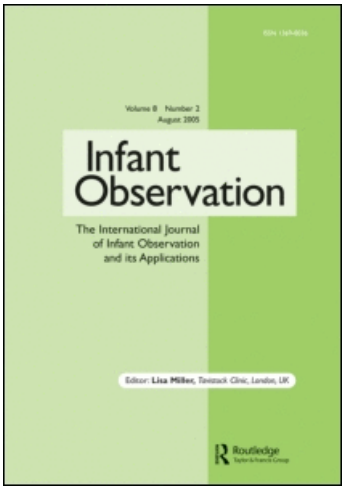

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An exploration of the quality of life in nursing homes: the use of single case and organisational observation in a research project

Wilfried Datler*, Kathrin Trunkenpolz**, and Ross A. Lazar***

The present article provides a brief introduction to the research project, 'Quality of Life in Nursing Homes' funded by the University of Vienna. Within the scope of this project, single case observation and organisational observation techniques based on the Tavistock/Bick approach were employed as research methods in an effort to explore the subjective wellbeing experienced by residents of nursing homes suffering from dementia. Further subjects of the investigation were aspects of the organisational dynamics which influence the evocation of such feelings of wellbeing. The main emphasis of the article is on the presentation and discussion of excerpts from the observation accounts which were carried out in one particular nursing home. The article outlines just how intensely inmates of nursing homes themselves, but also caregivers and members of other professional groups involved with them, are continually confronted with the experience of cognitive and physical decline, loss and loneliness, helplessness and dependency, and also with the theme of the unrelenting approach of death. The article also describes the ways in which these experiences evoked strong and overwhelming emotions in staff members and residents as well as in members of the research team. In addition, the article outlines the psychosocial processes within the organisation, which might possibly help members of the organisation better tolerate and allay such feelings, and the influence that these processes have on the dynamics of everyday relationships within the home, and, as a further consequence, upon the wellbeing of the residents.

A first version of this paper was presented in a workshop chaired by Branca Pecotic at the conference 'From Baby to Boardroom: the Tavistock–Bick method of Infant Observation and its application to organisations and in consultancy', 17–18 October 2008, Tavistock Centre, London.

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One particular aspect highlighted is the fact that there is no mental or social space at the nursing home specifically set aside to enable the residents and the staff to exchange thoughts about these experiences and to understand their emotional impact. The article concludes with remarks on the difficulties involved in observing in nursing homes where people suffering from dementia live.

Keywords: Tavistock/Bick observation method; Tavistock/Bick approach; single case observation; organisational observation; dementia; nursing home; quality of life; observation as a research method; qualitative research methods

Introduction

I. Mrs. R. is a resident of the nursing ward of a home for senior citizens we shall call 'House C'. She is 80 years old and suffers from dementia. She is so weak she has to sit in a wheelchair all day. With her assent, Vanessa Cerha, a young scientist, comes by once a week, for an hour at a time, to observe Mrs. R. in the course of her daily life.

As Vanessa Cerha enters the nursing ward to carry out her seventh observation, she is informed that Mrs. R'.s husband has arrived for a visit once again, and is sitting with Mrs. R. in the common room. A few moments later, the researcher approaches the couple, greeting them both with a smile.

Mrs. R. is sitting at a table together with her husband. She is wearing comfortable clothes and a blue bib that has not been properly tied and is therefore hanging down a bit at an angle on the front upper part of her torso. Her greasy hair has been combed back carefully and is clinging tightly to her head. Since Mrs. R. may not have noticed the arrival of the observer, the latter bends over more closely towards her. In her account we read:

> 'How do you do, I'm back once again, Mrs. R.'. I touch her hand, and she lifts hers a little. She turns her head a bit towards me. Her eyes remain rigid and appear to be staring straight through me. Her mouth is open and I can see the one tooth remaining in her lower jaw. I let go of her hand again and look for a suitable position for my observation. I see a chair standing by the wall, move it around a bit and am about to sit down as Mr. R. asks me to come and take a seat closer by.
> (Cerha, 2008, Obs. 6/2ff)[1]

Mr. R., who appears sad and depressed, keeps looking over time and again at his wife, who, in her turn, again and again also keeps looking back at Mr. R. Then Mrs. R. sighs loudly and her eyes fall shut:

> Her eyelids twitch a few times. She opens her mouth and shuts it, then opens it again. Her lips have collapsed inward a little. She moves her fingers slowly in her lap. Suddenly she is seized with a violent tremor. Afterwards, she opens her eyes again. She gazes into the distance.
> (Cerha, 2008, Obs. 6/2ff)

Mr. R. shakes his head and again turns towards the observer in order to tell her about his life now, but also about the life he once shared with Mrs. R. While he is talking Mrs. R. continues to keep her eyes shut.

> Her head moves like a pendulum from right to left. Mr. R. points at her and says: 'This is a sign of her sickness, a terrible sickness. Have I shown you this picture before?' He fishes about in his wallet and shows me a picture of Mrs. R. 'It is already 15 years ago that this picture was taken', he says with a melancholy tone of voice.
> (Cerha, 2008, Obs. 6/2ff)

Mr. R. again looks over at his wife, shakes his head once more, and continues to tell the observer how painful it is to be getting old. Pointing at Mrs. R., he says:

> 'She just sits there all day; most of the time her eyes are shut. She can't eat anymore, can't go to the toilet anymore. We can't go outside anymore. Just look at her! And yet, she's younger than me by two years. This disease is terrible. Well, I know she's the one who is badly off, not me, but I believe she's not getting any of it anymore'. At this very moment, Mrs. R. turns her head towards Mr. R. and croaks something. Her eyes are open wide and her left arm is raised. 'You see, and she can't talk anymore, either . . .' says Mr. R. He then shakes his head and gazes into the distance.
> (Cerha, 2008, Obs. 6/2ff)

Mrs. R. again collapses within herself and shuts her eyes. Time and again, for brief moments, spasms wrack her body, without, however, resulting in controlled movements or utterances. Meanwhile, Mr. R. talks about their children and then, again, also about Mrs. R.

> He talks about how she got her new teeth this week so as to be able to speak again. But he also says he doesn't believe she is ever going to speak again. He turns to her and says, 'Well? Do you know the lady? She's been here a few times now, you ought to know her!' Mrs. R. looks at me and says something. I cannot understand her, but even before she has finished talking, Mr. R. says: 'You see? You can't even have a conversation anymore'. Mrs. R. turns her head to face straight ahead and lets her shoulders droop down a little, shutting her eyes. Mr. R. continues talking. Once again, he mentions their daughter . . .
> (Cerha, 2008, Obs. 6/2ff)

II. When the observer's account is presented in the weekly seminar session, the seminar group soon arrives at the conclusion that Mrs. R. is actually reacting to many of the statements that Mr. R. is venting. For example:

- When Mr. R. expresses the opinion that his wife no longer understands what is going on around her, Mrs. R. appears to protest.
- When Mr. R. states that she can no longer speak, she appears to wish to demonstrate to the observer that the very opposite is true.
- And when she does not succeed in uttering clearly intelligible words, while Mr. R. so forcefully ascertains that it is no longer possible to have a conversation with her, she appears to give up hope.

While the seminar group reflects upon, and asks about the emotions that Mrs. R. may have been experiencing in this situation, feelings of sympathetic commiseration but also of anger spread through the group. Once more the initiatives taken by Mrs. R. remain unnoticed and so lead nowhere. And once more, Mrs. R. remains quite alone with all the emotions of being put down, of feeling hurt, of wanting to protest and of having her hopes dashed, of weakness, helplessness and resignation.

Likewise, the seminar group has difficulty in dealing with Mrs. R.'s emotions. At the same time, it is clear that the group will frequently be confronted with similar scenes in the individual and organisational observations still to be done in the context of the research project on 'Quality of Life in Nursing Homes'.

III. The work being done with the help of such observations has, over the past few decades, repeatedly led to notable publications. It makes a difference, however, whether one comes upon noteworthy results within the context of one's training and continued education and then publishes something about them, or whether one intends from the very outset to work with the Tavistock/Bick method of observation within the bounds of a given research project (Briggs, 1997; Lazar, 2000; Trunkenpolz & Hover-Reisner, 2008; Urwin, 2007). Michael Rustin (2006), in his comments on infant observation noted, however, that this distinction is rarely considered in the academic literature.

> The published literature on infant observation does not, for the most part, distinguish between "research" and other kinds of writing, and there is little published discussion of infant observation research methods. Because most infant observations are undertaken for educational purposes, it is generally the case that most observers do only one observation. ... Very little systematic comparison or accumulation of "research findings" has been feasible in this context. (p. 44; see also Rustin, 1989, p. 70)

Much the same can be said about publications featuring material derived from the observation of elderly people and, likewise, the observation of organisations. And yet Rustin's distinction applies equally in these cases, since a number of research methodological deliberations are required if the observations are not merely intended to benefit one's own learning process (Holman, Meyer, & Davenhill, 2006; Skogstad, 2004). If this method of observing is applied as a research method, then the primary aim is to generate knowledge in a methodologically controlled and reflective manner, and to combine this knowledge with existing theories in order to check on ways in which, with the help of such observational material, these theories can be developed further (Fatke, 1995).

We are, therefore, faced with a number of challenges when setting out to apply this observational method inside a nursing home as part of a research programme where we intend, among other things, to answer the following question: In what way do the organisational dynamics in nursing homes influence the relationships between the nursing home residents and the care-giving personnel and hence affect the quality of life of the residents of such institutions?

What follows is, first, a brief overview of the project under consideration and the significance attributed to organisational observations in connection and in company with single case observations within it. Secondly, a sketch of the individual steps taken in working through the material derived from these observations is outlined. Thirdly, we present material from the observation of nursing home 'House C'. Taking our cue from the analysis of these accounts, we shall then describe some problematic constellations of organisational dynamics characteristic to this particular nursing home, but which may also prove relevant for other comparable institutions.

'Quality of Life in Nursing Homes'—a research project of the University of Vienna

The research project 'Quality of Life in the Nursing Home' originated in and is being run by three departments within the University of Vienna. Within the framework of this project, members of the Departments of Sociology, Nursing Science and Educational Science are cooperating in carrying out investigations of five nursing homes in an effort to gain insights into the subjective quality of life experienced by people afflicted with dementia using a variety of research methods. In connection with these aims, the project hopes to develop:

- a concept of what constitutes quality of life under the special circumstances prevailing in a nursing home (with reference to life in nursing homes in general);
- useful instruments to measure such quality of life and the satisfaction derived from it, as well as the general conditions of life of the nursing home residents; and
- a set of hypotheses which will lead to further standardised investigations.

In this way, the project generates basic research data and a contribution to the methodology of social research. As it was well known that individual members of the Department of Education's research unit 'Psychoanalysis in Education' had already acquired experience working with the Tavistock/Bick method of observation in the context of a number of previous minor research projects, and as it was decided that this method should be employed as part of the research design, it was only logical that Wilfried Datler, as director of that unit, should be invited to contribute to and to collaborate in this project. Running in conjunction with a research project currently underway on 'Toddlers' Adjustment to Out-of-Home Care'[2], it was thus possible to establish a second major research project at the University of Vienna using the Tavistock/Bick method. Entitled 'Quality of Life in Nursing Homes', this new project employs applications and modifications of infant observation technique, which in this new context are being tested with regard to their research-related achievement potential.[3] The research group now participating in the research project on Quality of Life in Nursing Homes, where it will be employing applications derived from infant observation techniques, is

headed by Wilfried Datler and Kathrin Trunkenpolz. The project covers, among other things, the following two thematic areas:

1. We assume that it is conducive to the subjectively experienced quality of life of nursing home residents if they are able to maintain the continuous experience that the people who take care of them show an interest in their 'inner worlds' in everyday situations, and are thus able to take heed of their emotions, fantasies, and perceptions. In addition, the ways in which they care for the residents should reflect their ability to take the residents' own thoughts and feelings into consideration. In this context, we were interested to discover just how nursing home residents experienced their day-to-day lives and the relationships with the other people with whom they were involved. To look into these questions we chose to employ the principle of single case observations according to the Tavistock method. Employing the method originated by Esther Bick and already introduced in retirement homes by Davenhill, eight residents of two nursing homes were observed for a period of three months (Davenhill, Balfour, & Rustin, 2007).
2. Furthermore, organisational observations were carried out in both nursing homes in an effort to gain a better understanding of their organisational dynamics and organisational culture. In this paper, however, we shall only be referring to observational material derived from Home C.

In our research project, we link the results emanating from the analysis of the individual observations with those from the analysis of the observation of the organisations. This serves to address the following question: In what ways do the organisational dynamics of nursing homes exert an influence on the constitution of relationships between the residents and the care-giving personnel, and hence, on the subjective quality of life of its residents?

The use of organisational observation in the research process

Our research group's approach can be subdivided into three sections:

1. Precise formulation and preparation of the research task;
2. single case and organisational observations based on the Tavistock/Bick method; and
3. additional processing of the material with special regard to the requirements of the research theme (Datler, Hover-Reisner, Steinhardt, & Trunkenpolz, 2008).

Precise formulation and preparation of the research task

The first section of the research process involved, as central requirements:

- training the observers to observe properly;

- establishment of a work setting for the project team, and
- introductory talks with the directors of the nursing homes.

This section covered the time span from March to October 2007.

During their training period, observers carried out observations at nursing homes. While processing these accounts and in conversations with Ross A. Lazar, who monitored the project, it soon became apparent how difficult it was to regularly observe old, frail and disoriented people in care giving organisations, and then to analyse the resulting material (Davenhill et al., 2007). Accordingly, a seminar structure was developed whose purpose was to help establish a social and mental space (a container) which would enable and allow all participants to meet the requirements of their primary tasks throughout the project's anticipated three-year run.

This seminar structure comprises:

1. two seminars, run by Kathrin Trunkenpolz and Wilfried Datler, which take place once weekly during the entire run of the project;
2. three-day block seminars, once per semester, headed by Ross A. Lazar; and
3. continuous work in four small groups, within which, even during the lecture-free periods, particularly intense work on the observation material is carried out.

Three introductory meetings were conducted with the representatives of Home C. where, in particular, the implementation of the observation project was explained and clarified. In the course of these meetings, we felt obliged to present ourselves as people who, in an open-minded and purely interest-driven manner, were turning towards a field new to us, in an endeavour to find out more about the day-to-day activities in this home. In so doing, we were also attempting to distance ourselves from potential expectations held by the representatives of the nursing home—expectations, for instance, that we would take on consulting tasks during the research process.

Three introductory meetings took place at Home C. together with the director and the head of the ward. In addition, present on another occasion were the residents of the ward and the care-giving team. Subsequently, first reports about these introductory meetings were written.

Organisational observations using the Tavistock/Bick Method

In January 2008, the second section of the research process was initiated. In this section of the research process the single case and organisational observations were realised in the same manner well known from training and educational contexts (Hinshelwood, 2003; Hinshelwood & Skogstad, 2006).

In Home C., organisation observations were carried out in the foyer area, in the common room of the geriatric nursing ward, at the nurses' staff centre, in the laundry, in the administration area, as well as during a shift change of the care giving team, and during one occupational therapy session. These reports were

discussed at the weekly seminar meetings. At the end of the observation phase, an intermediary report was assembled, within which initial references to the research themes were worked out. In connection with this we also developed, together with Ross A. Lazar, a system of categorisation, based on the Tavistock Group Relations approach, which offered us an opportunity to bring individual data from the organisational analysis together into a synopsis of the results.

Additional processing of the material with special regard to the requirements of the research theme

In a third stage, the observational material was worked through once again, with a view to developing answers to the central research questions. This work was carried out in newly-composed small groups, who were thus far unfamiliar with the material. This, it was hoped, would ensure that ingrained thought and interpretation patterns were not unthinkingly taken over and repeated, while at the same time insuring that the findings got discussed by an ever-increasing number of different individuals.

In the summer of 2008, this phase of the work was concluded. At the present moment we are engaged in integrating the results of our analyses into an overall joint statement, dedicated to reporting the findings from Home C. This account of our work should provide answers to our central research questions as well as references to research findings already published. What follows are some first glimpses of the results of this work.

A first set of results regarding Nursing Home C.

Description of Nursing Home C.

Home C. was founded in the 1980s as a residential institution for senior citizens with a view to providing elderly people, not yet in need of nursing care, with an opportunity to live in a home, to eat there and to enjoy leisure time activities. In other words, this home was created for inhabitants who would be able to assume personal responsibility for their day-to-day activities, their social contacts and hence their own well-being.

In addition, a nursing ward was set up where residents could be given round-the-clock attention and support if they were ill or temporarily in need of care. Beyond that, it was intended that the services provided by the lying-in ward could be drawn upon if the care requirements of the residents became so great as to make their capacity to live independently impossible. In this way, it was thought, a transfer to a nursing home proper could be avoided.

In view of the demographic development and the expansion of out-patient medical services, enabling older people to remain resident in their own homes much longer, the demand for places for very old and physically frail people rose sharply. This has meant a change in the make up of the nursing ward of Home C.,

which now offers 55 long-term nursing places, all of which were occupied during our observation period.

This change process, affecting, in the first instance, the nursing ward of Home C., and subsequently the entire institution, was not planned for in advance, and appears only gradually to have become firmly anchored and to have fully become part of the self-definition of the people running Home C. It seems obvious, however, that the group of persons drawing on the services of the nursing ward has undergone considerable change. The 55 individuals now living there are extremely elderly, frail and, to a very large extent, demented. The nursing ward will remain the centre of their lives until they die, while their sense of well-being will be increasingly dependent on the manner and mode in which others attend to them, care for and nurse them.

In view of these changes, those now working on the ward are confronted with the subjects of frailty, dependency, sickness and death to a far higher degree than they were previously, and must now deal with all the associated emotions of anxiety, grief, helplessness, anger, despair, disgust, loneliness, shame and envy.

Regarding the situation of the home's management

The ways in which the residents and personnel are now obliged to struggle with these themes and emotions appears to have penetrated through to the management only in a rudimentary form. It became apparent, however, even at the time of the introductory meetings, that the director is very much interested in developing strategies that would exert a positive influence on the quality of life of the nursing ward residents. Thus, for example, the director pointed out that:

> ... from a systemic perspective, he is particularly interested in finding out which 'switches' need to be turned to achieve a higher quality of life for the inhabitants. He states that it is clear to him that there can be no assumption of simple causal connections in these matters, but, from an entrepreneurial point of view, it would still be interesting to know which five 'switches' would need to be thrown in order to increase the quality of life of the old people. He states that he is now working with 50 such switch points inside a black box without being sure which one to flick. (Trunkenpolz, 2008a, Obs. 1/2)

These statements, made by the director, do express his aspiration to provide the nursing home residents with a higher quality of life, and this corresponded with our feeling of being welcomed and invited to do our work. On the other hand, as we only realized later, we got no information about every day life on the nursing ward from him whatsoever. This seemed in line with the fact that the director had very little conception of how to influence the appropriate processes leading to the achievement of the goal of improving the ward residents' quality of life.

This became apparent in the course of the third initial meeting to which the research team, the entire ward team, the nursing home residents and their relatives had all been invited. The director had intended to set in train, under his

own moderation, a mutual process of getting to know one another and an exchange between all parties concerned. Unfortunately, this did not happen. On the contrary, we got the impression that there existed invisible gaps between the groups of people present that could not be bridged, and which, accordingly, prevented people from entering into any kind of lively human contact with one another.

Further accounts gave rise to the assumption that the director, while willing to oblige everyone he encountered in a friendly and accommodating manner, did not, however, have an adequate grasp of the emotional burden that personnel, relatives and residents have to deal with on a day-to-day basis. Therefore, it comes as no surprise that management has instigated no initiatives towards the creation of a social and mental space within the home that could be utilised:

- to exchange views on the hard-to-sustain life and work situation, and
- to give more thought to the influence of the emotions experienced during a given day on life and work inside the home itself.

We were unable to find references to the existence of such a social and mental space in the course of the further accounts.

The situation on the nursing ward

Interactions between nursing staff and home residents. Nurse S.'s manner of behaviour was characteristic of interactions between nurses and residents and is described in the following account. The scene begins as Nurse S. is busy feeding Mr. K.:

> Nurse S. now goes over to Mr. K., who is sitting in a wheelchair at the far end of the big table. In front of him are a plastic cup with coffee in it and a small key. Nurse S. stops and stands next to Mr. K., bends slightly forward, touches him on his upper arm and calls him by name. The old man raises his head a little. Nurse Susanne asks him whether he would like to have some breakfast. Mr. K. shakes his head. Nurse S. then says that he must take his medicine all the same. Mr. K. nods. The nurse now places a dispenser with medicines on the table and sits down at the head of the table next to Mr. K.
>
> Nurse S. feeds Mr. K. some porridge. As she does so, she rests her hand on the old man's upper arm. With each spoonful, she asks him if she may give him a little more. In his wheelchair, Mr. K. either nods or opens his mouth at once so that Nurse S. can feed him. Nurse S. waits each time until the old man has swallowed and then asks him again.
>
> (Trunkenpolz, 2008a, Obs. 2/6)

Nurse S. has a friendly and empathetic manner with Mr. K. and tries to relate her efforts to the way Mr. K. is behaving. This attentive approach can be seen particularly where physical matters are concerned: care for the body, food,

clothing or bedclothes that wrap around the body. On the other hand, it is hard to find concern for any of the other topics that occupy the old people. In this regard, it is notable how Nurse S. reacts when there is a noisily audible conflict between two residents at the neighbouring table:

> At the other table Mr. A. is annoyed because Mrs. B. has drunk from the full jug of water. He makes noises indicating his anger. Mrs. B, who at first denied drinking from the jug, drinks again from it, saying apologetically that she was very thirsty. Mr. A. knits his eyebrows angrily and shows Mrs. B. a plastic cup. Nurse S. pauses a moment and casts a stern look at the other table, where Mr. A. and Mrs. B. are sitting. Mr. A. signals to Nurse S. about what Mrs. B. has just done. Nurse S. does not take it up, but simply goes on looking stern.
> (Trunkenpolz, 2008a, Obs. 2/6)

Two lines later we read:

> Nurse S. is feeding Mr. K. again, but has now taken her hand from his upper arm. With every spoonful she asks him if he would like some more and waits for his answer.
> (Trunkenpolz, 2008a, Obs. 2/6)

In the course of working through a large number of such accounts, it became clear that nurses and residents hardly communicate in any serious way about those aspects of life that fall outside the nursing task and are therefore non-physical in nature. This is especially noticeable in the following scene, involving Mr. T., a nurse, and Klaudia Schneider as the observer.

Mr. T. is 83 years old and was observed by Klaudia Schneider for three months. The excerpted reports are from the final observation record and describe how the observer takes leave of Mr. T.

Klandia Schneider and Mr. T. are in Mr. T.'s room. It is time for them to say goodbye. When the observer says once more that she is there for the last time today, Mr. T.'s sadness is so expressive that the observer feels herself come under strong pressure and makes a remark that was not actually discussed in the seminar:

> Now the nurse comes in. I look at Mr. T. again. The presence of the nurse troubles me. I tell Mr. T. that I have a lot of work at present and that I have many things to do in the project, but that I might perhaps come and visit him again some time.
> (Schneider, 2008, Obs. 12/5)

Although a nurse is present and Mr. T. shows openly how much he is suffering, he cannot experience the presence of an empathetic person with whom he can share his feelings and who tries to comfort him when the observer has gone. Klandia Schneider reports:

> Mr. T. sobs. The nurse is standing next to us. I give Mr. T. my hand once more. I take my leave. The nurse stands next to me and watches. Mr. T. simply sobs. I leave the room. Mr. T. watches me go. As I am just leaving, I see how the nurse pulls Mr. T.'s

> pullover off. Mr. T. cries aloud: 'Ouch!' Even when I am out in the corridor I can still hear him crying.
> (Schneider, 2008, Obs. 12/5)

When we discussed this account in the seminar, it became obvious that there was a close link between the way Schneider spoke to Mr. T. and the fact that she often had experienced how the nurses had avoided concerning themselves with the inner world and associated feelings of residents even when they were free from immediate work pressure. In the changes of shifts or at special meetings where residents were discussed, it was still noticeable that the nurses do not reflect in any intensive and differentiated way on the 'inner world' of the residents. In this respect, the following excerpt from an account is characteristic showing how, on the basis of various documents, individual residents were discussed:

> Nurse P. now takes up the yellow folder and turns the pages to the first patient file. She reads the name of the resident and the nursing documentation of the past day and night. The focus is on the resident's blood pressure, the fact that he had a shower the previous day, had had visitors in the afternoon and was at the podiatrist. She concludes with, 'He is happy', and then passes on to the next resident.
> (Trunkenpolz, 2008a, Obs. 4/2)

With this focus on the nursing and medical aspects, about 50 residents are discussed in less than an hour, without any detailed exchange on the emotional condition of the residents. It is remarkable in this connection that even in the accounts where private conversations between the nurses were recorded nothing can be found where feelings are discussed.

In this way, for example, there is a report of a conversation between two nurses involving one of the nurse's forthcoming stay in hospital. Only the choice of hospital and the nature of the coming examinations were discussed, while not a word was heard expressing any fears or expectations about the approaching hospital stay.

How can this way of structuring everyday relationships be interpreted?. When we in the research team asked ourselves how this might be understood, we were reminded of the often-quoted 1959 study by Menzies-Lyth. In that historic work, Menzies-Lyth drew attention to the large extent to which nurses working in a hospital are confronted every day with threatening, fearful and burdensome feelings. Menzies-Lyth (1959) summarises this as follows:

> Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks, which, by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion

> and love, guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy for the care given to the patient. (p. 186)

Against this background, one may assume that the behaviour of the director described above, as well as the nature of the relationships existing between nursing staff and the old people as well as between the members of the nursing staff amongst themselves, serve to protect them from the strength of the barely tolerable primitive emotions constantly aroused in all those working with demented old people.

(a) We, ourselves, were well able to witness just how strong these feelings were by becoming aware of the dynamics that developed in the observation seminars accompanying our research work. For example, it was especially difficult for the members of the research staff who observed in House C. to give any thought to the feelings of the home residents they had observed. This thought process was delegated to the seminar leaders again and again. For long periods we had the feeling that we had to do all the work ourselves, and were at times in despair, because we could not succeed in persuading the observers, despite their having written excellent accounts of what they had witnessed, to focus on the inner worlds of the demented old people they had observed. And if, as if by chance, any thoughts were expressed about the inner worlds of the residents, they were often not picked up in the minutes.

    All the more passionate were the emotions that came up in the block seminars directed by Ross A. Lazar. Some of the seminar participants, who themselves came from nursing professions, could barely tolerate the idea that the tasks of the nursing staff might also include taking a serious interest in, and taking account of the residents' feelings. Some seminar participants were incensed at the 'demands' being made on nurses. One seminar participant began to weep and another considered resigning from the seminar, but remained when it became possible to begin a process of thinking about this dynamic within the seminar itself.

(b) The emotional burdens borne by the employees of Home C. were also expressed through reports about the behaviour of the cleaning staff. Workers in this group sometimes showed themselves to be emotionally touched by events in the home, as well as being overburdened by them, as can be seen in the following excerpt:

> Suddenly I heard the cleaner cry out aloud and begin to shout, which startled me. I looked across at the two women. The old woman was standing with her back to me and I could see that her pants were filthy with excrement at the back. The cleaning woman shouted at the old woman, 'I can't believe it! The whole corridor and you, everywhere is', she took a deep breath, 'everything is dirty, your dirt sticks everywhere ... crap everywhere ...'. The cleaner was beside herself. 'No, I've had enough! I'll

> leave the shit where it is. Until tomorrow, I don't give a damn …'. She nearly burst with rage. Even I cringed, although it had nothing to do with me.
>
> The old woman just stood there doing nothing. Nurse R. came along the corridor and the cleaner complained to her, but Nurse R. remains calm. She went and got a walking frame and taking the woman by the arm, cared for her. They left the room, but the cleaner went on raging, shouting, 'I don't care about any of that, cleaning up shit all day long, it's true, people who work in the nursing home just clean shit away all day long! …' She went on complaining to herself as she wiped the corridor for the second time. I could still hear her shouting, 'Shitting on stuff all day, you wouldn't believe it …'
> (Schneider, 2008, Obs. 12/4)

A plea for a more sophisticated view. This account could suggest that the cleaning staff generally do not communicate with the residents in sensitive ways. Remarkably, the cleaners in Home C. sometimes treat residents with greater interest and sensitivity than the nursing staff. Something similar could also be said to be true of the two occupational therapists who work in the ward.

To illustrate this, here is an excerpt from an account that took place one morning. Mrs. D., 90 years old, is lying on her bed with her eyes closed. The observer sits at some distance to one side of the bed. The door opens and a cleaner comes into the room:

> Now Mrs. D. has her eyes open again and is looking at me darkly, frowning. 'She always makes so much noise when she is with me!' The cleaner comes to Mrs. D.'s bedside and asks, 'What me? Noisy? Yes, I do have to see whether I can clean here … So how are you, Mrs. D.?' She takes Mrs. D.'s hand, making her pull a face. The lines of the frown on Mrs. D.'s brow are even deeper and she pulls the corners of her mouth down forcefully. She turns her head slightly to one side, towards me, and begins to cry. A few tears flow down her cheeks. The cleaner bends slightly over Mrs. D.'s head. 'Oh dear, what's wrong? Does it hurt somewhere?' Mrs D. shakes her head. Then the woman asks, 'Would you like me to stay with you for a bit?' Mrs. D.'s expression relaxes again, tears flow down her cheeks: 'Yes, stay here a while!' The woman sits down on the side of the bed next to Mrs. D. and has a long talk to her.
> (Pfarr, 2008, Obs. 5/4)

The cleaner's question about how Mrs. D. is feeling and the act of holding her hand make it possible for Mrs. D. to express her feelings. Even though the cleaner concentrates at first on Mrs. D.'s physical well-being, she seems to be sensitive to the fact that Mrs. D. is really suffering from mental anguish. The cleaner follows Mrs. D.'s wish that she should stay with her for a while and comforts her. In the end, however, she decides to fetch a nurse. The cleaner leaves the room:

> A few seconds later the cleaner comes back into the room, this time in the company of an Asian-looking male nurse. He turns to Mrs. D. 'Hello, Mrs. D. Are you in pain?'

> Mrs. D.'s eyes are open again and she shakes her head. The nurse says, 'So what's wrong?' Mrs. D. doesn't react and just looks at the nurse. 'Now you've got such a nice visitor, you don't have to be sad'. He gestures towards me with his hand and grins at me. When he notices that Mrs. D. doesn't look at me, he says again: 'Look! Such a pretty young girl!' Now Mrs. D. looks at me, raises her eyebrows, and says 'Oh yes, really!' I smile at her. Then she looks back at the nurse. 'Look, such a nice smile!' Then he laughs aloud. He says something more to Mrs. D., which I unfortunately can't remember. Then the nurse and the cleaner say goodbye and go. Mrs. D. now looks at me expectantly with wide eyes and asks, 'What do I do now?'
> (Pfarr, 2008, Obs. 5/4)

The nurse does indeed notice that Mrs. D. is sad. In contrast to the cleaner before, however, he hardly empathises with Mrs. D.'s emotional condition, but tries to distract her from her feelings and then leaves the room almost immediately. Mrs. D. is left alone in the room with her feelings.

Little cooperation between the members of vocational groups. Considering this distinction in the way feelings are or are not dealt with, it is worth noting that the individual vocational groups on the ward do not exchange ideas very much with one another, and hardly attune their work to one other at all. For example, only the nursing staff takes part in the daily change of shifts. And, in contrast to the original assurance that nurses and occupational therapists form a team which works close together every day in managing and caring for the residents, in the course of our observations, it was only possible to make contact with the occupational therapists *through* the nursing staff. Only when that happened could the observer find out that the occupational therapists had a separate telephone number as well as a separate office located outside the ward in the home's entrance area. Since the nurses knew little about the work of the occupational therapists in other ways as well, we were reminded of a quotation from Kahn (2005), who reports similar difficulties around staff cooperation in a children's home in his book *Holding Fast—The Struggle To Create Resilient Care Giving Organisations:* 'A certain type of intergroup geography marks disrupted or failed collaboration among groups within care-giving organizations. The organization resembles an archipelago: a group of islands spread thinly throughout a large body of water' (p. 109).

Final remarks

The fact that Kahn's remark refers to the dynamics of a children's home makes one ask the question whether there might be certain groups of problems under consideration which could be described in future studies as characteristic of certain types of nursing homes or nursing wards. Briefly and with caution, we would like to outline four problem constellations:

The concentration of nurses on body-related care actions

The various persons and groups who work in the field of nursing perform a large number of activities that result in little attention and interest being paid to the inner worlds and emotional states of people in need of receiving care. And, indeed, the same applies to the inner world and related feelings of those who work in the caring professions. This seems to serve the purpose of holding off threatening feelings and to result in all those concerned being able to have only a very low level of experience in relationships, which one could describe in Bion's terms as 'container–contained' (Trunkenpolz, 2008b).

This goes together with the focus on body-related nursing activities which help nurses to concentrate on areas of action for which they feel they have been well trained, and at the same time protecting them from being emotionally affected to such a degree that they could no longer perform their work. In this sense Foster (2001), in her article 'The duty to care and the need to split', formulates the apparently paradoxical hypothesis:

> . . .that workers may need to split off part of their emotional experience in order to preserve their own mental health and provide reliable services to their clients. . . . To retreat from emotional involvement with difficult clients is both a form of self-protection and a danger. In retreating, we cease to hold the client in mind as a whole person and we become deadened to unconscious communication, running the risk of not seeing what we need to see and consequently of not doing what we should be doing. (p. 81)

The scope available to the other vocational groups

As shown in our observations, occupational therapists and cleaners seemed to tend somewhat more sensitively to perceptions of the inner worlds of the residents than the nurses did.

They were seen to pay more attention to and take into account the feelings of the home's residents, and to express more of their own emotions (although sometimes in a rather undigested way). This seemed to us to be connected with the fact that members of these vocational groups—in contrast to the trained nurses—are not responsible to the same extent for their increasingly aging and frail residents, and do not come into such intimate contact with their ever-weakening bodily and mental functioning. This, we assume, has a considerable impact on the intensity and variety of the primitive anxieties that inevitably are aroused in the course of the work, hence producing different needs to defend against them.

Viewed from this perspective, it may also be surmised why the Home C. nurses, occupational therapists, and cleaning personnel, at least according to our observations, cooperated to such a limited extent. The occupational therapists and cleaning personnel appeared more prepared to raise or give vent to emotional issues. If the nurses were to come into closer contact with the occupational therapists and cleaning personnel, presumably they would have

found it harder to continue to block out their emotional involvement in the manner they had heretofore been accustomed to doing. This could conceivably lead to an escalation of fears about holding down their jobs, as their ability to work may, in fact, rely on a tendency to avoid too much conscious exposure to their own emotions.

Restructuring

In addition, the organisation is at present undergoing a restructuring process and the transition from an old-age home to a nursing home has not yet been completed. In such phases of major change the pressure of work is likely to be greater without one being able to rely on the people involved having built up enough of a 'mental space' which would enable them to think about individual persons as well as about relationships between these individuals and thereby to reach a greater understanding of them.

At the same time the organisation runs the risk of not yet realising how important it is to create a 'social space'[4] which can be used by the persons entrusted with management and care of the residents to exchange impressions and ideas with one another.

The aspect of dementia

If the residents of such a 'caring institution' suffer from dementia, this arouses not only fears and other negative feelings but also the suggestion that demented people no longer experience life in a rich, sensitive and differentiated way. If one believes this, one might soon conclude that it is neither worthwhile nor important nor even possible to find an approach to the inner worlds of demented patients in a manner conducive to understanding them. This can protect those working in such an institution from recognising all too precisely what threatening and troubling experiences one may have when one seriously considers the inner world of those suffering from dementia. By avoiding this, one can also protect oneself from getting into situations where one tries to understand demented people but does not succeed, thus running the risk of feeling the limits to one's own cognitive and emotional abilities in a painful way.

In this context, it should also be considered that observers and seminar leaders alike continually find themselves confronted with physical and psychical processes of decrepitude and experiences of loss when discussing or reviewing their observations of elderly and demented people within a seminar context. The emotional burdens deriving from this may differ from the threatening emotions raised in seminars where observations of infants or young children are the main focus. For as observers and seminar leaders deal with the suffering, pain and incapacities of small children, they can console themselves with hopes that these small children have a plethora of developmental stages still ahead of them and that, as a rule, they will learn to cope with suffering, pain and inabilities better as

they reach more mature stages of development (Balfour, 2006). Beyond that, early childhood also belongs to a phase in the observers' and seminar leaders' own past, whose present existence, as it were, provides living proof that the distressful phases of early childhood can be successfully overcome and survived.

Observers and seminar leaders, who, on the other hand, have as their task the discussion of observations centring on old and demented people see themselves confronted with painful situations, which may well become part of their own futures, and are, furthermore, reminded of the fact that demented old people—just like the observers and seminar leaders themselves—inexorably move closer towards their own decline and death with each passing day. However, this idea, as well as many other related considerations arising from this research, will require more and closer examination and discussion, both within our own research team as well as elsewhere.

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Notes

1. The first number indicates the number of the observation from which the quotation is derived. The number after the slash refers to the page of the report from which the passage has been excepted.
2. Homepage of the research project 'Toddlers' adjustment to out-of-home care': http://www.univie.ac.at/bildungswissenschaft/papaed/seiten/forschungseinheit/forschungsprojekte/x1_FWF%20Eingewoehnungsph ase%20in%20KinderKrippe.htm
3. The first Viennese scientist to employ young child observation techniques as an extension of infant observation and application to a research project was Gertraud Diem-Wille (1997). She initiated the first infant observation seminar held in Vienna under the expert direction of Isca Salzberger-Wittenberg and Anne Alvarez as the seminar leaders. Beginning in 1994, members of that seminar set out, with supervisory support from Isca Salzberger-Wittenberg and Ross A. Lazar, to conduct infant observation seminars, which have since become a core part of the curriculum for some post-graduate courses being offered in various institutes in Vienna (Diem-Wille, Steinhardt, & Reiter, 2006). To a somewhat lesser degree, this is equally true of the young child observation and

organisational observation seminars offering methodologies pioneered and first taught in Vienna by Anton Obholzer and Ross A. Lazar. The Infant Observation Study Group Vienna (IOSGV) today is comprised of 11 individuals, who regularly lecture on infant observation and its applications in Vienna.

4. 'Social Space': 'Hetherington et al. (1997) emphasise the place of professional judgement in a thoughtful 'space'. The social space is one in which the professional is permitted—and empowered—to work in a climate in which psychological and social factors are taken into account and then considered in a problem-solving activity'. (Briggs, 1999, p. 149)

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