Researching emotion: the need for coherence between focus, theory and methodology

Jan Savage
Royal College of Nursing, London, UK
Accepted for publication 17 September 2003

SAVAGE J. Nursing Inquiry 2004; 11: 25–34

Researching emotion: the need for coherence between focus, theory and methodology

There is a longstanding awareness of the significance of emotion in nursing and yet it remains one of the more elusive areas of practice. Surprisingly, there has been little discussion in the nursing literature of how the phenomenon of emotion might be understood or studied. This paper gives an overview of theoretical and methodological approaches to emotion, and how the researcher’s emotions may inform the research process. In addition, it draws on ethnographic research exploring the role of emotion in the practice and clinical supervision of a group of psychosexual nurses undergoing Balint seminar training to help highlight some of the inherent problems of researching emotion. The paper argues that these sorts of problems may be avoided or reduced by ensuring coherence between the research focus, the way emotion is theorised, and the methodological approach of the study.

Key words: Balint seminar training, emotion, methodology, psychosocial nursing, theory.

It has been widely acknowledged that emotion holds considerable significance for nurses and nursing. It has been argued, for example, that the caring undertaken by nurses cannot be divorced from feeling (Henderson 2001) and that individualised care requires emotionally skilled practitioners (de Lambert 1998). Nurses’ experience of powerful and distressing emotions at work, and the stress and burnout associated with these, have long been a focus of concern (Menzies 1970), with little known about how nurses learn to balance emotional engagement with detachment (Carmack 1997). Nurses’ claims to be best placed amongst healthcare personnel to develop emotional ‘closeness’ or rapport with patients have been incorporated into recent professionalisation strategies (Aldridge 1994; Savage 1997). Yet, ironically, attempts to professionalise nursing have been hindered in the past by its historical association with emotion rather than rationality (Davies 1995).

Perhaps the clearest acknowledgement of the relationship between emotion and nursing is to be found in work that draws on Arlie Hochschild’s (1983) analysis of emotion management to consider nurses’ deployment of emotional labour or emotion work (James 1989, 1992; Smith 1992; Staden 1998; Hunter 2001). The terms ‘emotional labour’ and ‘emotion work’ are somewhat contentious. Smith, for example, has suggested that ‘emotion work/management/labour intervenes to shape our actions when there is a gap between what we actually feel and what we think we should feel’ (1992, 7), while others have drawn a distinction between ‘emotional labour’ and ‘emotion work’. Lupton (1998), for instance, suggests that ‘emotional labour’ refers to the way that the feelings of others are responded to or managed, particularly in a social unit or workplace, with the intention of maintaining harmony. In contrast, ‘emotion work’ is the work of self-management carried out by individuals to ensure that culturally appropriate emotions are expressed. Yet whether the terms ‘emotional labour’ and ‘emotion work’ cover the same or distinctly different endeavours, considerable attention has been given to nurses’ management of emotions and their presentation of self during practice.
What has received less attention is the way that some nurses aim to identify, and then use, emotions experienced in the clinical encounter to help patients address psychosocial problems. In this form of practice:

The nurse attempts to form a relationship with the patient, within which feelings, thoughts and ways of relating (by the patient to the nurse, as well as to others), can be talked about in an open and honest way as possible in the here and now. The nurse uses his or her feelings and a personal sense of self as a therapeutic medium in relation to the patient (Griffiths and Leach 1998, 9–10).

Nurses’ skilled use of emotion as an element of psychosocial care, however, may go unrecognised in a climate characterised by demands for evidence-based practice, unless there is research that makes its use and benefits perceptible. Yet the study of emotion is far from straightforward, not least because of the variety of ways in which emotion has been theorised. There is continuing debate, for example, about the extent to which emotions involve the mind or the body, and thus whether they are concerned with meaning or feeling, or if they transcend these dichotomies (Leavitt 1996). Such debate is relevant to researchers because theoretical assumptions about emotion have methodological implications. For instance, those who assume emotions are primarily bodily phenomena are more likely to expect emotional experience to be more or less constant cross-culturally, and available to others by inference from signs such as weeping. In contrast, if emotions are considered mental events and thus more accurately understood as cultural artefacts, the meaning of signs such as weeping will be considered to vary radically cross-culturally. On this premise, access to the emotions of others will not be possible without detailed knowledge of the social context and social interactions in which emotion is expressed (Leavitt 1996). In addition, the suppositions held by researchers of emotion, such as the assumption that they will be able to distinguish their own emotions from those of others in the field (Craib 1995), will arguably shape their approach to research design, data collection and interpretation. However, with notable exceptions (for example, Ord 1998; Leavitt 1996), there has been scant discussion about the kinds of methodologies appropriate to investigate emotion, or the implications of assumptions about emotion for its study.

This paper aims to contribute to such a discussion by presenting the problems raised by an ethnographic study of practitioners who, with the support of Balint seminar training, used emotion as a tool in providing psychosocial care to clients with psychosexual problems. The main findings of this study and some of the questions raised by this form of care are reported elsewhere (Savage 2005). The focus of this paper concerns the issues raised by researching emotion, most notably the importance of ensuring a fit between conceptual and methodological approaches to emotion. The paper begins with a brief discussion of the ways in which emotion has been theorised, and the ways in which emotion already has been recognised as relevant to the research process. It then introduces the study and the assumptions that informed its approach, before providing a brief overview of the work of the group, together with the nature of Balint seminar training and psychosexual nursing. A case study is then presented to demonstrate the way in which nurses in the study work with emotion, followed by a discussion of the limitations imposed on the study by the assumptions that underpinned it. The paper concludes by arguing that researchers attempting to explore emotion need to make their suppositions about emotion explicit at the outset and endeavour to achieve consistency between their theoretical stance and their methodological approach.

**THEORISING EMOTION**

There is some argument that the concept of emotion is a specifically Western cultural category that is assumed to be a universal phenomenon. This is despite numerous anthropological studies that demonstrate how differently other societies define what Westerners call ‘emotion’ (Lutz and White 1986; Leavitt 1996). Within Western culture there is a ‘common sense’ view of emotions as subjective, inner states that ‘belong’ to the individual, and are to a large extent, the repository of the self. Emotions, in this view, are experienced in response to a person or some kind of phenomenon, and are generally a transient rather than an enduring part of the way that an individual relates to the world (Parkinson 1995). Perhaps because of its consistency with Western concepts about the person, this common sense view has, until relatively recently, influenced approaches to emotion within the social and behavioural sciences (Lutz and White 1986). For example, Parkinson (1995, 15) suggests that ‘psychology, like common sense, tends to assume that emotion is primarily an individual phenomenon’.

Among the different ways that emotion has been theorised within the social sciences (see Table 1 for an overview), most are concerned with:

- whether emotions are natural or cultural phenomena;
- the nature of the relationship between emotion, the body and the person; or,
- the association of emotion with reason or cognition.

Williams and Bendelow (1996) have organised such theories into three broad categories that help to provide a framework for this paper.

First, in what Williams and Bendelow call organismic approaches, emotions are understood as largely physiological.
responses, instinctual bodily changes or gestures that are felt by an individual and relate to that individual alone. Second, social constructionist approaches include a number of perspectives, ranging from those in which emotions are considered primarily social experiences, associated with, but not explained by bodily changes, to those where certain emotions have no physiological basis at all. These arguments emphasise historical and cultural variations in emotion, and suggest that complex social phenomena, such as moral attitudes or language, pre-exist and shape the experience of emotion (Abu-Lugnod and Lutz 1990). Jaggar (1989, 148), for example, has stated that ‘We have no access to our own emotions or those of others, independent or unmediated by the discourse of our culture’. Third, interactionist approaches are situated between organismic and social constructionist accounts, and argue that emotion comes into being when biophysical, personal and social experience interact.

Also relevant to the argument of this paper is the way in which the role of emotion in the research process has been theorised. Emotions (and their management) have long been recognised as significant phenomena in research because of their capacity to influence data collection and analysis (Craib 1995). Traditionally, academic research has been characterised by attempts at objectivity and rationality in which the feelings of the researcher were to be bracketed as tangential or something of a nuisance. However, qualitative, particularly feminist, researchers have long argued for an approach that makes use of, rather than denies the researcher’s feelings (Wolf 1996). Devereux argued as long ago as 1967 that we must know what happens within the observer if we are to understand what he or she observes, and there is now growing acceptance of the value of subjectivity or emotional sensibility in the research process (Rosaldo 1989; Okely 1992; Hastrup 1994; Behar 1996; Young and Lee 1996; Coffey 1999).

### Table 1  Overview of theoretical approaches to emotion (adapted from Lutz and White 1986)

<table>
<thead>
<tr>
<th>Materialism</th>
<th>Idealism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotions are considered material things, constituted biologically as movements of facial muscles, raised blood pressure or neuro-chemical processes, although the expression of emotion is modified to some extent by culture</td>
<td>Emotions are ideas or evaluative judgements, with little relationship to the body. In this view, emotions as judgements require a degree of social endorsement or negotiation and, as such, are not divorced from issues of power and social structure.</td>
</tr>
<tr>
<td>Interpretivism</td>
<td>Positivism</td>
</tr>
<tr>
<td>Emotions are not material but are constructed, or perhaps negotiated, by people during interactions with others. Emotion is mediated to a large extent by language.</td>
<td>In some disciplines, such as certain fields of psychology, the focus is often on the emotional or motivational causes of behaviour.</td>
</tr>
<tr>
<td>Universalism</td>
<td>Relativism</td>
</tr>
<tr>
<td>Emotion is a pan-human phenomenon, typically defined as an internal feeling state. Recognition of cultural variance is restricted to phenomena that are tangential to the essence of emotion, such as the language available for describing it</td>
<td>Emotion, or many aspects of emotion, is culturally specific. Emotions are socially endorsed judgements, rather than internal states of the individual.</td>
</tr>
<tr>
<td>Individualistic</td>
<td>Social</td>
</tr>
<tr>
<td>Particularly in evolutionary and psycho-dynamic approaches, the individual is considered the ultimate source of emotions that either conform with or contradict social expectations.</td>
<td>A distinction is drawn between emotions (private feelings that bear little relationship to culturally shaped or socially articulated norms) and sentiments that conform to social expectations.</td>
</tr>
<tr>
<td>Rationalism</td>
<td>Romanticism</td>
</tr>
<tr>
<td>Emotions are identified with the irrational, the disordered and the problematic.</td>
<td>The capacity to feel emotion defines what is human, and provides meaning in individual and social life.</td>
</tr>
</tbody>
</table>

In research, the theoretical stance adopted toward emotion will have implications for the way that emotion is

---

*Researching emotion*

investigated, influencing whether a researcher sets out to study emotion directly, explores ideas about emotion, or both, and subsequently shapes the types of methods used (Lutz and White 1986). According to Parkinson (1995), for example, researchers who want to investigate emotions must either depend on outward signs of emotion in others (or on the ways that others describe their emotions), or rely on their own experience as a source of data (Parkinson 1995). The researcher’s response in each case is inevitably shaped by their assumptions about the nature of emotion, such as the supposition that it is essentially an individual, private and internal experience. Their response will also pose considerable challenges. For example, to what extent can researchers know what they feel through introspection, let alone convey what they feel, if there is no way of ensuring a consistent link between an ostensibly private experience and a linguistic term to describe it (Parkinson 1995)? Alternatively, to what extent can one person (the researcher) understand or participate in the feelings of another on the basis of outward signs or descriptions of emotion (Desjarlais 1992)?

One response to the challenges posed by researching emotion has been to try to access the experiential world of informants by adopting their bodily practices. For example, Mitchell (1997, 83), a social anthropologist, has argued that adopting the practices of research ‘subjects’:

- can take one beyond simple mimesis, and into the realm of felt experience. This type of experience should not be ignored. Rather it can give us further, deeper insights into the practices that provoke them, and into the interpretations that are made of them.

Moreover, he suggests that felt experience can be understood as a form of cognition, of the same order as others such as semiotic cognition (relating to language or language-like phenomena) and practical cognition (related to embodied forms of knowledge). A similar point has been made by Rosaldo (1984, 43) who said: ‘Emotions are thoughts somehow “felt” in flushes, pulses, “movements” of our livers, minds, hearts, stomachs, skin (my emphasis).’

Mitchell provides an example of how he experienced emotional insights through practical participation, taken from his own fieldwork as an anthropologist studying the ways in which people learnt about religion in Malta. He describes an occasion where he joined some of his acquaintances in helping to clean the local church and was volunteered to climb up into a niche housing the statue of a saint in order to wash its protective glass panel. The statue itself was attributed with miraculous healing properties that could be conferred by touch. Squeezed in behind the glass screen and in close proximity to the statue, Mitchell was overcome by a strange sense of light-headedness, panic and fear that his companions found unsurprising. He was unsure to what extent he should attribute this sensation to the fumes of the cleaning agent. Yet he was also convinced that this practical participation (and the close contact with a revered icon that it led to) gave him important insights into the feelings of awe and affinity inspired by the Church’s saints and into the relationship between the Church and its local community. In this example Mitchell suggests that the emotional knowledge that he attained was not verbally acquired, but gained through the body. Moreover, his emphasis on practical mimesis suggests the assumption of a strong connection between the body and emotion.

This was very similar to the approach that underpinned my fieldwork with the Balint group. Through attempting to adopt the cultural practices of the group, I anticipated that I would share some of the felt experience of the group and would be able to use this experience as data. This approach seemed to fit to some extent with that of the group members who considered that feelings did not ‘belong’ exclusively to any one individual. As the group leader said:

It does seem to me to be so intertwined … what happens between the patient and their partner, what happens between the patient and the practitioner, what happens between the practitioner and the group and what happens between [the group and] the leader of the group.

**THE STUDY**

The study was primarily concerned with understanding the process of clinical supervision taking place during a Balint seminar programme for psychosexual nurses, and with exploring these nurses’ emotional experience as a form of nursing knowledge. An ethnographic approach was adopted, involving participant observation of the seminar group over the course of one training year, plus semistructured interviews with all seminar members and attendance at relevant additional activities attended by seminar members, such as study days.

As I discuss in more detail later, the study was informed by at least three assumptions. The first of these was an explicit supposition that emotion was a form of embodied cognition, experienced primarily as an internal state. The second assumption, initially unexamined, was that participation in the Balint training seminar would allow me to share the emotions felt by other members of the group. Third, I assumed that I would be able to recognise and give voice to these emotions. These initial assumptions about the nature and location of emotion had wide ranging effects, shaping, for example, the choice of methodology and the type of data that was focused on.
The group

The seminar group was comprised of eight expert nurses (the group members) and a seminar leader who were committed to meeting once a month for at least 2 years for the clinical supervision of members’ practice. The group members came from a variety of clinical backgrounds, such as family planning, midwifery or general practice, where they had gradually gained expertise in working with patients’ psychosexual problems as part of a wider clinical remit. After many years of integrating psychosexual work into their practice, all but one of the nurses in the study had become autonomous psychosexual counsellors, taking referrals from a range of sources, including general practitioners, mental health services and, to a lesser extent, sexual health clinics. Their clients were predominantly heterosexual, of various ages, with a range of sexual problems, such as impotence or loss of libido.

One of the principle aims of clinical supervision was for seminar members to understand and develop their practice through understanding the emotions that they experienced during a specific nurse/patient encounter. There was no attempt to manage or defuse emotion. Instead clinical supervision aimed to help participants identify the nature and source of the emotions they experienced in their practice so that these might subsequently be reflected back to patients, who might then recognise something new about themselves. With this in mind, participants were encouraged by the group leader to be led by their emotions rather than cognitive reasoning — to ‘feel rather than think’. This form of clinical supervision was provided through a process known as Balint seminar training.

Balint seminar training

Michael Balint developed a form of seminar training for clinicians based on experiential learning, initially to help family planning doctors develop skills to cope with the sexual anxieties of patients, and later to support general practitioners wishing to understand the doctor–patient relationship in greater depth (Balint 1963). The intention of Balint seminar work is to understand a patient’s emotional world, and explore the relevance of this to their health or illness. This understanding is arrived at through considering ‘the feelings generated in the doctor (sic) as possibly being part of the patient’s world’ (Balint et al. 1993, 47), and then using this experiential knowledge to help the patient.

Balint seminar training comprises a series of regular seminars (generally over a two-year period) in which participants take turns to describe their encounters with patients, particularly where they feel unsure or dissatisfied with their work. These case histories are presented from memory to encourage spontaneity, and significance is attached to events or impressions that are initially overlooked or omitted. During a presentation, other members of the seminar group are expected to listen carefully and non-judgementally, and then explore the nature of the practitioner/client relationship with a view to supporting the practitioner to develop new insights and skills (for more detailed description of this process, see Clifford 1998).

One of the central tenets of the Balint approach is that the learning that takes place in seminars is not the result of instruction or the progressive acquisition of intellectual knowledge. Rather, Balint groups aim to create an atmosphere of exploration in which participants can look and listen ‘to what is going on inside as well as outside themselves’ (Balint et al. 1993, 48). Balint seminar training is broadly psychodynamic in its approach in that it draws on ways of feeling and thinking that are psychoanalytic in style. Balint was among the first psychoanalysts to consider transference in the clinical situation as a product of the interaction between a patient and his or her particular clinician (Bacal 1987). Not surprisingly then, Balint seminar training draws on the concepts of transference and counter-transference. However, these terms have a number of meanings in the discourse of psychoanalysis and in the Balint context, their meaning is perhaps less specific than in some other fields. There is an assumption that feelings experienced in the therapeutic encounter have transferred from another context, and a further supposition that the way a practitioner feels during an interaction with a client is linked to the feelings a client has transferred into the encounter.

There is no literature that challenges the theoretical underpinnings of Balint training per se, perhaps because these remain largely implicit. Research suggests that some seminar participants find Balint’s atheoretical, unstructured approach difficult to grasp and that receptivity to Balint training may be partly a function of personality and learning style (Musham and Brock 1994). A trained leader is considered vital to the success of the seminar process, although there is currently scant literature on training for the role (Brock and Stock 1990), and leadership can take one of a number of forms (Norell 1991). According to Norell (1991, 379), wise leaders ‘prefer to behave as animatours’, and remain open to the possibility that some features of the

1Luhmann (2000, 104), for example, distinguishes between transference with a little ‘t’ — ‘the transference that we all act out of all the time … the way we all see one another through the fitting lenses of our own pasts and temperaments’ — and Transference with a big ‘T’ that refers to ‘the emotional intensity generated by the therapeutic relationship itself’.
clinician–patient relationship might also apply to the leader–group relationship (Norell 1991). Following a survey of Balint group work across the United States, Brock and Stock (1990, 37) highlighted difficulties in evaluating the effectiveness of the seminar process, but nonetheless expressed the opinion that:

the Balint seminar is as helpful to the process of accurate identification with the patient’s emotional state as the bedside examination is to physical diagnosis.

**Psychosexual nursing**

Psychosexual nursing is a form of psychosocial nursing — an approach to care and learning that makes use of psychoanalytic ideas and is underpinned by the principle that the practitioner’s own feelings that are aroused in work with distressed people can be used in a practical therapeutic way, both to understand the interaction and to hone the practitioner’s skill (Barnes 1998, xvi).

Psychosexual nursing rests on the development of a number of nursing skills, including the ability to observe and make use of both non-verbal information from the patient, and feelings generated in the nurse during the clinical encounter, in order to respond to patients with psychosexual problems, such as loss of libido or vaginismus.2 Significantly, psychosexual practitioners assume a strong association between emotion and the physical expression of sexuality: ‘an almost limitless expanse of emotions can enhance or subdue arousal and sexual activity’ (Skrine 1997, 1). Moreover, this connection between emotion and the sexual body is two-way. Not only do emotions influence the performance of ‘sex’, but the body provides a diagnostic tool in the identification of troubling emotion. More specifically, physical examination is understood to provide a route to understanding the emotions of a particular patient: ‘as the clothes come off and the body becomes more naked and exposed, so do the feelings’ (Skrine 1997, 16). This is not to say that emotions are necessarily viewed as physiological in nature, so much as written on or through the body in some sense, so that exposure of the body may allow the exposure of emotion, or allow emotion to be articulated. As Skrine (1997, 17) has said of the role of physical examination in the practice of psychosexual medicine:

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

Feelings generated in the nurse–patient encounter, whether as a result of verbal interaction or physical examination, were assumed (i) to arise with the patient; (ii) to be transferred to the nurse and, in a further step; (iii) transferred to the members of a seminar group who listened to a case-presentation. The research, in turn, was premised on a similar kind of assumption, that the feelings that the researcher experienced during training seminars would be those, or very much akin to those of the seminar participants.

**Case study**

The following section gives details of one case study that was presented during the study by one of the seminar participants whom I call Agnes, to demonstrate how the nurses worked, where emotion seemed to be located and how it appeared to be transferred to other members of the group. The client is disguised to protect her identity.

In her presentation, Agnes talked about her work with a client called Elaine, someone she had seen several times without developing any rapport. Rather, her sessions with Elaine were marked by keen discomfort. She described Elaine as a ‘fierce looking lady’, with sharp features and spiky hair. Elaine was complaining of loss of libido. Two years ago, in her mid fifties, she had married a man considerably older than herself. Before marriage they had a passionate sexual life but, once married, she suddenly lost interest in sex. She mentioned this to her general practitioner (GP) and he referred her on to a menopause clinic without further inquiry or discussion. She did not find referral helpful. Agnes learnt that Elaine had been having a difficult time since her marriage in a number of respects. Her father, with whom she had a very close relationship, was dying. Things had been difficult at work and she feared losing her job. After selling her own house and moving in with her husband, she missed her own space.

On reflection, Agnes found it difficult to recall the nature of the psychosexual work done during these sessions. She told of how she had suggested a physical examination, but Elaine had refused this on the basis that she knew there was nothing physically wrong. Agnes had probed for more detail about Elaine’s husband and received the impression that there might be some ambivalence in Elaine’s feelings toward him and his sexual needs. Agnes concluded by saying that she was uneasy about how little compassion she had been able to summon for Elaine, and did not seem to have much to show for the number of times she had seen her. However, she hoped that she would remember more as the group discussed her work.

---

2 Spasm of the muscles of the vagina that makes penetration difficult or impossible.
The group’s discussion of Agnes’ presentation started with agreement about how difficult it seemed to be for Agnes to become close to Elaine, and how unclear the group was about Elaine’s feelings for her husband. Agnes then added that Elaine’s mother had died when she was a small child, and this was one of the reasons why she was close to her father — he was the one who had brought her up. Given that he was significantly older, there was some discussion about whether the husband played a fatherly role for Elaine.

The group leader then asked what were the feelings of people in the seminar — how did they respond to what Agnes had told them? There was an air of discomfort in the group and much rather fruitless discussion. Participants seemed to experience great difficulty in identifying what they felt, if they felt anything. No one seemed to feel sad for Elaine, despite hearing about the various losses she had sustained — her home, her libido, the potential loss of her job, and the forthcoming loss of her father. The group leader suggested that the absence of feeling in the group probably reflected how difficult it was for Agnes to have any feeling about her patient. She asked Agnes to say more about what it was like to be with her. Agnes told how she had been very anxious to help Elaine and this seemed to have made her talk more than usual — there were no silences in their session, as if both nurse and patient were afraid to stop speaking. Agnes said that Elaine reminded her of a flickering light bulb, a dangerous current.

The highly charged, uncomfortable nature of the consultations seemed to be mirrored in the behaviour of the group — there was a lot of talking, interruption and, unusually, a good deal of argument and irritation. It was suggested that Agnes seemed to be pushing away members of the group in the way that she kept talking, without listening to what they were saying. Suddenly Agnes remembered something Elaine had told her during their last meeting, and she was astonished that she had forgotten to mention it before. When Elaine was in a previous relationship she had become pregnant. She was in her late 30s and realised that this was probably her last chance to have a child. She had really wanted to have the baby, but she miscarried. Elaine never became pregnant again. When the group heard this, there was a sudden surge of empathy for Elaine and recognition that her visit to the GP and his casual reference to the forthcoming loss of her father — one that had been compounded by more recent losses, and inflamed by a GP’s thoughtless treatment. Agnes thought that she now had some basis from which to explore Elaine’s presenting problem, her loss of libido.

**DISCUSSION**

This seminar work was considered to be useful by members of the group. However, it was one of many occasions during the research when I felt unsure about what was happening. The pain that I experienced during the discussion of Agnes’ case presentation, and that I seemed to share with other members of the group, was unusual. For the most part, I could not work out what I was feeling or how to understand what I felt. With hindsight I believe that this was partly because of inexperience in working in the group, but also because I was looking in the wrong place to understand the process of experiential learning that was occurring. The methodological approach to the study had developed from certain premises about emotion that did not fit well with what existed in the field. These original premises were not entirely common-sense assumptions about emotion as private, inner phenomena, but included the belief that emotions can be experienced through participation in a common set of practices, and are thus primarily located in the body. I was prepared to consider the emotions felt during seminars as collective rather than individual phenomena but I was nonetheless anticipating that they would be inner experiences that I would be able to identify and name. In practice, emotion was elusive: inwardly searching for its presence seemed to have the effect of dispersing it. It felt as if I was thinking about emotion (employing semiotic cognition, in Mitchell’s taxonomy) rather than feeling (emotional

---

1I am indebted to Diane Wells of the Association for Psychosexual Nursing for pointing out a number of factors that may have influenced my response. Most seminar participants learn through presenting their own practice, and from long-term immersion in the seminar process. In contrast, I brought no case studies to the group and attended for a relatively brief length of time. Moreover, the learning process associated with Balint seminar training contrasts strongly with the academic styles of learning that I was accustomed to.
cognition). On reflection, aided by listening to tapes of the seminar, it seemed that emotion was most strongly manifested within the group as a whole rather than within myself as an individual group member. More specifically, it was communicated through members’ interaction — the initial babble and cross talk (both in terms of interruption and irritation), and the subsequent ‘gentling down’ and sense of closeness amongst group members.

With hindsight, it seems that, rather than taking an individualised approach to studying emotion, it might have been more helpful to adopt a more interactionist view. Burkitt (1997), for example, challenges the view that the expression of emotion is an outward manifestation of an inner process. Instead he suggests that emotions are relational, constituted by social life and essentially communicative; they are expressions occurring between people, not inside a single person. This is not to ignore the physical components of emotion that are central to the individual’s experience of them. Instead, Burkitt (1997, 43) argues that emotions are culturally specific composites of the physical, practical and the discursive: ‘A culture provides for people an emotional habitus with a language and a set of practices which outline ways of speaking about emotions and of acting out and upon bodily feelings within everyday life’.

This is not to suggest that the relational approach indicated by Burkitt is the only way to study emotion. Understanding emotions as Rosaldo (1984) describes them — thoughts felt within the body — and using these inner experiences as data might have been appropriate in other contexts. Mitchell’s experience of cleaning the religious statue, for example, was clearly instructive for him in the context of his research. What I am suggesting is that designing research on emotion requires clarity at the outset about how emotion is to be understood within any particular study and, in addition, requires some coherence between this conceptual approach and the study’s methodology.

CONCLUSION

There is considerable interest about the role of emotion within nursing and yet, even in an era of evidence-based practice, there has been limited discussion about how emotion can be understood or investigated. This paper has described research that sought to understand both nurses’ use of the emotions experienced in clinical encounters, and the role of emotion in their clinical supervision through Balint seminar training. The aim has been to show some of the pitfalls associated with a lack of fit between a study’s focus, the theoretical assumptions made about emotion that inform research design, and the chosen methodology. In this case, the theoretical approach assumed a close connection between knowing and bodily experience, and took emotion to be a form of cognition shaped by social experience that was felt or expressed through the body. The methodological approach was developed from radical empiricism, which promotes participation (ideally using all the senses) in the cultural practices of study participants as a way of accessing their experiences, experiences that might otherwise remain individual and inward. Thus both theoretical and methodological stances, while assuming emotion to be a largely social phenomenon, located emotion within the individual and within the body. However, the focus of the study was predominantly on the dialogue that took place in seminars. Although participants took the body to be a route to the emotions of patients, the body played little observable role in seminars. Perhaps not surprisingly, looking for inner, individual experience of emotion seemed a less fruitful method than a more interactionist approach that focused on the relationships and interdependencies within the group.

It is not suggested that one theory of emotion, or one methodology for studying emotion is superior to any other. Instead the paper’s main aim is to highlight that there are a range of theories and methodologies available, and that an important part of the process of deciding what is the most appropriate approach for researching emotion is ensuring coherency between theory, methodology and the focus of the study.

ACKNOWLEDGEMENTS

I thank the nurses involved in the research described in this paper, as well as members of the Association for Psychosexual Nursing who have helped to shape my thinking about feelings and how to research them. I also thank Professor Kate Seers and the two anonymous reviewers for Nursing Inquiry, for their very helpful comments.

REFERENCES


---

**Nursing Inquiry**

**Call for papers**

**Special issue: ‘Virtual Nursing Practice and Inquiry’**

*Guest editor: Dr Margarete Sandelowski, Cary C. Boshamer Professor, University of North Carolina, USA*

Among the most dramatic features of western healthcare is the increasing turn to virtual environments for practice and inquiry. Clinical practice and research are now comprised of an array of tele-encounters between persons who do not share the same physical space. The patient is no longer necessarily the corporeal person behind the screens, but rather the hyper-texted, hyper-real representation on screen: the rhythm strip, the black-and-white or colorized image, or the numeric, graphic, digital, schematic, or other visual display. The clinician is no longer necessarily the flesh-and-blood person next to the bed or examining table, but rather a voice on the telephone, an e-mail correspondent, an on-line presence, or the tele-image of a face or hand holding a medical instrument. Researcher and research participant now increasingly meet each other on the internet and in cyberspace.

Accordingly, the editors of *Nursing Inquiry* invite scholarly works of any kind — theoretical or philosophical papers, reports of empirical research, creative/visual works — that address any topic in the realm of virtual nursing practice or virtual nursing research, including such topics as tele-nursing, nursing informatics, and virtual ethnography. All works should address the distinctive features and significance of the move to virtual environments for caregiving and inquiry for nursing practice, nursing research, or the evolution of nursing as a profession. The editors strongly encourage works that address virtual practice and research along key axes of difference: e.g., gender, culture, race/ethnicity, nationality, and geography.

The deadline for submission of completed works is: **31 December 2004**. Please send completed works to The Editor, *Nursing Inquiry*, School of Nursing, University of Melbourne, Melbourne 3010, Victoria, Australia; e-mail: ninquiry@nursing.unimelb.edu.au. Please direct all inquiries to Margarete Sandelowski at msandelo@email.unc.edu. For guidelines regarding presentation of articles, please see: http://www.nursing.unimelb.edu.au/ninquiry.htm.