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Shaping social situations: A hidden aspect of care work in nursing homes

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ABSTRACT

A significant aspect of care work in nursing homes involves dealing with emotional responses such as anxiety, fear, pain, depression and anger on the part of residents and their families. Previous care and nursing research on this topic centers around dyadic relationships and does not provide useful conceptualizations of how care workers actively deal with the social situations they encounter as part of their work. Drawing on ethnographic field work and interviews conducted in two Norwegian nursing homes, this article aims to describe and conceptualize a previously neglected aspect of good care work: the active *shaping of social situations* in order to lessen uneasy feelings of residents and their families. Three episodes of good work are described to illustrate how social situations can be shaped. Strategies include such actions as timing events, regulating one's presence, and composing social groups. The concluding section discusses some implications for nursing home management.

Introduction

Nursing homes are generally considered undesirable places to live (Farmer, 1996; Risberg et al., 2012). Moving to or having a family member move to a nursing home can be an upsetting experience, one that is associated with the loss of health, home, status and/or freedom to shape everyday life (Fiveash, 1998; Kofod, 2008; Whitaker, 2009). Dealing with residents and families who are experiencing such upsets forms a core aspect of work in nursing homes (Foner, 1995, p. 172; Whitaker, 2009). This facet of the work is not only important in terms of the emotional well-being of residents and their families, but it also contributes to carers' feeling that their work is meaningful and stimulating (Hansen, 2008).

The significance of care staff managing patients' emotional stress has been recognized by many scholars. Strauss, Fagerhaugh, Suczek, and Wiener (1985, p. 129), for instance, presume that dealing with the emotions of patients is an inherent ingredient in all kinds of healthcare work. They, and others, have tended to focus on interpersonal interaction, mainly the caregiver–care recipient dyad (e.g., Eriksson, 2002; Fosbinder, 1994). Another strand of nursing home research draws attention to the ways in which the well-being of residents is influenced by the overall atmosphere of the nursing home and features of the physical surroundings (e.g., Hujala & Rissanen, 2011; Lundgren, 2000). In this article we argue that the gap between the relationship- and atmosphere-oriented strands of research points to an under-theorized aspect of care work: *the active shaping of social situations as a part of care staff's work with the emotional responses of residents and their families.*

Using field research and interviews from two Norwegian nursing homes, this study explores and conceptualizes this largely overlooked dimension of care work. Before turning to the empirical analysis, however, we further outline the state of knowledge regarding work oriented towards emotional well-being in nursing homes. We also briefly describe the political and institutional context of Norwegian nursing homes.

State of knowledge

Several strands of research pay attention to the uncodified work on patients' emotions. Strauss et al. (1985, p. 131) focus

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on work directed towards the problems patients experience with their 'moods and identities' as a consequence of their health condition and treatment. They term the work 'sentimental work' and regarded it an inherent part of *all* work health care professionals engage in when responding to or taking into consideration a patient's reactions and emotions relating to specific procedures and examinations. This work is necessary 'either because it is deemed necessary to get the work done efficiently or because of humanistic consideration' (p. 129). Other strands of research more generally emphasize the importance of nurses' 'communication,' 'interpersonal skills' and 'interaction competence' for the emotional well-being of patients (Applegate & Morse, 1994; Custers, Gerben, Kuin, Gerritsen, & J.M., 2012; Fosbinder, 1994; Harrison, Pistolessi, & Stephen, 1989; Shattell, 2004; Sheldon, Barrett, & Ellington, 2006). These terms encompass such diverse social phenomena as information, explanation, humor, promptness, attention, touch, taking charge, and recognition of experiences (Drew, 1986; Fosbinder, 1994; Harrison et al., 1989; Kitwood, 1993; Routasalo, 1999; Shattell, 2004). The interaction between care workers and patients is undoubtedly important for the patients' emotional well-being. In Fosbinder's (1994, p. 1087) study, patients themselves emphasized that good interpersonal skills are more important than good clinical skills. In another study, patients overlooked by nurses reported that they had lost energy from being ignored, while those who were acknowledged by the nurses reportedly gained energy (Drew, 1986). Studies underlining the importance of reciprocity in relationships between patients and caregivers add a power perspective to this line of research (Bradshaw, Playford, & Riazi, 2012; Dowd, 1975; Grasser, 1996). An even more abstract vein of research on care work in general explores the care worker's *relationship* to the care recipient, with particular emphasis on its emotive and ethic dimensions. Eriksson (2002, pp. 62–3), for example, understands care as a responsibility and states that '[c]aring relationships form the meaningful context of caring ….' The 'holism' to which she refers, however, is limited to the patient's 'body, soul and spirit' (p. 63). Wærness (1984) coined the concept 'rationality of caring' to highlight that committed attending to other peoples' needs requires a different kind of rationality and perspective from the formal and abstract means–ends rationality that governs most efficiency measures. The rationality of looking after the concrete and shifting needs of individuals challenges the dichotomous thinking of rationality and emotion.

While these theories offer distinctive contributions to understanding the ways in which care workers deal with patients' emotions, it is still clear that they implicitly or explicitly conceive care workers as *interacting with the patient in a dyad*. This focus on dyadic relationships has, it seems, blinded researchers to the possibility that care workers may have a wider repertoire of techniques for inducing positive emotions, or dampening negative ones, among nursing home residents and their family members. In other words, the concept of care work strictly as a two-way interaction inhibits an analysis of care work as something more complex. These researchers do not, of course, claim that all care work is actually work on the person being cared for or that situational aspects are unimportant, but neither do they provide useful conceptualizations of how workers relate to the social situation in which the care work is taking place.

This oversight is also apparent in research that explores how atmosphere, esthetics and homelike environments affect the well-being of residents and visitors. Martin (2002, pp. 872–3), for example, constructs the ideal types of 'homey' and 'institutional' nursing homes that reflect the 'emotional climate' and social relationships of the institutions. Although she describes parts of the care work she observed, her argument regarding emotional climate is supported mainly by references to the attitudes, sensuous experiences and emotions implicated in or evoked by this work as experienced by staff, residents and particularly her, as researcher. Others emphasize, albeit critically, the more recent trends in decoration, odor, sounds, colors and other sensuous aspects employed by nursing homes to produce a 'homelike atmosphere' within the institution (Angus, Kontos, Dyck, McKeever, & Poland, 2005; Hujala & Rissanen, 2011; Lundgren, 2000). Kofod (2012), for example, describes how care workers in Danish nursing homes try to produce a cozy atmosphere by lighting candles, changing table arrangements, joining the residents at the table, and so on. While all of these studies point to other and more encompassing aspects of the care work than the interaction-focused ones, they fail to conceptualize these efforts as part of a more systematically employed repertoire of care techniques. More specifically, they merely *implicate* the social situation of the care work as an object of manipulation; they do not theorize it.

Of course, these researchers do not claim that care work is not situated, and several explicitly emphasize the analytical importance of the context and social situation (Benner & Wrubel, 1989; Wærness, 1984). The analytical importance of the social situation in understanding social structures is central in both sociology and social psychology (e.g., Goffman, 1959; Ross & Nisbett, 1991). Studies of care work, however, tend to conceptualize the situation mainly as a *social ontological fact* – an inescapable context the agents move in and out of and work within – and not as an object of agents' manipulation, i.e. something to be worked work *on*. Benner and Wrubel (1989, pp. 83–4), for example, consistently talk about 'the person *in* the situation' (emphasis in original). Many of Goffman's (1959, pp. 22–51) examples of 'performances' involve manipulations of the expressive elements in social situations, and this theoretical possibility needs to be incorporated into the conceptual framework of care and nursing studies. That care work in nursing homes implies shaping social situations in order to calm and recognize residents and their families is thus neither explicated nor denied in the social sciences; it is a theoretical hiatus in and among the existing theories.

Nursing homes in Norway

Norway belongs to the family of social democratic welfare states committed to treating all citizens with equal concern and respect (Vabø & Szebehely, 2012). Within this political context, nursing homes are part of a comprehensive infrastructure of statutory services, channeled through local authorities. A range of long-term care services – home-based as well as institution-based care – are available on a universal basis, dependent on need, not on age, family relationships or ability to pay. Even though aging in place policies have been comparably strong in Nordic countries, nursing homes