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Emotional Labour of Caregivers Confronted With Aggressive Brain-injured Patients☆

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ABSTRACT

Background: Aggressive behaviours are common with people who have suffered brain injuries and induce difficult emotions among certified nursing assistants and medical-psychological assistants who take care of them. These caregivers carry out emotional labour whose content and strategies are little known.
Aim: The study explores the emotional labour of certified nursing assistants and medical-psychological assistants faced with the aggressive behaviours of brain-injured patients.
Methods: Semi-structured interviews were conducted with 37 caregivers. Interviews were analysed via a thematic content analysis.
Results: The analysis shows that the emotional labour of caregivers varies in accordance with the state of "consciousness" or "non-consciousness" that they attribute to the brain-injured patient with regard to this aggressive behaviour. This is a deep acting strategy. Moreover, caregivers shut off their emotions in order not to transmit them to the patient. This surface acting has the first objective for the caregiver of maintaining control of the situation and a second objective of protecting the patient emotionally and therefore of being perceived as a "good" caregiver. Emotional labour also meets a need to preserve the professional self-image and professional status negatively affected in the interaction with the aggressive brain-injured patient.
Conclusions: Our study specifies the different strategies of the emotional labour of caregivers and their circumstances of use when they are confronted with aggressive behaviour by brain-injured patients. Targeted support for this emotional labour, such as training and practical analysis, is essential for the development of care practices promoting a caring relationship.

Introduction

Behavioural problems are common after a traumatic brain injury (TBI) or stroke (Chan, Campayo, Moser, Arndt, & Robinson, 2006; Ponsford, 2013a) and can persist for several years (Fleminger & Ponsford, 2005). Among other factors, they result from cognitive disorders (i.e., disinhibition, executive functions), and/or psychopathology (i.e. depression, anxiety, personality change). The behaviours are manifested through a disorder of control, such as aggression, or a disorder of drive (i.e., apathy) (Azouvi, Vallat-Azouvi, & Belmont, 2009) and are responsible for difficulties in social interactions (Ponsford, 2013b).

In general, caregivers, who are faced with difficult behaviours, feel negative emotions (i.e. anger, fear, guilt), and anxiety and are given additional workloads (Jenkins, Rose, & Lovell, 1997). To preserve the caring relationship with the patient who presents difficult behaviours, caregivers must work on their own emotions (Farrell, Shafiei, & Salmon, 2010). The expression of emotions obeys rules of emotional display, that is to say, social conventions dictating the emotions that must be expressed in a given situation and how to express them.

The concept of emotional labour (Hochschild, 1983) has been developed to examine the emotional demands of work and the individual styles of responding to these emotional demands. Emotional labour refers to the process by which workers are expected to manage their feelings and their emotions in accordance with organizationally defined rules and guidelines (Hochschild, 1983). By their emotional labour, workers can "create and maintain a relationship, a mood, or a feeling" (Hochschild, 1983, p. 440). Applied to situations of care, the emotional

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labour of caregivers involves producing emotions and affects in accordance with the professional social norms. This emotional labour also aims to maintain the well-being of the patient and preserve the care relationship. Emotional labour by caregivers is performed on the basis of emotional dissonance or emotional harmony experienced in response to that which concerns the patient (i.e. pain, emotions, uncertainty about treatment or other events related to the care context) (Mann, 2005). Emotional dissonance requires a resolution of the conflict between the emotions experienced and those that the caregiver thinks they should feel with regard to personal or socio-professional expectations.

Two main processes of emotional labour – *surface acting* and *deep acting* – represent how people manage emotions to meet work role demands (Hochschild, 1983). In surface acting, professionals modify and control their emotional expressions (Brotheridge & Grandey, 2002). For example, caregivers may exaggerate or fake a smile when in a bad mood or interacting with a difficult brain-injured person. In other words, surface acting refers to the expression of emotions that are not felt by the professional and internal feelings are left intact. Deep acting is the process of controlling internal thoughts and feelings to meet the mandated display rules (Brotheridge & Grandey, 2002). This strategy implies that the professional experiences emotion in "depth". For example, a caregiver may imagine himself in the difficult situation of one patient to try to feel empathy and look concerned.

The contextual approach of emotional labour emphasizes the role of social factors/constructs in emotional labours (Grandey, 2000; Syed, 2008). Emotions are socially regulated, prescribed and learned in relation to social contexts and cultures which emphasize some societal norms, ways of thinking and beliefs. This contextual approach is particularly relevant for understanding the impact and role of psycho-social factors (such as beliefs and lay thinking) that operate when professionals are confronted with uncertainty and ambiguity in their work activities. For example, persuasion strategies, avoidance, and search for a compromise were observed for caregivers taking care of patients who present difficult behaviours, such as brain-injured people (Michaelsen, 2012). Persuasion is supported by the belief that the patient will comply with the role that the caregiver assigns to them. Avoidance involves an emotional distance for the caregiver. Persuasion and avoidance can progress to the search for a compromise, which involves considering the position that the patient wishes to take in care, and presupposes the "intentionality" or the "consciousness" of the patient (Huet, Dany, & Apostolidis, 2016).

The social representations (SRs) theory (Moscovici, 1973) could offer a heuristic way of studying beliefs and lay thinking that could influence emotional labour in the context of the caregiver/patient relationship. This theory "offers a model of social knowledge, its social construction, transformation and distribution, and describes the function of experience and knowledge in social practices" (Flick, 1995, p.70). SRs are a system(s) of values, ideas and practices which permit individuals to orient themselves in their material and social world and to master it, and to enable communication among the members of a community (Moscovici, 1973). SRs are defined as socio-cognitive structure, a form of knowledge that is socially developed and shared, having a practical aim and contributing to the construction of a common reality for a social body (Jodelet, 1991; Wagner & Hayes, 2005). SRs have four essential functions, which are, understanding and explaining reality (*function of knowledge*), defining and maintaining individual and group identity (*identity function*), guiding behaviours and practices (*guidance function*), and justifying behaviours and standpoints a posteriori (*justifying function*) (Abric, 1994).

From a socio-psychological perspective, the purpose of our study is to understand the specificities and contributions of emotional labour by caregivers to building and maintaining a benevolent care relationship when they are confronted with aggressive behaviour by brain-injured persons. This study aims to identify the strategies used to manage the aggressive behaviour of patients. We also aim to analyse the relations between these strategies and socio-cognitive constructs (such as social representations), by exploring how these constructs constitute a basis for understanding aggressive behaviours and for explaining the implementation of the strategies associated with emotional labour.

Methods

Design

Our study is a qualitative exploratory study. We conducted semi-structured research interviews with caregivers in one functional rehabilitation centre and in one specialist residential care home in France. Patients admitted to these institutions have a variety of disorders (e.g., cognitive, motor, sensory). The intensity of the disorders varies from an extreme deficiency state (e.g., chronic vegetative state), a minimally conscious state or locked-in-syndrome (American Congress of Rehabilitation Medicine, 1995; Giacino et al., 2002; Jennett & Plum, 1972) to a minor deficiency state (e.g., difficulty in organizing his/her actions in a new task). Thus, some patients are dependent on others for all the acts of daily life and others are autonomous, and require light assistance or planning of their environment for certain activities. Between these two extremes, all levels of impairment and dependence are encountered. In France, caregivers who perform basic care and who help persons with brain injuries to perform everyday tasks are certified nursing assistants (CNAs) and medical-psychological assistants. The use of semi-structured interviews offers a safe, supportive and respectful environment for the participant to express emotions and experiences. The methods of the study are presented in accordance with the consolidated criteria for reporting qualitative research checklist (COREQ) (Tong, Sainsbury, & Craig, 2007).

Participants

Thirty-seven caregivers participated in the interviews and none dropped out. These were all caregivers working with victims of traumatic brain injury or stroke, who work in a functional rehabilitation centre or a specialist residential care home. The socio-demographic data and the socio-professional data of our sample are described in Table 1. The large proportion of women is explained by the significant feminization of these professions in France (Bessière, 2005).

Table 1
Demographic and professional characteristics of participants.

		Specialist residential care home	Functional rehabilitation centre	Total
Sex	Female	22	13	35
	Male	1	1	2
Age (y)	22–30	8	1	9
	31–37	4	6	10
	38–47	6	3	9
	48–57	5	4	9
	Average (SD)	37.48 (11.49)	40.79 (8.99)	38.73 (10.61)
Profession	CNA	14	14	28
	Medical-psychological assistant	9	0[a]	9
Length of service (y)	1–4	7	4	11
	5–9	8	2	10
	10–15	6	4	10
	16–35	2	4	6
	Average (SD)	8.49 (5.56)	14.14 (11.09)	10.63 (8.43)

Abbreviations: y, year; CNA, certified nursing assistant.

[a] No medical-psychological assistants worked in the functional rehabilitation centre, because it is a health care facility and these professionals work primarily in establishments which offer people social support.