating (21). Using such forceful words gives the atrocity story a dramatic quality and illustrate the conflict between life and death, where the protagonist 'we' (20), which can be deduced to be Lars and the other team members, appear as a rational and sensible, and capable of saving the patient from suffocating just like Li and Arber (2006), Webb and Stimson (1976) describe the function of atrocity stories. Furthermore, as I intend to show below, Lars' atrocity story also appears to project an emotionally loaded reception from the recipients.

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The filling of categorical attributions to the MCD patient seems to enhance and contribute to Martin's tragic character. Both Martin and the patient in Lars' story are not only patients they are also young and terminally ill. This allows for inferences concerning the attitudes and actions, which could and should be considered in caring for Martin. The choice and the elaborations of category attributions seem to frame the emotional nature of Martin's condition. Being terminally ill and young at the same time can be said to be a contradictory situation which may be difficult to handle emotionally for all parties involved in that these features can be seen as representing threats to 'a good death'. These interactional features may call for emotional responses from the recipients. Lars' story, then, does not appear to be a 'mere' evaluation and attempt to express a medical factual prognosis. If this was the case, he could have left out the last and more emotional part of the story from line 16. Interestingly, I was informed a while after this conference that Lars had told his 'atrocious story' about the young male cancer patient at conferences several times before and always in cases where the patient who was brought up for discussion was a young and terminally ill male patient.

While Lars is talking Victor is looking at him nodding. After having made his repetition (25) Lars leans forward and pushes one medical journal away and pulls another one over – at which time he gets a response from Victor.

A future scenario

English

- 1 Victor: Can I say something about this?
2 Lars: Mm
3 Victor: also because exactly what you are saying here Lars I also
4. had this thought after having spoken a little with you Eva
5. that that (0.2) Martin ends up being
6. admitted here and dying here (0.2)
7. Lars: H[m]
8. Victor: [th]en I am thinking that you don't have to be cloy (0.2)
9. clair voyant (0.1) to see (0.1) in the crystal bowl .hhh
10. that it will be (0.2) a course which will take its toll
11. [in] many ways (0.3) also on a human level
12. Eva: [Mm]
13. Victor: on all of us
14. Eva: Mm
15. Victor: [and] with [his] relationship [to those] children .hhh
16. Lars: [Mm] [mm] [mm mm]
17. Victor: >there cannot be any doubt as to who wears the pants in
18. this family that is emotionally with respect to the kids<
19. Eva: Yeah (0.2)
20. Victor: Eh (0.4)
21. Eva: Yes
22. Victor: Ehm
23. Lars: Whom is it they have (0.3)
24. Victor: It has (0.3) completely
25. Eva: Yea[:h]

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26. Victor: [T]hat is (0.1) >she is a woman who takes care of her job
27. Eva: Yes
28. Victor: and vacumes when she is home<
29. Eva: Mm
30. Victor: so it is Martin who is in charge of [all] of the emotional (0.2)
31. Eva: [yes]
32. Victor: practically isn't he (0.1)
33. Lars: (She will) get something to do
34. Victor: She will get something to do and this is a problem which
35. can be said to be is beyond our (0.1) competence >but I
36. am thinking if Martin is admitted here terminally<
37. (0.9) eh no matter where it is in the house it will be
38. really (1.1) then I think it will have an effect on everybody (0.2)
39. Eva: Yes
40. Lars: Can happen (0.2) very quickly I think
41. Victor: >Yes yes< but I am saying [we] we might as
42. Eva: [Mm]
43. Victor: [well get prepared for this] and say that then [we] should
44. Eva: [you are right]
45. Victor: also have established a forum where we can where we can
46. Lars: [yes]
47. Victor: have other than technical discussions [about] Martin eh
48. Eva: [Mm]
49. Lars: Yes
50. Eva: Yes
Com: Lars is holding his breath with some air in his cheeks
51. Victor: use CS and so on .hhh
52. Eva: Yes
53. Victor: >And with respect to the staff that gets the pleasure of
54. having the children [admitted] with their father
55. Eva: [(xxxxxx)]
56. Victor: and so on< because it=
57. [will] tear your heart apart
58. Eva: [Yeah] yes
59. Victor: det h:er [altså]
this [is]
60. Eva: [Mm] (0.1) But it is true it [is him who] really
62. Lars: [(xxxxxxx)]
63. Victor: It is him [who:eh]
64. Eva: [always] takes care [of those] kids
65. Lars: [(xxxxxx)]
66. Sara: M:mn
67. Pause: (0.3)

Danish

- 1 Victor: Må jeg sige noget om det
2 Lars: Mm
3 Victor: også fordi lige præcis det du siger der Lars den tanke har
4. jeg også haft også efter at have talt lidt med dig Eva
5. at at (0.2) hvis det ender med at Martin skal indlægges
6. her og dø her (0.2)
7. Lars: H[m]
8. Victor: [s]å tænker jeg så skal man altså ikke være cloy (0.2)
9. clair voyant for at ku se (0.1) i kuglen hhh at det blir
10. (0.2) et forløb der trækker søm ud [på] mange måder (0.3)
11. også sådan menneskeligt [Mm]
12. Eva: [Mm]
13. Victor: på os alle sammen
14. Eva: Mm
15. Victor: [og] med [hans] forhold [til] de [der] børn ikk .hhh
16. Lars: [Mm] [mm] [mm mm]
17. Victor: >der er altså ingen tvivl om hvem der har bukserne på i den familie sådan emotionelt i forhold til ungerne< (0.3)
18.
19. Eva: Jaeh (0.2)
20. Victor: Oeh (0.4)

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21. Eva: Ja
22. Victor: Øhm
23. Lars: Hvem er det de har (0.3)
24. Victor: Det har (0.3) fuldstændigt
25. Eva: Jae:[r]
26. Victor: [Al]tså (0.1) >hun er en kvinde der passer sit arbejde
27. Eva: Ja
28. Victor: og støvsuger når hun er hjemme<
29. Eva: Mm
30. Victor: så er det Martin som står for [alt] det emotionelle (0.2)
31. Eva: [Ja]
32. Victor: stort set ikk (0.1)
33. Lars: (får hun) hun får noget at tage sig af
34. Victor: Hun får noget at tage sig af og det er så et problem der ligger udover vores (0.1) kompetence kan man sige >men jeg
35. tænker hvis Martin bliver indlagt her terminalt<
36. (0.9) øh uanset hvor det er i huset så vil det (0.2)
37. altså (1.1)) komme til at gøre noget ved alle (0.2)
38. Ja
39. Eva: Ja
40. Lars: Kan ske (0.2) meget hurtigt tror jeg
41. Victor: >Ja ja< nå men jeg siger [vi] vi kan lige så
42. Eva: [Mm]
43. Victor: [godt indstille os på det] og sige så skal vi at så skal
44. Eva: [det har du ret i]
45. Victor: vi også her måske have etableret et forum hvor vi kan
46. Lars: Ja
47. Victor: snakke andet end teknisk om Martin [om at] øh
48. Eva: [Mm]
49. Lars: [Ja]
50. Eva: Ja
51. Victor: bruge faglig vejledning og så videre .hhh
52. Eva: Ja
53. Victor: >Og i forhold til det plejepersonale der får fornøjelsen af at have børnene med[indlagt]
54. [(xxxxxx)]
55. Eva: og så videre< for det kommer=
56. Victor: [til] at rive i hjertet
57. [Jaeh] ja
58. Eva: det h:er [altså]
59. Victor: [Mm] (0.1) Men det er rigtigt det [er ham der]
60. Eva: virkelig
61. [(xxxxxxxx)]
62. Lars: Det er ham [der:øh]
63. Victor: [Altid] på [de der] unger
64. Eva: [(xxxxxx)]
65. Lars: M:mn
66. Sara: (0.3)
67. Pause:

Victor asks Sara's permission to respond to Lars' story (1) in a preface. He, then, responds to Lars's question by commenting on the similarity between the former patient and Martin. Furthermore, he seems to unpack Lars' evaluative statement 'it is going to take it's toll' even more by presenting a rather detailed future scenario about the grim perspectives for Martin in the extract above. Victor appears to show his alignment and sympathy (Ruusuvouri, 2005) with Lars's comment by repeating and elaborating on what he takes as the point of his statement, a warning of future emotional impact, when he says that: 'You don't have to be cloy (0.2) clair voyant (0.1) to see (0.1) in the crystal bowl .hhh that it will be (0.2) a course which will take its toll [in] many ways (0.3) also at a human level' (8-10).

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In the story proper, Victor shares the knowledge he has about Martin as his psychologist and tells about his family, wife and two children and how their internal roles and relations are shaped. In his talk, he constructs Martin's character as being even more tragic by adding category attributions, enriching and elaborating further on the MCD: patient. Martin is not only a patient, young and terminally ill, he is also a father (15). He is the primary caretaker of them (line 63, 64) he 'wears the pants emotionally' with respect to the children (17, 18) because he has a wife, who takes care of her job and vacuums, when she is home (26, 28). The 'when' clearly indicates that she is not at home every day!

Victor starts to phrase how it will be if Martin is admitted terminally (36). However, he cannot – or rather – does not label how it will be. Instead, there is a pause for 1.1 sec. After the pause, Victor predicts that Martins case will have an effect on everybody (38), which means that the team members present at the conference also will be affected. The pause can be seen as an empty place, where the recipients are allowed to imagine how (terrible) it will be. Its sequential placement just before the conclusion and the emphasis on 'everybody' may indicate that this will not be easy and everybody at this conference will also be affected. The use of 'everybody' in the sentence is an extreme case formulation (Pommerantz, 1986). Here this formulation seems to justify a calling for the attention of 'everybody' sitting around the table. All the participants appear to be listening to what Victor is saying. Moreover Eva and Lars are responding verbally to Victor's predictions (39, 40). According to Edwards extreme case formulations perform 'interactionally significant narrative and rhetorical work' (Edwards 1997: 189) and in the next passages I will show how Victor in his future scenario descriptively and rhetorically works up a situation, where emotion talk and displays are made relevant for the occasion.

The fact that Martin's situation will have an effect on everybody (38) is a repetition of what he said in line 10, but it is now being upgraded to have an effect on everybody 'no matter where it is in the house' (37) and not 'just' on those present at the conference. When Victor is talks about Martin's admission to the hospital he uses the same technique. First of all Martin is admitted alone (36), which as mentioned, will 'have an effect on everybody'. Then Victor presents 'a worst case scenario' (53) by making the participants imagine how it will be if the children are admitted together with Martin. He is even asking the participants to think of the staff, who will have the 'pleasure' of dealing with this. It. By using the word 'pleasure' Victor is probably

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being ironic. What he in fact means the recipients have to imagine for themselves. As such the use of irony in the situated context may leave room for imaginations of how terrible it will be for the staff that will have the ‘pleasure’ of caring for Martin. The answer Victor gives is that: ‘It will tear you heart apart’ (57). The rhetorical emphasis on tear possibly enhances the emotional imagination of the horrid future perspectives for Martin and not least for the staff members who will be caring for him.

Metaphors and extreme case formulations

Emotions are said to be ‘the language of the heart’ so the use of the heart-metaphor together with the upgrading and the story structure support and enforce the emotional nature of Victor’s statement. The use of the ‘heart metaphor’ in this case, then, appears to contrast with the findings of previous research arguing that palliative nurses use a metaphoric language to maintain their professional distance, neutrality and reputation in talking about and with the dying and bereaved Frogatt (1995; 1998). Moreover, the ‘heart metaphor’ is embedded in an ‘extreme case formulation’ which intensifies the initial evaluation of the effect Martin’s future prospects might have on the staff. Firstly, Victor says: ‘It will take its toll’ (10) and later ‘It will tear you heart apart’ (57). Secondly, the patient’s children are mentioned just before and after these ‘punch lines’. This potentially makes the final conclusion even more heartbreaking. The use of the ‘heart metaphor’ in connection with the mentioning of the children may be seen as nicely timed in Victor’s narrative, which may lead up to emotion talk and/or displays. Also the heart metaphor seems to provide a kind of evidence of ‘being there’ and ‘knowing’ that according to Potter and Edwards ‘bolsters the validity of all kinds of stories and descriptions when they are in danger of being countered’ (Edwards, 1997: 189).

Victor suggests the need of another forum (45), where the team can have ‘other than technical discussions’ (47). The use of the term ‘technical talk’ here seems to refer to a medical and more factual discourse, which is prominent at most conferences. Consequently, it can be deduced that Victor is talking about a forum where the team can have ‘emotional talk’. Victor’s suggestion clearly indicates that conferences are not for emotional talk – and that supervisory room is called for. Victor’s ‘extreme case formulation’, i. e. the description of the ‘undesirable and/or intolerable’ future prospects both for Martin and the team, seems to justify his professional suggestion to establish another forum in which these ‘sensitive’ and ‘emotional’ matters can be talked about.

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Victor, unlike Lars, gets verbal responses during his commentary in the form of ‘mm’s’ and ‘yeahs’ on his comments about Martins situation – both from Lars and the nurse Eva (7, 12, 21, 25). These ‘mms’ and ‘yeahs’ are said in a very sympathetic tone of voice and can be seen as emotional displays indicating that the team can relate to the perspectives Victor is presenting. Moreover there seems to be an interactive process between these displays and the building up to emotion talk in the coda where Victor predicts that ‘It will tear your heart apart’ (57).

In three instances, Lars tries to enter the conversation – but without success^{ix}. Lars responds twice to Victor’s statements about the roles of Martin and his wife (23, 33) and once about the nature of Martins illness (40). First of all Victor makes the statement that Martin is wears the pants ‘emotionally with respect to the kids’ (18). Then Lars’ poses an un-finished question: ‘Whom is they have’ which is ignored by Victor. He just continues his telling about Martin with an un-finished extreme case formulation in line 24: ‘It has completely’ with an emphasis on completely. The recipients are never told what has ‘completely’ - they have to imagine this for themselves. In the situated context, this formulation practically seem to erase Lars’ question. Eva is clearly aligning with and orienting to what Victor is talking about and seems to understand what he is not saying explicitly (25).

Next Victor intensifies the situation and says that Martin is in charge of ‘all the emotional’ in an unfinished sentence. He is probably talking about the emotional matters at home, since he has just been talking about Martin’s absent wife. Then Lars makes his second contribution (33) in which he displays sympathy with the situation in Martin’s home and says: ‘She will get something to do’ referring to Martin’s wife. Finally Victor presents an extreme formulation by saying that ‘it will have an effect on everybody’ where after Lars makes his third utterance: ‘Can happen very quickly’ (40). All three contributions seem to bring the more emotional perspectives in Martin’s situation down to earth in a disruptive manner at sequentially vulnerable places in the discursive building up of a future scenario, which calls for a specific action. Lars’ contributions seem to be oriented towards concrete answers and possibly imply specific actions in different areas of the caring for Martin and his family. Victor only talks about a specific action when suggesting the need for clinical supervision. Noticeably, he makes this suggestion (40) just after Lars’ remark, where Lars seems to be orienting to his role as a physician at the conference. Victor, then, advocates for a forum where the team can have as he puts it ‘other than technical talk’ (45). This suggestion can be seen as a hint to Lars and his medical agenda which is explicitly

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rejected here. Victor's talk can be seen as discursive work for the establishment of this forum. From this perspective, Lars' comments are disturbing to Victor and those who collaborate with his agenda – both with regard to contents and sequential placement.

A second story

Overlapping Victor's speech (63) the nurse Eva takes the floor and tells a 'second story' in which she appear to unpack and elaborate on Victor's remarks about Martin's qualities as a father (Sacks, 1995 April 24: 764-772). With Ruusuvouri (2005) it can be stated that Eva in her second story is displaying 'empathy in action' (219). Ruusuvouri (2005) and Bülow (2004) have looked at the way in which stories provide for the display of empathy and sympathy in-interaction. Ruusuvouri, for instance, demonstrates how professionals show affiliation and sympathy with the patient by the telling of a 'second story' (Sacks 1995, April 24: 764-772).

In the specific situation, it is, moreover, worth noticing the intense transition (59-64) before Eva tells her story where Victor and Eva overlap each other. Lars also says something which unfortunately cannot be identified since he is mumbling. The co-operation and aligning between Eva and Victor seems obvious as well as their mutual empathy. The co-construction demonstrates 'an understanding of another persons situation and/or feelings and communicating that understanding back to the person so that they feel understood' (Pudlinski, 2005: 267). Also, they sit next to each other, whereas Lars is placed on the other side of the table. Victor repeats Eva's unfinished remark (63) in line 60. Eva ends up with the preface of her story (64), aligns with Victor and finishes his repetition (63) of her remark (60). The overlapping talk seems to illustrate the mutual, active sharing and recognition of the distress Martin's situation impedes (Bülow, 2004). Eva's story provides yet another piece in the building of Martin's tragic character and seems to unpack the dramatic coda by explicating why it 'will tear your heart apart' and revealing why Martin is such a caring father for his children. Another way of putting it is to say that the rhetorical effect of this extreme formulation is illuminated in the next sequences of the interaction at the conference. Thus it can be seen that emotion categories not only provide for a rational accountability but also perform the opposite. By 'the opposite' is meant permission for 'temporary inflammations of the passions' (Edwards, 1999: 277).

English

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1 Eva: One day he was late because (0.6) the boy he had just
2. come home from school and there was just something he
had
3. to talk with his [father] about (0.2)
4. Victor: [Yes]
5. Sara: °Noeh°
6. Eva: and he just just had to listen to this=
7. [before] he left [didn't he]
8. Victor: [yes]
9. (Sara): [(Yes)]

Danish

1 Eva: En dag kom han sent fordi at (0.6) knægten han var altså
2. lige kommet hjemfra skole og der var bare lige noget han
3. skulle snakke med sin [far] om (0.2)
4. Victor: [Ja]
5. Sara: °Nåe°
6. Eva: og det var han lige nødt til at høre på=
7. [inden] han kørte [ikk]
8. Victor: [Ja]
9. (Sara): [(Ja)]

Eva sets the scene in the preface to her second story: ‘One day he was late’ (1). Then, in the story proper the boy comes home from school, he has something to tell his father and Martin has to listen. The coda is presented in the previous extract (64): It is Martin who really takes care of those kids. By telling her story, the nurse, Eva, aligns with Victor’s picture of Martin as the primary caretaker in the family. Eva delivers her story in a very quiet and un-sensational manner which, in a sense, appears to be ‘understated’ compared to Victor’s worst case scenario. She is, for example, using the moderator ‘just’ twice (1-2). Sara and Victor position themselves as recipients and active listeners. They seem to align with Eva’s perspective and produce emphatic tokens (4, 5, 7, 8). Especially, Sara appears to be moved by the story, when she says ‘noeh’ in a baby-like manner – in a caring and gentle tone of voice (5). Eva’s story also results in the following immediate and sequentially closing response from Lars overlapping the last word in Eva’s story.

A final commentary

English

1 Lars: °[We] have to make sure that there is professional cover up
2. on weekends that is on behalf of physicians°
3. Ps: (1.0)
Com: Victor is nodding intently
4. Eva: [Mm]
5. Victor: [Mm]
6. Ps: (0.6)
7. Lars: °We we cannot be we cannot let him (0.7)
8. Eva: Mm (0.3)
9. Lars: I will be dammed if we can let him sail there then we
must get him (admitted) perhaps°
10. (E): Mm
11. Ps: (3.5)

Danish

1 Lars: °[Vi] skal også sikre os at der er faglig opmærksomhed i

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2. weekenden altså fra lægesiden°
3. Ps: (1.0)
Com: Victor nikker kraftigt
4. Eva: [Mm]
5. Victor: [Mm]
6. Ps: (0.6)
7. Lars: °Det det ka vi ikke være ham vi kan ikke lade ham (0.7)
8. Eva: Mm (0.3)
9. Lars: lade ham sejle der så må vi faneme få ham (indlagt)
 måske°
10. (E): Mm
11. Ps: (3.5)

By commenting in this way Lars seems to align with Victor's anxiety for the future (1, 7, 9) but he does not comment on the need for establishing another forum. Instead, he orients towards the MCD of a physician, and presents concrete medical solutions and actions for the future like making sure there is medical coverage at the weekends and mentioning the possibility of admitting Martin to the hospital (9). Lars' argument for these actions can be found in the stories of Victor and Eva. From these stories we know that Martins is young, dying, the primary care taker of two younger children – and last but not least – he has wife who is away a lot. So when Lars says 'we cannot let him' sail 'in line 8, he seems to be implying that Martin could be lost 'alone' without medical care at home. Hence the use of this specific metaphor here seems to perform discursive work in the context of production. Moreover, it adds yet another piece to the construction of Martin's tragic character. In accordance with Edwards (1999: 280), such graphic and visual detail manage things 'to be said and not just thought' and moreover seems to call for as well as justify some sort of action, which is precisely what Lars seems to be demanding. Just imagine Martin being somewhere – alone - on a big ocean – who would not want to help him out?! Before presenting his final solution: To admit Martin to the hospital, Lars swears and says: 'I'll be damned' in a seemingly tense tone of voice (9). This swearing appears to be an emotion display – perhaps an indication of a certain anxiety for the future – and, therefore, seems to emphasize Lars' request for a solution and action to the problem.

To sum up, the gradual elaboration of the MCD patient in the atrocity story and second stories seems to inspire a very vivid and metaphorical language which also appears to intensify the tragedy of Martin's early death. Moreover, these interactional features together with the use of extreme case formulations and metaphors can be seen as descriptive resources by which the participants seem to manage accountability and justify their intentions and actions.

After the conference, nothing was written in the nurses' or the medical journal. Martin's situation was not brought up in clinical supervision as Victor suggested,

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however, Martin was the main topic at many lunch- and coffee breaks. He got an open admission to the hospital so that he could be admitted anytime he needed medical attention and care. The team continued to be observant with regard to when he and his family was ready to talk more in detail about where, when and how he wanted to die. However, rather than discussing these questions Martin had a different agenda. Martin's idea of a good death trajectory did not correspond with that of the palliative team. He wanted to talk about how he could manage his next trip abroad with his family. Martin was focused on living until he died – instead of getting ready for dying while he lived.

Discussion

In health care professionals are constantly faced with the challenge of deciding when to intervene to intervene in patients' physical, social and mental lives. In palliative care this challenge has yet another dimension since there is not – as one of the physicians in my study put it – a dress-hearsal for death and dying. The implication of this remark could be that the care for the patient has to be correct and sufficient from the beginning – since cannot be altered or redone. This puts on a certain pressure on the team to succeed and 'do the right thing'. Especially when the patient, like Martin, is a young man with two young children.

The literature describes how palliative teams are ambitious, make judgements about the quality of death for patients and hold high expectations of their professional work (Kristjanson, 2001; Payne et al, 2004). These findings are supported by my study in which it is specified the way in which an interdisciplinary palliative team collaboratively reflects on and manages the emotional nature of their practices of having to deal with death and dying patients every day. Ochs (1994) has found that the relationship between the past, present and future perspectives can help us to frame events to a certain extent and give us a feeling of being able to control the uncontrollable. According to Ochs, it is an existential dimension of all story telling activity that the recollection of past events holds anticipation for future happenings. In this article I have shown how this linking is done interactionally between the stories from the past - Lars' atrocity story and Eva's story about Martin as a caring father -, and the future perspectives of these stories - presented in Victor's 'worst case future scenario' and Lars' commentaries about possible future actions. With Ochs I, therefore, claim that this linking more than assisting Martin in getting a good death serves as a mental preparation for what may happen and help the team find their way in the present and the future. In this regard, Bülow (2004) asserts that the active

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sharing of personal experiences, just like it happens in the talk about Martin, may transform these experiences into collectivised experiences and create a sense of belonging by confirming the bonds of a group.

Previous research in palliative settings, moreover, clearly indicates that the improvement of healthy and qualified teamwork and cross-disciplinary communication may reduce and help alleviate the stress in palliative care (Kristjanson et al, 2001, Payne et al, 2004; Zimmerman and Applegate, 1992). Kristjanson et al, 2001 has, for instance, suggested that palliative teams could work to develop processes for explicitly identifying potential bad deaths. This identification may allow for anticipation of potential challenges and difficulties in the care including a more open communication about realistic care expectations of patients and of team members. Attending to and reflecting on care objectives, strategies and processes, then, possibly prevents burn-out in palliative care because these reflections initiate a realistic improvement of palliative teams' cooperation and care of patients in the uncertain and challenging environments they operate in (West, 1999). Ideally speaking, these negotiations illuminate and assist palliative teams in dealing with potential challenges and dilemmas in palliative care like, for instance, the dilemma between respecting patients' autonomy and maintaining the palliative ideal of a good death (McNamara et al, 1995; McNamara, 2004).

Conclusion

This article has demonstrated how participants at the interdisciplinary conference in a palliative outpatient ward do emotion work in the talk about the caring of the terminally ill patient called Martin. Martin is a younger patient with a terminal cancer disease which may cause a spinal cord compression and a sudden death. Moreover, Martin has a wife and two younger children he practically is the sole caretaker of. These issues are illuminated in the talk and appear to represent a threat to the palliative team's ambition of providing a 'good death' for Martin and his family and seem to initiate emotion work at the conference. In the article, emotion work is defined as the interactional management of emotions consisting of emotion talk or/and displays and, moreover, the interactive work leading up to or following either emotion talk or displays.

In Martin's case, the interactional dynamics of story telling reveals a sequential pattern of interplay between the telling of an atrocity story, a future scenario, a second story and finally, a commentary on the previous stories where possible future actions

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are described. Moreover, there is a gradual elaboration and negotiation of the topics and categories mentioned in the course of the story telling. In this talk, membership categorization analysis provides a method of describing how ‘narrative talk is occasioned and produced as means of pursuing member-relevant activities’ (Housley, 2000: 440). It is evident that the stories told matter to both the tellers and hearers – but how and why it matters is displayed in the construction of Martin’s tragic character. He is a patient but he is also terminally ill and young and lastly, he is a father of two younger children and the primary caretaker of them and the housework in his family.

The rhetorical design of the future scenario with metaphors and extreme case formulations also seem to bolster the validity of the scenario and justify a specific call for action: The establishment of a forum in which the team can have ‘other than technical talk’. These features initiate an interactive process where emotion talk and emotional and sympathetic responses and displays seem to re-enforce each other. The emotion talk culminates with Victor’s prediction that Martin’s situation will ‘tear your heart apart’ and the displays can be seen in for example in the responses to the psychologist’s Victor’s future scenario, the nurse Eva’s second story and finally, in the physician Lars’ commentary in which he asserts that he will make sure that there is professional cover up at weekends. Thus I argue that the emotional statements and displays about Martin’s future prospects play a major part in the team’s decision process of what actions to take in the specific situation.

Table 1: Transcription symbols

[xx]	Square brackets mark the start and end of overlapping speech, aligned with the talk above or below.
Pause:(0.4)	Numbers in round brackets measure pauses in seconds.
.hhh	Audible in-breath.
He sle: pt	: Colons show degrees of elongation of the previous sound.
He was so ()::	Empty parentheses in the middle of a sentence indicates and insecurity about what is said
(): Yes	Empty parenthesis before the utterance indicates an insecurity about who speaks
xxx	The x’s are indications of the number of syllables, which seem to be spoken
Underlining	Pressure on the syllable that is underlined
°She did not want it°:	Raised circles (‘degree’ signs) enclose obviously quieter speech.
= :	‘Equals’ signs mark the immediate ‘latching’ of successive talk, whether of one or more speakers, with no interval.
↑↓	Vertical arrows mark pitch movement: Rising intonation is marked by an arrow pointing upwards and falling intonation by an arrow pointing downwards.
> She was so sweet <	When a part of an utterance is delivered at a pace quicker than the surrounding talk, it is indicated by being enclosed between ‘less than’ signs.
Com	Non-verbal action and other comments.

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Notes

ⁱ Interdisciplinary teams are teams, where the members continue to work from their particular professional orientations but undertake some joint collaborative work (Opie 1997)

ⁱⁱ According to Webb and Stimson (1976), an atrocity story is usually an eyewitness account of some atrocity, usually an experience that the narrator has undergone that has a highly personal and dramatic quality in which the major areas of conflict between the participants are revealed. Arber (in press), moreover, asserts that atrocity stories mainly serve to support the professional reputation of the teller.

ⁱⁱⁱ An extreme case formulation is a formulation in which a specific situation is described in extreme terms using extreme markers like, for instance, 'completely' (Pommerantz 1986). Pommerantz suggests that an extreme case formulation is a descriptive and persuasive practice which is used in justifying a course of action. Justifying a course of action involves 'portraying the precipitating circumstance as necessitating the action' (Pommerantz 1986: 228). This circumstance can be a problem circumstance, which is described as 'unfair, immoral, embarrassing, uncomfortable or in other way undesirable and/or intolerable' (ibid).

^{iv} Clinical supervision is described as being a reflective practice in which supervisees get a meta-perspective on their work which potentially enhances their professional security and competence. (Lund-Jacobsen & Holmgren, 1996; Arvidsson, 2000).

^v For more information on my ph.d.-project the reader can consult my dissertation: *Doing Emotion Work: Clinical Supervision in a Palliative Out-patient ward*.

^{vi} Please have a look at table 1.

^{vii} Lawton (2001), de Raeve (1994) and Raudonis (1992) discuss the problem of informed consent in their articles about ethical challenges in palliative research.

^{viii} The transcript is presented with English glosses in italics as I feel this is sufficient for the analyses I make in the article.

^{ix} The interaction between Lars and Victor in this paragraph can also be seen as an example where each of them is 'doing being their professional identity' as respectively a physician and a psychologist. However, since this is not the focus of this article I shall not elaborate further on the issue here but perhaps in a future article!

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Article II

Negotiating field roles in qualitative health research

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Abstract

This article illuminates the way in which roles and relationships in fieldwork-based health research are constantly interactionally constructed and reflexively situated. It is argued that previous qualitative health research appears to lack an exploration of the way in which fieldwork roles are negotiated and that the traditional bipolar constructions of 'insider/outsider' relationships in research fail to capture the complexity of how these positions are constructed interactively. Using a case study of interactions between a terminally ill patient and the researcher in a palliative¹ out-patient ward as a point of departure, the article demonstrates the way in which the patient seems to challenge the researcher's position in the field of study by recruiting her as a confidant and insider into a dialogue about the repercussions of the researcher's influence on the previous consultation. Supplementary data such as ethnographic observations, videotape recordings of the interdisciplinary conference and interviews with palliative team members and the patient display how this apparently unusual situation appears to be 'part' and 'parcel' of the setting. These data show how the same patient also challenges the professional identities of and relationships with team members and seems to orient towards the membership category: 'a troubled patient'. The exploration of the reflexivity of the talk ostensibly 'outside' the research project, therefore, seems to expose the normativity of the setting 'within' the project.

Keywords

Insider/outsider relationships, reflexivity, membership categorization analysis, terminally ill patient

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In ethnography there has been a longstanding debate about the ‘analytical tightrope between familiarity and strangeness’ (Coffey 1999: 47). Researchers are warned not to get too friendly and intimate with the setting and the people they are studying. It is claimed that they risk losing the ability to articulate the principles underlying their actions and look at the data in a scientific manner (Silverman 2004). Hammersley and Atkinson, for instance, state that:

The comfortable signal of being ‘at home’ is a danger signal. From the perspective of the ‘marginal’ reflexive ethnographer, there can thus be no question of total commitment, ‘surrender’ or ‘becoming’. There must always remain some part held back, some social and intellectual distance that the analytical work of the ethnographer gets done (Hammersley and Atkinson 1995: 115)

At the same time it is mandatory to be an insider to comprehend what is going on in the field of study. In this regard, Arminen maintains, *“in institutional contexts, the disclosure of the context-sensitive meaning of the activities may depend on access to participants’ knowledge or organisational particulars without which the analysis may remain insufficient”* (Arminen 2000: 437). As an insider, the researcher may feel at home but this also means that she is familiar with and has knowledge of the culture and language she is studying.

Much of the ethnographic literature seems to imply that once the analytical strangeness is lost it cannot be regained (Coffey 1999). It also stresses the necessity of consciously defining your orientation as a researcher (Silverman 2004). It is my contention, however, that the bipolar constructions of ‘insider/outsider’, ‘strangeness/familiarity’ relationships fail to capture the complexity of how these positions are constructed interactively (Naples 1997; O’Halloran 2003) and that previous ethnographic research still lacks an exploration of the way in which fieldwork roles are negotiated. This article, therefore, provides insights into how this happens and the way in which participants’ roles may affect the research process and its outcome. I concur with Allen (2004) in that *“our role in the setting is inherently connected with what we ‘find out’”* (Allen 2004: 16). In this light, ethnographic work can be seen as a process of negotiation affected by ethnographic tensions such as engagement, strangeness, distance and familiarity. This negotiation and the way in which participants orient to a different exogenous set of normative values and expectations can be understood and explained in more detail by looking at the reflexive relationship between micro-level interactions and their normative and

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institutional underpinnings from an ethnomethodological (EM) perspective. This approach is an inductive approach in which the ‘taken for granted’ is the topic for analysis (Garfinkel 1967; Heritage 1984; ten Have 2004). Common sensical, taken for granted structures and identities are bracketed in favour of studying and demonstrating how people make certain identities and structures relevant. EM explores how talk and setting are ”co constitutive, reflexively and indexically connected to each other” (Psathas 1999: 140) and the way in which the talk is ”modified, shaped, influenced, or constrained by contextual factors” (Psathas 1999: 141).

In the article, I explore how fieldwork roles are negotiated taking my point of departure in a case study of interactions between a terminally ill patient and myself in which she seems to challenge my position in the field of study by recruiting me as a confidant and insider into a dialogue about the repercussions of my influence on a previous consultation with a physician and nurse in a palliative out-patient ward. I will show in detail how this happened and the way in which our relationship was interactively managed. Additionally, I show how this locally situated interaction nonetheless appears to be reflexively related to historical, cultural and interactional practices of the ward. I claim, therefore, that the analysis of the conversation with this patient exposes the normativity of the setting.

Method

The data I present in this article is part of my ph.d. - project in which I research the impact of clinical supervision on how an interdisciplinary team do emotion workⁱⁱ at their weekly conferences in a Danish palliative out-patient ward. As a former oncological nurse and trained supervisor I was well acquainted with the field of study, a palliative outpatient ward, before I began the fieldwork and data collection. Altogether I spent 10 months in the ward collecting data primarily through ethnographic observations, videotaping of interdisciplinary conferences and sound taping of consultations with patients. I also made informal interviews with the members of the interdisciplinary team and patients and collected written information from journals – both medical and nurses’ journals.

It is often noted that case studies cannot be generalized in terms of the traditional understanding of generalization. However, I claim that there are aspects of my study which can be generalized as relevant to the understanding of other similar settings, i.e. hospitals, hospices or nursing homes where terminally ill patients/clients are cared for.

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What I am arguing here, in the terminology of Lincoln & Guba (2000), is that if there is a 'fit' – a similarity between my hopefully 'thick descriptions' of the palliative ward and other settings – i.e. the source (my context) and target cases (other contexts) – then the possibility of a generalizability exists. In the specific case, then, the descriptions of the interactions can be seen as being generalizable as descriptions of what any patient, researcher, physician, nurse or other would do given that he or she has the same array of interactional competencies as the participants in my study (Peräkylä 1997: 297).

Analysis of data

In the exploration of the way in which participants' roles are negotiated I have conducted microanalyses of interactions in the palliative setting inspired by conversation analytic (CA) studies of institutional settings (Drew and Heritage 1992; Arminen 2005; Psathas 1995). The data were transcribed according to conventions devised by Atkinson & Heritage (1984) and in the analyses I drew upon directions for doing interaction analysis laid down by CA with the aim of describing 'the structure and dynamics of the situated talk-in-interaction and how it evolves as a moment-by-moment achievement by the participants' (Ruusurvuori 2005: 207). Due to space limits, however, I only present microanalyses of interactions between the patient and myself supplemented by conclusions of analyses of supplementary data. CA studies of institutional setting have made a major contribution to the sociological understanding of the way in which official activities in institutional settings are accomplished in and through talk. These studies have been inspired by Goffman's writings on how "social interaction embodies a distinct moral and institutional order" (Heritage 1997: 222). This 'interaction order' comprises specific interactional rights and obligations, which are connected to the identities and roles of interactants in the setting. In this regard I draw on membership categorization analysis (MCA) as an important method for illustrating relationships between the setting, the order and the talk (Sacks 1995; Psathas 1999).

Lepper (2004) defines MCA as a: "a systematic analysis of the ways in which classes of persons – membership categories – and their activities – category bound activities (CBA) - are employed within a 'base environment' – a membership categorization device (MCD) – to assemble the 'inference rich', recognizable actions and descriptions which, Sacks proposed, form the foundations of social order" (Lepper, 2000:4). In other words MCDs "project different identity attributions" (Johnson &

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Paoletti 2004: 193) and can be regarded as "in situ achievements of members' practical actions and practical reasoning" (Hester 1997:221). MCDs can, therefore, be seen as members' resources for participants to do their business and make sense in social interactions. They provide for inferences about and orientations to what should/could be said or done in the respective categories. The idea is that categorization rules underpin meaningful action and these rules – called the 'inferencing machine' by Sacks (Lepper 2000: 15) - represent a given cultural knowledge. On the one hand they are means through which we are able to collectively share perspectives of what is going on and thus make sense of events. (Mäkitalo 2003). On the other hand they can also be seen as constraints for perception, reasoning and remembering. These actions are the category bound activities (CBAs). MCDs in a hospital can for instance be physicians, nurses and patients, and one would expect a physician to treat the patient medically, a nurse to provide the basic physical care of the patient and so on. So by tracing categories it is also possible to trace the way in which social identities, social relationships and institutions are constructed (Baker 1997).

To summarize MCA studies the way in which categories are employed in talk and text and what consequences this employment has in-interaction. MCA can be said to be a "rigorous way of recognizing and predicting members activities" (Lepper 2000: 24) and by "understanding how 'categorization work' is ongoing we can also understand how organizational context is invoked and made relevant by the parties since organizational identities are involved" (Psathas 1999: 142). Lastly, these identities establish structural relationships between people which imply certain roles and asymmetries, i.e. power configurations which are explicit in, for instance, physician/patient relationships.

Ethical considerations

The Danish data-supervision-board has given its consent to the project and all participants, patients and team members, and places have been anonymized. Also all participants signed a written consent, where they were also informed that they could refuse to participate and withdraw from the study at any time without consequences at any time. Still, achieving informed consents in an inductive field study seems to be almost impossible. Given the nature of the study it should not be possible to predict what is going to be the main topic or outcome of the research. Lawton (2001), de Raeve (1994) and Raudonis (1992) have attracted attention to the problem of informed

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consent in their articles about ethical problems in palliative research. De Raeve is quite radical in that she questions whether it is at all ethical to conduct research in such a sensitive setting. She is critical towards the notion that the anticipated research outcomes are "undeniable good" and is sceptical of the extent of the moral scrutiny that is practiced. De Raeve questions whether the free will of vulnerable groups is compromised because of their dependency and illness? Along with Dickson-Swift, James, Kippen, and Liamputtong (2006) de Raeve, therefore, raises the issue of the seductiveness of this kind of research in which it can be difficult to pinpoint the role of the researcher and that role confusion has profound implications for consent. Is the researcher a nurse, a friend, a visitor? In this regard Lawton (2001) talks about the researcher's dilemma of becoming so familiar with the setting and participants in the setting that patients and staff tend to forget that you are a researcher and, therefore, are obliged to look at events as possible data. Like Cannon (1989) describes in her three year study of women with breast cancer I got more close to some patients than others like, for instance, the patient I am discussing in this article and experienced the inherent role conflict there is in doing long term fieldwork. Moreover, I experienced several times an additional problem in palliative research. The patients die – and there is no way to renegotiate the informed consent. Taking these ethical perspectives into consideration I, therefore, informed patients about my project in more detail when I supplemented the written information orally and continually throughout the data collection. Furthermore, I had several feedback meetings with the team in which they also watched and got a chance to comment on some of the video's I had recorded. Still, there are no fixed answers to these challenges in qualitative health research in sensitive settings. Therefore - to quote Lawton:

A particular responsibility is thus placed on a researcher to use the data collected during such a study in a very careful and selective manner. Ultimately, it is his or her discretion and integrity that are at stake (Lawton 2001: 703)

The palliative setting

The interdisciplinary team in the palliative out-patient ward counts 13 members and consisted of physicians, nurses, one psychologist, physiotherapist, a dietician, a secretary and social worker. The ambition of the team is to provide a holistic care that can enhance the quality of life for the patient and his family in the final stages of life. The division of labour in the hospital meant that the palliative ward does not treat the patients' primary illness but only the symptoms connected to the illness. It counsels both patients and relatives and co-operates with other hospitals and wards, the

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hospital vicar the general practitioner and the home care. Because the ward is an outpatient ward, many patients comes from home to the ward for treatments. The team members also pay daily visits to patients who are admitted to the hospital.

Findings

The findings section has two parts. In the first part, I present an analysis of a conversation I had with the terminally ill patient called Iben. I use the term 'the researcher' instead of 'me' and 'I' in the analysis to illuminate the roles and relations between 'the patient' and 'the researcher'. In the second part, I discuss the conversation in light of additional data I collected in the palliative out-patient ward.

Presentation of Iben

In the beginning of my fieldwork, the palliative ward treated a patient called Iben. Iben was a terminally ill patient in her sixties who was diagnosed with an incurable cancer. She was a teacher and an intellectually sharp woman and on several occasions she displayed an interest in my work and asked more questions than any other patient. She, for instance, compared the my project to some of the topics she had taught as a teacher and almost like we were two colleagues working together she initiated discussions about the perspectives. The conversations with me appeared to make Iben forget her terminal condition and status as a patient for a while and I got the impression that our talks revived her professional background and personal dignity as a teacher.

A conversation with Iben

During the course of her illness, Iben suffered much pain and the palliative ward, therefore, attended her condition on a daily basis at the ward she was admitted to. The conversation between Iben and the researcher takes place just after such a consultation in which the researcher observed and audiotaped the consultation. In the conversation Iben seems to recruit the researcher as a confidant and insider into a dialogue about the repercussions of her influence on the previous consultation and Lars' behaviour. In their actions Iben and the researcher seem to display an awareness of the morally dubious in talking about someone, in this case the physician, Lars, who is not present to speak for himself. It can, therefore, be argued that they are practicing 'gossip' which is not seen as being fitted for the drawing room since it is *transgressing "of the boundary into the sphere that the subject of the gossip would call 'private'"* (Bergman 1987: 54). In the analyses of the excerpts below I

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illuminate the interactional features of the conversation which are characteristic of gossip like, for instance, presenting morally dubious information and packaging it like a secret. Furthermore, I discuss the interactional and moral implications of these findings.

In the first part of the consultation, Lars and the nurse, Eva, and Iben talk about Iben's pains which are consistent and difficult to cut down. In this talk Iben explicitly rejects several empathic statements from Lars in which he tries to imagine the kind of pain she is suffering. She, for instance, uses the analogy of giving birth to explain her pain, and says that men do not have 'this thing at all'. She, therefore, seems to construct Lars as an outsider and at the same time the two women present at the consultation, the nurse and the observing researcher, become possible insiders since both of them had given birth and were capable of understanding Iben's situation in this regard. As the physician and nurse leave the room, Iben indicates that she wants to talk to the researcher and saysⁱⁱⁱ:

Excerpt 1

English

1. Iben There were some things to observe here for you
2. Ps: (0.2)
3. R Mm (.)
4. Iben >I was thinking about it during the consultation<
5. R Mm
6. Ps: (1.3)
7. Iben There was indeed
8. R Thank you for that
9. Ps (0.4)
10. Iben Ha
11. Ps: (1.0)
12. R Now I shall not take any more of your time
13. Iben °But that's okay°
14. R °Is that okay°
15. Iben °That is okay°
16. Ps (0.9)
17. Iben Remove some chocolates
Com: Iben removes some chocolates from her bed.
18. R Mm
19. Iben Yes there was indeed (0.4)

Danish

1. Iben Her var nogle ting at observere for dig
2. Ps: (0.2)
3. R Mm (.)
4. Iben >Jeg tænkte på det undervejs<
5. R Mm
6. Ps (1.3)
7. Iben Det var der altså godt nok
8. R Tak for det
9. Ps (0.4)
10. Iben Ha
11. Ps: (1.0)
12. R Nu skal jeg ikke tage mere af din tid
13. Iben °Men det må du da gerne°

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14. R °Må jeg gerne det°
15. Iben °Det må du gerne°
16. Ps (0.9)
17. Iben Fjerne nogle chokoladedimser
Com: Iben is removing some chocolates from her bed.
18. R Mm
19. Iben Ja det var der da i hvert i fald (0.4)=

An unusual invitation

Iben offers the researcher an opportunity to talk about the previous consultation (1). Moreover, she explicitly appears to attract the researcher's attention by including her in her comment and saying "*There were some things to observe here for you*". The researcher seem to confirm Iben's comment with a "Mm". Iben, then, elaborates on her previous statement and explain how she had thought about this during the consultation. The researcher responds with yet another "*Mm*". A pause (1.3) (6) follows in which one would expect the researcher to take the floor and respond to Iben's invitation to talk about the consultation (Davison 1984; Pommerantz 1984; Sacks 1987). Iben, then, persistently repeats her comment and, furthermore, upgrades it by adding "*indeed*" (7) Perhaps the researcher is surprised by this unusual invitation and, therefore, hesitates to accept the invitation. This hesitance seems to be evident in the researcher's utterances in line 8 and 12. Apparently, the researcher does not appear to be comfortable to go on with the conversation until she gets an "it's okay" twice (13, 15). In the next sequence, Iben reveals that Lars is different when the researcher is present and packages her information in a secretive manner characteristic of gossip (Bergman 1987). Iben says:

Excerpt 2

English

1. Iben I can feel it on Lars you are here
2. Ps (1.3)
3. Iben: [I can]not say (0.2) but I [can]
4. R [()] [no]
5. Ps (2.0)
6. R How can you feel it
7. Ps (1.4)
8. Iben °Yes now I should not have said it°
9. Ps (0.2)
10. Iben Ha
11. Ps (6.3)
12. Iben Ehm he does'nt like you are standing (1.0) behind (0.2)
13. R No
14. Ps (0.6)
15. R Perhaps I should have been on the other side
16. I did consider it (1.9) but I did'nt want to stand there
17. either

Danish

1. Iben Jeg kan mærke det på Lars du er her
2. Ps (1.3)
3. Iben: Det [kan jeg] jo ikke sige (0.2) men det [kan] jeg

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4. R [()] [nej]
5. Ps (2.0)
6. R Hvordan kan du mærke det?
7. Ps (1.4)
8. Iben °Ja nu skulle jeg ikke have sagt det°
9. Ps (0.2)
10. Iben Ha
11. Ps (6.3)
12. Iben Uhm han kan ikke lide at du står der (1.0) bagved (0.2)
13. R Nej
14. Ps (0.6)
15. R Jeg skulle måske nok have stillet mig på den anden side
16. jeg tænkte godt på (1.9) men jeg ville ikke stille mig
17. der

Secrets

Iben says that she can feel it on Lars that the researcher is present (1). This information personally and professionally concerns the researcher since and, therefore, calls for some sort of response from her. Instead there is a pause (1.3) (2). Iben, then, takes the floor and in her next utterance (3) she becomes more reluctant and says that she should not be talking about this. Altogether she repeats and asserts the reluctance to talk about Lars's behaviour in four different ways during the conversation^{iv}. She says: "°Yes now I should not have said it°" (31), "But I should not say something like this" (73) and finally "Yes (0.6) Now I will not say anymore" (115). Hence Iben appears to package her information in a secretive manner as something she is not supposed to talk about. After another longer pause (2.0) (5) Iben finally succeeds in getting a response from the researcher (6). This secrecy seems to attract the researcher's attention and she initiates further exploration of the 'secretive' issue by asking: "How can you feel it?" (6). Iben answers and reveals that Lars does not like that the researcher is standing behind him during the consultation (12). The researcher says "No" (13) and together with her next utterance (15-17) her response can be seen as an alignment with Iben's remark as she reveals that she perhaps should have been standing on the other side of Iben's bed (15-17). In her next utterance, Iben appears to confirm this possible alignment by saying:

Excerpt 3

English

1. Iben I purposely avoided your eyes all the [time]
2. R [yes]
3. Iben (0.2)
you were supposed to be invisible [were you not]
4. R [yes]
5. R Mm
6. Ps (6.7)
7. Iben Eh:m
8. Ps (3.6)

Danish

1. Iben Det var med vilje at jeg undgik dine øjne hele [tiden]

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2. R
3. Iben du skulle jo være usynlig i virkeligheden [ikke] (0.2) [Ja]
4. R [ja]
5. R Mm
6. Ps (6.7)
7. Iben Øe:hm
8. Ps (3.6)

Iben says that she purposely did not look at the researcher during the consultation because the researcher was supposed to be ‘invisible’ (1). During the consultation, then, Iben appears to orient to the MCD patient by focusing on the topic of her pain in the talk with Lars and the nurse, Eva, and not comment on the role of the researcher. However, after the consultation in the talk with the researcher she demonstrates the way in which she at the same time orients to and understands the researcher’s role during the consultation as being an ‘invisible’ person (3). Iben’s remarks about the researcher’s invisibility indicate that she is both doing being a patient and doing being an analytic observer during the consultation (Sacks 1992). Hereby Iben displays a meta-awareness of the context of the consultation and of the way in which participants are supposed to behave in this setting. An awareness which seems nearly paradoxical considering her physical condition and the serious topic of the consultation. Iben seems to align with the researcher’s position and to construct a bond between the researcher and herself as if they were ‘working together’ in her remarks (1, 3). In this regard, the talk about something which should not be talked about (excerpt 2: 3) is capable of creating a bond between the parties involved in the talk - like two friends sharing a secret – or gossiping (Bergman 1987). The long pauses (6, 8) in which both Iben and the researcher have plenty of opportunities to take the floor may illustrate the secretive and ‘forbidden’ nature of the talk. According to Luckman (1987) gossip often: *“contains a piece of news involving morally dubious if not outright reprehensible action”* (Luckman 1987: ix). What, then, one might ask, could be morally dubious in what Iben is telling the researcher? The answer to this question can be found in the next part of the conversation in excerpt 4.

Excerpt 4

1. Iben But he is eh:m (3.0) I think a bit more formal in
2. reality but [or something] inhibited
3. R [mm mm mm mm]
4. Ps (0.3)
5. R Yes
6. Iben °inhibited° (0.3)
7. R M[m]
8. Iben [Is] a better word
9. R Mm
10. Ps (0.6)
11. Iben °I think°
12. Ps (0.2)
13. R Mm
14. Ps (0.5)

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15. Iben °It serves him right°
 16. Ps (1.3)
 17. Helle He has?
 18. Iben Yes
 19. Ps (0.6)
 20. Helle What are you thinking °that°
 21. Ps (0.3)
 22. Iben N::o but I am not thinking anythin[g]
 23. Helle [No] no=
 24. Iben But indeed
 25. Ps (1.3)
 26. Iben °E:hm°
 27. Ps (4.4)
 28. Iben No but he does not run it all like when you are here
 29. Ps (0.3)

Danish

1. Iben Jamen han er ø:ehm (3.0) tror jeg lidt mere formel i
 2. virkeligheden alts[å eller sådan noget] ufri
 3. R [mm mm mm mm]
 4. Ps (0.3)
 5. R Ja
 6. Iben °Ufri° (0.3)
 7. R M[m]
 8. Iben [Er] et bedre ord
 9. R Mm
 10. Ps (0.6)
 11. Iben °Tror jeg°
 12. Ps (0.2)
 13. R Mm
 14. Ps (0.5)
 15. Iben °Det har han godt af°
 16. Ps (1.3)
 17. Helle Har han det
 18. Iben Ja
 19. Ps (0.6)
 20. Helle Hvad tænker du °at°
 21. Ps (0.3)
 22. Iben N::ej men jeg tænker jo ikke noge[t]
 23. Helle [Nej] nej=
 24. Iben Men altså
 25. Ps (1.3)
 26. Iben °Ø:hm°
 27. Ps (4.4)
 28. Iben Ej men han kører jo ikke det hele helt så meget når du er
 her (0.3)

In excerpt 4 Iben answers the researcher's question about Lars and how he is different (excerpt 2: 6) when the researcher is present and says that he is more formal than he usually is (1), i.e. inhibited (6) and not running it all so much (28). However, Iben is not only describing Lars's behaviour she also evaluating it from a moral point of view by stating that: "*It serves him right*" (14). In their interaction Iben and the researcher seem to display an awareness of this morally dubious affair in talking about someone who is not present. The researcher's hesitance to take the floor evident in the many pauses throughout the conversation and Iben's repetitious statements in which she says that she should not be talking about this together with her reluctance to expand (22-25) on her evaluative statement and explain why "°it serves him right°" (14) can be interpreted as clear signals of this awareness. Iben's evaluative statement (15) is, moreover, put in a low tone of voice one might use, when the talk is about secrets or

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issues of a dubious nature. The manner in which Iben packages her information as a big secret makes you consider if she to a certain extent reconstructs the consultation to catch the researcher's interest. Another take on Iben's assessments could be that she is managing the researcher's impartiality in order not to involve or implicate the researcher in her evaluations but never the less stating them to attract her attention.

Jokes and social boundaries

In her elaboration on the way in which Lars is different when the researcher is present in the next part of the conversation (excerpt 5) Iben not only tells how he is different and that he does not like that the researcher is standing behind him, Iben also lets the researcher in on the interactional dynamics between her and Lars (1-3 and 14-21).

Excerpt 5

- | | |
|----------|---|
| 1. Iben | Then he has inherited one of my jokes and he told that |
| 2. | (0.5) bu:t:eh I did not repond to it today and he did not |
| 3. | like it |
| 4. Ps | (0.3) |
| 5. R | No |
| 6. Ps | (1.7) |
| 7. Iben | Exactly this habit where (0.9) |
| 8. R | Mm |
| 9. Ps | (0.2) |
| 10. Iben | I don't know if you got it |
| 11. R | No |
| 12. Iben | No |
| 13. Ps | (0.6) |
| com | Now Iben tells about the joke, which is about one of the
physicians in the ward. This has been cut out of the
transcript for confidentiality reasons. |
| 14. Iben | And he told it today (0.2) e::eh (0.6) an:d >now I have |
| 15. | now we have< used it twice now I dont think it is funny |
| 16. | any more (0.2) |
| 17. R | Mm |
| 18. Iben | it should have been a joke |
| 19. Ps | (0.3) |
| 20. R | Mm |
| 21. Iben | a bit inside between him and me [that's] the way I |
| 22. | analyse it |
| 23. R | [mm] |
| 24. Ps | (0.2) |
| 25. R | Mm |
| 26. Ps | (1.7) |
| 27. Iben | And it did not work out that way |
| 28. Ps | (0.2) |
| 29. R | No |
| 30. Iben | Because I let it simply |
| 31. R | Yes |
| 32. Iben | But I should not say something like this= |

Danish

- | | |
|---------|--|
| 1. Iben | Så har han arvet en af mine jokes og den fyrede han af |
| 2. | (0.5) me:nø:eh jeg reagerede ikke på den i dag og det |
| 3. | kunne han ikke lide (0.2) |
| 4. Ps | (0.3) |
| 5. R | Nej |
| 6. Ps | (1.7) |
| 7. Iben | Nemlig den der vane med hvis (0.9) |

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8. R Mm
9. Ps (0.2)
10. Iben Jeg ved ikke om du fattede den
11. R Nej
12. Iben Nej
13. Ps (0.6)
14. Iben Og den fyrede han af i dag (0.2) ø::eh (0.6) o:eg >nu har
15. jeg nu har vi brugt den< to gange nu synes jeg ikke den
16. var sjov mere (0.2)
17. R Mm
18. Iben Det skulle have været en joke (0.3)
19. Ps (0.3)
20. R Mm
21. Iben Lidt indforstået mellem ham og mig [sådan] analyserer jeg
22. det
23. R [mm]
24. Ps (0.2)
25. R Mm
26. Ps (1.7)
27. Iben Og det blev det ikke
28. Ps (0.2)
29. R Nej
30. Iben Fordi jeg lod den bare
31. R Ja
32. Iben Jamen altså sådan noget skal jeg ikke sige=

Iben tells the researcher how she did not laugh at one of Lars's jokes – one he had inherited from her (1) and that he did not like that (3). By telling and reconstructing the conversation with Lars she, moreover, exposes a certain fight for control over the conversation. She made a joke he had used twice now (15) – so she did not laugh at the joke (15, 16, 30) and she leaves him in a potentially awkward situation. In her account, Iben, therefore, displays features of gossip such as reconstructing and evaluating past events (Bergman 1987). Furthermore, she seems to use her interactional skills and resources as teacher as the one in possession of knowledge students need/are motivated for. In the specific situation, the 'only' difference is that she is not lecturing students but the researcher. In the talk she, therefore, has a 'giving-role' in contrast to her role as a patient in which she is in a 'receiving-position' as a victim of her terminal disease and in the need of the services of the palliative ward. MCDs are, as mentioned, interactional resources for participants to do their business. In this case we see the way in which Iben's orientation to her former role as a teacher appears to put her in control of the conversation and reverse her role as a submissive patient.

The conversation with Iben illustrates Luckman's point about the way in which gossip reveals much about the normative moral order of a society and "*the communicative construction and maintenance of that order*". (Luckman 1987: ix). The analyses demonstrate how the gossip can be used to drawing boundaries between social identities and field roles in the setting – in this case the physician and the patient - and moreover the way in which gossip signifies the change of alignment in this specific

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case. Quite obviously, Iben and I are now confidants and insiders and Lars is an outsider.

Reflexive relationships

In the next section of the article I turn my attention to and explore the reflexive relationship between the findings of the microanalyses above and observations of participants interactions with and about Iben in the field of study up until she died. In this exploration I include an interview with Iben and data from a clinical group supervision session in which Iben's situation was brought up. The purpose is to illuminate the way in which normative institutional inferences with regard to appropriate conduct appear to penetrate situated interactions and, therefore, help us further understand Iben's behaviour. The point is that participants orient towards a cultural frame and certain normative rules of conduct when they negotiate positions in the field of study. Moreover, participants have a history together affecting these negotiations (Gunnarsson, Linell and Nordberg 1997; Mäkitalo, 2003).

In Iben's case she initially treated the Lars as an insider. The division of labour in the hospital means that the palliative ward was not responsible for the primary treatment of the patients' illnesses and any information containing 'bad news'. At first this possibly meant that Iben was more open and felt more 'safe' in the relationship with Lars. They were doing hope-work^v together and creating a positive atmosphere in which they also exchanged jokes. I would go as far as to say that Lars and Iben interactively treated each other as equals in need of some kind of optimism and hope. Perhaps Lars needed hope so that he could distance himself professionally from the grim future perspectives and trusted that he was doing "the right thing" - and so did Iben as a patient. In an interview Iben told me that she was very satisfied with the palliative ward in the beginning of her admission to the hospital. Lars' attitude and his way of 'managing hope' by telling a joke once in a while gave her a sense of hope. This finding is supported by a previous study in an oncological setting which demonstrate the way in which euphemisms and a metaphorical and joking language can keep the hostile future away for while (Lutfey and Maynard, 1998). However, when Iben realized that she would not get well again she got upset with Lars. She felt that he in his seemingly optimistic mood had let her down in giving her a sense of hope for recovery when treating her pains – a sense which appeared to be unrealistic. Furthermore, her pains did not get better, only worse.

Iben can be said to be in a submissive position, having no control over her treatment.

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She had to trust the staff completely and depend on their good will. In an interview she told me that all she could really do was to choose who she would socialize with – she was not in a position to refuse treatment. This became her strategy of survival – so to speak. After my conversation with Iben informal interviews and ethnographic observations at both the palliative and the oncological ward she was admitted seemed to expose that she selected the nurses and physicians she wanted to talk to and her selection changed during the course of her illness. She even discussed the faults of other team members with her new favourite nurse leaving the nurse in a difficult situation. Also, the palliative ward's psychologist had been dismissed. Video observations from an interdisciplinary conference reveals the way in which an upset psychologist tell how Iben had told fictive things about him to a nurse at the oncological ward she was admitted to. Perhaps Iben could not face the fact that she was going to die and that neither she nor anybody else could control this terminal process. Evidently she appeared to control the only thing she could control: Who she talked to and how!

In Parson's work on the "sick role", he claims that patients' normative pattern of behaviour is to be a willing and passive recipient of the care and knowledge that the professionals can provide (Parsons 1975). Parsons finds that patients freely will give up their power to the professionals "*because they have a specialized knowledge and the patients do not have; professionals willingly accept this power*" (Shattell 2004: 716). Apparently, Iben was not willing to give up this power. Iben's situation was brought up at one of the clinical supervision sessions because several of the team members were frustrated over her behaviour. When Lars told about his experiences with Iben, he said that her attitude towards him made him feel like he was like a tool for her. "*She asks for my help but when she gets it she rejects it or says that it does not help her. She wants to talk about the medical business but I would rather discuss how she her last time could be*".

A 'troubled patient'

The reactions of the physician and psychologist indicate that they categorize Iben as 'a troubled patient' (Li and Arber 2006). According to Li and Arber (2006) nurses describe troubled patients "as dying from a terminal disease, which makes them difficult. Such patients are presented as irritable, demanding and critical of palliative care staff" (Li and Arber, 2006: 27) Li and Arber have examined the way in which categories of both troubled but also credible patients are constructed in talk by palliative staff members. The point is that there are some category-bound expectations

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of a terminally ill person in which the 'good' patient conforms and adapts to the rules and routines of the hospital is to be obedient and submissive. By not being 'a good patient' and by challenging the professional identities of and relationships with team members Iben's behaviour was marked as 'deliberately deviant'. Hence she was categorized as a difficult patient and at risk of being isolated (Li and Arber 2006). By recruiting me, the researcher, as a confidant Iben, therefore, gained a voice and perhaps a more independent, dignified and personal position than she had as a terminally ill patient. Our relationship possibly enhanced Iben's hope work in keeping the hostile future at a certain distance.

Conclusion

The analyses of interactions with and about the terminally ill cancer patient, Iben, illustrate a complex web of interests and needs, dilemmas and paradoxes in the field of study and thereby explicate the processes of negotiation and interactional construction of participants' roles. By tracing membership categories and the way in which they are evoked the article illuminates how the normative institutional context is invoked and made relevant by the parties involved. Iben does not orient towards her institutional role – the MCD - of being a patient. Indeed, it can be said to be a somewhat contradictory and paradoxical situation, when a terminally patient ill appears to take charge of the situation. Iben, therefore, challenges the normative positions and power relations between the participants and the way in which MCDs like 'patient', 'physician' and 'researcher' traditionally are supposed to behave in the field of study. The analyses of the conversation with the researcher suggest that Iben is striving to preserve and display her professional and personal dignity. In the light of the previous consultation she is possibly forced into a situation in which she needs to be seen as more than 'just' a submissive patient. The consultation reveals that she seems to exclude her former friend, the physician, from the interaction and has put herself in a somewhat marginalized and perhaps isolated situation with nobody to talk intimately with. This situation may account for her interest recruiting the researcher as a confidant and packaging her information in a distinct manner - like a secret and gossip – to evoke the researcher's curiosity. In the conversation, she acts almost like a co-researcher inviting the researcher to a dialogue about the repercussions of her influence on the previous consultation. However, the researcher was not the only confidant she recruited during the course of her illness. The situation, therefore, appeared to be 'part' and 'parcel' of the setting. Analyses of supplementary data such as interviews with team members, video taping of the weekly interdisciplinary conference and ethnographic observations reveal the way in which she oriented

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towards the category of ‘a troubled patient’ and also challenged the professional identities of and insider/outsider relationships with other team members she interacted with.

To summarize an ethnographic mode of inquiry requires a situational awareness of when to observe and when to speak and of the possible roles and positions you negotiate as a researcher - both the roles the participants assign to you and the roles you claim. It emphasizes the importance of being extremely aware of your position in the field of study. Relationships between the researcher and the researched have a profound impact on the outcome of a scientific study. In this regard I argue that an EM informed perspective explicates the social conditions of the produced knowledge and thus heighten “*our sensitivity of how insider-outsider status is managed in the field*” (Allen 2004: 17).

Notes

ⁱTo palliate means to relieve from pain or discomfort which cannot be cured. Most patients in the palliative outpatient ward are terminally ill cancer patients.

ⁱⁱ The reader can consult my dissertation (author) for further information on the ph.d. – project. In the project I define emotion work as talk about emotions. In the first place this can be team members’ talk about their own previous or current emotional state and/or talk about the emotional states of patients and/or their relatives. Emotion work can also be the expression of emotions, emotion displays, which are team members’ non-verbal indications of being emotionally moved, indicated by their tone of voice, laughter, crying, and so forth. Lastly, emotion work can be the interactive work leading up to or following emotion talk or display as emotion work. This interactive work can, for instance, be performed through the telling of stories, the use of metaphors or the construction of reformulations.

ⁱⁱⁱTranscription symbols and the full transcription of the conversation can be found in the appendix

^{iv}Please consult the full transcription in the appendix.

^vThe use of the term here comes from the study of Peräkylä on hope work in hospitals (1991). He argues that conversation is important in constructing this hopefulness in the terms of just feeling better” or “getting better” (Peräkylä 1991:420). See also Beach 2001 and 2003.

Appendix

Transcription symbols

The symbols used in the transcription are based mainly on the conventions developed by Gail Jefferson (see also Atkinson and Heritage 1984).

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[xx]: Square brackets mark the start and end of overlapping speech, aligned with the talk above or below.

(0.4): Pause: Numbers in round brackets measure pauses in seconds; in this case 4 tenths of a second.

.hhh: Audible in-breath.

He sle:pt: Colons show degrees of elongation of the previous sound; the more colons the more elongation, roughly one colon per syllable length.

He was so (): Empty parentheses in the middle of a sentence indicates and insecurity about what is said

(): Yes: Empty parenthesis before the utterance indicates an insecurity about who speaks

Underlining: Pressure on the syllable that is underlined: The extent of underlining within individual words locates emphasis but also indicates how heavy it is.

°She did not want it°: Raised circles ('degree' signs) enclose obviously quieter speech.

=: 'Equals' signs mark the immediate 'latching' of successive talk with no interval.

↑ ↓: Vertical arrows mark pitch movement: Rising intonation is marked by an arrow pointing upwards and falling intonation by an arrow pointing downwards.

> she was so sweet < :When a part of an utterance is delivered at a pace quicker than the surrounding talk, it is indicated by being enclosed between 'less than' signs.

Com Non-verbal action and other comments

A conversation with Iben

1. Iben Her var nogle ting at observere for dig
There were some things for you to observe here
2. Ps: (0.2)
3. Helle Mm (.)
4. Iben >Jeg tænkte på det undervejs<
>I was thinking about it during the consultation<
5. Helle Mm
6. Ps (1.3)
7. Iben Det var der altså godt nok
There was indeed
8. Helle Tak for det
Thank you for that
9. Ps (0.4)
10. Iben Ha
11. Ps: (1.0)
- 12 Helle Nu skal jeg ikke tage mere af din tid
Now I shall not take any more of your time
13. Iben °Men det må du da gerne°
°But thats okay°
14. Helle °Må jeg gerne det°
°Is that okay°
15. Iben °Det må du gerne°
°That is okay°
- 16 Ps (0.9)
17. Iben Fjerne nogle chokoladedimser
Remove some chocolates
- Com: Iben is removing some chocolates from her bed.
18. Helle Mm
- 19 Iben Ja det var der da i hvert i fald (0.4)=
Yes there was indeed (0.4)
20. Helle Nej
No

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-
21. Ps (0.5)
22. Iben °Det ku jeg mærke° (.)
°I could feel it° (.)
23. Helle Mm=
24. Iben Jeg kan mærke det på Lars du er her
I can feel it on Lars you are here
25. Ps (1.3)
26. Iben: Det [kan jeg] jo ikke sige (0.2) men det [kan] jeg
[I can]not say (0.2) but I [can]
27. Helle [()] [nej]
[()] [no]
28. Ps (2.0)
29. Helle Hvordan kan du mærke det?
How can you feel it
30. Ps (1.4)
31. Iben °Ja nu skulle jeg heller ikke have sagt det°
°Yes now I should not have said it°
32. Ps (0.2)
33. Iben Ha
34. Ps (6.3)
35. Iben Uhm han kan ikke lide at du står der (1.0) bagved (0.2)
Ehm he does not like that you are standing (1.0) behind
(0.2)
36. Helle Nej
No
37. Ps (0.6)
38. Helle Jeg skulle måske nok have stillet mig på den anden side
I should maybe have stood on the other side
jeg tænkte godt på (1.9) men jeg ville ikke stille mig
der
I did think about it (1.9) but I did´nt want to stand
there
heller
either
39. Iben Det var med vilje at jeg undgik dine øjne hele [tiden]
I purposely avoided your eyes all the [time]
40. Helle [Ja]
[yes]
41. Iben for du skulle jo være usynlig i virkeligheden [ikke]
(0.2)
because you were supposed to be invisible [were you not]
42. Helle [ja]
[yes]
43. Helle Mm
44. Ps (6.7)
45. Iben Øe:hm
Eh:m
46. Ps (3.6)
47. Iben Så har han arvet en af mine jokes og den fyrede han af
(0.5)
Then he has inherited one of my jokes and he told that
(0.5)
me:nø:eh jeg reagerede ikke på den i dag og det kunne han
bu:t:eh I did not repond to it today and he did not
heller ikke lide (0.2)
like it
48. Ps (0.3)
49. Helle Nej
No
50. Ps (1.7)
51. Iben Nemlig den der vane med hvis (0.9)
Exactly this habbit where (0.9)
52. Helle Mm
53. Ps (0.2)
54. Iben Jeg ved ikke om du fattede den
I don´t know if you got it
55. Helle Nej
No

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-
56. Iben Nej
No
57. Ps (0.6)
com Now Iben tells about the joke, which is about one of the physicians in the ward. This has been cut out of the transcript for reasons of confidentiality.
- 58 Iben Og den fyrede han af i dag (0.2) ø::eh (0.6) o:eg >nu har jeg
jog
now we *And he told it today (0.2) e::eh (0.6) an:d >now I have*
sjov nu har vi brugt den< to gange nu synes jeg ikke den var
have< used it twice now I dont think it is funny
mere (0.2)
any more (0.2)
59. Helle Mm
60. Iben Det skulle have været en joke (0.3)
it should have been a joke
61. Ps (0.3)
62. Helle Mm
63. Iben Lidt indforstået mellem ham og mig [sådan] analyserer jeg det
a bit inside between him and me [that's] the way I
analyse it
64. Helle [mm]
65. Ps (0.2)
66. Helle Mm
67. Ps (1.7)
- 68- Iben Og det blev det ikke
And it did not work out that way
69. Ps (0.2)
70. Helle Nej
No
71. Iben Fordi jeg lod den bare
Because I let it simply
72. Helle Ja
Yes
73. Iben Jamen altså sådan noget skal jeg ikke sige=
But I should not say something like this=
74. Helle Hv hvordan synes du det er anderledes da
H how do you think that it is different
75. Ps (0.5)
76. Helle Var det min tilstedeværelse
Was it my presence
77. Iben Ja
Yes
78. Ps (6.6)
79. Iben Jamen han er ø:ehm (3.0) tror jeg lidt mere formel i
But he is eh:m (3.0) I think a bit more formal in
virkeligheden alts[å eller sådan noget] ufri
reality but [or something] inhibited
80. Helle [mm mm mm mm]
81. Ps (0.3)
82. Helle Ja
Yes
83. Iben °Ufri° (0.3)
°inhibited° (0.3)
85. Helle M[m]
86. Iben [Er] et bedre ord
[Is] a better word
87. Helle Mm
88. Ps (0.6)
89. Iben °Tror jeg°
°I think°
90. Ps (0.2)
91. Helle Mm
92. Ps (0.5)
93. Iben °Det har han godt af°

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-
- °*It serves him right*°
94. Ps (1.3)
95. Helle Har han det
He has
96. Iben Ja
Yes
97. Ps (0.6)
98. Helle Hvad tænker du °at°
What are you thinking °that°
99. Ps (0.3)
100. Iben N::ej men jeg tænker jo ikke noge[t]
N::o but I am not thinking anythin[g]
101. Helle [Nej] nej=
[No] no=
102. Iben Men altså
But indeed
103. Ps (1.3)
104. Iben °Ø:hm°
°E:hm°
105. Ps (4.4)
106. Iben Ej men han kører jo ikke det hele helt så
meget når du er her (0.3)
No but he does not run it all like when you are here
(0.3)
107. Helle Mm
108. Ps (1.5)
109. Iben På:e (1.0) sådan en øe::h medfødt øeh charme °det gør han
ikke nej°
in (1.0) with e:h such a natural charm °he does not do
that no°
110. Helle Nej
No
111. Ps (1.0)
112. Iben °Den er der ikke skruet helt så meget op for°
°It is not turned on so much°
113. Helle Nej
No
114. Ps (3.0)
115. Iben Ja (0.6) Nu vil jeg ikke sige mere (0.6) Nu skal du vende
min
Yes (0.6) Now I will not say anymore (0.6) Now you must
turn my
hovedpude om
pillow around
116. Helle Ja
Yes

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**Reformulations and reflection on emotions
in clinical supervision**

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English abstract

Clinical supervision (CS) is described as being a reflective practice in which supervisees get a meta-perspective on their work which potentially enhances their professional security and competence. Still some critics see CS as no more than an 'emotional outlet'. Until this article, however, it has not been investigated how reflection on emotions is done in CS. In the article, I look at CS as a particular discursive practice, 'a language game', and explore what characterizes this 'language game' based on the notion that what the supervisors are doing and showing the supervisees in-interaction is reflection in that CS is described as a reflective practice. The analyses demonstrate the way in which supervisors document problems in supervisees talk by focalizing potentially emotional and metaphorical elements whereafter they are reformulated into the supervisors' version and more general assessment of 'the real problem' by injecting normative as well as moral aspects into the talk. Towards the end of the supervisory sessions it can be seen how supervisees reproduce interactional elements of this 'language game'. I argue that supervisors become role models for the supervisees and that the 'supervisory language game' seems capable of enhancing supervisees reflexivity in that they collectively question emotional aspects of their practices introducing a meta perspective on the process of the their work which may affect not only decisions about care and treatments of patients but also interpersonal relations among staff members.

Keywords: Reflection, reformulations, language game, emotion work, clinical supervision.

Reformuleringer og refleksion over følelser i sundhedsprofessionel supervision

Manchet

Supervision beskrives som et refleksionsforum for faglige problemstillinger. Kritikere mener dog, at supervision blot er en 'følelsesmæssig ventil'. Indtil denne artikel er det ikke blevet undersøgt, hvordan refleksion over følelser 'gøres' i supervision. Inspireret af Wittgenstein (1953) ses supervision som en sproglig praksis, et 'sprogspil', og udgangspunktet for artiklen er at udforske, hvad der karakteriserer dette 'sprogspil' og hvordan refleksion 'gøres' i sundhedsprofessionel supervision. Dette sker ud fra en betragtning om, at det supervisorerne 'gør' og viser deltagerne i supervision må betegnes som refleksion. Artiklen viser, hvordan reformuleringer er et grundlæggende element i det 'supervisoriske sprogspil' over følelser og diskuterer betydningen af dette fund i forhold til kvalificering af praksis i arbejdslivet¹.

Key words

Refleksion, 'sprogspil', reformulering, følelser, sundhedsprofessionel supervision

Indledning

Supervision betegnes af supervisorer som et meta-perspektiv på praksis, der kan skabe refleksion og faglig udvikling (Lund-Jacobsen & Holmgren 1996). Per Schaarup (2000) har udfordret denne selvforståelse og hævdet at supervision kan føre til det modsatte – nemlig faglig stagnation fordi de samme tematikker konstant behandles i supervision. Begge synspunkter fokuserer på indholdet af det, der tales om og ikke måden, der tales på – og det er fokus i denne artikel, da supervision frem for alt ses som en sproglig praksis, hvor supervisorsgruppens deltagere introduceres til en bestemt måde at reflektere på i en social sammenhæng.

Uanset hvilken teoretisk retning den konkrete supervision bekender sig til kan supervision beskrives som en sproglig praksis, der har til formål i en given kontekst:

at skabe klarhed og forståelse for det sociale samspil, som udspiller sig imellem nogle professionelle (Schilling 1997: 12)

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Nærmere bestemt ser jeg den måde, som supervisor reformulerer de problemer, deltagerne i supervisionsgruppen bringer op, ses som at hun tilbyder et nyt 'sprogspil' (Schilling 1997; Wittgenstein 1953) til at reflektere over en situation med. Wittgenstein mener, at analyser af sociale sammenhænge - så som fx supervision - må tage sit udgangspunkt i at se på sprog og sproglige udtryk som noget, der har en bestemt funktion i og udspringer af den kontekst, de er den del af. Netop derfor er vi i stand til at skabe bestemte meninger ud af sproglige udtryk til trods for deres mange mulige betydninger. Begrebet 'sprogspil' søger således at indfange sproglige udtryks - både verbale og non-verbale - grundlæggende praktiske rolle, der er orienteret mod handlinger i en given praksis.

Denne artikel udforsker, hvordan sprogspillet om følelser foregår i supervision. Mit fokus er ikke at afdække mulige 'indre processer' i det enkelte menneske. I stedet ønsker jeg at se på de 'ydre og kollektive processer' og, hvad der bliver sagt og hvordan, plus hvilken betydning disse udsagn får for refleksionsprocessen i supervisionsgruppen. Artiklen kan derfor ses som et post-kognitivistisk bidrag til, hvordan refleksionsprocessen udspiller sig i en social sammenhæng som supervision. Post-kognitivistiske tilgange, herunder diskursiv psykologi og etnometodologi, kritiserer netop med afsæt i bl.a. Wittgensteins teorier (1953) for at undvige at udforske, hvad der allerede ligger 'seen but unnoticed' (Garfinkel 1967: 36) og i stedet tage afsæt i pre-determinerede teorier og kategorier om praksis i stedet for, som Wittgenstein siger: "*Let the use of words teach you their meaning*" (Wittgenstein 1953: 220).

I dette lys ser jeg læring som observerede ændringer i interaktionen frem for teoretisk baserede antagelser om deltagerens subjektive læringsprocesser. Menneskelig mentalitet og aktivitet anskues indenfor post-kognitivistisk tænkning som en: "*irreducible plurality of (language) games grounded in a variety 'forms of life'*" (Dror & Dascal 2002: 222).

Inspireret af Wittgenstein kan kognitiv udvikling - og læring - indenfor denne tænkning betegnes som en udvikling i evnen til at italesætte og skelne forskellige kategorier i vores omgivelser. Ny viden og 'nye sprogspil' giver således adgang til udvikling af nye begreber og udtryk på mange niveauer, som befordrer evnen til at

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kunne skelne mellem forskellige videnskategorier og anvende disse i en vurdering af og tilpasning af handlinger (Sheppard 1998). I forhold til det konkrete projekt kan 'det supervisoriske sprogspil' muligvis bidrage med andre ord, udtryk og vinkler på problemstillinger og dermed en anden måde at tale om dem på, hvilket kan få betydning for beslutninger vedrørende pleje og behandling af patienter og, som jeg vil vise i analyserne, relationerne i personalegruppen.

Tidligere forskning i Norden argumenterer for, at den vejledte føler sig bedre rustet til at klare udfordringerne i den daglige praksis efter refleksionen i supervision. (Teslo 2000: 34-36; Gadgil 1997; Iskov 1997; Arvidsson 2000; Pålsson, Hallberg and Norberg 1994; Lindahl & Norberg 2002; Severinsson 1995; Severinsson og Kamaker 1999). Kritiske røster i Norgeⁱⁱ har dog stillet spørgsmålstejn ved, hvorvidt metoderne i supervision er for domineret af psykoterapeutiske metoder og om:

refleksionsprocessen styrker kundskab, som er orienteret mod patienten, eller om den alene bidrager til sygeplejerskens subjektive behov for vækst og udvikling? (Lind 2002: 9).

De mener, at følelser frem for faglige begrundelser for handling har været prioriteret i supervisionen og andre kritiske røster har endvidere kaldt supervision for en 'følelsesmæssig ventil', hvor den ansatte kan tale om og komme af med de følelsesmæssige spændinger forbundet med sit job. Betragtningerne ovenfor indikerer at følelser er blevet negligeret som en del af den institutionelle praksis. Forskning indenfor det sociale og sundhedsmæssige felt underbygger disse tanker og peger på at det professionelle ideal om at være rationel og neutral stadig har stor betydning for den professionelles rygte og position (Nikanderⁱⁱⁱ; Arber^{iv}). Ifølge Nikander giver det sig fx udtryk i en agenda, som søger at undgå, at institutionelle beslutninger 'forurenes' af følelser, og netop derfor er supervision rummet måske et velkomment rum, hvor disse kan tematiseres. Brugen af ventil-metaforen om supervision understreger pointen om, at følelser er noget som man kan styre og lukke ud i bestemte sammenhænge.

Dette synspunkt står i kontrast til denne artikels teoretiske udgangspunkt^v, som argumenterer for, at vi ikke kan 'ikke kommunikere' følelser. De produceres og forhandles hele tiden i interaktion (Edwards 1999) og burde derfor være naturlig og

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legitim del af personalets overvejelser om udfordringer i praksis indenfor institutionelle kontekster. Indtil nu, har forskningen dog ikke bidraget med indsigter i, hvordan refleksion over følelser foregår i selve supervisionsrummet. Størstedelen af den forskning, som er lavet er baseret på interviews med deltagere efter de har modtaget supervision (Hyrkas 2006). Således bidrager denne artikel med ny viden indenfor dette felt og er båret af en hypotese om, at 'det supervisoriske sprogspil' kan ændre og muligvis opgradere personalets kommunikation af følelser i beslutningsprocesser omkring pleje og behandling af patienterne. Set i lyset af artiklens teoretiske udgangspunkt er formålet ikke, at diskutere hvorvidt supervision bidrager eller ej til supervisanernes "*subjektive behov for vækst og udvikling*" (Lind 2002: 9). Spørgsmålene er derfor for det første hvad der karakteriserer 'det supervisoriske sprogspil' og for det andet, hvilken betydning det har for, hvordan følelser italesættes i supervisionsrummet og senere i personalets daglige praksis.

Artiklen falder i tre dele. Først skitseres artiklens teoretiske og metodiske grundlag. Her uddyber jeg hvorfor og hvordan jeg indfanger det følelsesmæssige tema med de sproglige briller på. Anden del er analyser af tre eksempler fra supervisionsforløbet, som skal illustrere for det første grundelementerne i 'det supervisoriske sprogspil' og for det andet, hvordan deltagerne begynder at overtage og bruge disse elementer i deres måde at reflektere på. I tredje del sammenfatter diskussionen, hvordan interaktionelle analyser kan bidrage til udforskningen af refleksionsprocesser i praksis. Til slut konkluderer jeg på de centrale fund i artiklen.

Første del: Det teoretiske og metodiske grundlag

Denne artikel er baseret på analyser af et supervisionsforløb, som er blevet optaget på video og derefter udskrevet. Dette forløb indgår som den empiriske del af mit ph.d.-projekt om supervisions betydning for den måde sundhedspersonalet kommunikerer følelser på i deres daglige praksis – også kaldet for 'emotion work' eller 'emotionelt arbejde' på dansk (Hochschild 1983; Ravn-Olesen 1997). Forløbet betragtes som en eksemplarisk case for det 'sprogspil', der finder sted i et supervisionsrum^{vi}. I projektet definerer jeg 'emotionelt arbejde' som tale om følelser, følelsesudtryk og interaktivt arbejde, der leder frem til eller kommer efter tale om følelser og følelsesudtryk. I modsætning til psykologiske og kognitive tilgange, som udforsker hvordan følelser også eksisterer udenfor samtalen inde i hver enkelt person, ser jeg, som nævnt, følelser

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som noget, der forhandles og gøres relevante i en social sammenhæng. Dette udgangspunkt er inspireret af diskursiv psykologi (DP) (Edwards 1997; 1999) og etnometodologi (Garfinkel 1967; Heritage 1984). Både DP og EM beskæftiger sig med, hvordan mennesker skaber mening og social orden gennem deres tale og interaktion (Jørgensen og Phillips 1999). DPs ser især på, hvordan 'psykologi' og 'virkelighed' er diskursivt produceret, håndteret og gjort relevant af deltagerne i og gennem interaktion (Hepburn og Wiggins, 2005). Det betyder, at det udforskes, hvordan folk taler eller skriver om psykologiske temaer. I denne sammenhæng står følelser og, hvordan disse kommunikeres i interaktion centralt indenfor DP (Edwards 1999). For begge teoretiske retninger gælder det, at den metodiske tilgang i analyserne af data er induktiv og, at de benytter sig af konversationsanalytiske værktøjer ud fra en betragtning om, at al social handling og interaktion er et udtryk for organiserede mønstre, hvor deltagerne konstant tilpasser sig og skaber forståelse afhængig af de lokale omstændigheder (Stax 2006). Læseren af denne artikel bliver derfor præsenteret for en række 'mikro-analyser' af deltagernes udsagn, som er blevet udskrevet ifølge nogle bestemte detaljerede konventioner^{vii}. Det betyder, at deltagernes udsagn er udskrevet så præcist og så tæt på tale sprog, som det er muligt.

Opsamlende undersøger jeg i analyserne, som præsenteres i denne artikel, hvordan supervisorerne inviterer deltagerne i supervisionsgruppen til at tale om følelser og, hvordan deltagerne responderer på disse invitationer – altså, hvordan refleksion over følelser 'gøres' i den supervisoriske praksis. Inspireret af både Sacks (1995) og Wittgenstein (1953), som understreger sproglige udtryks praktiske orientering, forsøger jeg at demonstrere, hvordan:

practices are oriented to action, are situated and co-constructed in stretches of interaction and are given sense through the categories and formulations of participants (Potter 2000: 34)

Således uddyber jeg i det næste afsnit den teoretiske baggrund for reformuleringsbegrebet, som det bruges i analyserne. De forskere, som præsenteres i denne sammenhæng, kommer fra forskellige discipliner inden for det socialvidenskabelige felt og har beskæftiget sig med det reformuleringer indenfor det terapeutiske område fra et interaktionelt perspektiv. Det betyder, at de interesserer sig for interaktionelle processer og deres betydning for, hvordan deltagerne skaber

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mening i en social sammenhæng. De er alle inspireret af etnometodologiske induktive metoder og bruger konversationsanalytiske redskaber deres analyser.

Reformuleringer

Når deltagerne i en supervisionsgruppe fortæller om problemstillinger fra deres praksis er supervisoren en aktiv lytter, der naturligvis forholder sig til det de siger. Det gør hun ofte gennem at reformulere det, hun hører for herefter at søge en accept eller afkræftelse af reformuleringen. Det kan siges, at terapeuten udøver sin faglige ekspertise til at eksplicitere viden, relevans og til at kategorisere en given situation gennem sin reformulering. Litteraturen beskriver to forskellige måder at reformulere på, som kaldes for 'gists' og 'upshots' (Antaki et al 2005; Gafaranga & Britten 2004). 'Gists' er reformuleringer, der er refererer meget direkte til det, som tidligere er sagt. Hvis A fx siger: 'Det starter, når jeg ligger ned' så kan B fx sige: 'Ok, så du får det når du ligger ned?'. 'Gists' kan således ses som forsøg på at skabe en afklaring på, hvad der siges og demonstrere forståelse. Upshots, derimod, er reformuleringer, der kommenterer på og forholder sig til de talte eller det potentielt udtalte, der kan være i det, der reformuleres på. Hvis A fx siger: 'Når der sidder nogle og laver ansigter er der ikke noget gunstigt vækstklime på konferencen' og B reformulerer dette udsagn på denne måde: 'Så du føler det er vanskeligt at sige, hvad du mener?' kaldes reformuleringen for et 'upshot', da B udleder det A muligvis siger mellem linierne, altså implikationerne af det A har sagt (Antaki et al 2005). A her ikke sagt, at hun ikke ved, hvad hun skal sige, det er en implikation B udleder. Således kan man sige, at 'upshots' *"makes explicit a presupposition left implicit in the previous talk"* (Gafaranga & Britten 2004: 153). Reformuleringer kan således siges at have en meta-kommunikativ funktion: *"through which participants comments on the nature of the discourse in which they are engaged"*. (Drew 1998: 32).

Supervision er ligesom terapeutiske sammenhænge, det være sig læge konsultationer eller psykoterapi, en form for institutionel interaktion, hvor forskningen har vist, at deltagerne orienterer sig mod bestemte normer i deres opførsel (Drew & Heritage 1992; Arminen 2005). I disse sammenhænge påhviler det terapeuten at udrede klientens problem og det er klientens rolle at besvare terapeuten spørgsmål. Til trods for den asymmetriske situation er reformuleringsprocessen en co-konstruktion mellem supervisorerne og deltagerne i en supervisionsgruppe. Reformuleringerne opsummerer

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tidligere tale og inviterer, som det ses i eksemplerne ovenfor, i reglen også til modtagerens bekræftelse. Ifølge Davies^{viii} (1986) består reformuleringsprocessen af tre trin: Først definerer terapeuten – her supervisoren - problemet, så dokumenterer hun det for til slut at søge modtagerens accept af sin reformulering. For at definere problemet må supervisoren udvælge og fokusere på en bestemt del af det, som siges. Dette aspekt af problemet reformuleres til supervisorens version af, hvad det 'virkelige problem' er. Derfor kan reformuleringsbegrebet anskues som et nøglebegreb for enhver supervisor, da alt hvad der foregår i supervisionsrummet er en forhandling mellem parterne om, hvad der er relevant/irrelevant at tale om. Konkret betyder dette, at supervisorerne søger deltagernes accept på deres reformuleringer før seancen kan gå videre. Med Heritages & Watsons ord kan man kalde reformuleringen for en måde at fastfryse 'to fix' et givent tema (Heritage & Watson 1979), som hermed udstilles og kræver klientens respons. Responsen på supervisorernes reformuleringer og spørgsmål kan således siges at være en slags 'lakmus prøve' på, hvor parate gruppens deltagere er til at tale om følelser.

Anden del: Reformuleringer som 'det supervisoriske sprogspil'

Artiklens anden del er baseret på tre analyser af, hvordan både supervisorernes og siden hen deltagernes reformuleringer var styrende for, hvordan følelser blev italesat. Supervisionsforløbet fandt sted i en afdeling, hvor hele personalet, et tværfagligt team på 13 personer, deltog i en supervisionsgruppe, som mødtes 10 gange hver 14. dag. De etiske, indholds- og tidsmæssige rammer for projektet blev forhandlet mellem deltagerne og mig, som den ansvarlige for projektets gennemførelse, inden den empiriske del og de to supervisorer blev introduceret i afdelingen^{ix}. Gruppen havde to supervisorer, Karen og Grete, fordi den var så stor. Alle seancer blev video optaget og jeg deltog som observatør. Desuden var jeg i afdelingen 2 måneder før og efter supervisionsforløbet, hvor jeg optog den ugentlige tværfaglige konference, 4 før og 4 efter supervisionsforløbet. Ind imellem optagelserne var jeg aktiv som forsker og supervisor i afdelingen, hvilket betød, at jeg brugte min faglighed som supervisor^x og dermed samme 'supervisoriske sprogspil' som supervisorerne med henblik på at få deltagerne i projektet til at reflektere over deres praksis.

Analyserne af supervisionsforløbet demonstrerer, hvordan reformuleringer er en grundlæggende del af 'det supervisoriske sprogspil', hvorved supervisorerne viser at de

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har hørt og anerkender det, gruppens deltagere siger. De første to eksempler: 'Tidsspilde' og 'Jeg kan mærke det i maven' er karakteristiske for, hvordan supervisorerne reformulerer de problematikker supervisionsgruppens deltagere bragte op gennem hele supervisionsforløbet og giver dem en følelsesmæssig dimension. Endvidere illustrerer disse to eksempler, hvordan det var supervisorerne og ikke deltagerne, der reflekterede 'gjorde refleksion' i den første halvdel af supervisionsforløbet. I Eksempel 3: 'Hvad betyder det' ses det, hvordan deltagerne mod slutningen af supervisionsforløbet overtager og anvender elementer i 'det supervisoriske sprogspil'. Eksemplet viser, hvordan en deltager sammen med supervisoren bygger videre på de spørgsmål, der stilles til det tema, som er i fokus. Endeligt kan eksempel 3 demonstrere, hvordan denne udbygning kan være med til at forberede gruppens deltagere på interaktioner i den daglige praksis.

Eksempel 1: 'Tidsspilde'

I eksempel 1 drejer samtalen sig om, hvor man kan dele de oplevelser man har med patienterne. En af deltagerne, Maja, siger, at man måske godt kunne holde sig tilbage med at fremlægge noget på den ugentlige tværfaglige konference på grund af blik og kropssprog fra de, som deltager i konferencen. I den forbindelse spørger supervisorerne lidt senere en anden af deltagerne, Julie, om hendes oplevelse af en situation fra den sidste supervision, hvor hun fik lejlighed til at tale længe om en udfordrende patient, hun er kontaktperson for. Julie siger, at det var dejligt at få lov til at tale uden at blive afbrudt, men at hun samtidigt har tænkt på, om ikke det var spild af tid, da personalet kender patientens historie. I eksempel 1 kommer en anden af deltagerne, Ea, også med en respons. Eksemplet starter med, at supervisoren, Grete, reformulerer det, hun har hørt Julie og Maja sige på denne måde:

Eksempel 1^{xi}

1 Grete: Men det er lidt det, som jeg også hører du si siger Maja
2. det med når *man* så (0.2) på en konference eller (0.2)
til
3. fredagsmødet (0.6) måske holder noget tilbage fordi *man*
4. simpelthen er bekymret for om synes de andre nu at det
5. her nu går tiden med det eller kommer *jeg* til at spille
6. de andres tid eller (0.7) eller:øh (0.8) ansigts (0.4)
7. udtrykkene og kropssproget (0.2) virker utålmodigt (0.3)
8. sådan lidt (0.2) trom[men] på bordet (0.3) så kan *jeg*
9. Ea: [mm]
10. Julie: [ja ja]
NV: Den anden supervisor Karen trommer på sin stol med to
fingre

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- 11 Grete: overhovedet tillade *mig* at bruge folks tid og fortælle
12. *mig* selv den samme historie en gang til
13. Julie: Ja
14. Grete: eller fortælle *jer* °den samme historie° det er *jo*
15. Pause: (5.1)
16. Grete: °Det er *jo* et godt spørgsmål°
17. (J): Ja
18. Pause: (1.4)

Problemdefinition og dokumentation

I sin reformulering definerer supervisoren, Grete, problemet som, at "*man*" (2) "*måske holder noget tilbage*" (3) med at sige noget, fordi 'man' er bekymret. Man kan således se, hvordan hun giver definitionen af problemet en følelsesmæssig dimension, da hun taler om, at man er "*bekymret*" (1). Noget, som hverken Maja eller Julie har formuleret i deres udsagn. Denne følelsesmæssige dimension dokumenterer hun med Julies og Majas udsagn (Grete henviser til Majas udtalelser i linie 1, 6, 7 og i 5 og 6 henviser hun til noget, Julie har sagt lige inden eksemplet starter). For det første kobler hun det at være med bekymret med "*at spille andres tid*" (5, 6), og for det andet bruger hun Majas forklaring om, at folks nonverbale udsagn godt kan afholde hende fra at sige noget (6, 7). Dvs. at Gretes reformulering kan siges at være et 'upshot', da hun udleder de mulige implikationer at det, hun har hørt Maja sige: at ansigtsudtryk og non-verbalt sprog gør, at man ikke siger noget, og at man derfor er bekymret for at spille de andres tid.

Supervisors 'footing'

I skiftet fra dokumentationen til definitionen i eksempel 1 sker der også et skift i Gretes brug af pronominer. I dokumentationen af reformuleringen bruger hun personlige pronominer så som "*du*" (1) og "*jeg*" (5, 8). I definitionen siger Grete, at '*man*' holder noget tilbage (2), fordi "*man*" er bekymret (3), og bruger det upersonlige pronomen "*man*". Skiftet er således et perspektivskifte fra at være personlig, som fx kan ses ved at Grete først taler direkte til en deltager i gruppen og sige '*du*' (1) til at være mere upersonlig, distanceret og generel og sige "*man*" (2, 3). Herved skabes en distance til følelsesmæssige tema, der kan gøre det mindre risikabelt for modtagerne at komme med en respons. Endvidere virker Gretes formulering, hvor hun siger "*det med når man*" (2), som om hun illustrerer noget vi alle sammen kender til. Udtrykket "*det med*" kombineret med brugen af "*man*" kan derfor siges at 'normalisere' den følelse af bekymring, som Grete udtrykker i sin definition og gøre det helt naturligt, at mærke og

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føle efter, især set i lyset af den dokumentation: folks non-verbale udtryk, Grete lige har fremlagt. Opsamlende ses det, hvordan supervisor underbygger sin faglige vurdering gennem brugen af personlige pronominer, tale og direkte henvisninger til noget hun har hørt deltageren sige for herefter at uddrage relevante og naturlige forhold af denne tale.

Gretes perspektivskifte fra at referere til noget Maja har sagt til at sige noget, der fremstår som en mere generel vurdering kalder Goffman for 'footing' (Goffman, 1981: 151). Begrebet 'footing' illustrerer det forhold at talere og lyttere er i stand til hurtigt at skifte positioner under samtaler (Beck-Nielsen, 2003). Goffman (1981) inddeler talerrollen i tre: animator, author og principal. Animatoren er den, der fysisk taler. Author er den, der oprindeligt har ytret en holdning eller følelse og måske også har valgt sammensætningen af ordene, som de siges af animator. Endeligt er principal er den person, hvis synspunkt aktuelt udtrykkes i en given formulering (Clayman 1992: 165). I det konkrete eksempel er Maja og Julie authors mens Grete kan siges at være både animator og principal. Med disse analytiske begreber skelnes der således mellem taleren og kilden. Nok er det Grete, som taler, men det er ikke hende som holdes ansvarlig for dokumentationen af problemet, det er authors, altså Maja og Julie. Derfor kan man argumentere for, at 'footing' er med til at underbygge supervisors neutralitet i interaktionen præcis ligesom Clayman (1992), der har undersøgt 'footing' i nyhedsinterviews diskurser, har fundet 'footing' gør i journalisternes måde at håndtere interviewsituationen på. Til trods for, at det er to forskellige institutionelle sammenhænge, der er tale om, kan det professionelle ideal om neutralitet siges at gælde for dem begge (Arminen 2005).

'Footing' kan endvidere være med til at befordre en nuancering og perspektivering af problematikken ved at præsentere den ud fra forskellige synsvinkler fra et konkret til et mere abstrakt plan, der fx er illustreret i de moralske perspektiver 'at man ikke bør spille andres tid', der er indlejret i Gretes reformulering. Disse perspektiver foldes ud i Gretes følgende udsagn, hvor hun skifter 'footing' fra tredje til første person ental og siger:

man simpelthen er bekymret for om synes de andre nu at det her nu går tiden
med det eller kommer jeg til at spille de andres tid (3, 4)

samtidigt med at hun får hjælp fra Karen, der trommer på bordet og malende illustrerer

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Gretes pointe.

Dette skift virker empatisk og anerkendende, da det lader til at Grete identificerer sig med de to sygeplejersker. Skiftet resulterer også i respons fra Julie og Ea, som det kan ses i linie 9 og 10, hvor de overlapper hinandens tale, hvilket er med til yderligere at understrege deres enighed og bekræftelse af Gretes udsagn. Julies respons i linie 12 bekræfter tilsyneladende Gretes reformulering, men hendes spørgsmålet får ingen yderligere respons. Grete fortsætter med tilsyneladende at imitere Majas eller Julies indre dialog. Det kan igen ses i hendes brug af personlige pronominer så som "jeg" (8) og "mig" (12) i forlængelse af henvisningen til det det, de har sagt. Hun stiller yderligere to spørgsmål, med et samme moralske omdrejningspunkt (11, 13). At hun fortsætter med at uddybe sin reformulering kan tyde på, at hun ikke får den respons hun ønsker fra deltagerne og hermed illustrere Davies' (1986) pointe om, at hvis terapeuten, her supervisoren, ikke gør det netop vil præsentere sin version ikke én men flere gange i løbet af samtalen.

Tidsmetaforen

Gretes brug og elaborering af 'tidsmetaforen' implicerer, at tid er en slags kontainer, som man kan åbne eller lukke, altså kontrollere og derfor også med risiko for, at man kan 'spilde' tiden (Lakoff 1994). Indenfor DP derimod ser man på, hvilket interaktionelt og retorisk arbejde metaforer gør. Edwards (1997 og 1999) peger på, at metaforer er konceptuelle ressourcer, der:

where they occur in any language, whatever the metaphorical base, are available for discursive employment' (Edwards 1999: 280).

I det konkrete tilfælde kan Gretes elaborering på 'tidsmetaforen' gennem introduktionen af nye og forskellige personlige stedord fra linie 5-13 være med til at nuancere de moralske og potentielt implicitte følelsesmæssige implikationer, der er bundet til 'tidsmetaforen', som Grete har ekspliciteret (4). Ligeledes inddrages ikke blot Julie og Maja, men også alle de andre tilstedeværende deltagere i problematikken, gennem Gretes imitering og udbygning af den fiktive indre dialog omkring denne metafor (11). Det ses fx ved, at det tredje spørgsmål er formuleret meget direkte og inddrager konkret de, som er til stede i rummet, hvor de to andre spørgsmål er formuleret mere upersonligt og herved kommer til at introducere en mere generel og

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normativ problematik (14). Måske derfor får ingen af spørgsmålene videre respons i form af svar eller kommentarer.

Supervisor vælger at lukke sekvensen med en evaluerende kommentar (16), som deltagerne i gruppen nu kan gå hjem og fundere over! Det naturlige i at stille den slags spørgsmål i en indre dialog er understreget ved at Grete siger ”jo” hele to gange (14, 16). Som vi skal se i de næste to eksempler i denne artikel, er dette lille ”jo” en tydelig markør og del af ‘det supervisoriske sprogspil’, der netop er med til at understrege og underbygge den normativitet, supervisorerne introducerer i deres tale. En lang pause afslutter sekvensen. Tavsheden brydes af en reflektiv dialog mellem de to supervisorer, hvor de introducerer andre meta-perspektiver på temaet ’spild af tid’. Den ene supervisor siger fx, at hun ser snakken om spild af tid og hvornår noget er stort eller småt nok til at blive talt om kan opfattes som et udtryk for en lineær og målbar opfattelse af, hvordan man bør udnytte tiden, og hvad der er rigtigt og forkert.

Opsamling på eksempel 1

Eksempel 1 viser, hvordan supervisoren, Grete, giver definitionen af problemet en følelsesmæssig dimension, da hun taler om, at man er ”*bekymret*” (1). Grete, dokumenterer denne problemstilling i reformuleringerne ved at henvise til, udvælge og tolke på elementer i deltagerens udsagn, hvorefter hun reformulerer disse til mere generelle betragtninger om, hvornår noget er ’spild af tid’. Med dette perspektiv skifte transformerer og synliggør Grete deltagerens potentielt underforståede følelsesmæssige udsagn samtidigt med at der introduceres moralske meta-perspektiver på, hvad man kan tale om på konferencerne gennem Gretes imitering af Majas og Julies indre dialoger. Et meta-perspektiv er jo netop **er** defineret ved tale om talen, som i denne sammenhæng er, hvad man kan tale om på konferencerne. Med Edwards ord (1999) kan man sige, at udbygningen af tidsmetaforen sammen med Gretes ’footing’ skaber mulighed for at udtrykke, nuancere og ikke kun tænke følelser. Således er metaforer ikke blot: ”*motivated by their conceptual use, but what they allow us to say and do*” (Edwards 1999: 280).

Eksempel 2: ’Jeg kan mærke det nede i maven’

Det næste eksempel, eksempel 2, viser ligesom eksempel 1, hvordan den følelsesmæssige tematik er i fokus i supervisorernes reformuleringer. Som i eksempel

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I udbygges dette tema gennem supervisorernes 'footing' og deres elaborering af de metaforer deltagerne bruger. Herved gøres potentielt implicitte følelsesmæssige udsagn eksplicitte, hvilket kan forstærke og understrege det følelsesmæssige tema.

Eksempel 2 starter lige efter supervisorerne har indledt supervisionen efter pausen i den 5. supervision. I både den 4. og 5. seance, har deltagerne givet udtryk for, at de ikke altid synes det er lige let, at sige noget på de ugentlige tværfaglige konferencer i afdelingen og det samme gælder for supervisionen. I sin reformulering henviser supervisor Karen således til – og dokumenterer sin problemformulering – med tre indlæg fra forskellige deltagere på forskellige tidspunkter i løbet af de sidste to supervisionsseancer, hvilket er meget karakteristisk, da reformuleringer

may serve to demonstrate understandings of the cumulative import of a previous string of utterances (Heritage & Watson 1979: 150).

Karen siger:

Eksempel 2

1. Karen: Øe:h (0.7) altså det er jo vigtigt at kigge på (0.6)
2. altså Grete og jeg har i hvert i fald ikke en intention
3. om at klæde nogen af eller hænge nogen til tørre eller
4. udstille nogen
5. Pause: (1.8)
6. Karen: e:hm men som du også siger Julie jeg kan mærke det
7. nede i maven (0.7) ja okay [og det var]
8. (): [det er Julie]
9. Karen: Nej undskyld
10. Sofie: Det gør ikke noget
- NV: Karen forveksler navnene på Sofie og Julie. Louise griner
11. Sofie: Du kiggede på mig så jeg tænkte at det var nok mig
12. Karen: Ja ()
- NV: Louise griner fortsat.
13. Karen: det var fordi du sagde det så tydeligt
14. ikke du sagde det også Vera ja jamen jeg kan mærke det
15. men jeg ved ikke om jeg får det sagt rigtigt og og når
16. man mærker noget i sin mave så er det jo (0.4) nogen
17. gange vældigt svært at undertrykke det fordi (0.2) det er
18. så (0.7) emotionelt altså det fylder jo i os
19. Pause: (1.5)
20. Karen: og og det der med tilladeligheden af at det er jo okay
21. (0.2) altså sådan ser min verden i hvert fald ud (0.4) at
22. det er okay (0.2) at (0.4) man her kan få lov at mærke
23. noget (0.4)
24. Pause: (1.5)
25. (): Mm

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Problemdokumentation og transformation

Indledningsvis (3) henviser Karen til en kommentar lige før pausen fra Louise, som dog ikke nævnes ved navn, om at der kan være nogen, der kan være bange for at blive *"klædt af"*, når gruppen taler om de interpersonelle relationer og følelser i gruppen. Karen fokuserer på Louises forbehold og hypotetiske illustration af, hvad der kunne ske, i sin reformulering. Hun siger, at det hverken Gretes eller hendes intention at *"klæde nogen af"* (2, 3) ved at gentage og elaborere på 'klæde af' metaforen gennem andre gængse metaforer (3), der udtrykker følelsen af at være blottet i en social sammenhæng. Således kan elaboreringen fungere som et retorisk virkemiddel, der kalder på en bekræftende respons fra modtagerne. Denne respons udebliver.

I stedet er der en forholdsvis lang pause (12), hvor ingen tager ordet. Karen fortsætter derfor med at uddybe det følelsesmæssige tema, som Davies (1986) har beskrevet 'terapeuten' vil gøre når deltagernes accept udebliver. I Karens næste dokumentation (6, 14, 15) henviser hun til først til noget Julie (6) og dernæst Vera (14, 15) tidligere har sagt^{xii}. Der er lidt forvirring i begyndelsen af Karens reformulering (8-11), da hun forveksler navnene på to af gruppens deltagere. Hun ser på Sofie, samtidigt med, at hun henviser til noget, som Julie har sagt. Karen citerer Julie og Vera for at have sagt, at *"jeg kan mærke det"* (14) og at *"jeg"* ikke ved om *"jeg"* får sagt *"det"* rigtigt (15). Disse udtalelser er måske underforståede, da hverken Julie eller Vera udtrykker sig sådan. Vi kan derfor ikke vide, om det er det de mener. Julie talte om, hvordan der ikke altid var et *"gunstigt vækstklime på konferencen"* fordi, som hun udtrykker det:

Jeg kan da nemt komme på situationer øh hvor én af os har taget noget op og andre af os har siddet og set meget utålmodige ud.

Karen transformerer således *"én"* – til *"jeg"* – altså Julie – i sin reformulering og udleder hermed at Julie kan *"mærke det"* (14) og måske ikke ved, om hun får sagt *"det rigtigt"* (15). I forhold til Vera transformerer Karen Veras oprindelige udsagn om, at *"det er svært at sætte ord på følelser"* og at hun *"får hjertebanken, når hun skal tale"*, til at Vera siger, at hun ikke ved, om hun *"får sagt det rigtigt"* (15).

Karens valg af dokumentation i sin reformulering kan således illustrere Davies' pointe (1986) om, at 'terapeuten', her supervisoren, reformulerer og transformerer problemet til hendes faglige version af, hvad problemet er og dokumenterer denne

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med henvisninger til deltagernes udsagn. Karens fokus virker til at være de personlige problematiske følelsesmæssige forhold, der kan være med at få sagt det, man gerne vil, så som fx usikkerhed. Hun siger dog ikke direkte, at Julie føler sig usikker. Karen illustrerer gennem sin tale, hvordan man agerer, hvis man er usikker (14, 15). For at få denne pointe frem, har Karen udvalgt og udledt den relevante dokumentation af det, de tre kvinder har sagt og formuleret den i 'jeg' form, måske da dette format virker empatisk og anerkendende og dermed inviterer til en bekræftende respons. At responsen udebliver kan skyldes dels at transformationen fra de oprindelige udsagn er for stor, dels at det følelsesmæssige tema er ømtåleligt og ingen derfor ønsker at byde ind med kommentarer, fordi de måske ikke ønsker at risikere 'at blive klædt af'.

Problemdefinitionen

Problemdefinitionen i Karens reformulering kommer efter dokumentationen (15-18) og er Karens citering af Veras og Julies udsagn. Karen siger, at problemet er, at:

når man mærker noget i sin mave så er det jo (0.4) nogen gange vældigt svært at undertrykke det fordi (0.2) det er så (0.7) emotionelt altså det fylder jo i os

Denne problemdefinition kan ses som værende en naturlig implikation af de beviser, som hun har fremlagt og derfor kan karakteriseres som et 'upshot'. I problemdefinitionen siger Karen at "*når man mærker noget i sin mave*", med henvisning til Veras ytring, så kan det være svært at undertrykke det for det "*er så emotionelt*" (10, 11). Her ses det, hvordan metaforen "*man mærker noget i sin mave*" bliver et udtryk for, at man er emotionelt berørt. Det legitime i at blive emotionelt berørt forstærkes i afslutningen af sætningen, hvor Karen siger "*det fylder jo i os*" (11). For det første siger hun "*jo*", hvilket kan understrege at det er helt naturligt, at følelser fylder. Brugen af "*jo*" kan også virke empatisk og henvise til deltagernes tidligere erfaringer med følelser, der fylder. Endeligt kan "*jo*" invitere til en bekræftende respons fra deltagerne i gruppen. For det andet siger hun at følelserne jo fylder "*i os*". Gennem denne formulering inddrager Karen ikke blot sig selv som et menneske, der påvirkes af følelser ligesom gruppen men i den givne kontekst taler hun også som en fag person og autoritet, der ved noget om, hvordan følelser fylder.

Det ses således, hvordan 'ventil metaforen' har fundet vej ind i supervisorsrummet i talen om, at følelserne 'fylder' meget og at de er svære at 'undertrykke'. Set i et

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diskursivt perspektiv kan denne metafors retoriske betydning være, at det er underforstået, at man kan være/er nødt til at lukke følelserne ud – altså tale om dem. Således kan man sige, at Karens brugs af 'ventilmetaforen' understreger en pointe om, at det er nødvendigt at tale om de følelser man har. og dermed efterspørger verbal respons fra deltagerne i gruppen.

Supervisors 'footing'

I skiftet fra dokumentationen til definitionen i eksempel 1 sker der et skift i Karens brug af personlige pronominer. Fra at sige "jeg", "du" og "os" (2, 6, 18) bruger hun nu det upersonlige pronomener "man" (16, 22). Skiftet er et perspektivskifte fra at være personlig til at være mere distanceret og normativ og skaber således en distance til følelsesmæssige tema, der kan gøre det mindre risikabelt for modtagerne at komme med en respons. "Man" kan her forstås som værende indeksikalt for - eller lig med - at det er normalt og naturligt- og derfor moralsk uangribeligt - at mærke og føle efter, især set i lyset af den dokumentation, som Karen lige har fremlagt. Karens skifter 'footing' fra at referere til noget Vera og Julie har sagt til at sige noget, der fremstår som en mere generel vurdering. Som vi så det i eksempel 1 er deltagerne i supervisionsgruppen authors mens supervisorerne er animator og principal. I eksempel 2 er Vera og Julie således authors mens Karen kan siges at være både animator og principal. Nok er Karen, som taler, men det er ikke hende som holdes ansvarlig for dokumentationen af problemet, det er authors, altså Vera og Julie. Karen afslutter sin reformulering med at understrege problemets moralske dimension med tilsyneladende at imitere en af deltagerens potentielle 'indre dialoger', som vi så det i eksempel 1. Hun siger: "*at det er jo okay (0.2) at sådan ser min verden i hvert fald ud*" (21).

Opsamling på eksempel 1 og 2

Karens problemdefinition i eksempel 2 illustrerer, hvordan hun bruger sin faglige ekspertise til at skabe et supervisorisk fokus på de svære følelsesmæssige aspekter, der kan være i det som Julie og Vera har sagt. Dette fokus underbygger hun gennem at transformere deltagerne: Julies og Veras ytringer fra potentielt at være implicit til at være eksplicit følelsesladede (Buttny 1996) – præcis ligesom vi så det ske i eksempel 1. Ligeledes sker der i begge eksempler en nuancering og perspektivering af problematikkerne ved at præsentere den ud fra forskellige synsvinkler fra et konkret til et mere abstrakt plan gennem supervisorernes 'footing' og udbygning af de metaforer,

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der er i spil i den konkrete situation. I eksempel 1 var der tale om 'tidsmetaforen' og i eksempel 2 elaborerer supervisoren Karen på 'klæde af' metaforen. Det abstrakte plan illustreres fx i de moralske diskussioner, der er indlejret i både Gretes og Karens reformuleringer. Her tænker jeg på Karens udtalelser om, at det må anses for at være naturligt, at man kan sige, hvad man føler – og på Gretes opfordringer til at overveje, hvornår og hvordan man spilder hinandens tid!

Eksempel 3: 'Hvad betyder det?'

Eksempel 3 kommer fra den sidste del af supervisionsforløbet. Eksempel 3 viser, at supervisionen sætter fokus på følelsesmæssige aspekter som en barriere, der kan gøre det svært at få spurgt ind til, hvad andre mener med det, de siger. Eksemplet udspringer af en snak om den hårde tone i afdelingen, hvor deltageren Sara lige har sagt, at hun synes det kan være svært at forstå kommentarer fra andre i personalegruppen. En anden deltager, Vera, siger, at hun føler sig godt rustet i forhold til at afkode, hvad der siges og fortsætter med et eksempel på den til tider hårde tone i afdelingen (1-13). Vera siger:

Eksempel 3

- 1 Vera: men jeg kunne forestille mig at *man* kommer sådan .hh øh (0.3)
2. ja som (0.3) *vi* har snakket om så mange gange en[gang] imellem
3. Sara: [mm]
4. Vera: [som] som (0.3) hov øhm (0.2) hvordan er det så li:ge (0.2)
5. Sara: [mm]
6. Vera: ment det her det her ikk (0.2) altså
7. Pause: (3.4)
8. Vera: Nå men *du* kommer og går jo også som det passer *dig* (0.3)
9. eller sådan (0.2) ikk=
10. Sara: Mm
11. Vera: eller sådan en bemærkning ikk
12. Karen: °ja° (0.2)
13. Vera: Øh (0.4) ja det gør *jeg* jo men:øh [he he]
14. Karen: [og hva]d betyder det
- NV: Flere griner i baggrunden
15. Vera: og hvad betyder det (0.2)
16. Karen: altså [hvad bety]der den egentlig
17. Vera [hvad ligger der i det]
18. Pause: (0.2)
19. Vera: Hvad ligger der i det
20. Pause: (0.7)
21. Karen: Om *du* nu var utilfreds=
22. Vera: Ja
23. Karen: med noget
24. Sara: Mm
25. Karen: °eller også° (0.3)
26. Louise: [ja]
27. Karen: gør *jeg* det godt nok [eller] (0.3)

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28. Sara: [ja]
29. Sara: [hm]
30. Vera: [ja]
31. Pause: (0.3)
32. Karen: Ø::h (0.3) og og det er jo (0.7) det er jo belastende
33. (0.7) °og gå og tænke over hele tiden<°
34. Vera: °ja°
35. Pause: (0.7)
35. Karen: °Hvad er meningen egentlig°
36. Pause: 1.2)
37. Karen: °det er jo ikk andet end at få tjekket af (0.6) hvad
38. mener du med det°

Problemdefinition og dokumentation

Problemet, som Vera beskriver i eksempel 3, er at man ikke altid forstår (2), hvad ens kolleger siger. Man kan modtage nogle kommentarer fra andre, som ikke er umiddelbart lette at afkode betydningen af (4). Denne situation udfoldes levende af Vera, som starter i generelle termer med at sige, at hun godt kan forestille sig, at "man" kan "sådan" komme i en situation, hvor det kan være svært at forstå, hvad der menes (1). Som hun udtrykker det: "hov øhm (0.2) hvordan er det så lige ment" (3). Denne formulering kan indikerer, at man måske er 'i god tro', men så kommer i tvivl om betydningen af det, kollegaen siger. Ved at sige "man" distancerer Vera sig personligt fra det hun taler om, hvilket kan gøre det lettere for hende at sige noget om eventuelle følelsesmæssige perspektiver. I dokumentationen for problemstillingen illustrerer Vera en tilsyneladende hypotetisk dialog givetvis for at illustrere, hvordan man kan komme i tvivl om, hvad den anden mener. Her bruger hun direkte tale og siger "jeg" og "du" (8, 9, 13). Det er således også interessant af bemærke, hvordan Vera skifter 'footing' ligesom supervisorerne i eksempel 1 og 2 fra problemdefinitionen til dokumentationen af problemet. Her tænker jeg på skiftet fra at bruge et upersonligt pronomen i problemdefinitionen (1, 4), mens der bruges personlige pronomener i dokumentationen (8, 9, 13).

Veras kommentar (1-13) kan også ses som en reformulering, 'et upshot', af det Sara tidligere har sagt, hvor hun 'pakker' Saras kommentar ud gennem den fiktive dialog. Hermed anerkender hun for det første det, Sara har oplevet, og for det andet almengør hun situationen ved at bruge ordet "man" (1) - præcis som vi har set i de tidligere eksempler i artiklen. Altså beskriver Vera en situation, som alle i personalegruppen kan have oplevet.

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En hypotetisk fremtidig situation

Vera og Karen bekræfter hinandens spørgsmål gennem gentagelser af dem (14-16). Herefter 'pakker' Karen Veras spørgsmål ud (21-38) og fortsætter med at uddybe, hvordan man kunne besvare kollegaens kommentar (8, 9) gennem en række spørgsmål. Karens eksempel kan således illustrere, hvad man kunne sige i en hypotetisk fremtidig situation således være med at forberede gruppe medlemmerne på, hvordan de kunne formulere sig i lignende interaktion. Karen skifter 'footing' to gange (21, 27), hvor hun, som vi har set før, skifter mellem et personligt konkret plan, hvor hun bruger direkte tale og siger "du" og "jeg" (21, 27) og et mere generelt plan, hvor hun siger "det er jo belastende" (32).

Udtrykket "det er jo belastende" plus gentagelsen af den generelle vending "det er jo" inden denne vurdering kan ses som en tydelig indikation på, at det er de svære følelsesmæssige aspekter, som der ønskes fokus på, og at Karen anerkender, at det naturligvis kan være "belastende" at være udsat for kommentarer, man ikke forstår meningen af. Det afdæmpede toneleje disse udsagn er fremsat i kan også være med til at understrege det belastende i at være udsat for den slags kommentarer på jobbet. Brugen af "jo" både her, men også til slut (37), virker empatisk og kan henvise, som i de tidligere eksempler, til deltagernes erfaringer med lignende situationer. Endeligt er "jo" med til at normalisere denne følelse og gøre det helt naturligt og forståeligt for alle, at man selvfølgelig må efterspørge betydningen af andres udsagn, når man bliver usikker på, hvad de mener.

Sekvensen afrundes med at Karen stiller et åbent spørgsmål "hvad er meningen egentlig" (35), som i den givne sammenhæng kan opfattes på flere planer, både meget konkret: 'hvad betyder det som den anden siger' og spørgsmålet kan også ses som en mere overordnet kommentar til temaet om den hårde tone i afdelingen. Som sådan er det underforstået, at det kun er helt rimeligt, at reagere på og stille spørgsmål til den slags kommentarer.

Opsamling på eksempel 3

Opsamlende illustrerer eksempel 3, hvordan supervisionsgruppens deltagere gentager dele af det 'sprogspil' vi så supervisorerne praktisere i det første eksempel, hvor et tema udbygges og nuanceres gennem hypotetiske spørgsmål i forlængelse af en

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reformulering. I dette tilfælde er temaet, hvordan man kan håndtere følelsesmæssigt udfordrende og måske uforståelige kommentarer fra ens kolleger. Således kan eksemplet vise, hvordan 'det supervisoriske sprogspil' kan være med til at ruste deltagerne i supervisionsgruppen til at takle interaktioner og relationer i den daglige praksis – og potentielt forbedre disse gennem en tydeligere feed-back.

Tredje del: Diskussion

Formålet med artiklens tredje del er at diskutere, hvordan interaktionelle analyser kan bidrage til udforskningen af refleksionsprocesser i praksis. I mange institutionelle sammenhænge opererer de professionelle ud fra normative teoretiske modeller for, hvordan de skal handle i bestemte situationer. Det gælder også for sundhedsprofessionel supervision. Disse modeller kan studerende og færdiguddannede fx læse om i lærebøger, eller de bliver måske introduceret i professionel træning og supervision. Peräkylä & Vehviläinen (2003) kalder dem for "*stocks of interactional knowledge*" (SIK) og argumenterer for en frugtbar dialog mellem konversationsanalyse (CA) og SIK, da de beskriver praksis henholdsvis induktivt og mere eller mindre deduktivt afhængigt af den konkrete praksis, der er tale om. Peräkyläs & Vehviläinens argumenterer for, at en frugtbar dialog mellem SIK og konversationsanalytiske tilgange kan være med til at bygge bro over den berømte 'teori/praksis kløft'.

Inspireret af Peräkyläs & Vehviläinens tanker ser jeg, at interaktionelle analyser af den supervisoriske praksis være med til at eksplicitere den og, hvordan refleksionsprocesser 'gøres' i supervision. Interaktionelle analyser kan give en mere nuanceret billede af, hvordan supervisorerne rent faktisk handler frem for forskrifter om, hvordan de 'burde' handle ifølge præ-definerede teorier og anvisninger, eller antagelser om, hvad der sker i supervisionsrummet. Dermed er der skabt grobund for en kvalificering og faglig udvikling af den supervisoriske praksis. Denne artikel har fx beskrevet 'det supervisoriske sprogspil' og hvilken betydning det får for, hvordan følelser kommunikerer i supervision. Analyserne demonstrerer, hvordan supervisorerne får sat fokus på netop det følelsesmæssige tema på bekostning af andre mulige tematikker, som også kunne være diskuteret. I det lys kan man hævde, at supervisorerne gør brug af deres magt til at definere, hvad der skal tales om og hvornår gennem deres reformuleringer.

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Seks uger efter supervisionsforløbet var slut optog jeg fire af de ugentlige tværfaglige konferencer i afdelingen. Det var interessant at bemærke hvordan 'det supervisoriske sprogspil' fortsatte på disse konferencer^{xiii}. Mødeledernes reformuleringerne var, som supervisorernes, omdrejningspunktet for *at* følelser blev italesat og *hvordan* de blev italesat. Analyserne af disse konferencer peger således på, at reformuleringer og emotionelt arbejde blev institutionaliseret – altså en naturlig del af praksis efter supervision. Dette kan man læse mere om i to andre artikler, jeg har skrevet (Nordentoft b og c). Disse fund er med til at nuancere og problematisere antagelsen om at supervision 'blot er en følelsesmæssig ventil'!

Konklusion

Denne artikel har gennem induktive analyser af tre karakteristiske eksempler fra et supervisionsforløb demonstreret, hvordan refleksion over følelser kan foregå i supervision. Analyserne illustrerer, at de interaktionelle ressourcer supervisorerne gør brug af i deres reformuleringer af det følelsesmæssige tema er centrale og styrende for *at* følelser sættes på dagordenen og *hvordan*. De første to eksempler viser, hvordan supervisorernes 'sprogspil' er konstrueret, mens det ses, hvordan deltagerne i supervisionsgruppen i den sidste del af forløbet kopierer og bruger væsentlige dele af dette sprogspil i det sidste eksempel

Supervisorerne trækker på deltageres forståelser, brug af metaforer og vurderinger som ressourcer i deres reformuleringer, hvor de bevæger sig fra et konkret og personligt til et mere abstrakt og generelt perspektiv i reformuleringerne. Gennem perspektivskiftet transformeres og synliggøres deltageres potentielt underforståede følelsesmæssige udsagn samtidigt med at 'den terapeutiske position', supervisors udlægning af problematikken, underbygges. Herved introduceres endvidere en bestemt normativitet og moral omkring følelser, da det fremhæves som naturligt og normalt at mærke noget i maven og tale om følelser. Artiklen konkluderer, at supervisorerne bliver en slags rolle modeller for gruppens deltagere og at deres 'sprogspil' gennem en inddragelse af forskellige perspektiver – fra konkrete til normative og moralske – er med til at kvalificere refleksion over følelser, da det fremmer en nuanceret refleksion over den problemstilling, der tales om og dermed kan skabe rum for ikke blot faglig udvikling men også bedre relationer på arbejdspladsen.

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Noter

ⁱ Man kan læse mere om dette i min afhandling: Nordentoft 2007a.

ⁱⁱ Egede-Nissen, Weslemøy (1992): Kunnskap eller terapi? Hovedopgave i pedagogikk. Pedagogisk Forskningsinstitutt. Universitetet i Oslo. Gadgil, Inger Eikeland (1997): Sygeplejefaglig vejledning. Personlig vekst og økt faglig kompetanse - To sider av samme sak? Hovedopgave ved avdeling for sygeplejevitenenskap. Institut for Klinisk Medicin. Universitetet i Tromsø.

ⁱⁱⁱ Nikander's kapitel er under udgivelse.

^{iv} Arber's artikel er ved at blive trykt.

^v De teoretiske og metodiske udgangspunkter uddybes i næste afsnit.

^{vi} Dette bygger jeg på følgende forhold: Som læseren vil se sammenholdes mine fund i analyserne med tidligere analyser af samme fænomener i lignende institutionelle kontekster. Desuden har adskillige supervisorer bekræftet det, jeg har beskrevet som værende repræsentativt for den supervisoriske praksis.

^{vii} Video optagelserne er transkriberet hovedsageligt ifølge de konventioner Gail Jefferson har udviklet (se Atkinson and Heritage 1984)

[xx]	Firkantede paranteser markerer begyndelse og afslutning på overlappende tale i forhold til talen ovenfor eller nedenfor
He spi::ste	Coloner viser hvor meget den sidste tone er forlænget. Jo flere coloner jo mere forlængelse.
xxx	x'erne er indication på, hvor mange stavelser, der virker til at blive sagt.
<u>Understregning</u>	Understregningen indikerer, hvilken stavelse, der lægges tryk på i talen.
°hun var°	Små hævdede cirkler viser at talen er stille/afdæmpet
↑↓	Opadgående eller nedadgående pile markerer stigende eller faldende intonation.
>hun var så sød<	Når en del af et udsagn siges hurtigere end talen omkring det indikeres dette med mere eller mindre end tegn.
.hhh	Indånding
hhh.	udånding
NV	Non-verbale handlinger og andre bemærkninger
(0.4): Pause	Numrene i runde parenteser måler pausen i sekunder. I dette tilfælde er pausen 4 tiende dele af et sekund.

^{viii} Davies har forsket i reformuleringens betydning for transformationer i terapeutiske samtaler.

^{ix} Alle deltagere i projektet – både personale og patienter har skrevet under på, at de er blevet informeret mundtligt og skriftligt om projektet. Endvidere er alle navne anonymiserede. Det betyder at de navne, som forekommer i artiklen, er opdigtede navne.

^x Jeg er tidligere uddannet sygeplejerske og sundhedsprofessionel supervisor.

^{xi} Alle pronomener er skrevet med kursiv i udskrifterne for at tydeliggøre artiklens centrale pointer omkring

^{xii} Disse udsagn er blot refereret her og udeladt i deres fulde ordlyd af pladsmæssige årsager

^{xiii} Se fx Nordentoft b og c.

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In review for 'Qualitative Health research'

Changes in emotion work at interdisciplinary conferences after clinical supervision in a palliative outpatient ward

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Abstract

This article describes changes in emotion work at weekly interdisciplinary conferences in a palliativeⁱ outpatient ward after clinical supervision (CS) has concluded in the ward. Critics of CS claim that the practice is a mere 'emotional outlet'. The article explores this notion but takes a different perspective on emotions, conceiving them as constantly negotiated in interaction, and it researches the similarity between how this is done during CS and at interdisciplinary conferences after CS. In this respect, CS is seen as a particular discursive practice for emotion work. The findings show how conferences after supervision become inspired by the "language game" in CS initiating meta-perspectives on the care and treatment of patients. Here the institutionalisation and construction of moderator's reformulations in particular seem to legitimize emotion work as a business in its own right by providing space for talking about and recognising emotions and specific actions taken by staff members. Moreover, meta-perspectives and ethical considerations arising from the meeting are focused and stimulated through breaks for reflection followed by 'the round', during which all team members are heard, and the use of a flip-over chart to write down keywords in the talk. These meta-perspectives illuminate a dual aspect of care in the sense that it serves the needs not only of patients but also team members. It is argued that this recognition captures one of the great challenges in palliative care namely to separate the carer's own needs from patients. The article, therefore, concludes that CS enhances professional development and prevents stress and burnout in palliative care.

Keywords: Clinical supervision, emotion work, language game, reformulations, interdisciplinary palliative conferences.

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Introduction

As an trained clinical supervisor I have often come across critics from management and among ordinary staff members in hospitals who do not approve of CS because, as they put it, CS is nothing but an ‘emotional outlet’, where people talk about and get relief from the emotional tensions relating to their job. Institutional settings that deal with practical decisions, evidence and facts are necessarily preoccupied by notions of neutrality (Nikander, in press). With regard to emotions, Nikander argues that emotion talk and categories in meeting talk, for instance, are considered to be a deviation from professional practice. Because of this deviant status, some justification has to be found for emotion work in order for it to be accepted (Buttny, 1993). This might explain the popularity of a different context like CS, where participants are less bound to generic neutrality. Similarly, several researchers have been critical towards CS in maintaining that it is too much under the sway of psychotherapeutic methods (Gadgil, 1997; Egede-Nissen, 1992). The critique questions whether the reflections in CS are, in fact, of benefit to the patient or merely the personal development of the health staff (Lind, 2002; Yegdich, 1998; 1999). The article looks at this critique by examining how supervisees apply their understanding of CS in their daily practice after CS.

In the article I draw upon Wittgenstein (1953) and regard supervision as a “language game”. Wittgenstein looked at language as a form of action – a “form of life” and he saw context and language as being intertwined and reflexively dependant on each other. According to Goodwin & Duranti, Wittgenstein used context as a point of departure to uncover, “the multifaceted variety of thought and action made available by the different language games that human beings engage in” (Goodwin & Duranti, 1992, p. 16). Hence language does not represent reality in a straightforward way. Rather Wittgenstein drew attention to the way in which words develop their meaning through use in the language game and that language use is oriented to action in practice. To quote Wittgenstein: “Let the use of words teach you their meaning” (Wittgenstein 1953, p. 220). In this respect it is widely recognised that there are considerable differences in how medical, surgical and psychiatric staffs communicate. Different medical professions have developed different language games where the same words, for instance, may have different meanings. An example of this is the term: “section”. In midwifery it refers to the surgical delivery of a baby whereas it refers to compulsory detention in mental health care. This article draws on a previous study, where I explore the language game for emotion work in CS (Nordentoft, b; c).

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In researching how emotions are communicated in CS, I have made ethnographic observations and carried out microanalyses of talk-in-action by using the methods of discursive psychology (DP) (Edwards, 1997) and ethnomethodology (EM) (Garfinkel, 1967). This focus on discursive dimensions of emotion work have challenged the more psychological and cognitive points of view regarding emotions. In this respect the ‘emotional outlet’ metaphor is a container metaphor (Lakoff, 1994), which seems to propose that emotions can be let in or out under specific circumstances. In contrast I see emotions as social phenomena that are constantly negotiated in-talk-in-interaction and have to be studied in the specific practical contexts “of attribution, discursive action and accounting” (Nikander, in press). The question this article explores is how supervisees pursue the supervisory language game for emotion work and how they display this understanding of the game in their talk and other actions at their weekly interdisciplinary conferences after CS in the palliative outpatient ward I where collected my data. In the next paragraphs I, therefore, review the relevant literature on CS and on emotion work in palliative care settings.

LITERATURE REVIEW

Clinical Supervision

Clinical supervision (CS) has been defined and is practised from different theoretical perspectives (Teslo, 2000), which generally emphasize the interface between reflective practice and CS (Clouder & Sellars, 2004). Anderson & Swim describe supervision as:

collaborative conversation that is generative and relational, through which supervisees create their own answers and in doing so experience freedom and self-competence” (Anderson & Swim, 1995: 1)

Many of these theoretical perspectives and methods derive from various kinds of therapy (Konsmo, 1994)ⁱⁱ. However, the aim of CS is not to be therapeutic in the sense that it invites to a discussion about supervisees’ private lives but to “improve development of the supervisee’s job identity, competence, skills and ethics” (Severinsson, 1995, p. 302). The focus of the talk in CS centres around “patients and one’s therapeutic work, in preference to oneself and one’s personal issues” (Yegdic 1999. p. 1272). In this respect Pålsson et al (1994) and Severinsson (1995) stress that nurses have a great need to talk about, receiving support and reassurance after they have been through emotionally demanding situations in their practice. Importantly, the nurses the researchers interviewed explained that they could not provide relief to each

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other in the immediate situation and therefore needed a space where they could do this afterwards. This may explain why most studies report that after supervision sessions the employee who has been supervised feels better equipped to cope with the daily professional challenges and interactions both with colleagues and patients (Teslo, 2000, p. 34-36; Gadgil, 1997; Iskov, 1997; Pålsson, Hallberg, & Norberg 1994; Lindahl & Norberg 2002; Rønning 2003; Arvidsson, 2000). Nevertheless, a close interactional investigation of emotion work in actual supervisory practices and of the ways in which supervisees understand and apply possible interactional resources from CS has not – to date - been undertakenⁱⁱⁱ. Previous research into CS has been based on qualitative interviews, supervisees' accounts (Severinsson, 1995; Pålsson, Hallberg, & Norberg 1994; Arvidsson 2000) and questionnaires (Teasdale, Brocklehurst & Thom, 2001; Lindahl & Norberg, 2002; Malin, 2000; Hyrkas, Lethi & Paunonen-Ilmonen, 2001).

CS has also been described as a way of improving communication and collaboration in multi- or interdisciplinary teams^{iv} (Hyrkäs & Appelqvist-Schmidlechner, 2003; Hyrkäs, Appelqvist-Schmidlechner & Pauononen-Ilmonen, 2002; Hyrkäs & Appelqvist-Schmidlechner & Haataja, 2006; Pålsson, Hallberg, & Norberg, 1994); Pålsson et al 1994 maintain that CS can be an important strategy for improving health staffs' self perception and confidence and hereby also for gaining a greater sense of their professional role in the team. The same points are made about CS in palliative care. Feld & Heyse-Moore (2006) and Jones (2003; 2005) report positive outcomes after staff received CS. Jones argue that CS can play a role “in helping a safe, effective and balanced delivery of care and promoting psychological health and well-being in palliative care nurses” (Jones, 2003, p. 168). Alongside several other researchers (Bégat, & Severinsson, 2006; Berg, Hansson, Welander & Hallberg, 1994; Mackareth, White, Cawthorn & Lynch, 2005; Severinsson & Kamaker, 1999), Feld & Heyse-Moore (2006) emphasize the importance of a setting, where it is possible for the employees to express their feelings and reflect on practice (Lund-Jacobsen & Holmgren, 1996; Arvidsson, 2000) in order to prevent burnout.

To summarize, CS is seen as a reflective practice, where staff can discuss issues from their work. In spite of building on therapeutic theories and methods, CS is not considered to have a therapeutic function since it is focused on the professional and not private lives of supervisees. Previous research stresses the beneficial impact of CS on health care practices and has been absorbed with what happens in CS. However, until now no one has looked deeper into how the CS intervention itself is conducted

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interactionally based on analyses of naturally occurring data such as video- or audiotape recordings of CS sessions. Moreover previous research lacks an examination of the ways in which supervisees display their understanding of CS in how they communicate in their practice after CS.

Emotion work in palliative care

The sociologist Arlie Hochschild originally coined the concept of emotion work in her study of flight attendants (1983). Hochschild demonstrated that flight attendants' work not only could be described not only in terms of the physical aspects of their job. She argued that the energy expended in the managing of emotion must also be considered and called this "emotion work". Many studies have been inspired by Hochschild's terminology and findings from 1983. In this respect health care environments, whether in the area of care assistants (Treweek, 1996), elderly care (MacRae, 1998), nursing (Henderson, 2001) and midwifery (Hunter, 2004) have been some of the prime sights for research on emotion work. MacRae (1998) talks about "caregiving as emotion work" because as she puts it "Caregiving involves much more than simply playing a role; it involves negotiating relationships" (p. 155). Alongside other studies in the field, then, her research shows how emotion work can be both self- and other-directed in the sense that it encompasses both the managing of the carer's own emotions and those of their clients'. Furthermore emotion work can be a benefit and a challenge for health care staff. On the one hand it can be a relief for them to talk about and show their emotions; on the other hand it can be a challenge if – as Hochschild suggests – they have to adapt to certain conventions for emotion display.

There is also a body of research on emotion work within the contexts of oncology and palliative medicine. Katz & Geneway (2002) and Thomas, Morris & Harman (2002) have explored emotion work in cancer contexts by both formal and non-formal caregivers. Frogatt (1995, 1998) has written about hospice nurses and their management of emotions. One of her major findings is that the strategies used by these nurses can be identified through their use of metaphors in talk. Inspired by Frogatt's work, Goodman (2001) discusses whether the use of metaphor can offer insights into nurses' experiences of their work and, like Frogatt, she concludes that nurses conduct emotion work in and through metaphorical language.

James (1992) has studied hospice nurses. She pursues a gender perspective and discusses the meaning of care from a historical and cultural perspective. James refers,

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for instance, to care having a dual nature, seeing it as comprising both “caring for” and “caring about” as elements of the activity and identity of women in a way that differentiates them from men and initiates emotion work. Zimmerman & Applegate (1991) have examined comforting strategies in responding to other team members who appeared to be emotionally distressed in hospice teams. They evaluate this strategy very positively. Staff members reported the comforting communication to be a significant predictor of team members’ satisfaction with team communication, and – interestingly enough – of task effectiveness.

There are very few interactional studies of palliative care settings that are based on natural data and apply EM and CA in their analyses. In my work, I am therefore indebted to Li & Arber (2006), who have studied ways in which palliative nurses apply interactional resources when they conduct emotion work collectively in talk showing how by means of this they seem to try to maintain a delicate emotional balance between each other. Li & Arber (2006) state that emotion work in palliative settings functions

to manage social interaction and to achieve interactional goals such as presenting oneself as a competent and caring individual (Li & Arber, 2006, p. 27).

Li & Arber show how emotion talk can help construct social cohesion, reciprocity and identity in the relationship between patients and nurses and they conclude that the construction of a shared and intimate relationship with each other and with patients is crucial to the identity of the hospice or palliative care nurse.

Given that my theoretical approach in the study of emotion work is inductive. I operate with a very open definition in my analyses. I see emotion work as talk about emotions. In the first place this can be team members’ talk about their own previous or current emotional state and/or talk about the emotional states of patients and/or their relatives. Secondly, emotion work can also be the expression of emotions, emotion displays, which are team members’ non-verbal indications of being emotionally moved, indicated by their tone of voice, laughter, crying, and so forth. Thirdly, I also characterize the interactive work leading up to or following emotion talk or display as emotion work. This interactive work can, for instance, be performed through the telling of stories, the use of metaphors or the construction of reformulations. In my study of emotion work I draw on interactional research on emotions in institutional settings and aim to look at the way in which mental states are realized in interaction.

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Nordentoft (a) presents analyses of how an interdisciplinary team carries out emotion work at a weekly conference in a palliative outpatient ward without supervision. The article uses the activity of story-telling as a point of departure to reach an understanding of how and why talk becomes emotional. The analyses support the findings of Li and Arber (2006) in showing how the collaborative and rhetorical construction of the category “troubled patients” initiates emotion talk. Moreover interactional features such as atrocity stories, second stories, the use of metaphors and extreme-case formulations seem to warrant emotion talk and to call for certain future actions. Interestingly, the moderator specifically suggests the need for another forum similar to CS, in which the team can have “other than technical discussions” with respect to the situation of the terminal patient who is been under discussion. I conclude that he seems to be referring to “emotional talk” here. Furthermore his suggestion appears to embody the notion of CS as a forum for “emotion talk” and to support Nikander’s (in press) and Arber’s (in press) findings on how the institutional ideal of neutrality is articulated in institutional interaction. The present study draws on my previous study (Nordentoft b; c) of ways in which emotion work is conducted in CS. This study incorporates and supplements research on reformulations, which has mainly been conducted in therapeutic settings similar to CS (Buttny, 1996; Davies, 1986).

Reformulations

According to Davies (1986) the primary function of reformulations is to exhibit understanding and formulations include activities such as explaining, summarising, furnishing “the gist” and “upshot”, which make explicit presuppositions that have been “left implicit in previous talk” (Gafaranga & Britten 2004, p. 153). Like Davies (1986) I use the term “re-formulations” for formulations for since they imply a selection and thus a transformation of the original material that is reformulated. Following Buttny (1996) it can be said that “the therapist (here the supervisor) uses her professional skills by reformulating client’s problems in a way that is suitable for further work in therapy” (Buttny, 1996, p. 126). Thus, reformulations can with advantage be viewed in light of their meta-communicative function “through which participants comment on the nature of the discourse in which they are engaged”. (Drew, 1998, p. 32).

Reformulations are an integral part of institutional interaction (Gafaranga & Britten, 2004), where they are primarily carried out by professionals. In spite of this asymmetry the process of reformulation is a co-construction between supervisor and

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supervisee. According to Davies (1986) it involves three stages: the definition of the problem, the documentation of the problem and finally the pursuit of consent from the client – in this case – the supervisees. Moreover Davies found that the therapist would continue to reformulate her version of the problem until the clients accepted it.

With regard to the supervision sessions my previous study (Nordentoft b; c) shows how the supervisor makes emotional topics relevant in the reformulations she makes from the accounts of supervisees, and how she rhetorically moves into and legitimizes her professional version, i.e. “the therapist’s version” (Buttny, 1996). These reformulations invite supervisees to do emotion work and also advocate emotion work as being natural and therefore morally irreproachable. Supervisees’ responses to these reformulations indicated whether they were ready to do emotion work.

To conclude emotion work has become an umbrella term for a field of research that has become broad and differentiated research both theoretically and methodologically (Wingard & Willhenganz, 2006) since Hochschild’s (1983) introduced the concept. This article builds on the findings of Li and Arber (2006) in relation to emotion in work in palliative care. They describe how emotion talk can be seen as an interactional resource, which helps construct identities and maintain intimate relationships between hospice nurses and their patients. Additionally I (Nordentoft, a) show how interactional features such as storytelling, metaphors and extreme case formulations initiate emotion work and seem to call for and legitimize specific actions with respect to the care and treatment of patients. Finally Nordentoft (b; c) have revealed how the construction of reformulations appears to be a significant feature of the supervisory language game that comes into play in emotion work.

METHOD

The data comes from ten months of collecting data in a Danish palliative ward through ethnographic observations, video recordings and participant observation of clinical supervisory sessions (21 hours), interdisciplinary staff conferences (20 hours). These 20 hours consist of video recordings of four hours before CS was instigated, 14 hours at during CS and lastly four interdisciplinary conferences six weeks after supervision was over. To increase the impact of the supervisory language game in the ward CS was introduced in two ways: firstly, through a supervision group, which met ten times for two hours each fortnight, and secondly, through supervision of the conference 14 times during the period in which the supervision

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group had meetings.

Video replaces the bias of the researcher with the bias of the machine and it is essentially passive but constant. Unlike participant observation with field notes which highlight some events more than others the video machine takes it all in from the angle in which it has been set up. So there are, of course, limitations to using video. The method is –like other methods – an expression of a particular angle on reality. The videotape can be said to be a transformation of the reality, and in any transformation certain information is always lost. It is less rich and ‘objective’. Therefore Peräkylä (1997) suggests that the researcher needs to pay attention to the inclusiveness of this kind of data. There are three important aspects they do not capture and these I have attempted to account for: extended temporal processes, ambulatory events and the impact of texts and other “non-conversational” modalities of interaction. Studies based on conversation analysis are focused on the sequential organisation of interaction. However, social worlds are also organised in terms of longer temporal processes as it is illustrated very nicely in two famous studies in a similar setting to mine. Here I am thinking of studies of dying patients’ trajectories in a hospital setting by Glaser and Strauss (1968) and by Sudnow (1967). I have therefore used a longitudinal design and made both audio and video recordings during the ten months I spent in the palliative ward. Each event in a hospital setting demands a variety of data-collecting methods if everything that goes on is to be captured. In this case my ethnographic observations of daily routines contextualised the recordings I made of specific activities. Still, the audio and video recordings have given me the opportunity to go back and forth across my data to trace re-concurrent patterns in the analyses.

Process of analysis

The data were transcribed according to conventions devised by Atkinson & Heritage (1984). In the analyses I made systematic and rigorous comparisons of recordings of interdisciplinary conferences after supervision with recordings before CS was instigated. Initially I practised what is referred to as “unmotivated looking” (Psathas, 1995) in exploring and coding when and how interaction became emotional. I also drew upon directions for doing interaction analysis laid down by Pommerantz and Fehr (1997, p. 71-74) as well as by Sandlund (2004) and by Drew & Heritage (1992). They suggest that a sequence should first be selected and the actions in the sequence characterised. Second interactants’ packaging of actions should be considered including ways in which their selection of words initiates certain interpretations of the

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actions performed and of ways in which topics are talked about. The options the speaker's specific packaging offers the recipient should then be studied. Finally, timing and taking of turns should be looked at to see how they provide for certain options and interpretations and how a specific turn has been obtained by the current speaker. Does the previous speaker select the next speaker or has the speaker selected himself to speak – and why? Later in the analytic process my approach became increasingly abductive (Alvesson & Skjöldberg, 1994). I studied literature and research on CS and emotion work, compared and applied previous findings in my analyses and tested interpretations with rival hypotheses during this process.

Ethical considerations

Writing about emotions and moreover doing so through the use of video inherently calls for some ethical considerations since participants are easily recognizable. I did not, therefore, record the first three weeks of fieldwork. Moreover I stressed that the video recordings were for research purposes only. The Danish data supervision board has given its consent to the project, and all participants, patients and team members, along with places have been rendered anonymous. Furthermore all participants signed a written consent in which they were also informed that they could refuse to participate and withdraw from the study at any time without consequences of any kind. Despite this, achieving informed consent in an inductive field study is a negotiable matter (Li & Arber, 2006)^v. Given the nature of the study it ought not to be possible to predict what is going to be the main topic or outcome of the research. In the study I therefore had several feedback meetings with the team, during which they also watched and discussed with me some of the videos I had recorded. Moreover I supplemented the written information orally by telling patients about my project in more detail when I got closer to some patients and team members than others and experienced the inherent role conflict there is in doing long-term fieldwork (Cannon, 1989; Dickson-Swift, James, Kippen & Liamputtong, 2006). I was faced with an additional problem in palliative research. Patients die – and then there is no way to renegotiate their informed consent. Unfortunately, there are no fixed answers to these challenges in research. Therefore to quote Lawton:

A particular responsibility is thus placed on a researcher to use the data collected during such a study in a very careful and selective manner. Ultimately, it is his or her discretion and integrity that are at stake (Lawton 2001: 703)

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FINDINGS

In next paragraphs, I start by explicating significant features of the supervisory language game for emotion work in order to illustrate the similarity between emotion work in and after CS. This is for instance exemplified, for instance, in analyses of how supervisors reformulated and created a focus on emotional topics in CS in ways that resembled those that moderators used at conferences after CS. I, then, describe the palliative setting and the interdisciplinary conferences before and after supervision was instigated. In this respect, I specifically elaborate on four major changes at the conferences that were clearly inspired by the supervisory language game: The reflective break, the round, the use of flip-over charts and the construction of supervisors' reformulations.

The organization of clinical supervision

Although a variety of themes were brought up throughout the ten supervision sessions and the fourteen supervisions of conferences, there were some basic organisational features of the sessions, which, interestingly enough, were transferred and applied at conferences after supervision and made the conferences more focused on emotion work in palliative care.

Firstly, supervisors constantly clarified the context of the talk in the supervision of the interdisciplinary conferences and in the supervision sessions. The first time the supervision group met a contract was made, where the purpose and limitations of the group's work were written down together with ethical considerations. Moreover, the main themes for the next session were outlined before the closing of each session. Similarly at the conferences, the supervisor started the supervision of the conferences by negotiating with the team the purpose of the conferences and their expectations of her role at the conferences. A fundamental structure of both activities was 'the round', which meant that the thoughts, ideas or comments of supervisees were heard one by one. The intention of these rounds was to stimulate democratic dialogues. During the round supervisors were active listeners and from time to time they reformulated supervisees utterances. In fact my analyses indicate that reformulations seemed to be the basic feature of the supervisory language game in which supervisors explicitly showed that they heard and recognised what supervisees said and how they felt. In the next paragraph I demonstrate in detail how these reformulations are constructed and illuminate emotional aspects of the talk. Supervisors also used a blackboard to write down and sometimes organize key words in supervisees' talk. Finally supervisors occasionally introduced breaks for reflection after the initial presentation of the

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patients and problems brought forward during which supervisees were invited to reflect on what they had heard for a few minutes in silence. After the break there was a round during which the reflections of supervisees were heard.

Emotion work in clinical supervision

Excerpt 1 below is characteristic of how the supervisors demonstrated their professional expertise in creating a focus on potentially difficult emotional aspects in what the supervisees said. In the excerpt the supervisor, Karen, refers to and reformulates three utterances by three supervisees, Louise, Vera and Julie, from the previous two supervision sessions (3, 5, 7). Moreover she also mentions the other supervisor, Grete (1) in the talk. In my analysis I wish to demonstrate how Karen – just like Davies (1986) proposes - reformulates and transforms the problem in the supervisees' talk into her professional version of what the problem really is and documents this version with reference to statements from supervisees. In this process I show how Karen shifts from personal to more general perspectives in the talk, which is called “footing” by Goffman (1981). She also elaborates on metaphors introduced by the supervisees. In the analysis I see metaphorical expressions as interactional resources available for discursive deployment. I follow discursive psychology in exploring what people are doing when they are using emotion words (Edwards 1997), which involves investigating how and when supervisors work up specific metaphors and what the interactional impact of their actions and expressions might be for emotion work in CS.

Excerpt 1^{vi}

Danish

1. Karen: Øe:h (0.7) altså det er jo vigtigt at kigge på (0.6)
2. altså Grete og jeg har i hvert i fald ikke en intention
3. om at klæde nogen af eller hæng nogen til tørre eller
4. udstille nogen
5. Pause: (1.8)
6. Karen: e:hm men som du også siger Julie jeg kan mærke det
7. nede i maven (0.7) ja okay [og det var]
8. (): [det er Julie]
9. Karen: Nej undskyld
10. Sofie: Det gør ikke noget
- com: Karen forveksler navnene på Sofie og Julie. Louise griner
11. Sofie: Du kiggede på mig så jeg tænkte at det var nok mig
12. Karen: Ja ()
- com: Louise griner fortsat.
13. Karen: det var fordi du sagde det så tydeligt
14. ikke du sagde det også Vera ja jamen jeg kan mærke det
15. men jeg ved ikke om jeg får det sagt rigtigt og og når
16. man mærker noget i sin mave så er det jo (0.4) nogen
17. gange vældigt svært at undertrykke det fordi (0.2) det er
18. så (0.7) emotionelt altså det fylder jo i os
19. Pause: (1.5)
20. Karen: og og det der med tilladeligheden af at det er jo okay
21. (0.2) altså sådan ser min verden i hvert fald ud (0.4) at

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22. det er okay (0.2) at (0.4) *man* her kan få lov at mærke
23. noget (0.4)
24. Pause: (1.5)
25. (): Mm
- English
1. Karen: Er, (0.7) well it is is important to look at that (0.6)
2. it is Grete and I haven't the slightest intention
3. of undressing any one or hang anybody out to dry or to
4. expose anybody
5. Pause: (1.8)
6. Karen: e:rm but like you put it Julie I can feel it
7. in my stomach (0.7) yes okay [and it was]
8. (): [it is Julie]
9. Karen: No sorry
10. Sofie: That's okay
Com: Karen switches the names of Sofie and Julie. Louise is
laughing.
11. Sofie: You were looking at me so I thought it was probably me
12. Karen: Yes ()
Com: Louise is still laughing
13. Karen: it was because you said it so clearly
14. you see, it was you said it too Vera yes bu but I can
feel it
15. but I don't know if I am saying it right and and when
16. one feels something in one's stomach then it is indeed
(0.4)
17. sometimes very difficult to suppress it because (0.2) it
is
18. so (0.7) emotional (naturally) it fills us up
19. Pause: (1.5)
20. Karen: and and this thing about the acceptance that it
(naturally) is
21. okay (0.2) that is this is the way my world is anyhow
(0.4)
22. that it is okay (0.2) that (0.4) here one is allowed to
feel
23. something (0.4)
24. Pause: (1.5)
25. (): Mm

The undress-metaphor

At the beginning of the excerpt Karen refers to the supervisee, Louise's, comment just before the break (3). Louise said that somebody might be afraid of feeling "undressed", when the group is discussing interpersonal relationships and emotions in the group. Karen states that it is neither her intention nor the other supervisor Grete's intention to "undress anybody" (3). Moreover she elaborates on and unpacks this metaphor and uses two other metaphors for feeling/being exposed socially such as "hanging out" – to dry or to "expose anybody" (3). The elaboration and repetition of the meaning of the metaphor "to undress" demonstrate that she had heard and recognizes supervisees statements. It also seems to emphasize Karen's intention rhetorically and calls for some sort of acceptance from the listeners. However, Karen does not get any response from the group. Instead there is a pause (5).

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Transformation of the problem?

Since nobody takes the floor Karen continues to explain her point by referring to and reformulating Vera's and Julie's utterances (7, 14). Unfortunately she switches the names of Julie and one of the other supervisees, Sofie, in the beginning of her reformulation (8-11). Moreover, Karen's presentations are latently implicit in Vera's and Julie's talk. Her reformulation is a transformation of what they have, in fact, already said. For example, Julie talked about how there was not always a "favourable climate for growth" on the ward because, as she expresses herself: "I can easily think of situations where one of us has initiated a talk and the others have looked very impatient". Karen transforms "one of us" to "I" – that is Julie – in her reformulation. She also concludes that Julie can "feel it" and seemingly illustrates her insecurity by constructing Julie's and also Vera's inner dialogue in this situation (15).

The stomach metaphor

The definition of the problem in Karen's reformulation is that "when one feels something in one's stomach" it can be difficult to suppress because it "is so emotional" (16-18). This definition seems clearly to derive from the evidence that Karen has produced in the documentation (15, 16) and can thus be characterised as an "upshot". Here we also note how the metaphor to "feel something in one's stomach" (16) appears to signify that one is emotionally moved. With her statement Karen seems to include herself not only as a human being but also a professional who knows something about emotions and how they potentially affect people. Finally, it is noticeable that the outlet metaphor is used to verbalise the supervisees' emotions. The outlet metaphor can be seen when Karen expresses how emotions "take up space" (18) inside you. The rhetorical effect of this metaphor seems to be that the speakers Karen refers to - here the supervisees – have to let their emotions out. And the only way to let emotions out is to express them – verbally or non-verbally! Thus it can be said that Karen's use of the outlet metaphor seems to call for some kind of emotional response from the supervisees.

Supervisor's "footing"

The shift Karen makes from documenting to defining the problem brings about a shift in her use of pronouns. First she uses "I" and "you" in line 2, 6 and 13. Then she uses the impersonal pronoun "one" in line 16 and 22. This shift of perspective from being personal to being more distanced and general is called "footing" (Goffman, 1981). It seems to create a distance from the emotional topic, making it less risky for the recipients to respond. Here "one" appears to be indexical for it to be normal and

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natural – and therefore morally irreproachable – to sense what one is feeling, especially seen in the light of the documentation Karen has just produced.

The moral dimension

Karen finishes her reformulation by emphasising and normalising the moral dimension of the problem once more. Apparently, she imitates one of the supervisee's internal dialogues which can be seen in her use of the personal pronoun “my” (21), when she says

and and this thing about the acceptance that it (naturally) is okay (0.2) that is this is the way my world is anyhow (0.4) that it is okay (0.2) that (0.4) one here is allowed to feel something (20-23).

To sum up, excerpt 1 shows how potentially implicit emotional issues are made explicit in the supervisors' reformulations. The supervisor, Karen, uses her professional expertise to create a “therapeutic focus” (Buttny, 1996), in this case a supervisory focus, on potentially emotional aspects of topics that supervisees have introduced in previous talk.

Emotion work at interdisciplinary conferences before and after clinical supervision

The Palliative Setting

CS was instigated in a palliative outpatient ward. Researchers in palliative settings emphasize the emotional nature of the work in palliative care since it encompasses dealing with life and with death, with patients and with relatives on a daily basis within a limited amount of time, all factors which put emotional and professional pressure on the staff (Li & Arber, 2006; Payne, Seymor, & Ingleton, 2004; Vachon, 1986; 1987). There is one certainty: that life will end. “This single fact aside, uncertainty is the basis of the end-of-life experience” (Davison 2005: 208). Davison (2005) describes the palliative environment as “an uncertain dynamic environment with a certain conclusion” and, he continues, “prior to arriving at that certain conclusion it is the uncertainty that directs all attempts to provide care” (ibid, p. 208).

Within palliative care the ambition of interdisciplinary teamwork is to develop quality of care for patients by fulfilling most of their needs in the terminal stage of their life (Li, 2004). The palliative care setting has, therefore, been one of the prime sites for developing holistic care to give patients a “good death” through the input of

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professional knowledge from different disciplines (James, 1992; McNamara, Waddell & Colvin 1995). Death and the dying process within a palliative setting are conceptualised as a series of social events that includes both patients and their human relations - their friends, their relatives and the professionals. A death is defined as “good” if “there is an awareness, acceptance and preparation for death by all those concerned” (McNamara et al 1995, p. 222). Hence McNamara et al have found that one of the main stressors for palliative teams is to be found in threats to the goal of achieving a good death. The holistic ambition calls for an intense collaboration between the various professionals involved and several researchers (Payne et al, 2004; Vachoon 1986; 1987) have found that this cooperation is often not without tensions, which makes it even more important to explore and improve emotion work in this specific setting. In the palliative outpatient ward the interdisciplinary team consisted of thirteen employees: three physicians, five nurses, one secretary, psychologist, physiotherapist, dietician and social worker.

The interdisciplinary conference before clinical supervision

Once a week the team held a conference where they discussed how they could provide optimal care for terminally ill patients and their families. A variety of themes was brought up for discussion ranging from practicalities to more complex issues. The team accounted for and evaluated their actions and each member appeared to display his or her professional reputation in this collaborative setting just as Arber (in press) has described in her study. Finally the conferences were also used as a forum in which the team talked about patients, sharing experiences with each other and telling many stories about them. My observations show that the team did not only talk about patients before they pass away. Often they also discussed how relatives were coping after patients had died. My observations of the conferences before CS showed, however, that what were discussed were mostly medical and more factual issues that were discussed. The psychologist and one of the nurses took turns moderating conferences. The role of the moderator at these conferences was distinctively different before CS, when he or she mainly orchestrated who was to talk and when and formulated the final conclusions. They seldom reformulated topics that were brought up for discussion. Moreover nothing was written down during the conference to fix topics and team members’ comments, as was the case at conferences after CS. Finally, I observed that team members sat in the same places at most conferences. Team members who spoke less, such as the physiotherapist, the social worker, the dietician and some of the nurses, sat on the left side of the table, whereas team members, who

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were more active in the discussion such as the head nurse, physician and the psychologist sat next to each other at the right side of the table.

Changes in emotion work at conferences after supervision

When I entered the ward in May six weeks after CS had concluded the team profile and internal dynamics of the team were affected because the psychologist had resigned. His resignation also implied that somebody else had to moderate the conferences. The physiotherapist and social worker – some of the quietest team members at conferences before CS - volunteered to take turns moderating the conferences and they were apparently using supervisors as role models. In fact, the physiotherapist commented after supervision was over that she felt she had acquired “a new language” and was more confident with her role in the team than before CS. Below I briefly account for the structural changes of the conferences in a generalised table of events at conferences before and after CS. The table below shows that the conferences were more structured than before supervision. As mentioned, supervisors’ stressed and practised context clarification throughout the ten sessions by asking questions like: What are we doing? Why are we doing it, when and where? The Team had apparently been inspired by this procedure and practised various ways of doing context clarification before, during and after the conference. Before the conference patients were listed on the intranet so the team were prepared for the agenda for the conference. A flip-over was bought and it helped summarize what had been done, how and who had done it. Finally, discussions were concluded by deciding who should do what and if the patient should be on the agenda after two weeks. After two weeks the flip over was revisited and team members’ actions evaluated. This procedure was refined during the four conferences I observed in May. For instance the team used a different colour each time the patient was discussed to distinguish between discussions.

Differences between interdisciplinary conferences before and after clinical supervision

Conferences before CS	Conferences after CS
Patients who were candidates for the conference were written on a sheet of paper, which was hanging on the notice board in the conference room. Often these candidates were not listed until the day before the conference or even until the day of the conference. This procedure meant that team	Patients who were candidates for the conference were listed on the hospital intranet earlier than they had been before CS. These changes meant that everybody could be informed about conference patients in advance and prepare their comments. Moreover the secretary had time to locate the

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<p>members who were only working part-time in the palliative ward had to visit the ward on these days to get information about conference patients.</p> <p>The psychologist and one of the nurses took turns moderating conferences. Mostly the psychologist moderated the conferences.</p> <p>Team members sat at the same seats each time. The head physician and nurse plus the moderator on one side and team members who were not employed full-time in the ward plus most of the nurses on the other side of the table.</p> <p>The moderator orchestrated who talked and when. For instance he/she said: “Now it is Vera’s turn to talk, then Julie and finally I have put myself on the list”. There were few reformulations. If there were any they were embedded in a story about the patient.</p> <p>Nothing was written down during conferences. Usually the team agreed that either the physician or the nurse would dictate something for the journal depending on the nature of the discussion.</p> <p>The purpose of bringing patients up for discussion was often unclear. The team member would often say that the purpose was to “orientate” the rest of the team about the patient. The reason for the orientation was not explained.</p> <p>Team members told a wide variety of stories about patients and their relatives.</p> <p>There was not a break for reflection at conferences before CS</p> <p>Several team members – especially team members who were employed part-time (the physiotherapist, social worker, dietician) - seldom spoke unless they were involved with the</p>	<p>relevant papers/journals for the conference.</p> <p>The physiotherapist and social worker took turns moderating conferences.</p> <p>Team members did not have fixed seats but moved around sitting at different seats each time except for the moderator who sat at the end of the table – just like the supervisor did when she moderated conferences.</p> <p>The moderator’s role was more distinct than before CS. She not only orchestrated who talked and when, she also often reformulated topics and combined these reformulations with reflexive questions on the care and treatment of the patients.</p> <p>A flip-over was bought, where team members’ points and questions were written down by one of the team members who were not involved in the care of the patient being discussed.</p> <p>The purpose of bringing the patient up was written down on the flip-over. The preliminary discussion about the patient’s present situation, covering both treatment and social and psychological issues were also written in key words on the flip-over.</p> <p>Team members told stories that were linked to the key words on the flip-over</p> <p>After the preliminary discussion the moderator invited the team to reflect on these issues in a “reflection break” for a few minutes. She asked very openly everybody to consider “What do I think/feel about what I have just heard”.</p> <p>After the break for reflection the moderator took ‘a round’ where the ideas and thoughts of <u>all</u> team members were heard – including team members, who were not involved in</p>
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<p>patient who was brought up.</p> <p>There were seldom emotional evaluations or mutual recognition of each other's thoughts and actions.</p> <p>Many ideas for solutions of problems were presented. However, there was little summary or detailing of these ideas in terms of any discussion of work involved or of their potential effects. Questions such as: Who will act? When, why and how? were often not specified or addressed.</p> <p>Unless there were new developments in the patient's situation it was not brought up again.</p>	<p>caring for the patient.</p> <p>The round also occasioned emotional evaluations and mutual recognition of each other's thoughts and actions.</p> <p>Summations were written on the flip-over throughout the conference. Before closing the discussion there was a written record of who would do what and when.</p> <p>After a fortnight the same patient was brought up again, the notes on the flip-over were revisited and the patient's situation and the team's actions were evaluated. Finally current problems and questions were assessed.</p>
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In the rest of the article I wish to illuminate four features of the supervisory language game and show how they affected emotion work at conferences after CS. These are moderators' construction of reformulations, the round, breaks for reflection and the flip-over. Before the analyses I briefly introduce these features and how they were incorporated at the conferences.

Breaks for reflection, the round and flip-over

At conferences after CS the moderator initiated a break for reflection after the initial discussion and presentation of the conference patient – problems, possible needs and questions. These issues were written down - i.e. reformulated – in key words on a flip-over by a team member who was not involved in the care and treatment of the patient. The moderator then asked the team to look at the flip-over and reflect with an open mind on what they had heard up until then. After the reflection break the moderator took a round where one by one she asked for the thoughts and ideas of all the team members.

Because the flip-over and the round exposed the opinions of all the team members it also brought in outsider perspectives of team members who often did not speak at conferences before CS either because they were not involved in the care or treatment of the specific patient or because they did not feel comfortable in speaking up at conferences. The latter group used the keywords on the flip-over as a starting point for

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their talk after the reflection break. Thus the flip-over provided a way of fixing topics, and this appeared to make it easier for everybody to contribute with their thoughts and ideas. Moreover the reflection break seemed to stimulate team members' emotional comments, evaluations and recognitions of their own and each other's actions. For instance, the physiotherapist evaluated her own action like this after a reflection break: "I am glad I brought this patient up", and her colleagues responded "Good job, well spotted", "Yes, that was really good of you". These changes support previous research findings by indicating that CS potentially helps developing and supporting team-building in palliative care (Hyrkäs & Appelqvist-Schmidlechner, 2003; Pålsson et al, 1994). Nevertheless, as I will show in the next two excerpts, team members were also capable of challenging each other's emotions after the moderator's reformulations with regard to the care and treatment of patients.

Reformulations after clinical supervision

Before supervision moderators seldom reformulated emotional topics in the way it this was done after supervision, when both moderators reformulated what they had heard team members say from time to time. Moreover, emotional topics were often illuminated in these reformulations. I consider this change to be significant since my analyses of the conferences before supervision indicate that most emotion work was done in the telling of stories (Nordentoft, a). The point I wish to demonstrate about reformulations at conferences after CS is that this format appears to function as a kind of instant fixing (Heritage & Watson, 1979) and illumination of potential implicit and explicit emotional topics in the talk which team members can accept or reject Thus the two different formats, story-telling and reformulations can be characterised as different approaches to emotion work – a subjective versus a more collective approach. Story-telling does not invite to a collective and democratic negotiation of topics in the same way as reformulations do in conjunction with the round, where everybody is heard. Lastly, when the moderator reformulates, she also demonstrates active listening and shows that she recognizes what has been said. This strategy encouraged more team members to talk at conferences after supervision.

The second excerpt below displays how the physiotherapist, Sara and Louise, the social worker and also the moderator of the conference in question, reformulate why they have decided to bring up a terminal patient, Martin, up for discussion at the conference. A few days ago they have had a talk about Martin because they considered his behaviour to be a problem. In their reformulation they explain why, and we see how they both reformulate in a similar way to supervisors. With this excerpt I

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also wish to demonstrate how a request for elaboration of Louise's emotional reformulation initiates team members' emotional accounts of their opinions and actions. Emotion talk here seems to be used for rhetorical purposes to validate team members' utterances and actions. Moreover, the third excerpt from the round after the reflection break shows how outsiders' opinions are heard and how they question the premises behind team members' opinions and actions. Finally I want to draw attention to the format used by team members in their talk when they comment on Louise's and Sara's initial reformulations of the situation. Both in excerpt 2 and 3 they pose questions and do not present possible answers to the problem. This format appears to stimulate the dialogue about and the reflections on emotions at the conference.

The second excerpt starts here at the point where Sara has just told the group about her observations of Martin when he does exercises in the pool. Sara finds it to be a difficult situation because there is another patient doing exercises with Martin and because it seems like "things are somewhat exaggerated". She continues:

Excerpt 2

1. Sara: og jeg opfatter det som om at (0.2) ø:h at Martin (0.3) nok er
2. i i krise og er bange (0.5) men samtidig har han sådan lidt
3. (0.5) glat (0.2) overflade øeh (0.3) når man prøver sådan at
4. komme ind og bassinet er for mig heller ik det optimale sted og
5. begynde og tale for meget i dybden når der også er en anden
6. patient til stede så så det er sådan (0.6) ligesom en
7. balanceakt øh fornemmer jeg
com: Sara
8. Louise: .hh nå [men det vi det nej det] vi jo talte om det var at:øh
9. Sara: [nå men det fyldte nok bare]
10. Louise Martin havde en adfærd der der gør at han ligesom suger
11. opmærksomhed til sig gør og sådan (0.4) fylder (0.1) øh meget
12. øeh (0.1) i rummet og .hh (0.9)øe:h (0.8) det problematiske
13. (0.3) der (0.3) også kunne være (0.5) ø:eh i den adfærd det
14. var sådan (0.2) noget af det vi var (0.7) lidt inde på
15. Pause: (1.6)
16. Louise: Ja Ea
17. Ea: men jeg jeg tænker bare på (0.1) når du siger problematisk
18. (0.1) er det for os eller for Martin selv
19. Pause: (1.5)
20. Ea: altså hvem er det det
21. er et problem for °at han har den måde der°
22. Pause: (2.3)
23. Louise: (Ja)
24. Pause: (1.3)

English

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1. Sara: and I see it as if that (0.2) e:h Martin (0.3) probably is in
2. in a crisis and is afraid (0.5) but at the same time he has a
3. bit of a (0.5) smooth (0.2) surface er (0.3) when one tries
4. to get closer and for me the pool is not the best place
5. to start to go into too much depth when there is also another
6. patient present so so it is so sort of (0.6) like walking a
7. tightrope er I feel
com: Sara is now telling about an informal conversation the team members had a couple of days ago when Martin's contact nurse, Eva, had her day off. Then Louise takes the floor and continues to elaborate on this conversation
8. Louise: .hh [well what we that but what] we talked about that it was
9. Sara: [well but that probably took up space]
10. Louise: Martin had a way of behaving that means that he sort of
11. attracts attention towards himself and so on (0.4) takes up
12. (0.1) (a lot) eh (0.1) of space and .hh (0.9) e:h (0.8) the
13. problem (0.3) there (0.3) might be (0.5) e:h in this
behaviour
14. that was sort of (0.2) something about what we (0.7) touched
15. upon
16. Pause: (1.6)
17. Louise: Yes Ea
18. Ea: but I I am only thinking (0.1) that when you say it is a
19. problem (0.1) is it for us or for Martin himself
20. Pause: (1.5)
21. Ea: that who is it it a problem for that °he has that
behaviour°
22. Pause: (2.3)
23. Louise: Yes
24. Pause: (1.3)

The physiotherapist's reformulation

In line 1 the physiotherapist, Sara, invited by Louise, begins to reformulate how she sees the problem with Martin. She uses several metaphors in her description (3, 5, 7). She says that Martin “is afraid” (2) but still has a “smooth surface” (3). Hereby she seems to indicate that Martin may need to talk more “in depth” (5) about his emotions since he seems to be “afraid” and “in crisis” (2). She documents the problem using her own observations (1) and she accounts for not acting by explaining that she has tried to talk to him but that the pool is not the ideal place to discuss these matters since she also had another patient to take care of (4-6). She shifts footing several times as we have seen supervisors do. She uses personal pronouns when she documents and accounts for the problem (1, 4, 7) – except once where she uses “one”(3). The use of the impersonal pronoun may illustrate what an emotional and vulnerable business it is “walking the tightrope”(7), Sara calls it, to get beneath Martin's “smooth surface”(3).

The moderator's reformulation

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The moderator, Louise, continues and elaborates on Sara's reformulation by assessing the problem "that he attracts attention towards himself" (10, 11) and that they have been discussing the problems associated with this behaviour (13-15). This excerpt shows Louise documenting the problem in her reformulation using what Sara has just been saying (8-14). Louise twice uses "we", (8, 14), and her reformulation can be seen as an upshot since she makes explicit what could be implicit in Sara's statement about Martin. Thus she is transforming Sara's description of Martin's "smooth surface" (3) to a form of "problematic behaviour" (13). Hereby she implies that it is problematic if patients do not want to talk about their emotions. Finally, Louise shifts footing, just as we have seen supervisors do, between her documentation and the definition of the problem in her reformulation.

Request for elaboration

The head nurse, Ea, seems to challenge Louise's reformulation by requesting a clarification of "who is his behaviour is a problem for" (18, 19, 21). Ea is not involved in Martin's care, and so we can see she is capable of using her outsider position to ask reflexive questions that introduce a new meta-perspective on the discussion. By repeating the question (21) after a long pause (20) during which nobody takes the floor, and moreover by asking "who is it a problem for" and not "what is the problem" she seems to emphasize firstly the importance of the problem and secondly to draw attention to the fact that a problem is always a problem to "somebody". A problem does not exist in a vacuum. Lastly Ea lists the potential viewpoints on the matter – the team's and Martin's. Hence it can be argued that Ea's question captures the nature of emotion work in the specific situation in that she seems to be questioning the way in which the team is focusing on its own 'problem' instead of Martin's. In the following sequences we see how each of the team members tries to answer Ea's question give emotional accounts of why they think Martin's behaviour is a problem for Martin. Moreover, these accounts seem to reveal the implicit ideals of good palliative care and to legitimize the actions and opinions of the team members. For instance, the physician, Lars, explains that Martin's behaviour "might be a problem for Martin, because he might find that somebody might distance themselves from him". Lars also says that Martin makes things unpleasant for himself because this behaviour means that it is difficult to get close to him. Hence Lars seems, then, to be implying that "getting close" to patients is considered to be desirable in palliative care. This gives his emotional argument is given its rhetorical effect since he sets up a scenario which collides with good professional palliative practice in which the closeness between staff and patients are seen as one of the criteria (Li & Arber 2006; Frogatt 1995). Moreover

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Martin's distance potentially obstructs the palliative goal of bringing about a death that is "good" for him and his relatives (McNamara et al 1995)

The break for reflection and the round

After the initial discussion of Martin's situation Louise initiates a break for reflection. For a few minutes nobody talks and in the round after the pause each of the team members is asked to present their thoughts and reflections with respect to Martin. Excerpt 3 below presents the reflections of the dietician, Emma's, reflections. Just like Ea, Emma has not been involved in caring for Martin and in this excerpt she also challenges the other team members' actions and opinions. Emma begins by referring to two main points, which had been written down on the flip-over chart in the preliminary discussion about Martin. Firstly, what is the problem? (2) And secondly, are we afraid that we have overlooked some of his needs? (3). Evidently she is elaborating on the question posed by head nurse, Ea, who is it a problem for? (Excerpt 2; 17, 18) Hence Emma's comments shows how the flip-over together with the round assisted the team in keeping focused in their discussions and not – as it often happened at conferences before supervision – having their focused distracted by taking in many additional ideas and perspectives.

Excerpt 3

Danish

1. Emma: Ja jeg havde hæftet mig ved to af pindene derovre øh (0.2)
2. det første det er (0.2) hva er problemet lidt som Louise og
3. Ea også (0.2) jamen er vi bange for at vi har overset
4. nogen af deres behov altså har de givet udtryk for noget som
5. vi ikk kan opfylde eller (0.8) venter vi at der ska komme
6. noget rullende lige pludselig som der lige skal (0.4) tages
7. hånd om eller ser vi (0.4) ville vi gerne se nogle flere
8. reaktioner fra dem (1.5) og det kan godt være sådanlever
de 9. måske (0.2) og ss og sådan skal det bare være
10. Eva: Mm
11. Pause: (0.8)
12. Emma: øh det er deres (0.8) mønster det er °deres (0.3) øh (0.4)
13 livsstil om man vil°
14. Pause: (1.2)
15. Emma: og at (xx) tror vi ikk at de nok skal give udtryk hvis der
16. pludselig opstår et behov for hjælp og assistance °og alt
17. muligt°
18. Pause: (2.0)

English

1. Emma: I noticed two of the points noted over there eh (0.2)
2. the first it is (0.2) what is the problem a bit like Louise
3. and Ea too (0.2) but are we afraid that we have overlooked
4. some of their needs that is have they been giving
5. expression to something that we cannot fulfil or (0.8) are

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6. we expecting that something will come rolling in suddenly
7. which has to be(0.4) dealt with of or do we see that we
8. would like to see some reactions from them (1.5) and it can
9. very well be that they live like that perhaps (0.2)and ss
10. that's just the way it has to be
11. Eva: Mm
12. Pause: (0.8)
13. Emma: Eh it is their (0.8) pattern it is °their (0.3) eh (0.4)
14. lifestyle if you like°
15. Pause: (1.2)
16. Emma: and that (xx) don't we think that they will let us know
if
17. there suddenly is a need for help and assistance °and
18. that sort of thing°
19. Pause: (2.0)

With her initial questions (1-5) Emma introduces the emotional dimension as a dimension, which affects professional decision-making and action. Furthermore she expands on the premise for this question by describing and unpacking the insecurity her colleagues may experience (5, 6). Emma finishes by saying that perhaps some people do not display as many reactions/emotions as one could wish for and that's that (8-13). From her statement it can be deduced that their demand for openness from Martin's may as well be - in fact most likely a reflection of their (i.e. team members') professional need. Finally, she questions whether team members do not trust patients to call for help/assistance when they need it (16-18). At the end of this conference having discussed Martin's situation in detail, the team manages to open for up for the perception that Martin's lack of openness seems to be at odds with their professional need. Most accounts of Martin and his life seem to indicate that Martin is living the life he wants to live and that he is fully aware of his serious condition!

To summarize excerpt 2 displays how the fixing of topics in the reformulations means that they can be challenged and elaborated on word by word. The elaboration and explanation of "problematic behaviour" in this excerpt resulted in emotion work and clarification of whose need it primarily was to get Martin to be more open and talkative about his situation. Both excerpts reveal how team members refer to previous statements, unpack them and hereby show that they have paid attention to what has been said. In addition team members' comments before the reflective pause as well as in the round after the pause provided new perspectives on the care and treatment of patients. These perspectives initiated professional, moral and ethical discussions on how qualified care could be characterised in the specific context. Whose needs should be taken care of and how this could be done? These comments can therefore be said to question the premises on which problems of care and treatment are based and in doing so qualify reflections generated at conferences (Opie, 1997).

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CONCLUSION

Several researchers have been critical towards CS and questioned whether CS benefits staff or patients (Lind, 2002; Yegdich, 1998; 1999). Some critics of CS even claim that it is nothing more than an “emotional outlet”. In conclusion, however, I argue that such a description of CS would appear to be a simplistic description. I take a different perspective on emotions and see them as constantly articulated and negotiated in interaction. They are not, like the outlet metaphor proposes, something that can be controlled and/contained in the sense that they can be let out under specific circumstances. In this article I have therefore explored the similarity between the way in which emotion work is conducted in CS and at interdisciplinary conferences after CS. The article illuminates how the supervisory language game is capable of enhancing a democratic dialogue while at the same time uncovering potentially vulnerable emotional issues involved in the care of dying patients at interdisciplinary conferences after CS. Hence I claim that the supervisory language game may improve team reflexivity and ethical considerations in that team members collectively question their practices by introducing a meta-perspective on the process of the teams’ work which seems to affect attitudes to and decisions about the caring and treatment of patients.

The article demonstrates how the interdisciplinary team in a palliative outpatient ward understands the language game needed for emotion work in CS and how they display this understanding in-interaction at conferences after supervision. There were many changes at conferences after supervision and this article illuminates four features in particular from the supervisory language game and shows how they affect emotion work at conferences after CS. The four features are moderators’ construction of reformulations, ‘the round’, the reflective pause and the flip-over. Apparently using supervisors as role models, moderators documents problems in team members’ talk by focusing on potentially emotional and metaphorical elements after which these are reformulated into a more general assessment of the real problem by injecting normative as well as moral aspects into the talk. The reformulations seem to fix topics in a way which means that they can be accepted, rejected or challenged. The analyses show how negotiations about new and different reformulations involve emotion work in which team members – including the moderator appear to account for and legitimize their opinions and actions. By reformulating and explicitly putting emotional subjects on the agenda the moderator upgrades these topics as “businesses in their own right” (Li & Arber, 2006, p. 27). After CS reformulations seemed to be

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institutionalised. Prior to it these topics were mainly negotiated in the telling of stories (Nordentoft, a). There were few reformulations summarising what was up for discussion at conferences.

In the reformulation process the flip over is an important tool allowing keywords to be written down and it appeared to guide the discussion. Together with ‘the round’, when team members get a change to speak, the flip-over registers the opinions of all team members. That means that it also brings in outsider perspectives of team members who often did not speak at conferences before CS either because they were not involved in the care or treatment of the specific patient or because they did not feel comfortable in speaking up at conferences. Lastly the reflective pause after the preliminary discussion about the patients seems to initiate emotion work, a feature which was evident when team members’ challenged and recognised each other’s emotions in the round after the pause.

This study has contributed with insights into what takes place not only in supervision sessions but also in supervisees’ daily practice after supervision. Previous studies have almost exclusively focused on the subjective experiences of supervisees after receiving supervision and analysed them in the light of different models and theoretical approaches to supervision from, for instance, psychotherapy, counselling or nursing (Kilminster & Jolly, 2000). Many of these studies maintain that CS provides a space for emotional relief, professional confirmation and development of medical staff (Teslo, 2000, p. 34-36; Gadgil, 1997; Iskov, 1997; Arvidsson, 2000; Hyrkäs & Appelqvist-Schmidlechner 2003; Pålsson et al 1994).

The results I have presented here support these conclusions. In my analyses I have shown that after supervision supervisees use and apply interactional resources from the supervisory language game at the interdisciplinary conferences. Consequently it is reasonable to draw the conclusion that the supervisees have learned something. However, my view of learning is different from that embraced by previous studies. From my theoretical point of reference I regard learning as observed changes in interaction and I do not discuss subjective learning processes. Within post-cognitive thinking human mentality and activity are seen as an “irreducible plurality of (language) games grounded in a variety ‘forms of life’ “ (Dror & Dascal, 2002, p. 222). Taking our lead from Wittgenstein we can characterise cognitive development – and learning – as language development and by extension also a development in the ability to discriminate between and to articulate different categories of knowledge in our

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surroundings. New knowledge and new language games thus provide opportunities to develop new concepts in a variety of categories, and enable the use of these in evaluating and adjusting actions in specific contexts (Sheppard, 1998).

One drawback seems to my findings would appear to be that moderators at conferences before and after CS were different team members. If moderators had been the same individuals my findings would have been more convincing. On the other hand the change of moderators also manifests the changes in the team dynamics, since some of the quietest team members took on the responsibility of moderating the conferences after supervision. Lastly, it would have enhanced the validity of my study if I had recorded more than four conferences on video, and moreover analysed consultations with patients before and after CS to explore possible changes in how team members communicated emotions in this activity (Whittemore, Chase & Mandle, 2001).

My analyses of the data I have collected show how the supervisory language game introduces and legitimizes a different emotional vocabulary and a different organisation of talk at conferences after supervision. In addition premises for actions and the opinions of the team are questioned and qualified by bringing in outsiders' perspectives in the talk. These meta-perspectives illuminate a dual nature of care in the sense that care is invoked by the needs not only of patients' but also of team members'. Furthermore they have increased moral thinking and ethical reflections on care and treatment and thus support previous findings of research into CS (Severinsson & Kamaker, 1999; Berggren & Severinsson, 2006). This recognition captures one of the great challenges in palliative care namely to separate the carer's own needs from those of patients in wanting to achieve the palliative ideal of a death that is "good" for patients and for their relatives (McNamara et al, 1995). The changed perspective on problems from existing practice seems also to have affected not only decisions about care and treatments of patients, when to be active and when to withdraw, but also the interpersonal dynamics and relations between team members. I argue, therefore, that CS contributes with resources to professional development and helps prevent stress and burnout in palliative care. Lastly, these findings indicate that CS benefits not only the personal and professional development of health staffs' but also the terminally ill patients and their relatives. However, more research is called for into how CS specifically benefits care and treatment of patients.

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Notes

ⁱ Palliative care is defined as: "The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychosocial and spiritual problems is paramount. The goal of palliative care is the best possible quality of life for patients and their families" (WHO 1990).

ⁱⁱ Systemic supervision is, for instance, founded on theory and methods stemming from family therapy (Boscolo, Cecchin, Hoffman & Penn 1991).

ⁱⁱⁱ In a recent editorial for a thematic issue on clinical supervision in the *Journal of Nursing Management*, Hyrkas looks back on the research of CS until now. She stresses that "the CS intervention itself has remained almost without attention" which makes all the previous studies on the efficacy of CS doubtful. She, therefore, questions claims about CS, since they seem to be – as she puts it "without basis, background or a 'soundboard'" (Hyrkas, 2006, p. 574).

^{iv} Interdisciplinary teams are teams in which the members continue to work from their particular professional orientations but undertake some joint collaborative work, whereas "Multi-disciplinary teams are defined as teams where members, operating out of their disciplinary bases, work parallel to each other, their primary objective being that of coordination" (Opie, 1997, p. 263).

^v Lawton (2001), de Raeve (1994) and Raudonis (1992) discuss the problem of informed consent in their articles about ethical challenges in palliative research.

^{vi} The transcript is presented with English glosses as I feel this is sufficient for the analyses I make in the article. The symbols used in the transcription are based mainly on the conventions developed by Gail Jefferson (see also Atkinson and Heritage 1984).

[xx]: Square brackets mark the start and end of overlapping speech, aligned with the talk above or below.

(0.4): Pause: Numbers in round brackets measure pauses in seconds: in this case four tenths of a second.

.hhh: Audible in-breath.

He sle:pt: Colons show degrees of elongation of the previous sound. The more colons the more elongation with roughly one colon per syllable length.

He was so (): Empty parentheses in the middle of a sentence indicates an insecurity about what is said.

(): Yes: Empty parenthesis before the utterance indicates an insecurity about who speaks.

xxx: The x's are indications of the number of syllables that seem to be spoken.

Underlining: Stress on the syllable that is underlined: The extent of underlining within individual words locates stress but also indicates how heavy it is.

°She did not want it°: Raised circles ('degree' signs) enclose obviously quieter speech.

Com: Non-verbal action and other comments.

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Sprogspil om følelser i sundhedsprofessionel supervision

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Evalueringen er slut efter 5 måneders supervision af det tværfaglige team i en palliativ afdeling. En af deltagerne, Sara¹, kommer hen til de to supervisorer og siger, at hun ønsker at sige dem personligt tak for hele forløbet, at det har betydet meget for hende fordi - som hun udtrykker det: 'Jeg føler, at I har givet mig et nyt sprog'. Formålet med dette kapitel er at udforske betydningen af Saras udsagn. Hvad karakteriserer dette 'nye sprog'? Lever dette sprog efter supervisionen i personalets kommunikation på de ugentlige tværfaglige konferencer. Og hvis dette er tilfældet, hvordan påvirker det så kommunikationen på konferencerne? Således udforsker dette kapitel for det første hvad der karakteriserer 'det nye sprog' Sara føler hun har fået, og for det andet undersøges om dette sprog overføres til og får betydning for personalets måde at tale om og reflektere over følelser på i deres daglige praksis, her eksemplificeret ved den ugentlige tværfaglige konference.

Kapitlet er baseret på analyser af videooptagelser fra et ph.d. - projekt om supervisors betydning for den måde sundhedspersonalet kommunikerer følelser på i deres daglige praksis. Supervisionsforløbet fandt som nævnt sted i en palliativ afdeling, hvor hele personalet, et tværfagligt team på 13 personer, deltog i de 10 gange supervisionsgruppen mødtes. På grund af gruppens størrelse var der to supervisorer, Karen og Grete. Den ene supervisor, Karen, var også ordstyrer på 14 af afdelingens ugentlige tværfaglige konferencer i samme tidsrum supervisionsgruppen mødtes for at forstørre påvirkningen af supervision. Tanken var, at hun ville bruge sin faglighed og dermed sprog som supervisor i sin måde at lede konferencerne på. Det ville betyde, at gruppens medlemmer ville blive 'udsat for' det supervisoriske sprog både i

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supervision og på deres konferencer med en øget mulighed for at spore forandringer i deres sprog efter supervision. Af pladsmæssige årsager rummer dette kapitel dog kun eksempler fra supervisionsforløbet og de ugentlige tværfaglige konferencer efter supervisionen var slut.

Resten af dette kapitel falder i tre dele. Første del er en skitsering af det teoretiske og metodiske udgangspunkt for analyserne af henholdsvis to eksempler fra supervisionsforløbet og fire eksempler fra konferencerne efter supervision. I denne del forklares det, hvad forskeren kigger efter i videooptagelserne med de sproglige briller på, hvorfor hun gør det og endelig, hvordan analyserne er bygget op. Anden del præsenterer de to eksempler fra supervisionsforløbet, som skal illustrere for det første grundelementerne i kommunikationen i supervision og for det andet, hvordan deltagerne begynder at overtage og bruge disse elementer i deres måde at reflektere på. Artiklens tredje og sidste del udforsker ændringer på konferencerne efter supervisionsforløbet er slut og hvilken betydning disse ændringer får for, hvordan personalet kommunikerer.

Første del: Det teoretiske og metodiske grundlag for analyserne

Sprogspil

I dette kapitel ansues sundhedsprofessionel supervision som en sproglig praksis, hvor deltagerne kollektivt reflekterer på en bestemt måde i en social sammenhæng. Uanset hvilken teoretisk retning den konkrete sundhedsprofessionelle supervision bekender sig til kan formålet med supervision beskrives som at ville 'skabe klarhed og forståelse for det sociale samspil, som udspiller sig imellem nogle professionelle' i en given kontekst (Schilling, 1997: 12). Nærmere bestemt kan supervision ses som en introduktion af et nyt 'sprogspil' (Wittgenstein, 1953; Schilling, 1997; Nordentoft, 2007a) c) d)ⁱⁱ). Begrebet 'sprogspil' søger at indfange sprogets grundlæggende praktiske rolle, der er orienteret mod handlinger i praksis. Sproget og virkeligheden er i konstant bevægelse, hvor sproget får betydning gennem den måde, det bruges og sammensættes på, og sprogbrug er afhængig af den kontekst vi befinder os i – dvs. hvor vi er og, hvem vi taler med (Holmgren 2002). De forskellige sundhedsfaglige professioner har fx udviklet forskellige 'sprogspil' – eller måder at formulere sig på,

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hvor det er almindeligt anerkendt at der kan være stor forskel på, hvordan medicinsk, psykiatrisk og kirurgisk sundhedspersonale kommunikerer. Dette kapitel udforsker, hvordan det 'supervisoriske sprogspil' påvirker, hvordan personalet i en afdeling kommunikerer følelser. Nye ord kan give nye vinkler på problemstillinger og dermed en anden måde at tale om dem på, hvilket kan få betydning for pleje og behandling af patienterne. Udvikling og læring i denne sammenhæng forstås således som observerede ændringer i den måde deltagerne taler om følelser på.

En følelsesmæssig ventil?

Tidligere forskning i Norden har vist, at den vejledte føler sig bedre rustet til at klare udfordringerne i den daglige praksis efter refleksionen i supervision (Teslo, 2000: 34 - 36; Gadgil, 1997, Iskov; 1997; Arvidsson, 2000ⁱⁱⁱ). Kritiske sygeplejeforskere i Norge^{iv} har dog stillet spørgsmålstegn ved, hvorvidt metoderne i supervision er for domineret af psykoterapeutiske metoder og om '... refleksionsprocessen styrker kundskab, som er orienteret mod patienten, eller om den alene bidrager til sygeplejerskens subjektive behov for vækst og udvikling?' (Lind, 2002: 9). De mener, at følelser frem for faglige begrundelser for handling har været prioriteret i supervisionen, og andre kritiske røster har endvidere kaldt supervision for en 'følelsesmæssig ventil', hvor den ansatte kan tale om og komme af med de følelsesmæssige spændinger forbundet med sit job.

Til trods for at disse betragtninger udspringer af forskning indenfor sygeplejefaglig vejledning, som sundhedsprofessionel supervision af sygeplejersker tidligere er blevet benævnt, er det forfatterens holdning, at disse udtalelser peger på at følelser generelt er blevet negligeret som en del af den institutionelle praksis og derfor også kan omfatte andre faggrupper, som også er potentielle læsere af denne bog. Forskning indenfor det sociale og sundhedsmæssige felt underbygger disse tanker og peger på at det professionelle ideal om at være rationel og neutral stadig har stor betydning for den professionelles rygte og position (Nikander^v; Arber, 2006). Konkret giver det ifølge Nikander sig fx udtryk i en kommunikationsmåde, som bærer præg af en tilsyneladende rationel argumentation, der ikke er 'forurennet' af følelsesmæssige udsagn, når der skal træffes beslutninger. Netop derfor er supervisorsrummet måske et velkomment rum, hvor følelser kan tematiseres. Brugen af ventil - metaforen om supervision understreger denne pointe. Ventilmetaforen er en kontainermetafor

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(Lakoff, 1994), som beskriver følelser som noget vi kan opbevare og lukke ud i specifikke sammenhænge.

Emotionelt arbejde

Dette kapitel bidrager med ny viden om sundhedsprofessionel supervision, da der ikke før er lavet analyser af videooptagelser af supervisionsseancer samt af, hvordan personalet kommunikerer følelser på konferencer før og efter supervision. Kommunikation af følelser kaldes også for 'emotion work' eller 'emotionelt arbejde' på dansk (Hochschild, 1983; Ravn - Olesen, 1997). 'Emotionelt arbejde' defineres mere præcist som tale om følelser, følelsesudtryk og interaktionelt arbejde, der leder frem til, eller kommer efter, tale om følelser og følelsesudtryk. Det kan fx være brugen af metaforer eller små fortællinger om patienter og pårørende. I modsætning til psykologiske og kognitive tilgange, som beskriver hvordan følelser også eksisterer uden for samtalen inde i hver enkelt person, udforsker dette ph.d. - projekt 'kun' de ydre, synlige og kollektive processer omkring følelser, dvs. hvad der konkret siges og hvilken respons det sagte får. Det betyder at analyserne beskæftiger sig med, hvornår og hvordan deltagerne giver udtryk for følelser og hvilken respons de får af de andre i gruppen (Edwards; 1997; Edwards 1999; Garfinkel, 1967; Heritage, 1984).

Observationerne af supervisionsforløbet viser fx, at supervisorernes reformuleringer var omdrejningspunktet for dialogen i gruppen og at de følelser, der rørte sig i gruppen, var et centralt tema i supervisorernes reformuleringer af det deltagerne bragte op. Det næste afsnit i dette kapitel ser derfor nærmere på, hvad reformuleringer er – og hvad deres formål kan være i interaktionen.

Reformuleringer

Når deltagerne i en supervisionsgruppe fortæller om problemstillinger fra deres praksis er supervisoren en aktiv lytter, der naturligvis forholder sig til det de siger. Det gør hun ofte ved at reformulere det, hun hører for herefter at søge en accept eller afkræftelse af hendes udlægning. Endvidere er reformuleringen et udtryk for en forandring, en transformation, fra noget oprindeligt til noget andet, hvor terapeuten gennem sin reformulering udøver sin faglige ekspertise til at eksplicite viden, relevans og til at kategorisere en given situation. En stor del af den litteratur, der findes om reformuleringer, stammer fra interaktionelle analyser af terapeutiske

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sammenhænge. Supervision er ligesom terapeutiske sammenhænge, det være sig læge konsultationer eller psykoterapi, en form for institutionel interaktion, hvor forskningen har vist, at deltagerne orienterer sig mod bestemte normer i deres opførsel (Drew & Heritage, 1992; Arminen, 2005). Således påhviler det terapeuten at udrede klientens problem og det er klientens rolle at besvare terapeutens spørgsmål.

Når reformuleringer kommenterer på og/eller forholder sig til de talte eller muligvis uudtalte antagelser, der måtte være i det, der reformuleres på, kaldes de for 'upshots' (Antaki et al, 2005). Et eksempel på et 'upshot' kunne være, hvis A fx siger: 'Når der sidder nogle og laver ansigter er der ikke noget gunstigt vækstklime på konferencen' og B reformulerer dette udsagn på denne måde: 'Så du føler det er vanskeligt at sige, hvad du mener?' Eksemplet viser, hvordan B udleder det, A muligvis siger mellem linierne, altså implikationerne af det A har sagt. A har *ikke* sagt, at hun *ikke* ved, hvad hun skal sige, det er en betydning, B udleder. Endvidere kan B's reformulering ses som et 'meta - perspektiv' på det A siger, da hun sætter A's udsagn ind i en bestemt tolkningsramme, som fremhæver de følelsesmæssige aspekter i det, A siger. Pointen er, at denne tolkningsramme er med til at sætte dagsordenen for, hvordan, der kan/skal tales om A's udsagn. Reformuleringer kan således siges at have en meta - kommunikativ funktion, hvorigennem: '...deltagerne kommenterer på karakteren af den diskurs de er optaget af' through which participants comments on the nature of the discourse in which they are engaged'. (Drew, 1998: 32).

Til trods for den asymmetriske situation, hvor forskningen har vist at supervisor og supervisorer/deltagere orienterer sig mod bestemte roller, er reformuleringsprocessen en co - konstruktion mellem ordstyrer/supervisor og deltager/supervisorer. Reformuleringerne opsummerer det som tidligere er sagt og inviterer, som det ses i eksemplet ovenfor, til en eller anden form for bekræftelse fra modtageren. Ifølge Davies^{vi} (1986) består reformuleringsprocessen af tre trin: Først defineres problemet, så dokumenteres det og til slut søger terapeuten - her supervisoren - modtagerens accept af sin reformulering. For at definere problemet må terapeuten udvælge og fokusere på en bestemt del af det, som siges. Dette aspekt af problemet reformuleres til terapeutens version af, hvad det 'virkelige problem' er. I eksemplet ovenfor ser vi, hvordan B henviser i sin dokumentation til noget, som A har sagt – nemlig, at 'de laver ansigter'. Dette udsagn underbygger hun den udvalgte problemdefinition med:

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At A har svært ved at sige noget. Hvis B ikke får modtagernes accept vil hun nu præsentere sin version ikke én men flere gange i løbet af samtalen, hvor hun ofte vil dokumentere sin fortolkning med 'beviser', som her, i form af konkrete henvisninger - fra klientens egen fortælling. Derfor kan reformuleringsbegrebet anskues som et nøglebegreb for enhver supervisor, da dialogen i supervisorsrummet kan siges at være en forhandling mellem parterne om, hvad der er relevant/irrelevant at tale om. Konkret betyder dette, at supervisor vil søge deltagernes accept på hendes reformuleringer indtil hun får den (Davies, 1986).

Anden del: Reformuleringer som 'det supervisoriske sprogspil'

Efter gennemgangen af, hvad der karakteriserer en reformulering og dens formål præsenteres nu to eksempler fra supervisorsforløbet, som viser hvordan reformuleringen konkret bruges og får betydning for hvordan, der tales om følelser i supervisionen i starten og i slutningen af forløbet. Analyserne demonstrerer, hvordan reformuleringerne kan siges at være en grundlæggende supervisorisk metode, hvorved supervisorerne viser at de har hørt og anerkender det, deltagerne siger (Nordentoft 2007 c^{vii}).

Deltagernes udsagn er udskrevet så præcist, som det er muligt – altså i tale sprog^{viii}. Disse udskrifter er foretaget ifølge nogle bestemte detaljerede konventioner^{ix}, ud fra en tese om, at mening og betydning skabes i konkrete specifikke interaktioner, hvor det ikke blot er væsentligt at se på hvad der siges, men også hvornår og hvordan det siges. Endvidere er pauserne også målt i tid, da både kortere og længere pauser siger noget om interaktionens forløb og deltagernes forhold til det, der siges. Grundantagelsen er, at al social handling og interaktion er et udtryk for organiserede mønstre, hvor deltagerne konstant tilpasser sig de lokale omstændigheder. Ved desuden at arbejde med optagede samtaler, der kan genspilles igen og igen, er tanken at vi kan undgå '... at finde det, som vi forventer at finde – og kun derved kan vi blive overrasket' (Stax, 2005: 173). Dvs. at fokuseringen på fx deltagernes indre motiver eller på, hvordan eksterne institutionelle regler kan påvirke det sagte må vige til fordel for en afdækning af den lokale systematik i samtalen. Oversat betyder det, at forskeren ser på, hvad supervisorsgruppens deltagere og supervisorer rent faktisk gør – og ikke tager afsæt i, teorier omkring, hvordan de burde handle og hvorfor

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Eksempel 1: 'Tidspilde'

Det første eksempel: 'Tidsspilde' kommer fra begyndelsen af supervisionsforløbet. Eksemplet er karakteristisk for, hvordan supervisorerne reformulerer de problematikker deltagerne bragte op gennem hele supervisionsforløbet og giver dem en følelsesmæssig dimension. Det illustrerer også, hvordan de to supervisorer støtter hinanden, når problemstillingen i reformuleringerne skal underbygges. I Eksempel 2: 'Hvad betyder det' ses det, hvordan deltagerne mod slutningen af supervisionsforløbet flere gange 'tænker højt' og formulerede refleksive spørgsmål sammen med andre i gruppen i forlængelse af en reformulering. Det konkrete eksempel viser, hvordan supervisantens sammen med supervisoren bygger videre på de spørgsmål, der stilles til det tema, som er i fokus. Endeligt kan eksemplet demonstrere, hvordan denne udbygning kan være med til at forberede deltagerne på interaktioner i den daglige praksis.

I eksempel 1 drejer samtalen sig om, hvor man kan dele de oplevelser, man har med patienterne. En af deltagerne, Maja, har sagt at man måske godt kunne holde sig tilbage med at fremlægge noget på den ugentlige tværfaglige konference på grund af blik og kropssprog fra de, som deltager i konferencen. I den forbindelse spørger supervisorerne lidt senere til den sidste supervision, hvor en anden af deltagerne, Julie, blev interviewet om en udfordrende patient, hun er kontaktperson for. Julie sagde, at det var dejligt at få lov til at tale uden at blive afbrudt, men at hun samtidig har tænkt på, om ikke det var spild af tid, da personalet kender patientens historie. I eksempel 1 kommer en anden af deltagerne, Ea, også med en respons. Eksemplet indledes med, at supervisoren reformulerer det, hun har hørt Julie og Maja sige på denne måde:

Eksempel 1

- 1 Grete: Men det er lidt det, som jeg også hører *du* si siger Maja
2. det med når *man* så (0.2) på en konference eller (0.2) til
3. fredagsmødet (0.6) måske holder noget tilbage fordi *man*
4. simpelthen er bekymret for om synes de andre nu at det
5. her nu går tiden med det eller kommer *jeg* til at spilde
6. de andres tid eller (0.7) eller:øh (0.8) ansigts (0.4)
7. udtrykkene og kropssproget (0.2) virker utålmodigt (0.3)
8. sådan lidt (0.2) trom[men] på bordet (0.3) så kan *jeg*
9. Ea: [mm]
10. Julie: [ja ja]
Com: Den anden supervisor Karen illustrerer den første
supervisors pointe med at sidde og tromme på sin stol.
11 Grete: overhovedet tillade *mig* at bruge *folks* tid og fortælle
12. *mig selv* den samme historie en gang til
13. Julie: Ja

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14. Grete: eller fortælle *jer* °den samme historie° det er jo
15. Pause: (5.1)
16. Grete: °Det er *jo* et godt spørgsmål°
17. (J): Ja
18. Pause: (1.4)

Reformulering: Problemdefinition og dokumentation

I sin re - formulering definerer supervisoren, Grete, problemet som, at '*man*' holder sig tilbage (3)^x med at sige noget, fordi '*man*' er bekymret. Man kan således se, hvordan supervisor giver definitionen af problemet en følelsesmæssig dimension, da hun taler om, at man er '*bekymret*' (4). Noget, som hverken Maja eller Julie har sagt højt. Denne følelsesmæssige dimension dokumenterer hun med Julies og Majas udsagn (Grete henviser til Majas udtalelser i linie 1, 6, 7 og i linie 5 og 6 henviser hun til noget Julie har sagt lige inden eksemplet starter). For det første kobler hun 'at være med bekymret' med 'at spilde andres tid' (5, 6), og for det andet bruger hun Majas forklaring om, at folks nonverbale udsagn godt kan afholde hende fra at sige noget (6, 7). Dvs. at Gretes reformulering kan siges at være et 'upshot', da hun udleder de mulige implikationer at det, hun har hørt Maja sige: at ansigtsudtryk og non - verbalt sprog gør, at man ikke siger noget, og at man derfor er bekymret for at spilde de andres tid.

Stedord

I skiftet fra problemdokumentation til problemdefinition i eksempel 1 sker der også et skift i Gretes brug af stedord. I dokumentationen af reformuleringen bruger hun personlige stedord så som '*du*' (1) og '*jeg*' (5, 8)^{xi}. I definitionen siger Grete, at '*man*' holder noget tilbage (2), fordi '*man*' er bekymret (3), og bruger det upersonlige stedord '*man*'. Skiftet er således et perspektivskifte fra at være personlig, som fx kan ses ved at Grete først taler direkte til en deltager i gruppen og sige '*du*' (1) til at være mere upersonlig, distanceret og generel og sige '*man*' (2, 3). Herved skabes en distance til det følelsesmæssige tema, der kan gøre det mindre risikabelt for modtagerne at komme med en respons. Endvidere virker Gretes formulering, hvor hun siger 'det der med når man' som om hun illustrerer noget vi alle sammen kender til. Udtrykket '*det der med*' kombineret med brugen af '*man*' kan derfor siges at 'normalisere' den følelse af bekymring, som Grete udtrykker i sin definition og gøre det helt naturligt, at mærke og føle efter, især set i lyset af den dokumentation: folks non - verbale udtryk, Grete lige har fremlagt. Opsamlende ses det, hvordan supervisor

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underbygger sin faglige vurdering gennem brugen af personlige stedord, tale og direkte henvisninger til noget hun har hørt supervisanten sige for herefter at uddrage relevante og naturlige forhold af denne tale.

Supervisors 'footing'

Gretes perspektivskifte fra at referere til noget Maja har sagt til at sige noget, der fremstår som en mere generel vurdering kalder Goffman for 'footing' (Goffman, 1981: 151). Begrebet 'footing' illustrerer det forhold at talere og lyttere hurtigt kan skifte positioner under samtaler (Beck-Nielsen 2003). Goffman (1981) inddeler talerrollen i tre: animator, author og principal. Animatoren er den, der fysisk taler. Author er den, der oprindeligt har ytret en holdning eller følelse og måske også har valgt sammensætningen af ordene, som de siges af animator. Endeligt er principal er den person, hvis synspunkt aktuelt udtrykkes i en given formulering (Clayman 1992: 165). I det konkrete eksempel er Maja og Julie authors mens Grete kan siges at være både animator og principal. Med disse analytiske begreber skelnes der således mellem taleren og kilden. Nok er det Grete, som taler, men det er ikke hende som holdes ansvarlig for dokumentationen af problemet, det er authors, altså Maja og Julie.

Indre dialoger og moralske perspektiver

'Footing' kan være med til at befordre en nuancering og perspektivering af problematikken ved at præsentere den ud fra forskellige synsvinkler fra et konkret til et mere abstrakt plan, der fx er illustreret i de moralske perspektiver 'at man ikke bør spille andres tid', der er indlejret i Gretes reformulering. Disse perspektiver foldes ud i Gretes følgende udsagn, hvor hun skifter 'footing' fra tredje til første person ental og siger: 'man simpelthen er bekymret for om synes de andre nu at det her nu går tiden med det eller kommer jeg til at spille de andres tid' (5) samtidig med at hun får hjælp fra Karen, der trommer på bordet og malende illustrerer Gretes pointe.

Dette skift virker empatisk og anerkendende, da det lader til at Grete identificerer sig med de to sygeplejersker. Skiftet resulterer også i respons fra Julie og Ea, hvor de overlapper hinandens tale (9, 10), hvilket er med til yderligere at understrege deres enighed og bekræftelse af Gretes udsagn. Julies respons bekræfter tilsyneladende Gretes reformulering (12), men hendes spørgsmålet får ingen yderligere respons. Grete fortsætter med tilsyneladende at imitere Majas eller Julies indre dialog. Det kan

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igen ses i hendes brug af personlige stedord så som 'jeg' (8) og 'mig' (12) i forlængelse af henvisningen til det det, de har sagt. Hun stiller yderligere to spørgsmål, med samme moralske omdrejningspunkt (11, 13). At hun forsætter med at uddybe sin reformulering kan tyde på, at hun ikke får den respons, hun ønsker fra deltagerne. Hermed illustreres Davies' (1986) pointe om, at hvis terapeuten, her supervisoren, ikke får den ønskede respons netop vil præsentere sin version ikke én men flere gange i løbet af samtalen.

Brugen af forskellige personlige stedord i eksempel 1 er med til at nuancere samtale temaets moralske perspektiver. Grete siger:

* Kommer jeg til at spille *de andres* tid (5).

* Kan jeg overhovedet tillade mig at bruge *folks* tid (11). Julie virker til at bekræfte relevansen af dette spørgsmål ved at sige 'ja' (12), men kommer ikke med yderligere respons, så Grete reformulerer spørgsmålet for tredje gang:

* Eller (tillade mig) fortælle *jer* den samme historie en gang til (13). Det sidste spørgsmål får ingen respons og efterfølges af en pause.

Det tredje spørgsmål er formuleret meget direkte og inddrager konkret de, som er til stede i rummet, hvor de to andre spørgsmål er formuleret mere upersonligt og herved kommer til at introducere en mere generel og normativ problematik. Ingen af spørgsmålene får videre respons i form af svar eller kommentarer og supervisor vælger at lukke sekvensen med en evaluerende kommentar, som deltagerne i gruppen nu kan gå hjem og fundere over (15)! En lang pause afslutter denne sekvens. Tavsheden brydes af en refleksiv dialog mellem de to supervisorer, hvor de introducerer andre meta-perspektiver på temaet 'spild af tid'. Den ene supervisor siger fx, at hun ser snakken om spild af tid og hvornår noget er stort eller småt nok til at blive talt om som et udtryk for en lineær og målbar opfattelse af, hvordan man bør udnytte tiden – hvad der er rigtigt og forkert.

Opsamling på eksempel 1

I forhold til eksempel 1 kan man opsamlende sige, at supervisoren, Grete, giver definitionen af problemet en følelsesmæssig dimension, da hun taler om, at man er '*bekymret*' (4). Grete, dokumenterer denne problemstilling i reformuleringerne ved at henvise til, udvælge og tolke på elementer i

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deltagernes udsagn, hvorefter hun reformulerer disse til mere generelle betragtninger om, hvornår noget er 'spild af tid'. Med dette perspektivskifte transformerer og synliggør Grete deres potentielt underforståede følelsesmæssige udsagn samtidig med at der introduceres moralske meta-perspektiver på, hvad man kan tale om på konferencerne gennem Gretes imitering af Majas og Julies indre dialoger. Et meta-perspektiv er jo netop defineret ved tale om talen, som i denne sammenhæng er, hvad man kan tale om på konferencerne.

Eksempel 2: 'Hvad betyder det?'

Eksempel 2 kommer fra den sidste del af supervisionsforløbet. Eksempel 2 viser, at supervisionen sætter fokus på de svære følelsesmæssige aspekter, som en barriere, der kan gøre det svært at få spurgt ind til, hvad andre mener med det, de siger. Eksemplet udspringer af en snak om den hårde tone i afdelingen og begynder lige efter at, Sara^{xii}, en af deltagerne, har fortalt, at hun af og til synes det kan være svært at forstå kommentarer fra andre i personalegruppen. En anden deltager, Vera, siger, at hun føler sig godt rustet i forhold til at afkode, hvad de andre i personalegruppen siger og fortsætter med et eksempel på den til tider hårde tone i afdelingen (1-13).

Eksempel 2

- 1 Vera: men jeg kunne forestille mig at *man* kommer sådan .hh øh (0.3)
2. ja som (0.3) vi har snakket om så mange gange en[gang] imellem
3. Sara: [mm]
4. Vera: [som] som (0.3) hov øhm (0.2) hvordan er det så li:ge (0.2)
5. Sara: [mm]
6. Vera: ment det her det her ikk (0.2) altså
7. Pause: (3.4)
8. Vera: Nå men *du* kommer og går jo også som det passer *dig* (0.3)
9. eller sådan (0.2) ikk=
10. Sara: Mm
11. Vera: eller [så]dan en [be]mærkning ikk
12. Karen: °ja° (0.2)
13. Vera: øh (0.4) ja det gør *jeg* jo men:øh [he he]
14. Karen: [og hva]d betyder det
com: Flere griner i baggrunden
15. Vera: og hvad betyder det (0.2)
16. Karen: altså [hvad bety]der den egentlig
17. [hvad ligger der i det]
18. Pause: (0.2)
19. Vera: Hvad ligger der i det

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20. Pause: (0.7)
21. Karen: Om *du* nu var utilfreds=
22. Vera: Ja
23. Karen: med noget
24. Sara: Mm
25. Karen: °eller også° (0.3)
26. Louise: ja
27. Karen: gør *jeg* det godt nok [eller] (0.3)
28. Sara: [ja]
29. Sara: [hm]
30. Vera: [ja]
31. Pause: (0.3)
32. Karen: Ø::h (0.3) og og det er jo (0.7) det *er jo* belastende
33. (0.7) °og gå og tænke over hele tiden°
34. Vera: °ja°
35. Pause: (0.7)
35. Karen: °Hvad er meningen egentlig°
36. Pause: (1.2)
37. Karen: °det er jo ikk andet end at få tjekket af (0.6) hvad
38. mener *du* med det°

Supervisantens 'footing'

Problemet, som Vera beskriver det i eksempel 2 er, at man kan modtage nogle kommentarer fra kollegerne, som ikke er umiddelbart lette at afkode betydningen af. Det betyder, at '*man*' ikke forstår, hvad der bliver sagt. Ydermere kan den manglende forståelse skabe tvivl om den andens hensigt. Situationen beskrives levende af Vera, da hun i generelle termer starter med at sige, at hun godt kan forestille sig, at '*man*' kan komme '*sådan*' (1) i en situation, hvor det kan være svært at forstå, hvad der menes (1). Denne formulering kan indikere, at man måske er åben og positiv, men så kan komme i tvivl om betydningen af udsagnet: '*hvordan er det så lige ment*' (3). Hermed anerkender hun det, Sara har oplevet, og normaliserer situationen ved at bruge ordet '*man*'. Det, Sara har oplevet, kan alle i personalegruppen have oplevet! Faktisk kan man se Veras kommentar som en reformulering, 'en upshot', af det, som Sara tidligere har sagt, hvor hun 'pakker' Saras kommentar ud ved at eksemplificere den med et konkret spørgsmål, en lille indre dialog, man stiller sig selv i forbindelse med kommentar, som en af kollegerne kunne finde på at komme med (4, 6 og 8, 9).

I dokumentationen for problemstillingen imiterer Vera en tilsyneladende hypotetisk dialog givetvis for at illustrere, hvordan man kan komme i tvivl om, hvad den anden mener. Her bruger hun direkte tale og siger '*jeg*' og '*du*' (8, 9, 13). Brugen af '*man*' kan her tjene et dobbelt formål. Dels distancerer Vera sig personligt fra det hun taler om, hvilket kan gøre det lettere for hende at sige noget om eventuelle følelsesmæssige perspektiver dels giver '*man*' – som tidligere nævnt - det hun siger en '*normativ*'

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karakter kan dermed retfærdiggøre hendes udsagn. Endvidere er det interessant at bemærke, hvordan Vera skifter 'footing' ligesom supervisorerne i eksempel 1 fra problemdefinitionen (1, 3), til dokumentationen af problemet (8, 9, 13). Her tænkes på skiftet fra at bruge et upersonligt stedord i problemdefinitionen, mens der bruges personlige stedord i dokumentationen.

En hypotetisk fremtidig situation

Vera og Karen hinandens spørgsmål gennem gentagelser af dem (14-16). Karen 'pakker' Veras spørgsmål ud (21, 38), da hun fortsætter med at uddybe, hvordan man kunne besvare kollegaens kommentar (8, 9) gennem en række spørgsmål. Karens eksempel kan således illustrere, hvad man kunne sige i en hypotetisk fremtidig situation og således være med at forberede gruppe medlemmerne på, hvordan de kan begå sig i lignende interaktion. Karen skifter 'footing' to gange, hvor hun, som vi har set før, skifter mellem et personligt konkret plan, hvor hun bruger direkte tale og siger 'du' og 'jeg' (21, 27) og et mere generelt plan, hvor hun siger 'det er jo belastende' (32).

Udtrykket 'det er jo belastende' plus gentagelsen af den generelle vending 'det er jo' inden denne vurdering kan ses som en tydelig indikation på, dels at det er de svære følelsesmæssige aspekter, som der ønskes fokus på, dels at Karen anerkender, at det kan være 'belastende' at være udsat for kommentarer, man ikke forstår meningen af. Det afdæmpede toneleje disse udsagn er fremsat i kan også være med til at understrege det belastende i at være udsat for den slags kommentarer på jobbet. Brugen af 'jo' både her, men også til slut (37), er endvidere med til at normalisere, som tidligere, denne følelse og gøre det helt naturligt og forståeligt for alle, at man selvfølgelig må efterspørge betydningen af andres udsagn, når man bliver usikker på, hvad de mener.

Sekvensen afrundes med at Karen stiller et åbent spørgsmål 'hvad er meningen', som i den givne sammenhæng kan opfattes på flere planer, både meget konkret: 'hvad betyder det som den anden siger' og spørgsmålet kan også ses som en mere overordnet kommentar til temaet om den hårde tone i afdelingen. Som sådan er det underforstået, at det kun er helt rimeligt, at reagere på og stille spørgsmål til den slags kommentarer.

Opsamling på eksempel 2

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Eksempel 2 illustrerer, hvordan deltagerne gentager dele af det 'sprogspil' vi så supervisorerne praktisere i det første eksempel, hvor et tema udbygges og nuanceres gennem nye reflektive spørgsmål i forlængelse af en reformulering. Det er central pointe, at denne udbygning kan være med til at forberede deltagerne på interaktioner i den daglige praksis gennem at øve sprogspillet på hypotetiske fremtidige situationer i den daglige praksis. Eksempel 2 markerer således overgangen på dette kapitels første og anden del, som ser på, hvordan personalet i den palliative afdeling kommunikerer på de ugentlige tværfaglige konferencer efter supervision.

Tredje del: Ændringer på konferencerne efter supervision

Artiklens tredje del udforsker, hvordan personalet, som også er supervisionsgruppens medlemmer, kommunikerer på konferencerne efter supervision. For at indkredse det 'nye sprog', som Sara taler om, beskrives først den ugentlige konference og dens formål efterfulgt af to idealbilleder: et af konferencen før supervision og et af konferencen efter supervision. Idealbillederne er baseret på forskerens observationer og analyser. Herefter udvælges og uddybes tre markante ændringer, som får betydning for den måde, hvorpå personalet taler om følelser på konferencerne efter supervision.

Formålet med den tværfaglige konference

Formålet med den ugentlige tværfaglige konference er at diskutere, hvordan det tværfaglige palliative team kan yde en optimal og holistisk pleje og behandling af de patienter, som bringes op på konferencen. Dette formål betyder, at forskellige temaer lige fra praktiske problemstillinger til mere komplekse vendes på konferencen. Videoptagelser af konferencerne peger på, at der især er to tilbagevendende temaer, som kommer op. For det første ønsket om at give patienterne en god død. Personalet taler fx om, hvornår det er tid at trække sig tilbage, respektere patienterne og de pårørendes valg og ikke aktivt tilbyde mere assistance. Observationerne viser endvidere, at teamet ikke blot bekymrer sig om de forhold, som gør sig gældende inden patienterne dør. En del diskussioner drejer sig også om, hvordan en patients ægtefælle og børn klarer situationen efter patienten er død. For det andet bruges konferencerne også til at teamets medlemmer redegør for deres handlinger i deres kontakt med patienterne. Disse 'orienteringer', som de kaldes, tjener flere formål. De er med til at synliggøre og legitimere den enkeltes handlinger ligesom det også er muligt at få feedback på om der evt. er noget som kunne gøres bedre eller anderledes i

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det enkelte tilfælde. Endelig bruges de også som en anledning til at dele oplevelser med resten af teamet, de kan ses som en slags 'emotionel debriefing', som fysioterapeuten kalder det på en af konferencerne efter supervision.

Observationer af forskelle på konferencer før og efter supervision

Konferencen før supervision	Konferencen efter supervision
<p>Konferencepatienter blev skrevet på en lap papir, der hang på opslagstavlen i konference rummet.</p>	<p>Konferencepatienter blev skrevet ind på sygehusets intranet. Denne ændring betød, at alle var klar over konferencen indhold og havde mulighed for at forberede eventuelle indlæg. Desuden kunne sekretæren også sørge for at journalerne var klar i god tid.</p>
<p>Personalet satte sig det samme sted hver gang. Ledelsen plus ordstyreren på den ene side af bordet og de, der ikke var ansat fuld tid i afdelingen på den anden side af bordet og for bordenden</p>	<p>Personalet havde ikke faste pladser, men rokerede og sad forskelligt ved hver konference på nær ordstyreren, der sad for bordenden.</p>
<p>Ordstyrerrollen gik på skift mellem psykologen og en sygeplejerske. Dog var det mest psykologen, som var ordstyrer.</p>	<p>Ordstyrerrollen gik på skift mellem fysioterapeuten og socialrådgiveren.</p>
<p>Ordstyreren afgjorde, hvem der talte. Fx sagde han/hun: Nu er det så Vera, bagefter er det Julie og så har jeg sat mig selv på. Der var meget få reformuleringer. Hvis der var nogen, var de oftest indlejret i en historie om patienten.</p>	<p>Ordstyrerens rolle var tydelig. Hun kom ofte med opsamlende reformuleringer kombineret med refleksive spørgsmål til pleje og behandling.</p>
<p>Formålet med at bringe en patient op var ofte utydeligt. Ofte blev der sagt, at det var for at 'orientere' om patienten. Hvorfor, blev ikke præciseret.</p>	<p>Efter en indledende diskussion af patientens situation, hvor både behandlingsmæssige, sociale og psykiske forhold blev afdækket og formålet med at bringe patienten op blev skrevet ned i stikordsform på flip overen, inviterede ordstyreren til en 'refleksiv pause' på små 5 minutter efter supervision. Pausen kaldes en refleksiv pause, da ordstyreren inden pausen bad deltagerne om at reflektere over det de havde hørt.</p>
<p>Der var flere – især de halvtidsansatte -, som næsten aldrig sagde noget, med mindre de også havde kontakt med den patient, man talte om – bl.a. fysioterapeuten, socialrådgiveren og diætisten.</p>	<p>Efter den refleksive pause tog ordstyreren en runde, hvor alle blev hørt – også de, der ikke var involveret i plejen af patienten.</p>

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<p>Der blev fortalt mange farverige historier om patienterne, som gik i mange retninger. Personalet kom menterede sjældent anerkendende på hinandens handlinger.</p> <p>Der var mange ideer til løsninger på de problematikker, som blev bragt op, men få opsamlings og dermed afgrænsninger, som er en forudsætning for at diskutere en given problematik mere dybtgående. Der blev ikke skrevet noget ned under konferencerne. I reglen blev man enige om, at enten lægen eller sygeplejerskerne ville diktere noget til journalen efter konferencen. Men oftest blev det ved den mundtlige samtale.</p>	<p>Observationerne af dialogen efter de reflektive pauser gav anledning til emotionelle evalueringer og kollegial anerkendelse af hinandens tanker og handlinger.</p> <p>Afdelingen anskaffede en flipover, hvor de pointer og spørgsmål personalet kom med blev skrevet ned af én fra personalet, der ikke var involveret i den patient, man talte om. Patientens situation blev taget op igen efter 14 dage. Her så man på det, der var skrevet ned 14 dage tidligere og man evaluerede, hvordan det var gået siden sidst og talte om, hvad der kunne være af nye problemer.</p>
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Tre forandringer efter supervision

De næste delafsnit går tættere på, nogle af de ændringer forskeren har observeret i personalets kommunikation på konferencerne efter supervision. Inden præsentationen af tre centrale forskelle, som fik betydning for personalets emotionelle arbejde på konferencerne, samles der kort op på konferencer før og efter supervision.

Som man kan se, er der mange forskelle på konferencerne før og efter supervision. Dog er det en afgørende pointe, at man ikke kan foretage en direkte sammenligning mellem konferencerne og dermed sige, at forandringerne skyldes supervision. I løbet af de 10 måneder hele processen forløb skete der naturligvis også andre ting i afdelingen, som har betydning for, hvordan personalet kommunikerede på de ugentlige konferencer. Selvom en del af ændringerne på konferencerne muligvis ikke kan tilskrives supervision er der dog visse elementer, som ikke var der før supervisionen, og som bærer tydeligt præg af 'sprogspillet' i supervision. I de næste afsnit fokuserer artiklen på tre af disse elementer i 'det nye sprog'. Det drejer sig for det første om ordstyrerens brug af reformuleringer, for det andet runderne, hvor alle deltagere på konference fik lejlighed til at sige, hvad de mente og tænkte og endelig de reflektive pauser efter den indledende status på patienternes situation fysisk, psykisk og socialt. Analyserne peger på, at følelser fylder meget, når der træffes beslutninger om patienter og pårørendes pleje og behandling. Det er tydeligt, hvordan det 'supervisoriske sprogspil' er med til at opgradere og sætte fokus på betydningen af 'emotionelt arbejde' 'as a business in its own right' (som en selvstændig aktivitet) (Li & Arber, 2006: 27), der er med til at legitimere og forklare personalets overvejelser og

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handlinge på konferencerne efter supervision.

Reformuleringer efter supervision

Efter supervision kan man sige at reformuleringer institutionaliseres. Det betyder, at de bliver en integreret måde at opsummere problematikker og konklusioner på under konferencerne (Nordentoft, 2007 d^{xiii}). De næste afsnit ser på reformuleringernes konstruktion og betydning for, hvordan der tales om følelser på konferencerne.

Analyserne viser, at der med reformuleringerne lægges op til en anderledes måde at tale om følelser på. Før supervision var der meget få reformuleringer. Da fyldte små fortællinger om oplevelser med patienter og pårørende konferencerne mere, og de var – naturligt nok - ikke præget af den samme forhandling og mere direkte tale om følelser, som reformuleringerne lægger op til (Nordentoft, 2007 b^{xiv} og d). Reformuleringerne bliver en måde at fastfryse - 'to fix', som Heritage & Watson (1979) beskriver det, et givent tema, som hermed udstilles og kræver deltagerens respons. Analyserne viser, at når ordstyrerens reformuleringer udfordres er forhandlingen af nye reformuleringer om, hvordan en given situation kan karakteriseres, fyldt med emotionel tale og små historier, der bruges til at begrunde handlinger og holdninger i den aktuelle situation. Med udgangspunkt i et konkret eksempel uddyber de følgende afsnit disse forhold.

Udfordrende meta-perspektiver

Eksempel 3 viser, hvordan ordstyreren, Louise, reformulerer og sætter fokus på følelser som tema meget lig den måde supervisorerne gjorde det i supervision. Endvidere er det tydeligt, hvordan oversygeplejersken, Ea, som ikke indgår i pleje- og behandling af den patient, der tales om, tager en rolle på konferencen, som minder meget om den rolle, supervisorer har i supervisionsforløb. Gennem de spørgsmål hun stiller, anlægger hun meta-perspektiver på de temaer, som bringes op, og udforsker baggrunden for personalets handlinger. Det ses, hvordan Eas udfordring af problemdefinitionen i reformuleringen fører til emotionelt arbejde i gruppen, da de enkelte medlemmer i gruppen begrunder deres tanker og handlinger med emotionelle overvejelser, der berører både patienten og hans familie, men også hvordan de selv har det med patientens situation.

Personalet taler om den unge terminalt syge cancerpatient Martin. Eksemplet starter

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lige efter det tværfaglige team har lavet status på Martins behandlingsmæssige situation. Louise opfordrer nu fysioterapeuten Sara til at fortælle om en snak, de havde om Martins psykiske tilstand for et par dage siden.

Eksempel 3

1. Sara: og jeg opfatter det som om at (0.2) øh (1.0) at Martin (0.3)
2. nok (0.4) er i i krise og er bange (0.5) men samtidig har
3. han sådan lidt (0.5) lidt glat (0.2) overflade øeh (0.3) når
4. man prøver sådan (0.5) at komme ind og bassinet er for mig
5. heller ikke det optimale sted og begynde at tale for
meget i dybden
6. Eva: nej
7. Sara: når der også er en anden patient til stede
8. Eva: Mm
9. Sara: så så det er sådan det er sådan (0.6) balanceakt
10. Eva: Ja
11. Sara: øh fornemmer jeg
com: Sara fortæller videre, at de, som var på arbejde for et
par dage siden da kontaktsygeplejersken Eva havde fri
havde talt om Martin. Louise uddyber nu Saras referat af
denne snak:
12. Louise: .hh nå [men det vi det nej det] det vi jo talte om det
13. var at:øh
14. Sara: [nå men det fyldte nok bare]
15. Louise: Martin havde en adfærd der der der gør at han ligesom
suger
16. opmærksomhed til sig gør og sådan (0.4) fylder (0.1) øh
17. fyldt meget øe:h (0.1) i rummet og .hh (0.9) øe:h (0.8) det
18. problematiske (0.3) der (0.3) også kunne være (0.5) ø:eh i
19. den adfærd det var sådan (0.2) noget af det vi var (0.7)
20. lidt inde på
21. Pause: (1.6)
22. Louise: Ja Ea (0.2)
23. Ea: Ja men jeg selv jeg tænker bare på (0.1) når du siger
24. problematisk (0.1)er det for os eller for Martin selv (1.5)
25. altså hvem er det er et problem for °at han har den måde
der°
26. Pause: (2.3)
27. Louise: Ja
28. Pause: (1.3)

Reformulering: Problemdefinition, dokumentation og 'footing'

Sara siger, at hun ser at Martin har en 'glat overflade' (3), men at han er 'i krise og bange' (2). Hun har prøvet at tale med ham, når hun laver øvelser med ham i vand, men et vandbassin er ikke det mest ideelle sted at snakke. Louise fortsætter og udbygger Saras reformulering med at præsentere problemet, som hun ser det, at han 'suger opmærksomhed' (15, 16) og at hun og Sara har talt om, hvad problemet med det kan være. Louise dokumenterer således problemet med hendes og Saras samtale. At Louise siger 'vi' (12) kan signalere, at hun taler i forlængelse af og er enig i Saras reformulering. Louise skifter også 'footing' i skiftet fra dokumentationen til problemdefinitionen. I dokumentationen, Saras og hendes snak om Martin, siger hun

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'vi' (12), mens hun beskriver problemet i tredje person ental og siger '*det problematiske der kan være i det*' (17, 18). Igen, som i de andre reformuleringer i dette kapitel, er der et skift fra en personlig til mere upersonlig tiltaleform som kan give større distance til følelsesmæssige tema. I Louises reformulering transformeres '*den glatte overflade*' (3) til '*problematiske adfærd*' (17, 18) og man kan argumentere for, at Louise transformerer et følelsesmæssigt tema til at være et problem. Dvs. at det er problematisk *ikke* at ville tale om sine følelser.

'Hvem er det et problem for?'

Ea efterlyser en uddybning af reformuleringen og udfordrer den ved at spørge: '*Hvem er det problematisk for*' (25). Således giver Ea problemet et subjekt og peger på det faktum, at et problem altid er et problem for 'nogen', det eksisterer ikke i et tomrum, da vi lever og færdes i sociale sammenhænge, der er med til at afgøre, hvad der er problematisk eller ej. Derfor kan man også argumentere for, at hendes spørgsmål er et 'meta - spørgsmål', dvs. en snak om spørgsmålet, der beforder dialogen om problemets 'proces' – altså – hvordan det er opstået. I de næste sekvenser forsøger deltagerne på hver deres måde at besvare Eas spørgsmål (25) med emotionelle begrundelser for deres synspunkter. Lægen Lars siger fx, at det kan blive et problem for Martin, fordi han muligvis vil opleve at '*nogen*' tager afstand fra ham og fortsætter med at sige, at han personligt har svært ved at 'nå ind' til ham i perioder. Heraf kan man udlede, at det er følelsesmæssig nærhed eller distance Lars taler om. At Lars oplever det som problematisk at han ikke kan etablere den ønskede nærhed til Martin indikerer også, hvad succeskriteriet eller præmissen for god palliativ pleje og behandling kan være: nemlig at man kan 'nå ind' til patienterne og få en 'ægte' samtale om deres situation med dem.

Socialrådgiveren og kontaktsygeplejersken fortæller små historier om Martins hjemmeliv og problemer 'bag facaden', som de ser dem og disse historier er fyldt med følelsesladede udtryk. Fx siger sygeplejersken, at Martin 'ligger og vrider sig på sofaen' fordi han har mavesmerter samtidigt med at hustruen 'nærmest grædende tager ud af døren' på arbejde, da hun endnu ikke har taget orlov. Resten af deltagerne på konferencen lytter intenst og sukker dybt! Det virker som om, både sygeplejersken og socialrådgiveren argumenterer for, at Martin må have brug for at tale mere om sine følelser end han gør, og at hustruen burde tage orlov.

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Runden

Efter at det tværfaglige team har lavet en status på Martin' situation fysisk, psykisk og socialt inviterer ordstyreren til en refleksiv pause. I runden efter den refleksive pause bliver alle deltagerne på konferencen én for én bliver bedt om at komme frem med deres tanker og overvejelser om Martin. Eksempel 4 nedenfor viser diætisten Emmas overvejelser. Emma har ligesom Ea ikke været involveret i Martins pleje. Hendes kommentar er et eksempel på, hvordan runderne generelt bidrog til, at der kom nye reformuleringer, kommentarer og meta - perspektiver fra professionelle i plejegruppen, der normalt ikke blev hørt så meget, hvis de ikke deltog i behandlingen. Emma siger:

Eksempel 4

1. Emma: Ja jeg havde hæftet mig ved to af pindene derovre øh
2. (0.2) det første det er (0.2) hva er problemet lidt
3. som Louise og Ea også (0.2) jamen er vi bange for at 4.
- vi har overset nogen af deres behov altså har de givet 5.
- udtryk for noget som vi ikk kan opfylde eller (0.8)
6. venter vi at der skal komme noget rullende lige
7. pludselig som der lige skal (0.4) tages hånd om eller 8.
- ser vi (0.4) ville vi gerne se nogle flere reaktioner 9.
- fra dem (1.5) og det kan godt være sådan lever de
10. måske (0.2) og ss og sådan skal det bare være
11. Eva: Mm
12. Pause: (0.8)
13. Emma: øh det er deres (0.8) mønster det er °deres (0.3) øh
14. (0.4) livsstil om man vil°
15. Pause: (1.2)
16. Emma: og at (xx) tror vi ikk at de nok skal give udtryk hvis
17. der pludselig opstår et behov for hjælp og assistance
18. °og alt muligt°
19. Pause: (2.0)

Emmas refleksion viser, hvordan flipoveren får stor betydning for, at personalet sammen med runden holdt fast i nogle centrale temaer og spørgsmål, der blev bragt op på konferencerne. Emma starter netop med at referere til to centrale punkter, der er skrevet ned på flipoveren. For det første; Hvad er problemet? Og for det andet: Om Martin og hans hustru giver udtryk for deres behov/følelser. Emma bygger således videre på Eas indledende spørgsmål: Hvad er vi bange for? (3) og introducerer den følelsesmæssige dimension, som en faktor, der har betydning når professionelle træffer beslutninger og handler, når hun siger: Er vi bange for at vi har overset noget? (3 - 4). Endvidere uddyber hun præmissen for dette spørgsmål ved at beskrive og sætte ord på den usikkerhed kollegerne kan føle (6 - 8). Emma slutter med at sige, at måske er der bare nogle mennesker, som ikke viser så mange reaktioner, som man kunne

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ønske og sådan er det (9-14). Af det Emma siger, kan man udlede, at hun mener, at man skal stole på, at patienterne nok skal sige til, når de har brug for hjælp (16 - 18). Med sin kommentar indikerer hun, at det i den konkrete situation mere er personalets behov end patientens ønske at tale om hans situation.

Analyserne af personalets kommentarer i runderne efter de refleksive pauser viser således, at der kom nye perspektiver på pleje og behandling af patienterne. Disse perspektiver inviterede til fx faglige, moralske og etiske diskussioner om, hvordan kvalificeret omsorg kan defineres i den givne sammenhæng som fx, hvis behov der skulle varetages og hvordan. Man kan derfor konkludere, at disse perspektiver er med til at kvalificerer refleksionerne på konferencen, fordi de stiller spørgsmål ved grundlaget for de problematikker, der tages op på konferencen (Opie, 1997).

Refleksive pauser

I tre ud af fire konferencer efter supervision blev der holdt en reflektiv pause. I alle tre tilfælde virkede det som om pausen gav deltagerne anledning til at sætte beskrivelsen af deres handlinger på den første del af konferencen i perspektiv. Disse blev således evalueret efter pausen og eksemplerne nedenfor illustrerer, hvordan kollegerne anerkender og bekræfter dem på forskellig vis. I det første eksempel taler personalet om en cancerpatient, som hurtigt var blevet meget dårlig. Fysioterapeuten havde taget patienten op for nyligt på en konference og hun tager nu selv initiativ til at evaluere denne beslutning efter refleksionspausen.

Eksempel 5

1. Sara: Altså jamen (0.8) jeg tænker det sådan meget min
2. erfaring hvor jeg står at hvor var jeg glad for at
3. selvom lige den dag jeg tog hende op her ikke ligesom 4.
4. så at hun havde et behov faktisk for resten af
5. afdelingen det kun vi måske have diskuteret [hvorvidt]
6. hun skulle=
7. Lars: mm
8. Sara: til læge eller hvad
9. Eva: Mm ja=
10. Sara: Ø:ehmm og det er simpelthen gået så stærkt=
11. Lars: °Det var meget godt fanget af dig synes jeg°
12. Eva: °[ja]°
13. Lars: °[rigtigt godt]°
14. Pause: (0.8)
15. Sara: Ja altså
16. Lars: Men det var det da
17. Eva: °ja°
18. Louise: Det det det det er da en god
19. Sara: tak
- com: Sara læner sig frem og lader som om hun bukkes samtidig

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med at hun siger tak
20. Louise: Ja he he

Eksempel 5 kan illustrere tre ting. For det første er det bemærkelsesværdigt at fysioterapeuten selv tager initiativ til at evaluere sin egen handling positivt. For det andet støtter de to kolleger, Lars og Eva, hinanden i at rose Sara. Det ses fx ved, at de taler i forlængelse af hinanden (10 - 12) og overlapper hinandens tale (11 - 12). For det tredje begynder ordstyreren Louise at underbygge og cementere Lars' og Evas udsagn (17) – men Louises evaluering gøres færdig af Sara, som bukker samtidig med at hun siger 'tak' (18). Situationen kan ses som et eksempel på, at det betragtes og anerkendes som en naturlig ting at evaluere, hvordan man følelsesmæssigt har det i forhold til en given situation. Fysioterapeutens evaluering af egen handling understreger dette, da man ellers kunne tænke, at der skal mod til at fremhæve egne handlinger. Det er forskerens indtryk, at det ikke var noget hun ville have gjort før supervision. Ligesom der heller ikke tidligere er eksempler på, at personalet anerkender hinanden på konferencerne, som vi ser her.

Anerkendelse af følelser

Det sidste eksempel, eksempel 6, uddyber, hvordan personalets følelser anerkendes på konferencerne efter supervision. Samtalen har drejet sig om, hvordan man kan give den mest optimale pleje og behandling til en ung terminalt syg patient, som hedder Hans. Hans er meget selvkørende og efterspørger ikke ekstra service. Temaet for samtalen er, om personalet kan stole på, at Hans siger til, hvis han har brug for hjælp. Eksemplet starter med at sygeplejersken Julie fortæller om hendes bekendtskab med Hans, hvor hun bl.a. nævner en læge ved navn Lone. Louise er ordstyrer og Maja er kontaktsygeplejerske for Hans. Amalie, som er læge, kommer også med respons i eksemplet.

Eksempel 6

1. Julie: Jeg har oplevet ham en gang hvor han kom akut (0.3)
2. jeg tror det var Susanne (0.2) og mig (0.2)
3. Maja: ja da han havde ho[ld] i ryggen
4. Julie: [ja]
5. Julie: og da havde han og da henvendte han sig da helt klart
6. og krævede nærmest at blive behandlet og det skulle
7. bare være nu
8. Pause: (0.3)
9. Louise: Okay=
10. Julie: Så der han kan godt sige når [han synes] [det er]
11. Maja: [det kan han godt]

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12. Sara: [M:m]
com: Maja sidder og nikker
13. Pause: (0.3)
13. Julie: Og holde fast på at det her skal være nu med det
14. samme (0.2)
15. Sara: Det er jo rigtigt=
16. Julie: Og hvad det er han skal [bruge] [ikk]
17. Maja: [Ja]
18. Sara: [ja]
19. Julie: (xxxxx) og jeg kendte ham slet ikke
20. Pause: (0.4)
21. Maja: Jeg er helt tryk ved at
22. Julie: og var [meget sådan]
23. Louise: [Ja ja]
com: Julie holder hænderne parallelt op foran sig
24. Pause: (1.0)
25. Louise: (xxxx)
26. Pause: (0.5)
27. Julie: Såe
28. Pause: (0.8)
29. Louise: Det er da vigtigt og være tryk ved (0.2) ved (0.3) hans
30. reaktion
31. Amalie: Ja
32. Louise: I den sammenhæng
33. Pause: (8.0)

I eksempel 6 ses det, hvordan Majas følelse af tryk anerkendes på flere måder. Det sker ved at kollegaen Julie fortæller en historie, hvor konklusionen underbygger Majas følelse. Det er interessant at se, hvordan de sammen begynder at bygge historien op (1 - 4), hvor Maja supplerer med oplysninger, som Julie ikke har givet om situationen og hvor de overlapper hinandens tale (3, 4, og 10, 11). Disse elementer er interaktionelle elementer, der er med til at illustrere både sympati for og empati med hinandens følelser. Endvidere udtrykker fysioterapeuten Sara også enighed med det, Julie fortæller (12, 15). Endelig bekræftes og anerkendes vigtigheden af Majas følelse af tryk i ordstyreren Louises afsluttende kommentar (29).

Samlet viser eksemplerne fra konferencerne efter supervision således, hvordan personalet både formår at udfordre hinandens følelser i forhold til patienterne (eksempel 3 og 4) og at anerkende dem (eksempel 5 og 6).

Konklusion

Udgangspunktet for dette kapitel har været fysioterapeuten Saras kommentar om, at hun følte, hun havde fået et nyt sprog gennem supervision. Formålet med kapitlet har derfor været at udforske for det første hvad der karakteriserer 'det nye sprog', og for det andet at undersøge om det overføres til og får betydning for personalets måde at

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tale om følelser på i deres daglige praksis – her eksemplificeret ved den ugentlige tværfaglige konference. Supervision forstås således som en sproglig praksis, 'et sprogspil' (Wittgenstein 1953), og kapitlet peger på, at reformuleringer er et afgørende element i 'det supervisoriske sprogspil' for at det følelsesmæssige tema bringes frem og for hvordan dette sker. Reformuleringer kommenterer og samler op på det, som bliver sagt i en samtale og kan således siges at have en meta - kommunikativ funktion. Endvidere indikerer betegnelsen re - formulering også at der er sket en transformation fra noget oprindeligt til noget nyt. I de konkrete analyser ses dette ved at henholdsvis supervisorerne og ordstyreren bevæger sig fra et konkret og personligt perspektiv til et mere abstrakt og generelt i reformuleringerne. Dette perspektivskifte kaldes for 'footing' og der argumenteres for at skiftet er med til at legitimere og nuancere problemstillingen og inddrage moralske og normative aspekter i dialogen. Det er således tydeligt, hvordan elementer fra det 'supervisoriske sprogspil' så som refleksive pauser, runder og ikke mindst ordstyrerens reformuleringer er med til at forstørre og legitimere følelser, som et relevant tema at bringe op i en faglig sammenhæng. Analyserne demonstrerer, hvordan reformuleringerne kan betragtes som en 'fiksering' af et tema, gruppen enten kan acceptere, modsige eller bede om at få uddybet og, at de sidste to tilfælde fører til emotionelt arbejde med at forklare og begrunde handlinger og tanker. Endvidere giver de refleksive pauser anledning til kollegiale anerkendende og emotionelle evalueringer. Endelig betyder runden, at meta - perspektiver fra personalemedlemmer, der ikke er involveret i patienten og derfor normalt ikke siger noget, er med til at kvalificere refleksionen over følelser på konferencen.

Afslutningsvis peger analyserne på, at supervisorerne bliver rollemodeller for, hvordan man kan sætte det følelsesmæssige tema på dagsordenen og reflektere over følelser. Analyserne af interaktionerne på konferencerne efter supervision peger på at sundhedsprofessionel supervision fremmer faglig udvikling på arbejdspladsen gennem en introduktion af meta - perspektiver i samtalen.

Refleksionerne over problemstillings indhold og præmisser udløser fx klarhed over og kollegial forståelse for at omsorgen for patienterne kan være både personalets og patientens behov. Det 'supervisoriske sprogspil' kan således synliggøre hvilke personlige og professionelle følelser, der kan være forbundet med at arbejde med

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patienter, som skal dø, og dermed gribe fat en af de store udfordringer i omsorg og pleje, nemlig at kunne adskille egne behov fra patienternes. Denne erkendelse kan være med til frigøre ressourcer til og befordre faglig udvikling i arbejdslivet ved at forebygge stress og udbrændthed hos plejepersonalet, da de måske bliver mindre ambitiøse i plejen af de døende patienter og deres familier. Derfor argumenterer artiklen for, at 'det supervisoriske sprogspil' kan ændre praksis, da det kan give nye perspektiver på og/eller synliggøre gamle mønstre i pleje og behandling, som er en forudsætning for, at man kan ændre disse.

Efterskrift: Om følelser bag kulissen

Dette kapitel fokuserer på de positive forandringer forskeren har observeret på konferencerne efter supervision. Det er dog kun én af mange mulige historier, der kunne fortælles. Kapitlet kunne også have handlet om følelser 'bag kulissen'. Her tænkes på mere subjektive udlægninger af, hvordan supervisorerne og forskerne oplevede forløbet. Eller på alle de interpersonelle følelser i gruppen, der så dagens lys i supervisionsforløbet. Processen var ikke ukompliceret og lige ud af landevejen. Dog kan resultaterne i dette kapitel ses som et udtryk for, at det er vigtigt som supervisor at holde fast i 'det supervisoriske sprogspil', da elementer af dette tilsyneladende overføres og får betydning for deltagernes anerkendende måde at kommunikere på efter supervision.

Noter

¹ Alle deltagere i projektet – både personale og patienter har skrevet under på, at de er blevet informeret mundtligt og skriftligt om projektet. Endvidere er alle navne anonymiserede. Det betyder at de navne, som forekommer i artiklen, er opdigtede navne.

¹ Wittgenstein (1953) har opfundet begrebet 'sprogspil'. Schilling (1997) har koblet dette begreb til supervision mens jeg har brugt begrebet i analyserne af, hvordan supervision praktiseres i artiklerne, som indgår i min ph.d.-afhandling: Nordentoft 2007a). Dette kapitel er baseret på Nordentoft 2007 c) og d).

¹ Barbro Arvidsson har skrevet en doktorafhandling om supervision af sygeplejersker ved Lunds universitet.

¹ Egede-Nissen, Weslemøy (1992): Kunnskap eller terapi? Hovedopgave i pedagogikk. Pedagogisk Forskningsinstitutt. Universitetet i Oslo. Louise. Gadgil, Inger Eikeland (1997): Sygeplejefaglig veiledning. Personlig vekst og økt faglig kompetanse - To sider av samme sak? Hovedopgave ved afdeling for sygeplejevitenenskap. Institut for Klinisk Medicin. Universitetet i Tromsø.

¹ Nikanders artikel: 'Emotion categories in Meeting talk'. er under udgivelse til bogen: Discursive

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Research in Practice. A. Hepburn & S. Wiggings (Eds.). Cambridge: Cambridge University Press.

¹ Davies har forsket i reformuleringens betydning for transformationer i terapeutiske samtaler.

¹ Analyserne i kapitlets anden del udspringer af analyser, der er præsenteret og uddybet i Nordentoft 2007c.

¹ Der er stor forskel på tale- og skriftsprog. Fx taler vi sjældent i grammatisk korrekte sætninger, hvor der fx kan sættes kommaer, som man kan i skriftsprog. Derfor er der ikke sat kommaer i udskriftterne. Endvidere indikerer fx små runde cirkler °lille° at ordet er sagt i et meget lavt toneleje, en understregning viser, at der er lagt tryk på den stavelse, der er understreget og firkantede parenteser betyder at talerne overlapper hinandens tale indenfor de [firkantede parenteser], som illustreret. Længden og placeringen af pauser i samtalen tilskrives også stor betydning for den efterfølgende respons.

¹ Video optagelserne er transkriberet hovedsageligt ifølge de konventioner Gail Jefferson har udviklet (se Atkinson and Heritage 1984)

[xx]	Firkantede parenteser markerer begyndelse og afslutning på overlappende tale i forhold til talen ovenfor eller nedenfor
He spi:ste	Coloner viser hvor meget den sidste tone er forlænget. Jo flere coloner jo mere forlængelse.
xxx	x'erne er indication på, hvor mange stavelser, der virker til at blive sagt.
<u>Understregning</u>	Understregningen indikerer, hvilken stavelse, der lægges tryk på i talen.
°hun var°	Små hævdede cirkler viser at talen er stille/afdæmpet
↑↓	Opadgående eller nedadgående pile markerer stigende eller faldende intonation.
>hun var så sød<	Når en del af et udsagn siges hurtigere end talen omkring det indikeres dette med mere eller mindre end tegn.
.hhh	Indånding
hhh.	udånding
NV	Non-verbale handlinger og andre bemærkninger
(0.4): Pause	Numrene i runde parenteser måler pausen i sekunder. I dette tilfælde er pausen 4 tiende dele af et sekund.

¹ Tallene i parenteserne henviser til det/de linienummer/re, der henvises til i transskriptionen.

¹ Stedord og 'jo' er skrevet i kursiv i transskriptionen for at tydeliggøre de moralske pointer og pointerne omkring 'footing'.

¹ Den deltager, som efter supervisionen sagde, at hun følte hun havde fået et nyt sprog.

¹ Analysen af eksempel 3 i kapitlets tredje del udspringer af en analyse, der er præsenteret i Nordentoft 2007 d.

¹ I Nordentoft 2007 a uddyber, hvordan personalet kommunikerer følelser på en konference uden supervision.

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