# Emotional Labour in Residential Settings: Implications for Staff Support

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# Rationale and Research Question

- Patients/families want to feel cared **about**
- Paid care workers often develop emotional bonds with patients/families and find this rewarding
- **Emotional labour** under-recognized/valued, despite implications for burnout, care quality
- More important yet more challenging with constrained resources
- How do employees manage their own and others' emotions?

# Study Design

- Qualitative design
- In-person, semi-structured interviews
- Letters of invitation sent to all HCA/RN employees at one health care facility
- Interviews recorded, transcribed verbatim
- Analysis

# Participants (n=26)

- 12 HCAs and 14 RNs
- 12 working primarily in palliative care; 9 residential LTC; 5 other (behavioural, rehab, respiratory)
- 6 male, 20 female
- Four visible minority
- Age: range 19-59 (avg 43.65)
- Years of experience:  range 3 – 29 years (avg 12.06)
- Hours per week: range 4-72 hours (avg 32.26)
- Annual household income (avg ~ $55,000-$60,000).

# Making Patients/Families Feel "Cared About"

- Patient newly admitted to institutional setting
- Provision of physical care
- Family dynamics and relationships
- Expected transfer of care setting
- Cognitive and physical illness (and symptoms)
- Death/dying and bereavement (and symptoms)
- Resource constraints on care and/or 'high expectations'
- Negative experiences with other health care providers

# Working with Patient/Family Emotions

- Drawing out emotions from patients and families
- Monitoring and assessing emotions
- 'Being friendly' – developing relationships
- 'Being cheerful' – using humour
- 'Being calm' – non-verbal strategies
- 'Being there' – physical presence as emotional support
- 'Being honest' – communication and reassurance
- 'Being responsive' – building trust and security
- 'Being empathetic' – compensating for status/identity loss

# The work of 'being friendly'

"[Smiling] just **eases up the tension** that I'm your nurse and you're my patient. No - I'm here to help you. It's not nurse/patient relationship. I'm here to help you. We can give help more than nurse/patient relationship. We can be, **I won't say friends**, because I don't spend time outside the work with them, but just kind of like it's more than patient/nurse."

# The work of 'being cheerful'

"[patient] was frustrated and … unhappy and she said 'this is why I don't like new people coming all the time because nobody knows exactly how to do this.' Then one of the HCAs he just stepped back and stopped doing what he was doing and - he was frustrated too cause he was running behind and was doing a fantastic job at being so patient and trying to meet her needs - and then he laughed and he said "Well you can be thankful because I'm not here tomorrow." And … we all kind of just stopped and **we laughed together and just the way it came out; and it just kind of diffused everything for that moment**."

# The work of 'being calm'

- "You develop that **tone of voice** for example. They respond to your **calming presence or approach** … you talk in not a loud voice but a regular voice because they sense when yourself becomes agitated when they scream and then you *[inaudible]*. So it's more like **self-control**…"
- "By nature of our personalities **sometimes we are always anxious for example and I think they sense that in us**. So if you are nervous they feel that so"…

# The work of 'being there'

"This one man, he was alone during his final breath, last breaths, and there was no one for him to come in. So I sat with him and did my charting at the end of the shift. And I let the oncoming nurse know what was happening and she did the same at the beginning of the shift. So he wasn't alone. I think it's little things like that too that we do that make a difference."

# The work of 'being honest'

"Sometimes you don't want to explain [the dying process] and you've had to explain it like five times before that. If I wanted to ask something if it was my family member lying in that bed I would… whether five other family members asked you I'd still ask you. And you would expect the same answer five times in a row. So you just have to grin and bear it and then again take your time if you need it."

# The work of 'being responsive'

"Especially when I get a new admission I always try to be very available and answer all the call lights and just talk to them and tell them what is to be expected and they really appreciate that. They want to be acknowledged; the family and the patient. So I think doing all of that makes them feel at ease and assured that they're going to be well looked after… And then when I say I'm gonna be back at a certain time, come back, so that they can trust you."

# The work of 'being empathetic'

"Some patients say 'I can't do this. I'm in so much pain. I say 'well can you just grab the rail?' [Patient] goes, 'well I'm not much help.' **And I said 'you're a tremendous amount of help; you're helping out a lot by grabbing that rail and trying to pull yourself over**' and then they feel so much better that they're being helpful about it. They're not being a burden. They think they're being a burden and a pain in the backside and so many times **I've said' you're quiet as a church mouse down here**….I wouldn't even know that you were down here.' And then they feel better."

# Patient/family emotion work requires personal emotion work

"**You have to figure out how you're gonna apply yourself to their rooms.** Some different patients would be shocked to see me in different rooms giving care because sometimes it requires being quiet. Sometimes it requires having lots of levity, poking fun. Sometimes it requires being completely serious and… it's like the lip reading. You just can't learn it overnight. **You really have to develop over time** and figure out how you're both gonna come out of the situation with the best result."

# Managing Personal Emotions

Work can generate negative personal emotions which cannot be expressed

- Difficult behaviours and conflict
- Death/dying
- Resource constraints, moral distress

# Practical Strategies

- Actively addressing issue
- Avoidance/withdrawal
- Active coping
- Talking/debriefing with others

# Cognitive-Emotive Strategies

- Professional detachment
- Not taking it personally: understanding, externalizing
- Focusing on the positive; humour; “consoling refrains”
- Not bringing it home with you

# Professional detachment

*[Re rude residents] "That's when I go to that flat affect. It's hard to control your emotions, going from one room and being laughing, to the next room and someone calling you an asshole…sometimes you just have to go, 'Ok, I'm here for business.'" (HCA, Other)*

*Re: death: "You dwell on it but only in a healthy way or to a certain point and then…you still think of [some deceased residents] years later, but not overly acute. You can't be, and I think this is with any professional…you're not gonna be obsessed with it or something" (HCA, Palliative)*

# Not taking it personally

*Re: coworker conflict: "A lot of our staff gets stressed out and we let out our frustration on each other when it's not really what the issue of what we're arguing about…there are things that haven't been dealt with" (RN, Palliative)*

*Re: non-compliant resident with ALS: "If I couldn't scratch my nose, just shoot me" (HCA, Other)*

*Re: screaming resident with dementia, sundowning: "…you kind of shut down that noise. You have just a little window, where for me personally, I say [to myself] oh yeah, [resident] is behaving like this because I was told that…so I know the cause and effect; not emotionally shut down, but I know why he is behaving like this" (RN, Other).*

*Re: family angry about care: "they're going through this and they're tired, they're irritable and their loved one is passing away. You have to be able to push through that, to understand from their perspective. It's hard though sometimes…" (RN, Palliative)*

# Focusing on Positive

*"If going into [resident's] room is gonna lift me up a little bit for the day, that's gonna make up for the rooms that I go into where I have to put up that wall and shield myself from some of the negative behaviours…a little bit of fuel to make you think, 'oh, it's really worth coming to work" (HCA, LTC)*

*"It's hard to see people struggle like that but there is a reward in being able to help meet those needs during this great struggle" (RN, LTC)*

# Work-Life Boundaries

*Re: workload stress: "When you leave the hospital, that's it. Your day is over. You tell yourself there is nothing more I can do." (RN, Palliative)*

*Re: workload stress: "If I leave the door [at work] everything stays behind, but an emotional level, yeah, you get tired" (RN, Other)*

*Re: moral distress: "Then I go home, and my life starts at home. I've got kids to look after, stuff, to do and life will go on" (RN, Palliative)*

# Future Possibilities

- Awareness of broader causes of increased needs for emotional labour, implications for well-being.
- Regular in-services, formal discussion about emotional labour, from front-line to management.
- Recognize, value skills of working with patient/ family emotions: training, organizational support
- Continue to address on-shift needs for employee emotional support (time/space, immediately available supports, debriefing) alongside culture change where needed (e.g., emotions not a 'weakness').

# Closing: Questions for Reflection

- Can you think of a situation where you couldn't give the care you wanted to give? How did you feel?
- Is the ability to manage emotions at work something one either 'has' or does not – or can it be learned?
- Is it possible to "leave work at work and home at home"?
- Can you think of a situation in which you tried to suppress an emotion at work? How did it make you feel?
- How much emotion is "too much" at work? For instance, is it ok to cry at work?
- Can you think of a situation in which you found it difficult not to take something personally? How did you feel?