The emotional labour of health-care assistants in inpatient dementia care

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ABSTRACT
Although there is much written on the emotional labour of nursing, there is
little research grounded in the experience of so-called 'unqualified' care assistants.
This paper is drawn from an ethnographic study conducted with care assistants on
three dementia care wards in one mental health trust within the United Kingdom
National Health Service (NHS). We describe the emotional labour carried out
by care assistants in their attempts to provide personalised care for people whose
cognitive degeneration renders conventional relationship-building very difficult,
produces unpredictable 'challenging behaviour' and calls into question the notion of
'feeling rules'. This context requires the ability to strike a balance between emotional
engagement and detachment, and it is the complexities of this relationship that
are the focus of this paper, arguing that a degree of detachment is a prerequisite
to engagement in this context. In conclusion, we argue that the contribution of
care assistants in this context needs to be better acknowledged, supported and
remunerated.

KEY WORDS – emotional labour, ethnography, dementia, care-givers, care-giving,
engagement, detachment.

Introduction

An estimated 820,000 people live with dementia in the United Kingdom
(UK) and this number is expected to almost double within the next
30 years as the population ages (Department of Health 2009). In 2009, the
Department of Health published the National Dementia Strategy, which
highlighted the importance of changing professional and public aware-
ness of dementia and developing the skills of dementia care workers
(Department of Health 2009). Such aspirations were very publically
challenged in 2011, when the health ombudsman published a damning

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report of the state of care for older people in the National Health Service (NHS). The report was based on the experiences of family members and suggested that services were 'failing to respond to the needs of older people with care and compassion' (Abraham 2011). In 2012 the Prime Minister, David Cameron, launched his 'dementia challenge', which aimed to build on the work of the previous strategy, promising improvements in care, public understandings of the disease, and research by 2015 (Department of Health 2012).

The majority of people diagnosed with dementia in the UK either require no care at all, or are cared for at home. Beyond the mild to moderate early stages of the illness, people with dementia are most often cared for in privately owned care homes. In the publically owned NHS, where the present study was undertaken, inpatient dementia care is delivered through Mental Health Services for Older People (MHSOP), and deals principally with a much smaller proportion of people with dementia who, because of the advanced state of their illness, are considered unmanageable in care homes. Outside specialist services, staff on general wards are often required to care for people with dementia because of associated physical ailments and it is these settings which made up the majority of the cases in the aforementioned ombudsman's report. This underlines the importance of specialist services such as those under discussion here and suggests that valuable knowledge and experience could be better shared between services.

Health-care assistants (HCAs), sometimes called auxilliaries or nurse's aides, provide most of the hands-on care for people with dementia in MHSOP. As a workforce, HCAs have a low occupational status, lack opportunities for training and career development, and are among the poorest paid staff in health and social care (Noelker and Ejaz 2005). Yet they make up about 70 per cent of the staff on the wards we studied, and the work that they do – washing, dressing, feeding and continence care; the 'bodywork' of care (Twigg 2000) – has a significant influence on patients' everyday quality of life.

The objective of the study from which this paper is drawn was to explore the motivations and rewards which sustain HCAs in this work, as well as the challenges they face and coping strategies they deploy. In this paper, we employ the theory of emotional labour to focus particularly on their strategies of engagement and detachment. Our aim is to raise awareness of the complex challenges and contradictions faced on an everyday basis by HCAs in dementia care settings, while also using this somewhat unique 'everyday' to challenge and augment theories of emotional labour.

When the position of HCA was created in the UK in the early 1990s, concerns were raised that, without commensurate training or professional ethics, these 'unqualified' staff would not be able to provide the same

standard of care as nurses. For such critics 'care' is understood as more than a set of tasks, but as 'a way of acting, being, or ontology of the nurse' (Huynh, Alderson and Thompson 2008: 199), and HCAs are positioned as 'technical', rather than 'vocational', workers. Additionally, the relatively poor pay, lack of coherent job description and resultant ambiguity of role sharing between nurses and HCAs led to the concern that the introduction of HCAs in the UK had been driven more by budgets than by the maintenance of professional nursing standards (Ahmed and Kitson 1993; Roberts 1994).

We now move on to describe the study from which this paper is drawn, before introducing our theoretical framework.

The research context

The project from which this analysis is drawn was an ethnographic study employing a collaborative approach to both data collection and analysis. Three researchers (SB, KS and JL), spent a combined total of one year of participant observation as supernumerary part-time HCAs in three different dementia care wards in the MHSOP of one mental health trust in the NHS.

Prior to starting work on the wards, each researcher completed a four-day induction to the NHS, which covered basics such as lifting and handling, health and safety, and hygiene. They then completed a two-day course on 'managing violence and aggression'. At the time, these courses covered the minimum training requirement for HCAs in the NHS. Additionally, two of the researchers attended a three-day training course on dementia, which was available (but not mandatory) for regular staff at the discretion of the employing Trust.

Many of the ward staff were initially very wary of the researchers and their intentions. Some openly voiced their misgivings about being 'spied on', while others were intrigued by the research, but uncertain about the researchers' role, for example, how 'hands-on' they would be. Some were more dismissive about the researchers' part-time participation, which they felt would not provide an adequate and authentic flavour of the job. Managing these kinds of impressions and expectations was a prominent feature of the researcher role, and not just at the beginning: the questioning, speculation and critique continued throughout the research.

In the first phase of fieldwork, each researcher spent three months on their designated ward, building a 'thickly' descriptive and reflective account of the experience which was guided by the following broad research questions: 'What motivates staff in these settings?', 'What obstacles to good care do they face?', 'What do they find stressful?', 'How do they cope?',

'What differences exist between different groups of staff?' and 'What are the implications for person-centred care?'[1]

The fact that each researcher had exclusive responsibility for one ward underlined the importance of first establishing a contextualised account, so that each ward could be understood phenomenologically before findings were compared. Therefore, although the researchers did follow an established format for recording field notes, separating observation from interpretation and reflection, they each focused primarily on understanding the implicit rules of their particular research setting. While the researchers did meet periodically during this first phase to share their experiences, this was opportunistic and informal 'story swapping' rather than systematic comparison, which did not begin until the first stage of analysis.[2]

At the conclusion of the first phase of fieldwork, the three researchers worked collaboratively to code the data, using a very open inductive approach in order to capture the particularities of each context. In collaboration with the Principal Investigator, JS, these open codes were developed into trees, and the analysis was then shared with the wider research team and advisory group.[3]

The second phase of fieldwork began with a shorter period of observation, designed to test the emerging analysis, fill in gaps in understanding, and address questions that had arisen from discussions with the research team and advisory group. The researchers then conducted interviews and focus groups with HCAs, nurses and management on each ward. In parallel, focus groups were also carried out with two separate groups of 'informal' family carers to provide a range of alternative perspectives on the experience of inpatient NHS dementia care. As they were recruited from the same locality, many of these carers had past experiences with the wards included in this study.

A total of 30 interviews and three focus groups were completed; of the interviews, 15 were with HCAs, 11 with staff nurses, three with ward managers and one with an activity co-ordinator. Interviews and focus groups were conceived as a chance for researchers to share some of their emerging impressions, and an 'active' (Holstein and Gubrium 1995) opportunity for staff to engage and challenge these impressions. To this end they were partly successful, as many participants appeared to appreciate the chance to tell 'their stories' in their own words. However, others appeared to be uncomfortable with the more direct and formal circumstance of the interview setting, and tended towards more guarded or defensive responses.

After the second phase of fieldwork, the researchers analysed the complete set of field notes according to the specific questions raised during the first analysis, as well as separately analysing the interview transcripts

according to the original coding frame. Following this, feedback sessions were organised to share with staff the emerging analysis and to invite their reflection and comment. Again, this process was partially successful. Relatively few of the people that had participated were able to attend, but those who did provided excellent feedback, which was incorporated into the developing analysis. In the longer term, we have continued to be involved with this same Trust in developing engagement strategies that attempt to bridge some of the conventional divides between researchers and frontline staff.

The research setting

The setting for the study was three hospital-based dementia wards in the MHSOP division of one mental health trust in the NHS. Ward A was an assessment ward located in an urban teaching hospital, which had 24 beds in shared bedrooms, and separate wings for male and female patients. The main options for patients who had been assessed on Ward A were: referral to a specialist unit or to a residential care home, or, occasionally, to return home. Ward B was a specialist unit in a small suburban hospital just outside the same city as Ward A, which had 13 beds in private rooms. This unit was described as a 'challenging behaviour' unit, the purpose of which was to take referrals with particularly acute levels of behavioural disturbance and distress. Ward C was also an assessment unit, but was located in a much smaller, rural community hospital and had only 10 beds in private rooms.

In spite of these differences, all three wards shared common features. Each provided full-time inpatient dementia care, was structured according to the same occupational hierarchies, employed nurses and HCAs according to the same contractual conditions, and organised staff according to very similar shift rotations. Each ward also comprised the same basic spatial elements: bedrooms, bathrooms, day rooms, staff rooms and clinic rooms. On each ward, the day was roughly broken up into early, late and night shifts, with an overlap for handover from one shift to the next. Early shifts were organised around waking, washing, dressing, breakfast and lunch, whereas the regular tasks on late shifts were tea and dinner and the main tasks on a night shift were putting patients to bed and performing periodic checks through the night. Additional routine tasks included toilet care, medication, baths and physical observations, as required. Nurses and HCAs also had ongoing responsibilities to complete care plans, feeding and bowel charts, and incident reports. There were no resident doctors on any of the wards; doctor's ward rounds usually occurred twice a week on each ward. Ward B also had a resident psychologist.

Although the patient group differed somewhat on each ward, the prognosis for the majority of them was uniformly bleak; the progressive decay of physical and cognitive functions which characterises dementia is irreversible. Moreover, the confusion which afflicts many of those with dementia can provoke unpredictable behaviour, and the management of this behaviour was a consistent component of the physical and emotional work of HCAs across all three wards.

We will now describe the theoretical framework employed in the paper, and relate it to the context so far described, before moving to the main presentation of data through a series of case studies.

Emotional labour in care-giving

The concept of emotional labour, which was introduced by Hochschild (1983) through an ethnographic study of flight attendants, describes the work involved in regulating emotional displays according to a set of occupational prescriptions. This regulation is based on an interpretation of the 'feeling rules' of a situation; a socialised guide to appropriate emotional displays in particular situations and within particular roles. Hochschild drew a distinction between 'surface acting' and 'deep acting'. Surface acting refers to the superficial production of a socially desirable emotional display: 'pretending to feel what we do not' (Hochschild 1983: 33). In contrast, deep acting refers to the adaptation of inner feelings to align with occupational demands: a self-enforced inner transformation, which involves deceiving oneself as much as deceiving others.

The concept of emotional labour has relevance for paid care work (Bolton 2000, 2001; Henderson 2001; Huynh, Alderson and Thompson 2008; Staden 1998), exploring the 'sheer emotional work required to sustain the traditional image of smiling nurses, holding patients' hands' (Smith 1992: 8). Many of these studies are constrained by an assumption of shared values between carers and patients, which can be traced back to some of Hochschild's assumptions about feeling rules. Hochschild studied emotions in occupational settings as a product of socialisation through feeling rules. Although she recognised that different social and cultural groups might construct and interpret these rules differently, she still maintained the existence of shared meanings delivering shared, if contestable, norms regarding the interpretation and display of feeling. This has led some to critique her work for not grasping fully the politics of emotions, the role of power and the fundamental ambiguity of feeling rules (Holmes 2004). These problems are reproduced through many of the studies of nursing which have used Hochschild's work alongside the guiding assumption that

the nurse–patient relationship can be one of mutual understanding and satisfaction (Smith 1992; Theodosius 2008). Morse (1991), for example, talks of the 'covert negotiations' which are mediated by commitment from the nurse and willingness from the patient and which shape the quality of the therapeutic encounter. Though Morse discusses the existence of conflict, unwillingness and resistance, these are seen as deviations from shared norms over the meaning of care and the responsibilities of patients and carers.

Such assumptions do not generally hold in the everyday interactions between staff and patients on the wards we studied. In these places, feeling rules have not been socialised – or perhaps they could be said to have been 'unsocialised' – and the meanings and expectations of care cannot be assumed to be shared among patients and carers. This means that before we can evaluate the emotional acting of HCAs, we need to pay attention to the ambiguity of the rules they are expected to interpret in deciding how to act. The environment of the dementia ward offers its own distinct set of behaviours, relations and emotions, and a particularly ambiguous set of feeling rules. One of the first challenges facing staff on such wards is to determine the appropriate emotional display, on whose authority; personal feelings, as well as those of co-workers, patients and families, and external sources of information such as policy documents and practice guides, all have an influence, which produces an emotional landscape of conflict and uncertainty.

The distinction between public and private spheres is fundamental to Hochschild's work, both in the sense that she saw emotional labour as an exploitation of women's private emotion work, and also in her use of Goffman's (1990) heuristic front stage/back stage distinction to describe the partitioning of emotional labour in the workplace. The wards that we observed were in one sense private places; hidden places, behind locked doors, their social function lying in their ability to contain 'impurities' (Douglas 1966). Inside the ward, the private and public spaces were very malleable. Some of the most ordinarily private acts of patients were made public, through the regular discussions of patients' bowel movements, for example. At the same time, staff also brought their own 'private' matters into the public spaces, in speaking to each other about things which they might have kept hidden had they been caring for people who were fully cognate. Therefore it felt as though the private and public worlds had been inverted: for patients and staff, the most private acts and utterances were often made public.

In this paper, we seek to augment our theoretical possibilities by situating emotional labour within a framework of power relations derived from the work of Michel Foucault. Foucault's (1982) understanding of power as productive and relational leads us to an understanding of feeling rules in

this environment as the product not of consent, but conflict, and only partially understood by HCAs. This framework also allows us to look at the regulatory work afforded by the physical positioning of bodies in hospital wards (Foucault 1977), and the regulatory action of different ways of thinking about the body, which prescribe certain ways of inspecting and interpreting the actions of bodies, producing particular 'truths' about them (Foucault 1973).

The conventional truth of the dementia patient has been drawn from biomedical ways of seeing and interpreting bodies through which 'older people are reduced to their bodies and their malfunctioning' (Twigg 2000: 392). This model, which views dementia as a disease which acts independently on the passive body of the patient, exerts great influence on the organisation of dementia care in the UK. However, it has been widely critiqued in attempts to 'activate' the dementia patient as an individual with personality, motivations and desires (Brooker 2007; Kitwood 1997). The severity of the impairments experienced by many patients on the wards we studied provided a constant challenge to this more progressive way of seeing. These conflicting discourses were embodied by staff in their daily work, which we describe here as the passive/active narrative of the dementia patient: in order to 'engage', to empathise and provide personalised care to patients, staff were first required to 'detach', to accept the medical positioning of their patients as passive victims of an uncontrollable illness.

Engagement has been defined by Simpson (2009: 1013) as 'nurses' affective and motivational response at work' and as the outward expression of physical involvement, cognitive vigilance and emotional connection. For HCAs, engaging with patients beyond the basics of task-oriented care was an important source of motivation, reward and satisfaction.

However, to say that engagement represents 'going beyond' some minimum standard of care is not to imply that emotional labour is not required for the 'basic' provision of care for people with dementia. The hidden hospital ward and the 'dirty work' (Hughes 1962) carried out there demonstrates a 'going beyond' of dominant Western cultural norms of decency and dignity in the bodywork of care (Twigg 2000). The cognitive degeneration associated with dementia means that conventional relationship-building is extremely difficult. The majority of the patients we encountered on these wards had significant difficulties with a range of activities that the majority of people take for granted. This was just as true for relational and emotional activities as it was for physical ones. Therefore, the first challenge for staff in trying to meet the needs of patients was to learn how to connect with them, often in the absence of verbal communication.

Several previous studies in the nursing literature have positioned engagement and detachment as opposing poles on a single dimension

(Henderson 2001; Kahn 1990; Kralik, Koch and Wotton 1997; Maslach and Leiter 1997). This means that the individual can detach only at the expense of engagement, usually due to stress and burnout (Astrom *et al.* 1990; Carmack 1997; Morse 1991; Omdahl and O'Donnell 1999; Schaufeli and Bakker 2004). Though providing important insights into the balancing act that is required in care work (Carmack 1997), this approach posits a superficial positive/negative construction of the two concepts, where detachment produces a carer who is not 'fully present' (Kahn 1992), rather than allowing for their interdependence.

Though we do not seek to undermine the importance of working toward greater levels of engagement, we would like to use our data to disturb the thinking underlying this either/or relationship. We now present a series of case studies, using our data to describe the deployment of emotional labour in negotiating engagement and detachment. In the following cases all participant names have been changed.

'Putting her arm around her'

Physical affection was frequently observed between staff and patients. Many staff alluded to the potentially calming or therapeutic function of physical contact for patients. Physical affection was also seen by staff as an expression of humanity; an attempt to draw out a sense of the person beneath the impairment, and thus counter the sometimes de-humanising effects of institutional care. Therefore, our initial appraisal of physical affection is that it represents engagement:

> As Rachel [an HCA] walked away she spotted Anna [a patient] sat opposite me at the table reading papers. 'Hello!' she said, to Anna, grinning and putting her arm around her to hug her and asking how she was. Anna told her she was all right and Rachel gave her a kiss on the side of the forehead and told her she'd be back. Anna looked over at me and smiled, raising her eyebrows. (Field note, Ward C)

This excerpt illustrates the relatively unusual levels of reciprocity that expressions of affection can prompt from patients with advanced dementia; though a smile and a raised eyebrow might seem insignificant, they suggest an awareness of context, humour and sensitivity to social cues. This appears to contribute to a mutually positive relation: what is rewarding to staff can be beneficial for patients.

Physical touch is recommended to staff in their training as a way of putting patients at ease, nurturing trust and, in some circumstances, avoiding or addressing unpredictable behaviour. Therefore the distinct rules of physical engagement are underwritten by the medicalised illness narrative of dementia. Touch is also at the centre of more progressive psycho-social approaches to care which aim to explore different sensory experiences with

dementia patients as a means to connect with them and perhaps access aspects of their personhood which cognitive methods fail to grasp (Bate and Robert 2002).

Despite this support for the use of touch, the context in which it is used requires examination: in the field note above, as it was not the patient who initiated the physical contact, her raised eyebrows might instead indicate surprise at the unsolicited affection. Furthermore, although her smile implies that the patient did not 'mind', the kiss and hug do reveal a certain power relation, a physical rule of engagement by which the personal space of a patient can be invaded and their bodies touched by staff without prior permission.

Embodied approaches to care aim to move beyond the illness narrative which casts the patient as passive; however, when these approaches are used in a context where gaining consent from the patient is very problematic, then it might be that the patient remains passive even through the more 'active' approach.

If the context changes, then the manner in which both patient and staff are positioned changes also. Sometimes it was the case that patients instigated affectionate physical contact; perhaps a patient sitting in the day room would put their arms out for a hug from a passing HCA. Below, SB reflects on one example of a patient whose whole experience on the ward appeared to improve through a change in context and the opportunity for non-threatening physical contact:

When I first came, Katie [a patient] seemed to rarely come out of her room and the times when you were aware of her presence was when she was screaming in resistance to some intervention. The psychologist advised trying to expose her to the life of the ward a bit more and to make sure there was regular physical contact with her that was not intervention related – otherwise she might come to associate contact with something she doesn't enjoy. When she is in the day room she very rarely screams and mostly seems to be quite cheerful – smiling, rubbing her hands together and giggling, and grinning at staff when they walk past. Today is the best I've seen her, she is laughing and holding her arms out for hugs and her mere presence brightens the whole ward. (Field note, Ward B)

The outcome here seems positive; nevertheless, this example also shows how physical positioning and contact can be used instrumentally to promote behavioural transformation.

The rules of physical engagement were also distributed unevenly among individuals. Staff could be very wary of physical advances from patients, particularly those who were known for 'aggressive' behaviour. This behaviour provided one example of patients perhaps unknowingly taking control of the rules of physical engagement. The fact that such instances were so often prompted by a particular invasion of their privacy seems to support the conception of this behaviour as resistance. However, as instances

of resistance this behaviour generally served to reinforce staff control over individual patients. Nevertheless, within this guiding norm were everyday examples of the manner in which staff behaviour was also shaped and controlled by the demands of the ward.

This wariness also applied to interaction between two patients, where staff became cautious onlookers; guardians against escalations in confusion or aggression. Constrained by a mutual lack of insight, memory and ability to communicate, patient relations could become confrontational. The staff response was quite clear cut: keep the two parties separate if possible and intervene physically if required. When, in rare cases, patients appeared to form an amorous attachment, staff tended not to intervene until the relationship was deemed to have become 'too physical'.

The cautiously permissive manner that staff responded to amorous relations between patients illustrates the combination of empathy and pity which the passive/active narrative invokes. For many staff, it seemed that there was so much within the behaviours associated with dementia that they could do nothing to change, that they would hold on to those opportunities they did have to improve a patient's wellbeing, even if only momentarily. However, this response also infantilises patients: both the permissiveness and the containment is based on the notion that patients do not know what they are doing, which removes any sense of authenticity from their social relations. This example demonstrates one implication of the passive/active narrative, that a measure of engagement and detachment can be simultaneously present in the actions of HCAs. This will now be explored further through our second case study.

'If they were going home'

Moving from the example of the 'gift' (Bolton 2000) of physical affection – contentious though it might have been – we now turn to the other side of the exchange, which is the reward staff might derive *from* the gift of their labour. The transient nature of any improvements in wellbeing for patients who are defined by a narrative of progressive cognitive and physical decline circumscribed the nature of rewards in this work, as shown in the following excerpt from an interview with Sarah, an HCA on Ward A. The excerpt begins with her response to a question about the things she liked most about the job:

S: About the job, sorry, the job. I can't say it's rewarding because it's not, no, if they were going home then yes, we've had a couple who have gone home and you think that is nice and the families, I mean, I've actually stayed close to one of the families now, because her husband passed down here.

R: Oh right, and you've kept in touch with her?

S: Yes, there is another lady as well who I speak to now and again as well. So no I can't say that it is rewarding at all, only to myself I can say, 'I've done that well' and you can feel good yourself. But I don't really know, I don't know, I think we're a good team, very good team, we have our down parts where we're slagging each other off now and again (laughs), but no I think we are a good team and it is nice if you can see the patients going home, but I think we do have a lot to put up with the relatives, a hell of a lot.

Sarah returns to the theme of reward and satisfaction in the following excerpt:

R: Have your feelings about the job changed at all over the time that you've worked here?

S: I love it more, yes I do, love it more, yes.

R: Why do you think that? How is that?

S: Well as I said, you don't get no satisfaction at the end of the job, you can go home and think I've done a good shift, I've done a good job, but you don't actually get any satisfaction, do you know what I mean? All you can do is as I've just said, you've done a good job, you've done your job right, but I just love it 100 per cent, absolutely 100, I mean you get your off days, but then you think, 'right, that's it, it's done now'. (Sarah, Ward A)

These excerpts provide insight into the complexity of attempts to quantify the rewards of this work. For Sarah, the rewards of the job had an absolute limit, shaped by the fact that she was caring for people who, by and large, would not get better and return home. Nevertheless, she claimed to love the job '100 per cent', which appeared to derive from a sense of pride in doing the job to the best of her ability, as well as from secondary aspects of the job such as teamwork.

Sarah also mentioned the families of patients, some of whom she had stayed in contact with – though it should be noted she also referred to family members as a source of stress. This ambivalence toward family members was shared by many staff. Often, on reflection in interviews, staff would express empathy for the plight of families. Nevertheless, interactions observed on the ward and alluded to in interviews more commonly indicated a very strained relationship between family members and staff, particularly HCAs. The personal conflict involved in 'handing over' caring responsibilities to ward staff, as well as the distress caused by entering this environment, provide obvious conditions for such strain. The HCAs also experienced a sense of disempowerment and frustration when qualified staff nurses presented the 'public' face of the ward to visitors; this was one of the ways in which

HCAs felt undermined by their 'unqualified' status; their bodywork keeping them at the bottom of the hierarchy (Twigg 2000).

Certain staff, Sarah among them, referred in interviews to their own experiences of being a family member, rather than a staff member, on a similar ward. For Sarah, this personal experience of institutional care (as a family member) was a motivating force:

I really, really do enjoy the job, plus my dad had Alzheimer's and dementia and Parkinson's, I wasn't actually in the job then and the manager who was on here before kept asking me if I wanted a job and I used to say 'No, I can't do it, I can't do it', which, at this time I was a domestic working on this ward as it was, then when we lost dad, which was 11 years ago now, something just clicked and I just applied for the job. (Sarah, Ward A)

Sarah talked about the shock of the diagnosis, the difficulties of learning about dementia through the experience of a close family member, and the frightening, disorienting environment of the hospital ward. She also talked about the guilt she felt when handing over her father's care, first to a ward and then a private nursing home. In the standards she set for herself and for others in the job, Sarah drew heavily on this experience. In the example she offered above, about the family member with whom she had remained friends, Sarah referred to the importance of her own experience:

It was heartbreaking for her, she used to sob, yes, and I told her about my dad and what have you and I think she felt relaxed that she could come and talk to me because I had experienced it, I don't tell everybody about my dad by no means because it's not a thing you . . . but if I can help somebody by my experience then I will do. (Sarah, Ward A)

Although it seemed that Sarah was able to use her own experience to engage in deep acts of emotional labour, this had considerable emotional consequences. For example, she reported elsewhere in the interview that she took her work home with her, that she was sometimes unable to get the voices of patients out of her head, but refrained from bringing domestic problems into the work arena. This provides a distinct illustration of the public–private relation of the ward for staff members: it seems Sarah did not fit the inverse model, in which staff share their private lives openly on the ward. Perhaps this is part of a recognition of the personhood of the patient, a suggestion which finds support in this last excerpt of Sarah's interview, which is about dealing with death on the ward:

R: What about facing death on the ward in general, like, how do you feel about providing end-of-life care?
S: There again it's stupid because I talk to them.
R: I've heard that, I've heard that from others too.

S: Oh have you? I talk to them as though they are just asleep and I tell them everything I'm doing and it's like with Jack [a patient], Pauline [a nurse] did ask me if I wanted to help wash him and everything and I said yes, I was given the choice, perhaps that helped me to cope with it. But no, it doesn't bother me at all and I just talk to them like they are asleep and give them respect, dignity, as much as you can. (Sarah, Ward A)

In the first excerpt, Sarah talked about the absolute limit on job rewards given that patients face an inevitable decline; frequently this meant they would die on the ward. In spite of this knowledge, she still required a surface act of self-deception – pretending the deceased was simply asleep – in order to provide the necessary care in laying out the body. In this self-deception we see evidence of detachment: emotional distancing from the event of death itself. However, this detachment is deployed in the interests of tending to the preparation of the body in a respectful and dignified manner. Through Sarah's story we can talk about the necessary deployment of detachment in the interests of engagement, and we can acquire a sense of the work required to keep a deployment of emotional labour in place and to derive reward and satisfaction from it. Our discussion now moves to a fuller consideration of detachment through the third case study.

'A quite unconcerned reaction'

Although engagement represents the positive ideal for staff, evidence of detachment must be interpreted according to reasonable expectations: staff do not have infinite resources to undertake the emotional labour of engagement so far described. At least some of the time, detachment can be used deliberately to avoid becoming irritated or 'burning out' (Astrom *et al.* 1990). Not engaging fully, that is, can sometimes be better than engaging negatively.

We regularly observed a level of desensitisation to the 'dirty work' of daily care, which one nurse from Ward A referred to as not being 'shit shy'. Yet this desensitisation did not necessarily signify absolute detachment, as this note from Ward B suggests:

Clare's commitment to the job reached new levels in my estimation as she stood there patiently cleaning the dirt from under Robert's nails while he lay there spitting occasionally and playing with himself. 'He likes to have a fondle in the bath' was Clare's quite unconcerned reaction. (Field note, Ward B)

Here, Clare's ability to support the patient's personhood depended on her ability to establish some emotional distance and to draw strategically from the passive/active narrative. On the one hand, Robert did not know what he was doing, therefore he should not be chastised for socially inappropriate behaviour. Were he seen as fully cognate, Clare might have been less tolerant

of his behaviour. On the other hand, Clare's comment recognised Robert's active wants and desires. Desensitisation could therefore work positively for both staff and patient: enabling HCAs to respond in a manner that, in this example, was sensitive to a loss of social awareness without completely disabling a sense of personhood.

Yet there was also a dismissive quality in Clare's response. If she had been fully engaged, perhaps she would have given Robert some privacy, if not by leaving the room completely, for safety reasons, then perhaps by leaving the bath side, instead of continuing to clean his nails. Once again, behind this indifferent response appeared to be the assumption that although there was a person in front of her, with drives and desires like any other, he was not a complete person, who might have preferred some privacy. Here, therefore, was a surface act of engagement which depended on establishing detachment – not primarily in the sense implied in the field note, of establishing distance from an inappropriate act, but rather in establishing distance from the full truth of the patient's situation. In this instance, desensitisation worked to produce an appearance of engagement, which was certainly not without merit (the patient was ascribed some sense of personhood). However, without the more demanding, reflexive work of deep acting, only a partial sense of personhood was evoked. We will continue on the theme of 'activation' through our last case study.

'You can take them pills'

Humour offers further insight into the productive work of desensitisation. Humour was a frequent and often ambiguous presence on the ward, among and between staff and patients; evaluating when laughter was directed 'at' or shared 'with' could be highly problematic. At times patients could seem cognate beyond the medical narrative of their illness, in demonstrating a sharpness of wit which appeared to confound their supposedly fragile grasp of social cues, perhaps through an awareness of the interactive subtleties of body language or moments of ironic insight about their own plight. Yet once the immediate laughter subsided, there was often little left to smile about. Therefore while on occasion humour could facilitate meaningful, if temporary, access to personality, it also offered evidence of the absolute distance between staff and patients:

Back in the day room now and Sue [a nurse] was giving out medication. Raj [a patient] was engaged in his usual pastime of trying to grab things and put them in his mouth, which makes the medication trolley a particular hazard. However, there were still no spare seats so it required my full time attention to keep him from putting large amounts of tablets in his mouth. Iris [a patient] was given her tablets and told Sue in her broad regional accent that 'you can take them pills and shove 'em up yer arse', which prompted laughter from all the staff. (Field note, Ward B)

Like physical affection, humour can only be understood in context. Here, there were several relevant contextual elements: first was the personality of this particular patient, Iris. For some staff, she was a favourite due to the witty glimpses of personality she offered – as in the example above. Other staff found her loud and demanding of special treatment. This divided opinion about Iris could in part be derived from the experience of different shifts: during the day Iris could often display relatively unusual levels of insight compared to the other patients; however, at night she could become extremely paranoid and would sometimes not sleep at all. The above exchange took place during the day, and there is a sense of the attachment to Iris in the staff's good-humoured response. Nevertheless, although this type of attachment might have helped staff remain motivated in their job, this did not necessarily produce greater engagement in the immediate context; so the laughter might signify: 'that's just Iris acting up, how endearing, now on with the task in hand'. The immediate physical situation provided an example of routinised, task-oriented practice: a day room where most patients were sitting with lap belts around them, waiting to be given medication which they had not chosen to take, and which they had no opportunity to refuse. Although the patients were clearly the least powerful in this situation, staff were also regulated by the medical directive regarding the administration of regular medication to this population of patients; the unpopularity of the task often resulted in staff nurses, who were responsible for preparing medication, giving the job of actually administering it to the HCAs. This was the case in the excerpt above; after this lack of success Sue gave the job to the researcher, SB:

I was now sitting next to Iris as Sue had asked me to see if I could get her to take her liquid paracetamol. She said that she had already had her medication today and I said that she still needed to have her paracetamol. She said that she didn't have any pain at the moment, and I countered that this was because she took regular paracetamol and it would only stay away if she continued to do so. Still she was not happy to take it and she started telling me what tablets she had already been given that day, of which she remembered all, and who had given them to her. (Field note, Ward B)

Here, SB gained brief insight into the challenges of performing routine institutional tasks with a patient who refused their own objectification. SB was certainly sympathetic to this plight, nevertheless he was at this moment not required to reflect on the use of medication, but rather administer it, and the active patient he encountered was not the one required for the efficient discharge of this task. Such experiences offer insight into the challenges of person-centred models of care within institutions which are still organised around the routine administration of medical tasks. As the situation

unfolded, Iris offered further insights into the construction of a patient identity:

Perhaps most insightful, and also upsetting, was the recount she then gave me of her time on the previous ward, where she had gained a very bad reputation because she did not like the way they tried to force food and medication on her. She said that this angered her and she would lash out, which she felt was out of character. Iris remembered clearly when she was transferred from this ward, remembering also the feeling of arriving at a new ward where her reputation had preceded her through the warnings contained in her notes. (Field note, Ward B)

Reflecting on this incident after the end of the shift, SB continued:

To me, the fact that she not only remembered events of a few weeks back, but was also capable of thinking rationally about the nature of her behaviour and the reaction to it by the staff was oddly disconcerting. One of the ways that I feel able to keep a positive outlook toward many of the patient's emotional states is through the reassurance that they don't really seem to know what is going on, thus, so long as you try and make it as comfortable as possible then you needn't constantly think about the unanswerable harshness of being shut away in such a place the entire time. Iris seemed to feel real remorse for the way she had behaved and also said she was much happier now that she was usually able to eat and sleep when she wanted. In the moment, I used this to prompt her to show how good she was now by taking her paracetamol, which she did with a smile for my efforts. (Field note, Ward B)

These reflections offer further insight into the combined work of engagement and detachment within a surface act of emotional labour. The immediate occupational prescription in this scenario was to administer the medication to Iris. SB eventually completed the task through a certain level of engagement: he listened to and sympathised with Iris's perspective. Nevertheless this sympathy had to be put aside to complete the task, which he achieved through a kind of trick of negotiation. He read Iris's reaction as acknowledgement that she realised but did not mind being 'tricked'; an inherently problematic interpretation given the circumstances. SB therefore deployed a surface act of engagement: listening, acknowledging and sympathising, up to a point. To be able to complete the task, he was required to detach from the truth of the patient's situation, which he had glimpsed through this relatively cognate encounter, and which he reflected on later: the uncomfortable truth that at least some of the patients were more aware and insightful than routinely acknowledged.

Therefore, the laughter which greeted Iris's first reaction soon subsided, and though it seemed to momentarily celebrate her resistance, at an absolute level it did not affect an altered state of truth for Iris – who was still required to accept medication against her will. As a deployment of emotional labour, this surface act was effective and relatively humane in getting the job done, for example without overt coercion. However, medication

administration was only one occupational prescription in that situation; another, arguably, was the more general responsibility to treat patients as people. Yet, if SB had not detached from the 'unanswerable harshness' of the situation, if he had continued to engage with Iris as a person, then he would not have been able to complete the task. The question then would have been: 'How do we give this person their medication in a manner which respects their own choices and desires?' Iris's comments suggested that she did not want to take the medication at all, generating a tension that SB resolved through a combination of engagement (in order to be caring and responsive) and detachment (in order to complete the task at hand). We will now draw these case studies together through our discussion.

Discussion

Through these cases we have argued that some detachment is required to keep some engagement intact, and *vice versa*. In claiming that flight attendants needed to mentally detach to do their jobs, Hochschild (1983) recognised the productive work of detachment. This presents detachment as an active emotional choice; a putting aside of certain feelings in the interests of completing one's job, as we also observed. This does not mean that detachment may not, in some cases, indicate a disinterested or uncaring attitude on the part of HCAs. As suggested earlier, detachment is often described in the nursing literature as a failure to engage and an expression of burnout (Astrom *et al.* 1990; Carmack 1997; Morse 1991; Omdahl and O'Donnell 1999; Schaufeli and Bakker 2004). We would like to augment this understanding with the view that detachment can work in the interests of engagement: in some circumstances, to detach is to engage. In this environment, if getting the job done does not always appear as the most active and inclusive form of care, this points as much to the ambiguous and conflicting demands of the medicalised/personalised discourses of health care as to the strengths or weaknesses of individual carers.

As we have argued, an apparent lack of engagement might also reflect the conflicting feeling rules in an environment where commonly accepted assumptions of socialisation often do not apply. Initially supposed to indicate engagement, the first case study illustrated that physical affection could also indicate detachment, underlining the ambiguity produced by the non-existence of shared feeling rules. From this basis of conflict, our second case used Sarah's story to illustrate the individual work required to maintain engagement. This included the production of a deep act of empathetic

awareness, but resulted in emotional work being taken home, which was an unreciprocated exchange. Sarah's story also showed the active deployment of detachment in the form of self-delusion that was required to cope with the emotional demands of end-of-life care. In our third case, we showed how Clare's desensitised and somewhat disinterested reaction in the bath scene expressed a kind of partial engagement, which in turn invoked a partially activated person in the dementia patient. The challenges associated with attempting to both get the job done and recognise individual personhood was then further analysed through the final case.

In drawing attention to the productive work of detachment, we argue that it needs to be evaluated in a context-sensitive manner. To take empathy as an example, there would seem validity to the claim that a genuine concern for the people one is caring for should translate easily into empathetic care (Smith and Lorentzon 2005). However, in the demanding and often unpleasant context of HCAs' everyday work, a greater labour is required to translate a genuine regard for the person into a professionally competent and caring persona – the image of the 'smiling nurses, holding patient's hands' (Smith 1992: 8). In the following field note, KS reflects on her inability to prevent a patient becoming aggressive in the toilet:

> I feel also that the patient can sense my lack of experience and confidence – whereas the other care assistants would just take care of business in the toilet with brisk efficiency, leaving no opening for her to become 'aggressive', I am slower and more tentative, which maybe increases her frustration and creates opportunities for her to express that frustration. (Field note, Ward A)

The 'brisk efficiency' with which KS characterises the other HCAs' approach does not immediately strike a chord of progressive, personalised care. It tells of a 'task' rather than 'person' orientation; a defining characteristic of traditional and outdated styles of care (All-Party Parliamentary Group on Dementia 2009). Yet at the same time, this excerpt highlights the limitations of this type of binary thinking, because in many potentially de-humanising activities, an efficient task-orientation may actually minimise personal distress (Argyris 1986). This is a situated form of empathy, described as professional closeness: 'not so much a matter of being closer to the individual who is ill, but rather one of being close to the truth of that individual's current dilemma' (Bray 1999).

In recognising the productive role of detachment in competent caring, it is not our intention to disregard its potentially damaging, if sometimes inadvertent, effects. For example, we observed that detachment can limit the extent of empathy that some staff offer to new, disoriented and distressed patients; it can also inhibit staff's ongoing commitment to quality

improvement, because it can prevent them from noticing problems and engaging with solutions the way non-detached newcomers might. Detachment therefore has the potential to become passive neglect (Quinn and Tomita 1997), and there is a need for reflective caution in developing this more nuanced understanding of engagement and detachment.

Conclusion

The altered conception of engagement and detachment that we have argued for requires recognising that detachment is not all bad and underlines the need to support the considerable work that HCAs deploy in their attempted engagement. Through our data, we have argued that simplistic evaluations of good and bad care are deeply problematic because of the conflicted nature of the physical, emotional and discursive rules of engagement in this environment. What represents engagement from an HCA, such as a hug, might represent something very different to the patient who receives it, and the tensions that have to be negotiated for an HCA to extract a sense of job satisfaction might be extremely hard to quantify. This sits uneasily alongside the lack of quantifiable rewards actually offered them.

This brings us to the importance of the organisation taking responsibility for the emotional lives of care-givers (Kahn 1993). At present, in the UK, HCAs are among the most poorly paid staff in health-care organisations. They receive minimal basic training, and their official job descriptions do not reflect the range of physical and emotional skills required to do the job. They are responsible for the majority of the daily personal care on these wards, yet in comparison to nurses they are given very little ongoing occupational support and are offered few opportunities to have their opinions heard.

The implication of the current organisational response to HCAs is that 'non-qualified' equates to 'unskilled', and, therefore, not in need of greater financial or emotional support. Through our presentation of data, we have attempted to counter this assertion. The decisions that HCAs are required to make require great subtlety and sensitivity, as well as urgency in many cases. To negotiate the complexities of their patients' needs, dispositions and communication abilities, while also delivering the practical aspects of good care, demands a high level of emotional output and superior skills in self-regulation, which are little-recognised characteristics of the role of HCAs.

More research is required with this occupational group, to develop ways in which they might be better supported in their work through training

and supervision. The question of training is a complex one: the HCAs we worked alongside displayed tacit skills and knowledge which could be better recognised, reflected on and developed through education. However, when educational opportunities did arise, HCAs often found them alienating, condescending and impractical. A similar story was told in relation to supervision. When HCAs did receive supervision, it was often from the ward manager, which could mitigate against a sense of open and impartial reflection. The argument that we have presented here has highlighted the complexities of this working environment, centred on the paradox of the passive/active patient narrative. In attempting to negotiate such an environment, HCAs must be given the space to reflect on the relationship between thought and action in their everyday encounters with patients. Therefore, we suggest that developing a model of supervision along the lines of qualified nurses' clinical supervision, which is delivered by someone outside the ward, could greatly benefit HCAs.

The active/passive patient narrative as embodied by staff on these wards illustrates the constitutive nature of contradictory discourses of good care. The emotional labour of engagement and detachment that we have described illustrates the ongoing challenge of providing personalised care in the context of dementia care services. We have attempted here to draw attention to the complex emotional environments experienced on these wards and the emotional resources required of the staff in these settings, which act as vital determinants of the experience of both staff and patients in the care process.

NOTES

1 While HCAs were the principal focus of the research, the nurses who work alongside them on a day-to-day basis were also included, and the relations between the two groups became an important theme. For further discussion, *see* Lloyd *et al.* (2011).
2 For a more detailed discussion of the collaborative approach to this research, *see* Scales, Bailey and Lloyd (2011).

3 In addition to the PI, there were four co-applicants who were involved in supporting the researchers in their fieldwork and also collaborated in the interpretation and analysis of the data. The advisory group was made up of 12 representatives of dementia care services from across the participating trust as well as a local representative of the Alzheimer's Society and patient and family carer support services.

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