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Chugging along, going with the flow, collegiality and chaos

A micro-political essay on interpersonal troubles within care situations in Sweden

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Abstract

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A lot of time and care have been put into exploring and explaining the power relations between nurses and nursing assistants, the emotional investment appropriate in care work, different views on leisure time for staff in this context (Warming, 2019; Habel, 2021; Jervis, 2002; Crocker, 2019). Less work has been done in exploring the complex relationships care workers have with their patients and how staff navigate troubling situations that arise in these relationships as well as how staff feel when these troubling situations occur. The purpose of this study is thus to highlight and explore how care workers in different care institutions navigate troubling interactions with their patients. Eight care workers were interviewed from four different care institutions in Sweden using semi structured interviews. Three full days of overt participant observations were implemented at a daily activities facility. The daily activities facility had patients of all genders at the ages of 18-65. Concepts and theoretical reasonings were borrowed from Robert M. Emerson (2015, 1962) and his studies of interpersonal troubles. Patterns that cut across both interviews and fieldnotes are a number of different strategies that seemed to be commonly used to resolve challenging interactions with patients emerged when the material was analyzed. These methods included (a) ignoring the troubling behavior, (b) distracting the patient and thereby interrupting the troubling behavior, (c) asking colleagues for help and lastly (d) involving a formal third party. The power relations visible in the material were also significant, suggesting that the power balance between staff and patient might shift and twist a great deal without necessarily changing fundamentally. Through the analysis of the empirical material three traces emerged: (I) Chugging along/going with the flow, (II) Collegiality, (III) Chaos and last resort. The informants also described feeling a variety of emotions when dealing with challenging interactions with their patients: insecurity, shame and fear. The study points to the importance of exploring and noticing the patterns in interpersonal conflict related by care workers to further the field of conflict sociology.

Keywords: Challenging behavior, troubling interactions, micropolitics, conflict sociology

Popular science summary

This study explores and highlights the complex relationships care workers have with their patients, as well as the tensions that arise in these relationships. Using field notes from three days of observations at a daily activities facility in a mid-sized city in Sweden as well as eight semi-structured interviews I explore the troubling situations care workers describe facing in their everyday work as well as the strategies they use to resolve such situations. The care workers interviewed in this study worked at four different kinds of care institutions. Some worked at the daily activities facility where I did my observations, some worked in the home care industry, some worked at a forensic psychology facility and some worked as personal assistants. To help me analyze the empirical material I use concepts borrowed from Robert M. Emerson (2015, 1962) and his studies of interpersonal troubles.

A number of different strategies in dealing with troubling behavior emerged when I analyzed the material. These were (a) ignoring the troubling behavior, (b) distracting the patient and thereby interrupting the troubling behavior, (c) asking colleagues for help and lastly (d) involving a formal third party. Through the analysis three traces emerged: (I) Chugging along/going with the flow, (II) Collegiality, (III) Chaos and last resort. The informants also described feeling a number of different emotions when dealing with troubling behavior, such as fear, insecurity, shame and stress. The study points to the importance of noticing and exploring the patterns in interpersonal conflict related by care workers to further the field of conflict sociology.

1 Introduction

During the summer of 2020 I was working at an assisted living facility in a fairly large city in Sweden and had an experience with a patient that came too close for comfort and made me feel insecure and quite shocked. I told a colleague what had happened and got the advice to report the incident to my boss and to my employer. During the process of reporting the incident, a lot of colleagues, mostly women, told me about similar things that had happened to them. This made me curious to know how often things like this happen and what strategies staff have in dealing with challenging interactions with their patients.

The situation could be interpreted from a power perspective and my feeling is that in the care industry, most speak of the power staff have over patients as well as the power relations staff have among themselves (Jervis, 2002; Nimmon & Stenfors-Hayes, 2016; Cooke & Baumbusch, 2020). What I have found less of in the litterature is how patients can claim power in their relationships with staff. Power is always present in the relation between individuals and between individuals and institutions though (Dillon, 2014). Dillon (2014) argues that power relations don't need to be viewed as oppressive, but can rather be a component of our actions and interactions that cannot be separated from them. I would also argue that to understand the power relations present in and between macro-political institutions, it is important to also understand how trouble arises in the relationships between people.

My experience in combination with the power perspective got me interested in exploring how things of this nature occur in the care industry and how care workers interpret and navigate situations that are experienced as challenging or scary. I also got curious to know which feelings/- or emotions arise, among care workers, in such situations.

The purpose of the study is therefore to highlight and explore how care workers in different care institutions navigate troubling interactions with their patients from a micro political and power perspective i.e. interactions that are experienced as challenging or scary. With "care situations" I refer to elder care, daily activities facilities, personal assistance and forensic psychological facilities, although this thesis deals exclusively with observations from a daily

activities facility in a mid-sized city in Sweden and interviews from staff at this facility as well as with staff from the other types of facilities. From this purpose I developed the following questions:

- What strategies are used among staff to respond to challenging interactions with patients, as they are narrated by staff?
- In which ways are power relations made visible in challenging interactions between staff and patients?
- What emotions are reported by staff, in connection to challenging interactions with patients?

The informants participating in this study all speak Swedish and work in a few different care institutions and therefore use slightly different terms when referring to the people they work with. The different terms they used in Swedish were for example: *brukare, deltagare, patient* etc. The informants also sometimes used all of these terms quite interchangeably. For simplicity's sake I have chosen to translate all of their terms to “patient” as the study could potentially be difficult to understand otherwise. Some of the informants, but not all of them, also had some training in how to deal with violent behavior from their patients.

Challenging or troubling interactions in this study refers to quite a broad variety of situations such as language barriers, emotionally abusive behavior from the patient, threats, physically violent patients etc. But not things like physically heavy aspects of care work such as lifting people and so on. I use the terms *challenging interaction* and *troubling interaction* quite interchangeably in the study to make it easier and less repetitive to read.

2 Previous research

According to the purpose of the study, to highlight and develop knowledge about how caregivers in different care facilities navigate challenging interactions with their patients, it becomes relevant to present previous research in the fields of care work. I will divide the chapter in two parts; narratives of care work and power relations in care work.[1]

2.1 Narratives of Care Work

In this part of the chapter some studies concerning the lived experience of care workers and how they frame their work experience will be presented.

By using photographs, group discussions as well as written and oral narratives about four photographs chosen by each individual participant, Shenk (2012) explores the lived experiences and views of direct care workers. The study involves 15 nurses and med techs working at an assisted living and special care assisted living community for people with dementia in Charlotte, North Carolina (Shenk, 2012). This photo ethnographic data suggest that by focusing on the essential relationships and interactions, rather than primarily on the required care, we can begin to see the caregiving experience as a communal rather than an institutional experience. Shenk (2012) writes that there is a certain need for care providers to get emotionally involved with their residents in order to give quality care. This may shift our focus to the people involved rather than emphasize their roles as providers or recipients of care (Shenk, 2012).

As Shenk shows there is a delicate balance between primary care work and essential relationships and interactions in care work. There also exists in the field of care work a certain ambivalence between support and control, as the study presented below shows us.

[1] I have used google scholar and Lund Univeristys search function LUBsearch to search for previous research. I typed in “power relations in care work” in LUBsearch and got 6821 results. I then narrowed the search to the years 2010-2022 and got 4281 results. I also tried typing in “the micropolitics of care work” in the same search engine and got 38 results with the same limitations as before. I also tried different combinations of power relations and nursing, power relations and assisted living, micro-politics and nursing in google scholar. I also typed in just Robert M Emerson in LUBsearch and found 716 results. I also tried with care workers AND narratives AND experiences in LUBsearch and got 2619 results.

Drawing on Haraway's so-called a-modern analytical model, Warming (2019) explores the lived ambivalence, between support and control, that arise in care work. She does so through an analysis of the entanglements of age, emotions and formal position in intergenerational encounters at a residence for young people suffering from social and mental distress in Denmark. The data was gathered through ethnographic fieldwork in the form of observations altering between passive observation and a more participating observation. She also used some voluntary written correspondence, such as text messages and emails (Warming, 2019). By identifying the dominant norms associated with resident and professional in the social space of the residence, Warming (2019) identifies what might, according to Haraway's theory, be termed popular, oppositional and inappropriate practices and explores the emotions and power relations linked to them. Warming (2019) frames her analysis in, among other things, neoliberal youth policies about age, abnormal personalities and professionalism as well as in rules, norms and routines. The analysis demonstrates how "messing with other people's emotions" and trying to change their behavior are regarded as manipulation when it challenges norms or power relations rooted in spatially anchored perceptions of appropriate practices. It is seen as empowerment if it is done in accordance with norms that correspond to the roles and intersecting binary constructions of childish/young/insane client - adult professional (Warming, 2019).

Because of the ambivalence inherent in care work as discussed above, there is a need for care workers to be adept in psychosocial and interpersonal skills as well as having the technical competence for the job, as the study below shows.

In 2019 McAllister et al. conducted a narrative study with the aim of exploring nurses' stories and recollections of working the night shift. Thirteen Australian nurses participated and data were gathered using the biographical narrative interview method (McAllister, Ryan, Simes, Bond, Ford & Brien, 2020). Drawing on Riessman and Hawkins, the analysis was made in accordance with the thematic form of narrative analysis which interrogates what a story or a group of stories are about. The narrative analysis produced three themes: "strange and challenging experiences"; "colleagues can be mentors (or not)"; "textbook knowledge is only part of what is needed on night shift". The authors conclude that working the night shift requires nurses to be adept in psychosocial and interpersonal skills as well as having technical and physical competence (McAllister et al, 2020).

This ambivalence is also evident in the conceptions of working hours, as the next study that I will discuss shows. There is a contradictory understanding of working hours stemming from an assumption of an inseparability of working and leisure time, especially in the live-in care industry where the lines between work and leisure time easily become blurred.

Using Goffman's theoretical concepts of fictive kin and manager of the self narratives of working hours in the live in care industry in Germany is analyzed (Habel, 2021). The analysis draws on six expert interviews with pioneer brokering agencies. The author argues that the agencies have two contradicting understandings concerning working hours in live-in care work. Working hours are either understood as a fixed, intersubjectively measurable category or as a subjective phenomenon, leaving scope for diverging opinions (Habel, 2021). These divergent understandings of working hours are evident in the assumption of an inseparability of working and leisure time, and in the understanding of leisure time as a personal need and a valid demand from the workers (Habel, 2021).

2.2 Power relations in care work

In this part of the chapter studies pertaining to the different power relations care workers experience at work will be presented. As in the section above, the studies will be presented in chronological order beginning with the oldest one.

Power relations are visible in the field of care work as in nursing homes and similar facilities where nursing assistants often are the most numerous staff, yet they rarely have much power in their relationships with nurses and other staff (Jervis, 2002). Jervis (2002) uses ethnographic methods and a grounded theory approach to explore power relations among nursing assistants and nurses in an urban nursing home in the United States. In many nursing homes, the nurses are the ones ethically and legally responsible for the competence of the care provided although the nursing assistants are the ones to most often provide this care. This means that many nursing homes rely on the militaristic paradigm for staff organization known as “chain of command” where the nursing assistants are subordinate to the nurses (Jervis, 2002). This, according to Jervis (2002), often leads to tension among the staff. Conflict and inequality have a long history in nursing (Jervis, 2002). Furthermore, the professionalization of care work has had a detrimental effect on the often uncredentialed

nursing assistants who have long performed nursing tasks but can no longer call themselves nurses (Jervis, 2002).

Unlike the study above that explores the power balance between nursing assistants and nurses, the study below explores how physicians perceive their power in relation to their patients in a hospital setting.

The authors of this article (Nimmon & Stenfors-Hayes, 2016) have used semi-structured interview data to examine how physicians perceive their power in their encounters with patients. The study was conducted within five Royal College specialties at the University of British Columbia in Canada. The specialties were: Internal medicine, Surgery, Pediatrics, Psychiatry and Family medicine. They used a three stage process for the analysis and Bourdieus social theory as a tool for analyzing and understanding the data (Nimmon & Stenfors-Hayes, 2016). The authors found three broad categories for how physicians perceive their power: 1. perceptions of holding and managing power, 2. perceptions of power as waning and 3. perceptions of power as non-existant or irrelevant. The authors argue that physicians learn to enact ethical patient-centered communication through reflective, effective and professional use of power in the encounter with their patients (Nimmon & Stenfors-Hayes, 2016).

Unlike the study above, the study below highlights the importance of collegiality in a nursing home in the USA and identifies how gender and a shared experience as low-wage care workers can build solidarity among workers.

According to Crocker (2019) gender is always present in the ways people resist structures, but in the care industry workers often confront the competing demands of their own interests, the interests of their coworkers and managers and the interests of their patients. Her article examines the micropolitics of resistance among low-wage care workers in a gendered organization, using Scotts conceptualization of routine resistance to aid her analysis (Crocker, 2019). Drawing on ethnographic material from 10 months of observations and 30 interviews in a nursing home in Berkman, USA, Crocker (2019) illuminates two factors linked to gendered work as especially important for peers' support of each other's rule breaking. These are perceptions of residents' safety and the expectation of coworker reciprocity. Crocker (2019) argues that the success of routine resistance hinges upon the support of coworkers.

Furthermore she finds that such solidarity both is a consequence of routine resistance and a necessary precursor to it (Crocker, 2019). She further argues that such solidarity stemms not only from their shared experience as low-wage workers, but also on an expectation of cooperation extending both from gendered occupational standards and from their perceptions of shared experiences as women and as mothers (Crocker, 2019). Thus she argues that the same features of employment that serve to devalue care work, also can be a source of coworker solidarity among nursing assistants and other care workers (Crocker, 2019).

Unlike the study above, which examined sources of solidarity among workers, the study presented below examines how bullying and incivility at two long term care homes impacted the workers there.

Drawing on Madison's theory, Cooke and Baumbusch (2020) used critical ethnography, interviewing 33 nurses, residential care aides (RCA), support staff and managers in two long term care homes in British Columbia, Canada. The interviews were semi structured. They also conducted over 100 hours of participant observations in these long term care homes (Cooke & Baumbusch, 2020). Analyzing the material, three themes emerged that illustrate the power relations underpinning RCAs encounters with incivility and bullying at work. These three themes are; requesting help, receiving help and resisting help/ing. Requesting help outlines how bullying and incivility made RCAs reluctant to seek help from their coworkers. Receiving help highlights how power relations and notions on worthiness and reciprocity impacted RCAs receipt of help from their coworkers. Finally Resisting help/ing illustrates how workplace relationships imbued with power relations led to some RCAs refusing help from their coworkers, led some longer tenured RCAs to resist helping newer RCAs and dictated the extent to which some RCAs provided care to residents for whom another RCA was responsible (Cooke and Baumbusch, 2020).

In conclusion, the studies presented here often use ethnographic methods (Jervis, 2002; Baumbusch, 2020; Crocker, 2019), such as interviews (Nimmon & Stenfors-Hayes, 2016; Baumbusch, 2020; Shenk, 2012; McAllister et al, 2020; Habel, 2021; Crocker, 2019) and observations (Baumbusch, 2020; Shenk, 2012; Warming, 2019; Crocker, 2019). Some studies also collected written data such as emails and text messages (Warming, 2019) and so on, one study used photographs (Shenk, 2012) as a starting point for data collection. This is quite

similar to my study as I use semi-structured interviews and observations as methods for data collection.

The studies are from all over the western world and represent a number of theoretical approaches. Three of the studies are from USA (Shenk, 2012; Jervis, 2002; Crocker, 2019), one from Denmark (Warming, 2019), one from Australia (McAllister et al, 2020), one from Germany (Habel, 2021) and two from Canada (Cooke & Baumbusch, 2020; Nimmon & Stenfors-Hayes, 2016).

In the previous research the theoretical approaches are grounded in Haraways feministic theory (Warming, 2019) when describing the ambivalence that arises between support and control in care work. McAllister and colleagues (2020) instead chose Riessman and Hawkins for their theoretical framework of their narrative analysis concerning working the night shift. Habel (2021) opted for concepts borrowed from Goffman to help her analysis of the understanding of the balance between work and leisure time in the home care industry. Jervis (2002) uses a grounded theory approach to explore how the power imbalance between nurses and nursing assistants change when nursing assistants take over more of the practical care work from the nurses in an urban nursing home in the USA. Nimmon and Stenfors-Hayes (2016) uses Bourdieus social theory as a framework for their analysis. Crocker (2019) uses Scotts conceptualization of routine resistance to aid her in examining the micropolitics of resistance among low-wage care workers.

In conclusion there are a number of social theories that can be useful in studying the social interactions in the field of care work. I have chosen to use Emerson's theory in the present study as I find his concepts useful in exploring and understanding the sometimes subtle strategies care workers use in troubling interactions with their patients.

3 Theory

Basically all social phenomena emerge in concrete interpersonal interactions, or they are shaped by such interactions. This means that, since most human behavior is social, the subject matter of sociology ranges over a broad scope of issues, from the intimate family to organized crime and from the divisions of race, gender and social class to the common beliefs of a culture[2]. Social constructivism is a part of the field of sociology and assumes that people create their understanding of the world by their social standing and previous experience. Social constructivism is also a very multi-faceted theory (Alvesson & Sköldberg, 2017). According to Berger and Luckmann (1966), the social world is constantly constructed and interpreted by the actors involved through their previous experiences and socialization into society. Social reality originates in the thoughts and actions of people and is maintained by these thoughts and actions (Berger & Luckmann, 1966). Social order is therefore something that is created by humans through social interaction (Alvesson & Sköldberg, 2017). Different settings and context create fundamentally different conditions for social interactions (Emerson & Pollner, 1976; Emerson & Pollner, 1978; Emerson & Pollner, 2018). How people interpret and experience a specific social phenomena or action can vary wildly depending on the context and the social standing and experience a person has (Emerson & Pollner, 1976). However, sociology has traditionally been concerned with broad societal issues such as the areas mentioned above and not all researchers have been interested in the micro-politics of interpersonal relations (College of Arts and Sciences, 2021; Emerson, 2015, p. xxvii).

I would argue, however, that to properly understand the forces that change society and the social problems of today we have to also understand how discord and interpersonal trouble originate in the micro-sociological interactions between people. As Emerson and Messinger (Emerson & Messinger, 1977) points out, any social setting generates a number of ambiguous and informal troubles that may, eventually, be defined as deviant. To better understand why some deviant behaviors come to be it is important to understand how they grow to be deviant (Emerson & Messinger, 1977). I have, therefore, based on the purpose of the present study and the questions posed in it, chosen to use Emerson's concepts as a theoretical framework for my study.

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[2] College of Arts and Sciences (2021-12-13). *What is Sociology?*. https://sociology.case.edu/what-is-sociology/

This chapter will be divided into two parts; first the micro-political perspective will be presented and then a part about power in social relations will follow.

3.1 A micro-political perspective

In this part a micro- political perspective of social relations will be presented. This can be understood, more specifically, in terms of various aspects: *unilateral responses*, *informal others* and *formal third parties*. A section of this chapter will also be devoted to explain what Emerson calls *bilateral responses* and *remedial complaints*.

3.1.1 Unilateral responses

Unilateral responses are actions taken by the troubled party to relieve a troubling situation without involving the troubling party in the solution. In these cases the troubled party responds without consulting with the other, and may in some instances be without the other's knowledge (Emerson, 2015: 70). Unilateral responses may, according to Emerson (2015: 71) take one of three forms,; self-targeted changes, managerial responses and preventive actions.

Self-targeted changes refer to actions taken by the troubled party to make changes within oneself, *managerial responses* are actions taken by the troubled party to manage the consequences or implications of the troubling behavior. *Preventive actions* seek to discourage or prevent troubling behavior in another (Emerson, 2015: 71). The troubled party may use one or several of these tactics to resolve a troubling situation as we shall see in my analysis later in this study. Self-targeted changes may be such things as trying to work with oneself to be more understanding and patient and try to act in a way that might be more accepting of the other (Emerson 2015: 71). Self-targeted changes may accompany and be a result of the troubled party's self-questioning over the legitimacy of their feeling of irritation (Emerson, 2015: 72). An example of self-targeted changes might be working with ones own self-doubt and feeling of inadequacy in dealing with a patient, as one of my informants described. He described feeling insecure in his dealings with a patient as he was unable to see past the patient's illness and see the human.

Managerial responses might be such things as trying to manage irritating sounds (caused by others) by quietly turning down the sound of the TV. Another example of managerial responses might be to use earplugs, as one of my informants described doing when dealing

with a patient he described as very manipulative and insulting. In these cases the troubled party doesn't involve the other in the solution and the troubling party might not even notice the change (Emerson, 2015: 74). Another unilateral response that might be used is *preventive actions*, which is just as the term suggests actions taken to prevent troubling behavior from persisting or reoccur (Emerson, 2015: 77).

3.1.2 Formal and informal others

In some cases, though, the troubled party cannot solve the situation by themselves and may in those cases involve a third party in the solution of the problem. This might be a *formal other*, such as police, therapists and so on (Emerson, 2015: 14). The troubled party may also turn to an unofficial third party to voice complaints and seek support, this unofficial third party is what Emerson (2015: 135) calls *informal others*. It could be a friend, colleague, family member etc. (Emerson, 2015: 135). The troubled party can turn to a colleague or friend for advice on how to proceed to solve the troubling situation. The troubled party might also turn to an official third party or *formal other*, which is an official authority in some capacity. This might be the police or representatives of other social institutions (Emerson, 2015:14 206-207).

3.1.3 Bilateral Responses and remedial complaints

The troubled party may also use what Emerson (2015: 13) calls a bilateral response, one form this may take is what Emerson (2015: 96) calls a *remedial complaint*. This is when the troubled party turns directly to the troublemaker to make a complaint (Emerson, 2015: 91-92, 96). This is often done in an attempt to directly involve the troublemaker in the solution of the problem (Emerson, 2015: 13-14, 96). They can do this by making a complaint or asking the troublemaker to get involved in finding a solution that works for both parties (Emerson, 2015: 14, 96).

3.2 Power in social relations

Many types of everyday troubles begin as private concerns and worries according to Emerson (2015: 32). Emerson (1962) also points out that many social relations entail ties of mutual dependence between the parties. According to Emerson (1962) power is a property of the social relation not of the actors involved in this relation. Thus power can fluctuate between actors in a social interaction and may not be the same throughout the relationship. Power in a relationship depends to a large part on the mutual dependency inherent in any relationship

(Emerson, 1962). This means that power, to Emerson (1962), is reciprocal between the actors in a social relationship and that the power of A over B is equal to, and based on, the dependence B have in relation to A. In relationships where one actor has more power than the other, the more dependent actor might use two strategies in order to balance the relationship and regain some of the power. An unbalanced relation is unstable because it encourages the use of power which sets in motion processes Emerson (1962) calls *balancing operations* or *cost reduction*.

Cost reduction is a process involving a change of values which reduces the pain inflicted in meeting the demands of a powerful other, these changes does not necessarily change the balance or imbalance of the social relation however, and must thus be distinguished from *balancing operations* which are processes that alter the nature of the relationship between the two actors (Emerson 1962). According to Emerson (1962), cost reduction tends to generally function to deepen and stabilize social relations.

Balancing operations can be divided into four different types, according to Emerson (1962). These are;

1. B reduces motivational investment in goals mediated by A,
2. B cultivates alternative sources for gratification of those goals,
3. A increases motivational investment in goals mediated by B and
4. A is denied alternative sources to fulfill those goals (Emerson, 1962).

Furthermore, some power relations involve the notion of *authority* which is more than balanced power, rather it is a directed power which can be deployed only in channels defined by the norms of the group. *Authority*, according to Emerson (1962), is usually referring to the power vested in an office or a role. The occupant of such a role has simply been singled out to speak for the rest of the group in its dealings with the groups members. Thus authority emerges as a transformation of power through a process of legitimation (Emerson, 1962).

4 Method

Ethnomethodology is a research method that uses field observations and ethnography as primary methods for data collection. The method focuses on the study of everyday life and social interaction as well as on seeing mundane things as remarkable (Silverman, 2013:2-3). By using ethnomethodology, and by studying social phenomena in its so-called natural habitat, one can get a more detailed picture of the social phenomena at hand and the way people understand and make sense of this particular social phenomena (Emerson & Pollner, 2018). This can help when trying to understand how certain ideas are the product of a particular way of understanding events and how people help establish and sustain certain understandings of a particular social phenomena (Emerson & Pollner, 1975). This means that I have been inspired by both ethnomethodology and ethnography when collecting data for this thesis.

In this chapter the chosen method is discussed and motivated, selection of informants and implementation presented, ethical considerations and method of analysis is also presented. The chapter will begin with a general discussion of qualitative methods and then a discussion of the chosen methods in more detail will follow. Thereafter follows a presentation of my selection of informants and how interviews and observations have been implemented in the study. The last two parts of the chapter will discuss the ethical considerations that have been made during this project, as well as the method used to analyze the empirical material used in this study.

4.1 Qualitative study

The present study is a qualitative study which means that the researcher is placed in the social reality that is to be studied and analyzed. Furthermore, analysis and data collection is more or less simultaneous and done in reciprocity (Silverman, 2013:2). The researcher collects her data through personal interactions with the people directly connected to the phenomenon being studied, this often takes place for quite a long duration of time (Creswell, 2014: 234). In qualitative research, the researcher herself collects the data, which may be done in a number of ways such as interviews, observations, collecting documents and so on (Creswell, 2014: 235). The focus is always on the meaning the informants themselves put in the phenomena and their own actions (Creswell, 2014: 261).

This study was realized through eight semi structured interviews and three days of observations because the purpose of the study required a depth of material rather than a huge quantity of material. The interviews (see 4.2) were made with eight people from a number of different care professions such as nursing students, personal assistants and staff at a daily activities facility for people with different disabilities. The observations (see 4.3) were made at the daily activities facility. Interviewing people in different fields of care work gave the material a wider variety and illustrated that similar issues and strategies arise in different fields of care work. Using both interviews and observations made it possible to get a relatively holistic picture of how care workers navigate challenging situations with their patients (Larsson, 2009). The pros and cons of the chosen methods will be discussed further in this chapter.

4.2 Interviews

Interviews can be divided into different categories depending on how they are structured. They are most often divided into structured, semi structured and unstructured interviews. Structured interviews are clearly planned out and follow strictly planned questionnaires. Semi structured interviews are structured around a few preplanned themes and may have a few general and broad questions prepared beforehand (Alvesson, 2011).

In the present study, I have used semi structured interviews to collect the empirical material because this form of interview allows for more freedom to pursue follow up questions than structured interviews and still provide a somewhat structured framework for the conversation (Ahrne & Svensson, 2011). This form of interview also allows for the informant to give exhaustive answers to the questions and also pursue some tangents to the general theme of the interview (Ahrne & Svensson, 2011). Semi structured interviews have given my informants room to discuss exactly what a challenging situation can be, and have broadened my understanding of what challenging situations a care worker can face and how they interpret challenging situations. It has also given me the opportunity to ask follow up questions without diverging too much from the purpose of the study (Alvesson, 2011).

This method of interviewing also had the advantage of making both the informant and me more comfortable, since the interview felt more like a conversation than an interrogation. A potential problem with the method is that it is easy to get stuck on a question or tangent and

the interview might start to diverge too much from the purpose of the study (Alvesson, 2011: 16). To counteract this potential problem an interview guide was used where a list of general themes and questions were listed (Ahrne & Svensson, 2011). The interview guide used in this study is provided in appendix 1.

4.2 Observations

Observations can be realized in a number of different ways and the researcher doing the observation might be more or less open with the purpose of their participation in the activity being studied. In what is called covert participatory observation the researcher infiltrates a field of study and takes on a new persona until the study is done (Ahrne & Svensson, 2011). This method is most commonly used in investigative journalism and can be difficult to use for research purposes as the Swedish research councils (2002) ethical guidelines state that the subjects of the study have to be informed of the purpose of the study and give their consent.

Therefore, so-called overt participant observation, where the people being observed have been informed of the purpose of the observation and why the study is being made (Swedish research council, 2017), have been used in the present study. It is also important to prevent any damage and make sure that the people being observed are anonymous when doing overt participatory observations (Swedish research council, 2017). One disadvantage of this kind of observation is that the behavior of the people being observed might change because of my presence (Ahrne & Svensson, 2011). The risk of this happening in the present study was judged to be rather minor though, since the staff at the facility where the observations were made were rather used to having new staff following them around to learn the job by observation. My observation was not radically different from the form of observation made by new staff and my presence didn't significantly disturb the function of the facility. Furthermore, I was rather passive as an observant and only partly took part in the activities being performed. For example, I was present when a patient was going for a nap and I talked to a few of the patients and explained to them why I was present.

I thought a lot concerning my role as a researcher and noticed that the treatment I received as researcher was markedly different from the treatment I have received when I have done similar observations in my role as a new employee. Especially from staff, who treated me with more curiosity and a willingness to share their experience with me. This could be just

that it was a different facility from the ones I have been working at, but it could also be an effect from my presentation as a master student from the university rather than as a new nursing assistant.

4.3 Selection of informants

The choice of informants for this study have been made through a selection of convenience where acquaintances in the care sector have been of assistance in finding informants. The informants are four members of staff from a daily activities facility in a mid-sized city in Sweden, three nursing students and one person working as a personal assistant (see Table 1). Three observations have also been made at the daily activities facility, where they were kind enough to let me follow one of their staff around for a total of three days. The daily activities facility was chosen for observation because they have the most patients coming during the day and the staff are accustomed to show new staff around. I have chosen to call the people interviewed for this study *"informants"* as I feel this best describes their role in the study. They have informed me of their work and their emotions in connection to challenging situations.

I have chosen not to put much emphasis on gender in this study, though it could have been interesting, because the informants put emphasis on personal chemistry rather than gender in relation to challenging behavior. I also found that there were sufficient interesting things in my material without putting much emphasis on potential gender dynamics. Had I chosen to take gender into account on top of the subtle power dynamics I already found interesting to discuss, this essay would have become too long for the scope of this project. I also fear that the essay would have become too sprawling and difficult to read had I taken gender issues into account to a sufficient degree. Looking at the gender dynamics present in the empirical data collected for this study might however be an interesting project for the future. The pseudonyms I have given my informants are therefore gender neutral as far as possible.

Name	**Age**	**Education**	**Employment**
Jamie	24	Social worker (*socionom)*	Personal assistant
Ingar	21	Nurse	Internship
Kim	21	Nurse	Summer job/ care assistant

Alex	59	Occupational therapist /assistant nurse	Support assistant
Elliot	21	Nurse	Summer job at care home
Urd	64	Social educator	Activity educator
Eli	41	Support teacher	Support assistant
Jay	44	Occupational therapist	Occupational therapist

Table 1 shows the age, education and current employment of the informants.

4.4 Implementation

The interviews were implemented, as mentioned above, with the help of an interview guide (appendix 1). Five of the interviews were made in person and three were made over zoom due to the geographical distance. Of the interviews made in person, four were made at the informant's place of employment and one was made in the home of the informant. All interviews were also recorded on my phone if the interview was made in person or on my computer when made over zoom via the recording function on zoom.

The observations were made at the daily activities facility over a period of three full days. The first of the observations were made directly after one of my interviews. The other two were carried through at a later date and no interviews were conducted in connection to those observations though I asked a few questions during the day. I had a supervisor who showed me around the facility and I followed her around during all three days to observe the activities. I also asked her a few questions during the observations for instance regarding her feelings concerning a patient that was taking a turn for the worse and had started showing signs of dementia. I also asked her questions regarding some activities that I didn't quite understand, such as why some patients did a certain type of physiotherapy. The observations were open and all staff knew why I was there, the patient group I was with during the day also knew I was there for a school assignment.

4.5 Ethical considerations

Research has an important role in today's society and as such the researcher has to ensure that their research follows some fundamental ethical guidelines. Research activity today has requirements on both the quality of the research and on the integrity of the researcher. It is

therefore important for the researcher to reflect and consider their ethical standpoints in their research (Gustavsson, Hermerén & Petersson, 2005). This study has therefore been implemented in accordance with the Swedish research councils (2002) four ethical requirements. These four requirements are information, consent, confidentiality and utilization. According to Gustavsson, Hemerén and Petersson (2005), one can summarize the ethical guidelines with words such as honesty, openness, orderliness, deference and so on. Below is a description of each requirement and their significance to the present study.

Requirement of information is the requirement that the informants of the study are informed regarding the purpose of the study and that all participation is voluntary and can be terminated (Swedish research council, 2002). In this study, all of the informants got informed in connection to the interviews and the observations that all the collected data is only going to be used for the purposes of the study. They also got informed of the purpose of the study when asked if they were willing to participate.

The requirement of consent is the requirement that the informants themselves have the right to decide the extent of their participation and give consent for it (Swedish research council, 2002). In this study each and every one of the informants got asked beforehand if they wanted to give an interview. They also got informed before the interview that they had the right to terminate their participation at any point without repercussions, the same information was shared before the observations.

The third of the four ethical requirements is the *requirement of confidentiality*, which describes the fact that all the personal information of the informants are treated with confidentiality. Furthermore, the information is used in such a way that no outsider can get access to it (Swedish research council, 2002). The declaration of Helsinki states that every precaution must be taken to ensure the privacy of the research subjects and to minimize the impact of the study on their physical, mental and social integrity (Swedish research council, 2017). In this study all informants are anonymous and all notes and recordings from interviews and the observations will only be saved until the publication of this study.

The fourth requirement is the *requirement of utilization*, which describes how the data collected is utilized. According to this requirement the collected empirical data can only be used for research purposes (Swedish research council, 2002). The data collected for this study

has in accordance with this requirement only been used to answer the questions posed by the present study and no material from the interviews and the observations has been saved beyond the publication of this study.

4.6 Method of analysis

Using an abductive approach I collected my empirical material parallel to choosing a theoretical framework for analyzing the material. According to Alvesson and Sköldberg (2017) an abductive approach means that one has a general idea of the theoretical and empirical field of research, but one collects ones empirical material parallel to reading up on theory. This approach can be useful when trying to approach a field with an open mind and to facilitate one's ability to see patterns and deep structures in ones empirical material (Alvesson & Sköldberg, 2017). One should, according to Alvesson and Sköldberg (2017), have a broad general idea of the previous research done in the field at hand as well as some idea of the work done in adjacent fields to be able to see new things in one's empirical material. In my material I found, for example, that Emerson's notion of power in micro political interactions was not always enough as I found evidence of power dynamics in my material that was not as straightforward as Emerson describes (Emerson, 1962). I found that my empirical data showed that power relations may shift and change temporarily even though the relationship stays fundamentally the same. A patient might rebel in small ways and the staff might feel temporarily intimidated or insecure but the power relations between them are not fundamentally changed. An example of this might be, as one of the informants in this study describes, when a patient got angry at the staff and told them off for coming into her home and deciding things for her. The staff just ignored her and thus reestablished their authority in relation to the patient.

The interviews were recorded on my phone or on my computer through the recording function in zoom. I also took notes during the observations. The recordings and fieldnotes were then transcribed for an easier analysis process. I then color coded the material in accordance with patterns/categories that stood out to me and read it through again and changed or added to some of the categories. The categories I eventually ended up using are chugging along/going with the flow, collegiality and chaos/last resort. I ended up with these categories because I feel they best describe what my informants were saying and what I could observe myself when doing the observations. I then choose some citations from the material

for analysis within my theoretical framework grounded in Emerson's theory[3]. The material consists of stories of the micro politics of troubling behavior retold by my informants, this means that the material is reflected through my informants' way of interpreting their own actions and the actions of others (Silverman, 2013:34). Thus the material reflects only what my informants felt important to tell me and the material may therefore be framed in ways that put responsibility on some parties and not on others and vice versa.

4.7 Trustworthiness

Trustworthiness refers to the quality, authenticity and truthfulness of qualitative research. It also relates to the trust or confidence readers have in the result (Cypress, 2017). Trustworthiness, according to Cypress (2017), is both a goal of the study and something to be judged during the study as well as after the research is conducted. Trustworthiness or truth are, in qualitative research, a social agreement. What we judge to be true or trustworthy is what we can agree, conditioned by time and place, as true and trustworthy. Validity in qualitative research is also challenging because of the necessity to incorporate rigor and subjectivity as well as creativity into the scientific process (Cypress, 2017).

By covering more of the variation in different views the generalisability of the present study is also enhanced (Larsson, 2009). In this study this variation has been achieved by interviewing both men and women of varying age and backgrounds. As my informants also work in slightly different fields, but always closely with their patients, generalizability through context similarity (Larsson, 2009) should also be possible. Some of my informants work with the elderly in care homes, some as personal assistants, some with the mentally ill and some working at a daily activities facility for people with a variety of challenges. They all worked in close proximity with their patients though and faced similar challenges in their everyday work, which gives the material a wide variety which could increase the generalizability of the study (Larsson, 2009).

[3] The signs used in the transcriptions were: (...) indicates that I have cut a portion of the transcription out when using it as a citation in the text as not all of what an interviewee said was super relevant to the study. … (three dots in a row, without the brackets) indicates that an interviewee trails off without finishing their sentence. Fat letters with a colon behind such as **T:** shows that I interjected with a question or comment, when the informant answers it is marked with another fat letter and a colon, such as **A:**. XXX indicates that the interviewee named a city or town that I have edited out for anonymity.

5 Analysis

In this chapter the results and analysis will be presented through various citations from interviews and observations that I find especially interesting and enlightening in relation to the purpose of the study. Some of Emerson's (1962, 2015) concepts are used as a framework for the analysis. The presentation will start with more subtle troubling situations and gradually analyze more and more extreme situations. I have tried to translate the citations as close to the original Swedish as possible though some sentences had to be altered a bit for them to make sense in English. Through the analysis of the empirical material three traces emerged: Chugging along or going with the flow, Collegiality, Chaos And Last resort.

5.1 Chugging along or going with the flow

I will start by illustrating more subtle troubling situations mostly solved through unilateral responses, but not exclusively. The situations cited in this part of the chapter are of a more subtle kind, later in the chapter more extreme situations will be illustrated.

The first example is from a nursing student talking about his internship at a forensic psychiatry facility. According to the narrative, the informant and another student is playing cards with a few of the patients:

> Yeah, so… we were playing cards once and there was a patient that, eeeh, he said “stop cheating, damn it”, kind of, and I didn’t know if it was a joke or not. But it made me feel uneasy and so on. And it got very quiet around the table… some worry that it would escalate into something worse. So yeah, some worry, uncomfortableness, eeh, and some fear that something would happen, eehm, well yeah… That's the three main ones I guess. (Ingar, nursing student)

The problem in this situation is that a patient becomes at least a bit verbally aggressive and the staff member is uncertain of whether this confrontation is meant as a joke or if the patient really is angry. The staff member becomes scared that the situation will escalate beyond his control and feels uneasy. He therefore chooses not to engage with the angry patient out of fear that he will do or say something that may make the situation worse. The staff member felt worried, uncomfortable and a little bit scared that something else might happen because of the patient's unpredictable behavior.

This can be interpreted as self-targeted changes (Emerson, 2015: 71-73) because the staff chooses not to address the troubling behavior and just tries to distract himself by continuing to play cards. He chooses not to consult the other staff member either and just pretends as if nothing happened, hoping that the disturbing comment made by the patient was just a joke. This patient's behavior might also be interpreted as a balancing operation (Emerson, 1962) in relation to the staff member's authority. The patient uses verbally aggressive language to assert some control over the situation and to establish their autonomy in relation to the staff.

> We continued playing … This particular patient was known for wanting a lot of attention so we thought that if we, thought afterwards that if we start talking to him about this it will be like, eehm, answer to this want of attention or what you call it … so we just… instead of listening, just continued playing cards and that was that, sort of. (Ingar, nursing student)

In this case the staff unanimously decided not to respond to the patient's provocation and just continued playing cards. They motivate this after the fact by referring to the patient's excessive need for attention and that responding would just make the patient do more and more extreme things to attract the attention of the staff. As stated above this is a case of self-targeted changes (Emerson, 2015: 71-73) because they decide not to engage in the troubling behavior and use the card game as a way of distracting themselves. Furthermore, the patient's slightly aggressive behavior can be interpreted as a balancing operation (Emerson, 1962) where the staff are partially dependent on the patient to make the card game a nice social event even though the power balance remains fundamentally the same. When the patient becomes aggressive they challenge the power of the staff by not behaving in a socially acceptable manner. This shows, as Emerson (1962) points out, that the power- dependence relation is fundamentally reciprocal, the staff invites the patients to a social event but if the patients don't engage in it nothing happens. It also shows, as McAllister et. al. (2020) suggests that significant interpersonal skills are needed in care work as well as the technical skill for the job. Without this interpersonal social skill the staff would probably have had a harder time dealing with a patient acting out such as in the citation above.

Furthermore, by not engaging with the patient's behavior they assert their authority in relation to the patient and show that they are not dependent on the patient to legitimize their authority (Emerson, 1962). The staff's authority derives from their job title and the care industry rather than from the patient's approval of them in this case.

Another example of unilateral responses is the citation below. This person describes a patient with dementia that is very manipulative and good at finding things the staff are sensitive to and uses this to challenge the staff and put down their self-esteem. The informant is a nursing student describing their first summer job.

> (…) And she, eeh, really knew, you know, what spots to press on to make people completely, you know, destroyed. It was, you know, she had her routines for each member of the staff. One she called… You know, in some way she could read people really well and, kind of, really, put pressure, eeh, where it hurt. And there were a lot of people who couldn't take that, it was kind of… Eeeh, you almost had to enter with earplugs sometimes because it could get too much. (...) Really the only way you could do it, you just have to pretend not to hear anything and just kind of chug along, there is nothing…(Kim, nursing student)

This member of staff chooses not to say anything to either the troubling patient or to other staff members and tries to just ignore the troubling behavior. Here the staff uses self-targeted changes (Emerson, 2015: 71-73) by not challenging the troubling patient and just ignores the behavior and leaves as soon as possible. The patient is portrayed as very manipulative and finds ways to put people down, this might be interpreted as a way for the patient to use balancing operations (Emerson, 1962) as a way to assert herself in the relationship with staff members. It might also, as Shenk (2012) discuss in her article, show that staff can get quite emotionally involved with their patients. In this case though, this involvement leads to the patient being able to find ways to hurt the staff, rather than being a way for staff to give quality care as in Shenks (2012) study.

The staff member in this case also uses a form of managerial response (Emerson, 2015: 74-76) by using earplugs when he is working with this patient so that he doesn't have to listen to her insults all the time. The patient is described as suffering from dementia and of course needs help, but at the same time she is an adult and might find it difficult to accept help, especially in situations or periods in which she is more clear headed. To assert some self-esteem again she thus chooses to insult and manipulate the staff. The staff in this case are trying to help the patient have a normal everyday life, but the patient might find their help to be an attack on her autonomy and thus fights back by being insulting towards the staff. By using earplugs the staff also robs the patient of her way of asserting some control over her life. Thus the power balance between the two is back to normal, so to speak, and the patient are once again clearly dependent on the staff. This might be interpreted as the power balance being reciprocal, as Emerson (1962) shows, but here the dependence relationship remains the

same even though the patient tries to assert some control in their relationship and manage to shift the power balance to some degree.

The citation below is from a young male nursing student talking about his first job in a nursing home. He describes an interaction he had with an elderly woman with dementia.

> Uhm, well, I might have experienced some … like this, I was in XXX, it was a few years ago, and I was at a patient's place and she was, what do you call it, she opened the door and she was standing there naked and had no idea what was happening. And she was very aggressive in her demeanor. When I went inside, inside her apartment, I noticed that the stove was on really high, like max heat. So I tried to kind of tell her, "Well, should we turn the stove off now?" (laughs). And she got really angry and told me, like, "You can't come in here and decide things for me" and she came up really close and put her hands on my face, and she said something like, aah, no wait, it was like this. I said something like "No, now I got sad" and she went up to me and put her hands on my face and said "Gosh, Elliot are you sad?" (laugh) and (laugh) and, aah, it felt like she came a bit too close for comfort. (Elliot, nursing student)

The patient is a woman with dementia and she opens the door naked, the staff don't really know how to react because of the unfamiliar situation and choose to focus on the fact that the stove is on. This could be interpreted as a form of self-targeted change (Emerson, 2015: 71-73) since he chooses to distract both himself and the patient by focusing on the stove instead of on her state of undress. He tries to get the patient to turn off the stove and she gets angry and when he says something about being sad the patient comes up really close, too close for comfort according to the informant. He laughs nervously when he talks about this, which might suggest that the informant is indicating the sensitive nature of the subject and defines it as a bit embarrassing to talk about, or it could just be that he is nervous about being interviewed.

> **T:** Ok, so … so how does that make you feel when you encounter stuff like that? When you get confronted by a naked woman out of the blue?
> **I:** Well, you know, a naked woman, it is what it is, you know. The worst part is when you get a bit scared, you know. When she marches right up to you and grabs your face, of course you get a bit scared (laugh). But, yes, of course it is a bit weird, when a naked woman opens the door and is standing there with someone she never met before (laughs). But I try to go in there with respect and then I just stand back and just listen to her, you know, let her aggression take its course until it subsides. And you might say something like "Okay, how about getting you dressed?" (laugh). You kind of disarm her in a way. (Elliot, nursing student)

The informant recalls getting a bit scared when the patient comes up to him in an angry manner and puts her hands on his face. This suggests that we tend to get scared in situations

that are unfamiliar to us and that doesn't meet our expectations. But he uses self-targeted changes (Emerson, 2015: 71-73) when he tries to just put some distance between himself and the patient and stay calm in the face of her anger. He says he disarms her in this manner, which suggests that her anger and state of undress is a way for her to assert some power over the staff and get some control over her life back. This is clear when she says things like “you can’t come in here and decide things for me” like in the previous citation. This phrase suggests that the patient gets frustrated over the lack of control she perceives that she has in her own life. The staff robs her of her autonomy (Emerson, 1962) when they don’t react to her anger and just ignores it and moves on. The two examples above might be interpreted in a similar fashion as the case with the manipulative lady. This patient also suffers from dementia and assert herself by getting aggressive and telling the staff that they “can’t come in here and decide things for me” When the staff decides to just go along and let her anger subside on its own he also assert his own authority (Emerson, 1962) by showing the patient that her anger does not matter, he will do his job anyway.

The situation below took place in a facility for daily activities for people with different kinds of disabilities. They were kind enough to let me come and observe their activities for a day and the situation described took place just before lunch.

> Me and one of the staff and two of the patients had been sitting around the lunch table. When we have been sitting for a while talking, another group walks in on the premises and settles down in another room. The other group is quite loud and one of the patients in the room I am in starts hyperventilating. One of the staff sees that the patient starts to get worried and stands up behind the person and puts their hands on the patient's shoulders and starts to give the patient a massage. The staff asks the worried patient to take a few deep breaths as they have been practicing and the patient soon starts to calm down. The patient explains to me that they have tinnitus and because of this don’t like noise and loud sounds. They also ask who the other group is, and the staff explains to both the patient and me that it is an outside group that sometimes uses the premises to eat lunch. (Observation 1, 2021)

The staff here uses preventive action (Emerson, 2015: 77) when they recognize the risk of troubling behavior and move to prevent it. They have apparently seen this behavior in the patient before and have a working strategy for how to prevent it from escalating. The staff also know that this patient calms down when touched and when using breath control and have from what I can tell been using bilateral tactics such as making a remedial complaint as to involve the patient to find a strategy for calming down in situations this patient finds troubling (Emerson, 2015: 13, 96). This strategy is then used as a preventive action

(Emerson, 2015: 77) in situations as the one described above. The staff also clearly understand the importance of explaining what the disturbing sound is to further calm the patient down as she calmly explains the noise to the patient.

Another situation involving a patient that is sensitive to new impressions is described by the interviewed informant below who is an occupational therapist at a daily activity facility. In the citation he is speaking about an incident that happened to him at his last place of employment where he worked with people with autism that were nonverbal.

> But there they had a lot of challenging behavior and a lot of the patients were very sensitive to new impressions. They got easily worried and irritated by different impressions and they couldn't express themselves verbally and instead they threw a shoe or something but that was more … it was clear why, but I never felt touched by it so I got sad or anything but you were tired in the evenings. But I never got sad and I can't say I got scared either, it was ok but of course one got stressed knowing there could come a shoe flying or a coffee cup. (Jay, Occupational therapist)

The informant describes a situation where the patient is nonverbal and tends to throw items when angry or stressed. The informant claims not to be scared or emotionally touched by the patient's action because the informant knows why the patient throws things. The informant non the less profess to be a bit stressed and get tired by the patients behavior. The informant suggests that because he knows that the patient gets stressed by new impressions, he knows that the thrown item most likely means that the patient finds the surroundings to be stressful and feel they get too many new impressions. The informant doesn't really explain what he did in this situation to calm the patient down and quickly moves on to another subject, suggesting he finds it a bit difficult to talk about or maybe he doesn't find this situation very interesting to talk about. The informant explains a bit of his strategy for dealing with troubling situations in the citation below.

> Well, I trust my ability to back off and act very low affective, it could be things like not saying too much and keep your voice calm and preferably sit down when you get in to the room and not be too close to the person and kind of see the little things that are a security for the patients. It could be, for example certain clothes or how you make your coffee and such things and to be able to take advantage of that and really be… at the same time you have to be calm and read the little details and everything that happens. And, sort of, well really be engaged in it. (Jay, Occupational therapist)

The informant explains how he used to handle the patient's troubling behavior by using self-targeted changes (Emerson, 2015: 71-73) such as backing off and trying to keep calm until the troubling behavior stops and he once again can try to engage with the patient. He

also describes using preventive actions (Emerson, 2015: 77) such as keeping his voice calm and sitting down when engaging with the patient. He also uses preventive action (Emerson, 2015: 77) when he wears certain clothes and prepares his coffee in such a way as to not upset the patient and make sure that the troubling behavior doesn't occur again.

The citation below is from my field notes from my observations at a daily activities facility and happened just after lunch. Me and one of the staff just got back to the facility after a walk.

> When we get back to the daily activity facility, one of the patients is sitting and waiting for their cab. The patient seems a bit worried and asks us why the cab hasn't arrived yet. My supervisor answers that the cab is probably on the way and that she can call the cab company and ask them. Before she gets a chance to do that another staff member shows up and tells us he has the cab company's app on his phone so he can see where the cab is. While he tries to figure out how the app works, my supervisor asks the patient if they want to sit down outside and wait for the cab with us. The patient agrees to this and seems a little bit calmer. We go back out and sit down on a bench and my supervisor explains to me that they recently changed cab companies and that the new company usually are on time, I nod. The staff ask the patient what they plan on doing when they get home, the patient answers that they don't really know. I catch sight of the cab and tell the others, they look up just as the cab drives into the parking lot and the patient looks happy when they see the cab. The patient gets up and gives the staff a hug, looks a bit pensive, and then gives me a hug as well. They tell me I get a hug as well so I don't get jealous. I smile at this, nod and say goodbye. (Observation 1, 2021)

In the example above the staff seems to use preventive action (Emerson, 2015: 77) to make sure the patient doesn't get any challenging behavior. They do this by listening to the patient and taking their worries seriously, they then explain that the cab is probably on its way and proceed to figure out exactly where it is. They also use preventive action (Emerson, 2015: 77) when they ask the patient if they want to go out and wait and thereby distracts the patient with questions and small talk. The staff in this situation also use the help of an informal other (Emerson, 2015: 135-161) because there are two people dividing the solution between them, one figures out where the cab is and the other distracts the patient.

The citation below is from a woman working at a daily activities facility. She describes a situation where her patient got really upset and how she solved the situation.

> **A:** Then there has been situations where…, well, I had another situation where there was a…, when she also got very angry at someone else and came running with a chair, and it got really, she got such power, she was just a small petite girl and then I just opened the door so she got out. So that was how I solved that, and then we sat down at a table outside, a garden table…

> **T:** So she could calm down a little when she got outside?
> **A:** Yes and then a colleague came out with a tray with grapes and coffee and such, because often when they get upset, they need a bit of extra care. (Alex, Support assistant)

The staff member above describes a patient who got very upset and violent, she kind of breezed over the description, probably to not reveal any confidential information. The staff member here uses managerial responses (Emerson, 2015: 74-76) by opening the door and letting the angry patient out where they can do less damage before calming down. The solution to this troubling behavior also involves an informal other (Emerson, 2015: 135) in the shape of a colleague who comes with grapes and coffee to further help the patient calm down and feel noticed. This also shows the importance of interpersonal competence as McAllister et. al (2020) discuss in their article. Significant interpersonal skill is needed when deciding how to deal with a patient that is upset and how to calm them down.

The citation below is from an interaction that I witnessed during an observation at a daily activities facility, between a staff member and a patient that got a bit upset over the war in Ukraine. The incident occurred during lunch.

> During lunch one patient gets a bit worried and upset so the staff tries to get him to explain what is wrong, after a while he tells us that he is very worried about the war in Ukraine. The staff tries to calm him down by telling him that there isn't much we can do about it here, but that Sweden and other European countries try to support Ukraine in every way possible. We talk about the war for a bit, but the patient still seems to be upset and he says that he wants to go home. The staff says that it is fine and while we finish our coffee, the staff ask the patient if it would feel better for him to continue talking about the war or if we should talk about something else. The patient answers that he would rather talk about something else, and we do. (Observation 2, 2022)

The staff here notices quite quickly that something is wrong and uses a form of remedial complaint (Emerson, 2015: 96) when she asks the patient what is wrong. By asking the patient what is making him upset she is involving him in the solution of the problem especially when she asks him if it would be better to continue talking about the war or if we should distract him by talking of something else. One might also interpret this as a form of preventive action (Emerson, 2015: 77) as she is preventing the trouble from escalating and perhaps also from happening again. It also shows yet again how interpersonal skills play an important role in care work (McAllister et.al, 2020), as she manages to get the patient to explain what is troubling him by talking to him. It also shows how getting emotionally

involved (Shenk, 2019) might help in the relation with patients as she reacts with empathy to the patients concerns and this seems to have calmed him down somewhat.

All the citations above have in common that the troubling behavior is rather minor and for the most part staff manages to solve it without involving their colleagues to a great extent. In many of the citations above the staff doesn't even have to involve the troubling patient in the solution. The prevailing strategy among all informants is to just ignore the behavior and/or try to distract both themselves and the troubling party with the task at hand. In the situations cited this strategy seems to work quite well and it was a very commonly used strategy among the people interviewed for this study.

Below, I will cite a few situations where the staff needs to consult or in some way involve a colleague in the situation to find a solution to the troubling behavior among their patients.

5.2 Collegiality

The citations below are from a young woman working as a personal assistant. She describes her patient as being somewhat short tempered especially with new staff.

> Uuuhm, yes, ehm, she is like, very aware and so on, ehm, and she has, I don't know, a bit of a short temper you could say, uuhm, especially when you are new, she has a bit of a bad temper. She wants, like, that you should know how to do everything immediately … She snaps at you, kind of, if you do something wrong. (...) Eeehm, well first of all you feel very nervous for the next time you have to do it… It is probably very different, but I got very nervous for the next time I had to do the same thing, you know. Eehm, so that's how it felt and, aah, but you didn't feel very good, you know. You thought you were bad, you know, at your job and… you know… aah, like you did something wrong, like she you know, genuinely, haha, genuinely, or her reaction is not, you know, proportional to what you did... ...Well, you thought that you had, like, hurt her and that she got injured…. but it wasn't like that, so you, aah… You felt, you got a bit, aah, guilt sort of…. mmh, you felt guilty kind of. (Jamie, Personal Assistant)

This patient gets very verbally abusive, especially towards new staff and this makes the staff feel uncertain and nervous. It also makes the staff question whether they are actually any good at their job. The patient's behavior could be construed as a kind of balancing action (Emerson, 1962) where she asserts her own authority in relation to the staff. By being abusive and snapping at new staff she clearly marks out that she is the one in charge and not the staff. The young woman speaking in the citation above also describes feeling guilty for not knowing exactly how this patient wanted things to be done. This also shows how getting

emotionally involved in ones job can be helpful, as the staff clearly cares about this patient's well-being (Shenk, 2019). But it might also make her job harder as she gets very hurt by the patients comments and feel that she is bad at her job.

> Uuuhm, it's hard to remember precisely, but sometimes maybe you just said sorry, kind of, if it was something where she could have gotten hurt kind of, eehm… Kind of, if it was, eehm, if it was those exercises you do for example, eehm, aah… She could, kind of, hehe … If you, kind of, bent and so, aah, she could say "ouch, what the hell!", kind of haha. (Jamie, Personal Assistant)

The citation above is an example of a patient that gets verbally aggressive towards the staff, especially new staff. This may be a way for the patient to assert power over the staff, but it makes the staff feel uncertain and afraid that they are bad at their job. They feel that they may have hurt the patient and thus feel uncertain and nervous when they have to do the same task again. This makes the staff feel guilty because they feel that they are not good enough at their job.

The staff in this case tries to pacify the patient by asking for forgiveness "just in case", especially if the situation is one where it is plausible that the patient might actually have gotten hurt. This situation is one in which the staff involve the troubling party by apologizing just so that they can move on and continue the exercise. The staff doesn't think that the patient has actually been hurt but in order to pacify the patient so that the situation doesn't escalate they take preventive action (Emerson, 2015: 77) by apologizing to the patient.

> Uuuhm, mm, sometimes it was, kind of, in some situations, how to explain this… I have to think of a specific example… Uhm, so everything was wrong and you understood that it was because it was the new staff that did it, kind of… The pillow was in the wrong position, kind of. Eeeh, and then it could, kind of, help if the other, who had been there longer, the other staff, did that task instead and then it was automatically right, kind of. (Jamie, Personal Assistant)

In the citation above the person describes a situation where the patient gets angry over a pillow in the wrong position and the staff can see that the patient really just is angry because it was the new staff that helped with the pillow. The staff solves this by letting a colleague who has worked with the patient for a longer period of time take over the task at hand. This makes the patient calm down, and is a good example of how staff can overcome a troubling situation by backing off and letting an informal other (Emerson, 2015: 135) take over the

situation. The informal other takes over and the staff that was involved in the troubling situation can back off and just stay in the room as support for the other. The staff in this situation doesn't talk to the patient about the fact that their behavior was inappropriate and made the staff feel insecure, but solves it by using self-targeted changes (Emerson, 2015: 71-73), finding ways to perform their job that the patient seems to accept.

This seems to suggest that the staff doesn't view the patient as fully responsible for their actions. The patient is, after all, unwell and in need of care and are, it seems, in the view of the staff excused for some behavior that would not be excused in a healthy person. The power relation in the three citations above seems to be quite different from what has been evident in previous citations. Here we have a situation where the patient is both dependent on the staff but also in some sense the one employing the staff as the patient has been present at the staff's job interview and approved the staff's application for the job, as this informant told me earlier in the interview. Thus the patient has somewhat more power over the staff then has been the case in other examples presented in this study. The patient demonstrates their power by getting angry at new staff and thus showing that they are in some sense the employer in this situation, but the staff also have power in this relationship as they can choose to work elsewhere and the patient are after all dependent on the staff for everyday life.

Other situations where colleagues can be a big help is when, like in the citation below, the staff and the patient don't speak the same language.

> Yes, not so long ago we got a new patient that only speaks another language, that doesn't use Swedish or signs, or have worked with and used pictures as communication. Eeeh, and that is challenging in that the patient and I don't have a working communication and how do you work with someone you can't communicate with? (...) You are with someone without verbal speech, you, eeh, we can't really understand… ehm, well, find a working communication but we can see glances, we read movements, we interpret sounds, movements, how the eyes look, but if you meet a patient that doesn't look at you and don't have the same verbal language and don't have signs, how do you communicate? So that is challenging, extremely challenging because you can't get a grip of the situation. (Eli, Support assistant)

The informant above describes a situation she found extremely challenging because she couldn't find a way to communicate effectively with her patient. They didn't speak the same language and the patient didn't know how to use signs or pictures or any other form of communication that the informant was familiar with. This suggests that challenges don't have to be the patient's behavior, as Emerson (2015) suggested, but can also be such simple things

as finding a way to communicate. If you can't find a way to communicate, it becomes impossible to work together. The citation above also points to the importance of interpersonal skills (Shenk, 2019), as the informant describes how she can look at glances, the patient's movements, interpret sounds and so on to try and understand what the patient is trying to communicate.

> But we do have staff that have the same native language, eeh, that communi … well speaks verbally with this patient and has to translate. Eeeh, but that is also a weird situation, that I have to first go to my colleague and ask them; Can you translate this? and then tell … you know say that to the patient or; can you ask the patient this? And then he speaks to the patient and I just stand there and stare and don't understand anything and then when the patient is finished speaking, then my colleague has to translate back to Swedish… so that is like a three party conversation, eeh, well like in any situation where you need a translator, eeh, but that is challenging because one don't … or I don't get a grip of the situation and I don't know if I make myself understood, I don't know if the patient understands what I mean and I can't continue the explanation. (Eli, Support assistant)

In this situation, the informant can get help from an informal other (Emerson, 2015: 135) in the shape of a colleague that speaks the same native language as the patient. The informant still finds the situation challenging though because she has to rely on a colleague to communicate with her patient and can't be sure she gets her point across. She also has to include the informal other (Emerson, 2015: 135) in every interaction she has with the patient, including interactions she might have wanted to keep private between herself and the patient and the informant finds it weird having to go through the colleague every time she needs to communicate with the patient. The informant also expresses frustration over not having complete control over the situation and having to be excluded from parts of the conversation, when the informal other (Emerson, 2015: 135) and the patient speak in their native language and she doesn't understand what they are saying.

Collegiality is important when communication between staff and patient are difficult, but also when a troubling situation has occurred and the staff needs to make sense of what happened, as the citation below will show.

> **T:** Let's see, I am curious to know … When something happens, how does it feel for you as staff, what emotions and thoughts go through your head, kind of?
> **U:** Well, I… I can only speak for myself. I think a lot: Have I done something wrong?, What happened?, Why did it turn out like this?. I can turn it around in my head and think of… think that I have done something wrong. But we are all different, I am that person… I often want to talk to someone, "Have I done something wrong here?" What should I…

T: You need some input, some feedback…?
U: Yes, I feel like I need that. (Urd, Activity educator)

The informant above describes what she usually feels after a troubling interaction with a patient. She describes second guessing herself a lot and how important she feels it is to be able to get feedback from an informal other (Emerson, 2015: 135), most of the time this is her colleagues. She needs to be able to walk through the troubling situation with a colleague and understand what went wrong and what she can do as a preventive action (Emerson, 2015: 77) for it not to occur again. This informant put a lot of the blame for the troubling situation on herself and needed to understand exactly what went wrong to be able to move on and let go of the situation.

In the citation below a nursing student talks about how he experienced some discomfort in dealing with a patient because he found it hard to not constantly think of the patient's diagnosis of paranoid schizophrenia. He felt a bit guilty that he couldn't see beyond the patient's diagnosis as they had talked a lot about the importance of seeing the people beyond the illness in previous lectures at school. He describes his struggle with himself to be able to relate to this patient. This shows that discussions with colleagues and professors before an interaction with patients also can lead to internal struggles and insecurities in staff that might not be obvious to either the patient or other staff. It might however impact the care the patient receives as the staff might be distracted by their own internal insecurities.

> Yes, yes, ehm, there are many at, ehm, a place like that with different, eehm, psychoses, or what you call it, and psychotic illnesses and so on, eehm, there was a patient that had paranoid schizophrenia and it was very hard to relate to this patient because I didn't know, eehm, what would trigger him.. his, you know, uuhm, what do you call it… Eeem, his, you know, when he goes into one of his psychotic episodes when he starts to think " Oh, no, everyone is watching me, what will happen?" and he starts to act out. I thought, what will trigger this, uuhm, and it was hard to, you know, see the person behind the illness, I could only see the illness. So that was a challenging meeting with a patient, because of that… I could only see the illness, not the human… so I thought about that… (Ingar, Nursing student)

This informant is a nursing student doing his internship at a forensic psychology facility, he describes feeling very nervous before meeting a particular patient. He feels nervous and insecure because this patient is known to get violent when in an ongoing psychosis and the informant is not sure what will trigger such a psychosis. He also describes feeling a bit ashamed because he can't get past this nervousness and see the person behind the illness and this makes it hard for him to interact with the patient. He doesn't talk to either the patient or

his colleagues about this though, rather he uses self-targeted changes (Emerson, 2015: 71-73) to reflect on what makes him nervous in this interaction and tries to work with his own mindset going into the interaction. This might suggest that troubling situations might arise just from our expectations of the interaction and the information we have about the other person even though nothing has actually happened.

In conclusion, we have seen in this part of the chapter that staff use a number of strategies when they ask each other for help navigating difficult interactions with their patients. Some choose to leave the interaction and let a colleague take over completely, some choose to just ask for help making themselves understood to the patient and some just need to talk the interaction over with an informal other (Emerson, 2015: 135-137) to understand what went wrong and how to prevent the troubling behavior from occurring again going forward. In the next part a number of more situations where extreme action (Emerson, 2015: 179) became needed is presented and analyzed.

5.3 Chaos and Last Resort

Sometimes challenging situations can lead staff to have to resort to extreme action (Emerson, 2015: 179) in order to solve the situations. The citations below are from a woman working at a facility for daily activities. She is describing a situation she found difficult where two patients got aggressive toward each other.

> **A:** (...) So, I thought of one…, there was something… I was alone with two patients that started to fight with each other and that was a challenging situation for me, you know. And we were outside of this facility, we have a few activities also outside, eehm, so we were at another workplace and helped with the laundry and the two of them started to fight and I, you know, I couldn't separate them because they… Well, I was alone with them.
> **T:** Aha, ok
> **A:** eeh, so, eeh, eventually I had to actually lift one of them out of the room and lock the door and talk to the other, eehm, and tell them off, to be able to separate them. So that felt really hard I can tell you. But I had to just… Well, I had to solve the situation in some way. (Alex, Support assistant)

In the citation above the staff member remembers a situation where she was alone with two patients that started to fight with each other and she had to try and calm both of them down. She explains that she tried to talk them out of it, but they didn't listen to her and eventually she had to physically lift one of them out of the room to be able to use remedial complaints (Emerson, 2015: 96) and explain to the other patient that their behavior was unacceptable.

Furthermore, she remembers that she felt stressed out and that it was hard to deal with the situation alone. This might suggest that she might not have resorted to lifting one patient out of the room had she had an informal other (Emerson, 2015: 135) such as a colleague nearby to help her solve the situation.

> **A:** (...) And this continued for a while. Several months actually, they were really against each other.
> **T:** So these fights can continue for a long time?
> **A:** Yes, yes, so they remembered this. It started with one of them saying something to the other "Well, you didn't do much here" just something, and well he had done everything, the other, and he got really angry because he had done everything. And then it started that they wanted to fight physically.
> **T:** Oh my god, that sounds really hard. How did that make you feel?
> **A:** Well, I felt, I got a bit stressed out but I, I had to feel that, well I had to explain it somehow, but I couldn't talk them out of it. I had to just lift one of them out and tell the other to take the bus back home. Because he could do that on his own, but he didn't do that so when I came out with the other patient he was sitting on a bench a bit further away. (Alex, Support assistant)

The staff member tells me again that she tried to talk the patients out of the troubling behavior but that it wasn't possible. This suggests that she feels the need to justify her eventual use of physical force to separate the two patients. It might suggest that not being able to talk the patients down means a loss of perceived authority and legitimacy (Emerson, 1962) for her, at least in her own eyes.

The citation below is from a woman working at a facility for daily activities for people with different kinds of disabilities. She describes an event with a patient that became violent that took place a few years ago.

> **E:** Eehm, I once experienced, I want to call it, a massive episode, where the patient got hold of a massive clock, like that, with glas, it wasn't… All those are with plastic now (indicates a clock hanging on the wall behind us), but back then it was with glass-glass on the clock and he grabs it like a frisbee and throws it right across the room and just wroom (makes a sound effect of something flying in the air), glass shards everywhere, he runs barefoot and runs right through the glass shards towards me, because he was in very, very high affekt. Eeeh, and what do you do? Well the only thing I could do was, firstly, we are supposed to protect ourselves and then we are supposed to protect the patient, eeh, you can deflect blows, eeh, if you have to, you are kind of supposed to go with the motion so you don't harm the patient, eeh, so if he attempts to hit you, you are supposed to kind of catch his arm and swing back to go with the motion (shows me by swinging back a bit in her chair), so it's not just a dead stop. Eeeh, and then, eeh, this episode, eeh, it continued for an entire hour and it eventually ended with me bellowing, just; Go to your room and stay there! And all of a sudden he was completely calm

> and I have never… It is the only time, of all my years working, that… that I have had to raise my voice like that. But that was what was needed in that situation. (...)
> **T:** And you had been trying to calm him down for an hour before?
> **E:** Ooo yes… Yes exactly and, let me tell you, in that situation an hour is a really long time, it felt like a week. Eeeh, and at the same time my colleague and two other patients locked themselves in the kitchen, so I was all alone with this patient who was in such… was in such high affekt. (Eli, Support assistant)

In the situation above the informant describes a situation where the patient becomes quite physically violent and throws a clock at her. She responds as calmly as she can despite describing being scared. She describes the patient running towards her and trying to hit her and how she tried to not hurt him as she defended herself. She kind of glosses over the part where he gets physical, possibly because it was a traumatic event and she still finds it hard to talk about. She describes how she eventually gives up on trying to calm him down by using remedial complaints (Emerson, 2015: 91-92, 96) such as talking to him and just shouts at him to go back to his room, and somewhat to her own surprise this seems to help. She also points out that the potential informal third party (Emerson, 2015: 15, 135-161) that could have helped her out in this situation had to hide in the kitchen with the other patients, and this made her feel quite alone in having to deal with this rather aggressive patient. When the interview continues, Eli explains that they also considered calling a formal other (Emerson, 2015) such as the police, but it ended up not being necessary as the patient calmed down when the staff member finally lost her patience.

Furthermore, she points out several times that she tried for a long time to not lose her temper and just stay calm, this could be a way to rationalize and defend her eventual loss of temper. This can also be construed as a way for her to reassert her authority (Emerson, 1962) as a care professional. Losing one's temper is generally not considered very professional and this might be a contributing factor as to why she feels the need to explain several times that screaming at the patient was a last resort (Emerson, 2015) for her before having to resort to calling a formal other (Emerson, 2015: 14, 206-207) such as the police.

The citation below is another example of a situation where the staff feels threatened. It is from a young man working in the home care service.

> **E:** (...) And, it, it was also here in XXX, so, you know, I came to somebody's home and it was a rather young woman, between 30-40 years old, you know. So she starts telling me that, you know, she has been a member of hell's angels and that she has a g … aa, and that she has a

> gun at home. Aa, and so on, and she sits there telling me this, and then in some way it ends with “aa, Elliot, you are the only one in the home care service I have told about this, so if anyone else knows I know who told them” And in that situation you become quite scared and I probably should have said something to my boss or the home care service but I didn’t. (...)
> **T:** So why didn’t you tell anyone?
> **E:** Because in some way, aa, well, the fear… Because it felt, you know, real in some way.
> **T:** Ok, so are you afraid that she will threaten you with that gun or… What is it you are afraid of?
> **E:** It sounds comical when you put it like that but, that's right, that… that it would in some way escalate. So you know, and in some way the first impression she gives you is that it is serious, that she, you know, would do something more and it is hard to, you know, say something. (Elliot, Nursing student)

In the situation above the staff is new to the job and comes to the home of the patient for the first time. She tells him that she used to be a member of the criminal group Hell's angels and that she still keeps a gun in her home. She also tells him that he is the only person from the home care service that knows of this which is probably not true as a criminal history is most likely widely known by the home care company and other authorities, you also need to have a license to own a gun, but at the moment the staff member non the less feels threatened. The staff member feels threatened and afraid and doesn't dare to tell anyone else of this. In this situation the patient takes power in their relationship through a form of balancing operation (Emerson, 1962) by implicitly threatening the staff member and the staff member uses self-targeted changes (Emerson, 2015: 71-73) by just kind of ignoring the threat and continuing working, but he feels uneasy. This feeling of unease and uncertainty might also be exacerbated by the fact that he loses some of his authority (Emerson, 1962) as a care professional when the patient asserts control in their relationship by telling him of her criminal past.

The patient attempts to take power in their relationship with the staff by scaring him, but she is suffering from dementia and thus needs his help to be able to go through the day. By threatening him she is non the less showing that he doesn't have all the power she can also demand things of him and if need be use the gun to get what she wants. He also finds it hard to speak about with his colleagues which is perhaps why he doesn't involve neither his colleagues nor a formal other (Emerson, 2015: 14, 206-207) such as his boss or the police in this situation. He also stutters a bit when relating the story to me suggesting he still doesn't find it entirely easy to speak about.

In contrast to the citation above, where the staff didn't dare to ask for help among his colleagues or other authorities, the informant in the citation below relates to me how it is always ok to ask for help.

> When you work in the other facility, you are always two people in the building, eeh, and that's a plan of action because there is a…. a patient with challenging behavior. Eeeeh, but it's the same thing, ask for help, eeh, if you find yourself in a threatening situation, where there is a risk of injury, then you have to call 112. Lock yourself in the bathroom and call 112, it's all you can do and you are allowed to… (Eli, Support assistant)

This member of staff describes a strategy she always has in mind when dealing with challenging behavior. She points out that she always has the option to call a formal other (Emerson, 2015: 14, 206-207) to help her solve a situation she cannot solve herself. She seems to find a sort of comfort in knowing that she has the option to call a formal other (Emerson, 2015: 14, 206-207) such as the police should a challenging situation get out of hand and she is very careful to point out that it is allowed to do so should the need arise.

She uses the word "allowed" when speaking of this option which might suggest that calling a formal other (Emerson, 2015: 14, 206-207) to help is somewhat shameful and connected to a loss of pride in her work. There seems to be an implicit understanding that you as a care professional are supposed to be able to solve things on your own and not being able to do so is connected to a loss of authority (Emerson, 1962) in the eyes of both the patient and colleagues and not least in her own eyes. To call a formal other (Emerson, 2015: 14, 206-207) such as the police or some other authority might mean that she loses some of her own authority as a care professional and she thus loses both power and legitimacy (Emerson, 1962) in her relationship with both patients and colleagues.

> **E:** Mm, eh, aa, it, I could tell you about just one other, you know, a small one. It was the same thing here in XXX, the home care service. There was a patient who had, you know, psychological issues in some way and, you know, when you got to his home, he had this huge knife, almost a machete, laying around.
> **T:** Wow
> **E:** You saw it and I asked kind of like this "What is this, what are you going to use that for?", Kind of "No, you don't have to worry Elliot, that (laughs), that is just in case it gets too hard to live, you know" And you saw, just things like that, you know, that there are people who think like that. And it feels like there is a risk, you know, that you come to someone's home and you find them all cut up, you know. So, you know, that feels a bit scary, but you get surprises like that. (Elliot, Nursing student)

The informant above describes meeting a patient for the first time and finds out that this patient might commit suicide. The informant describes feeling insecure and scared that he might one day come to a person's home to find them dead. He does not, however, tell anyone, informal or formal other (Emerson, 2015: 135-161, 14, 206-207), about this and he seems to regret that a bit when he tells me about it. He instead seems to find it easier to use self-targeted changes (Emerson, 2015: 71-73) by just ignoring this information and distract himself and the patient by moving on with his workday. The possibility that he might find the patient dead someday seems to non the less be present in the back of his mind. This citation seem to suggest that the patient can claim power in their relationship with the staff by threatening to comit suicide. This shows that the patient is the one with fundamental power over their own body even though the health care system has taken a lot of this power from them by taking over a lot of the decisions regarding their physical health and what their days look like. This can be a difficult thing for the care professional to relate to in their everyday work as this citation seems to suggest.

In the citation below, Jay describes feeling a bit tense when confronted by challenging behavior.

> Yes but feelings connected to those kinds of situations, well, of course one can get, eeeh, tense or actually a bit scared because there have been patients that have become violent towards me here too. (Jay, Occupational therapist)

The informant reluctantly admits to having, on occasion, felt a bit tense or scared when he found himself in a situation where his patient became violent. He seems a bit reluctant to tell me of situations where things have made him feel a bit insecure, maybe because feeling scared is considered unprofessional and he is maybe afraid of losing some of his authority (Emerson, 1962) as a care professional if he admits to losing control sometimes.

In this part of the chapter a number of relatively extreme situations have been presented and analyzed. As is evident in this part, extreme situations can take a number of different shapes and staff have a wide variety of strategies for dealing with them. Some find themselves needing to raise their voice and scream at the patient to stop with the troubling behavior, while others find it easier to ignore the disturbing behavior and move on with their day. These extreme situations seem to be rather unusual though, judging from the material available to the present study.

In the next chapter I will discuss my material in relation to previous research and critically discuss my chosen method. I will end by suggesting projects that might be interesting to look at in the future.

6 Discussion

In this chapter I will discuss my material in relation to previous research and critically discuss my chosen method. I will end by suggesting projects that might be interesting to look at in the future. I will begin by discussing the result in relation to each of my research questions:

- What strategies are used among staff to respond to challenging interactions with patients, as they are narrated by staff?
- In which ways are power relations made visible in challenging interactions between staff and patients?
- What emotions are reported by staff, in connection to challenging interactions with patients?

6.1 Strategies used when dealing with troubling interactions with patients

A number of different strategies that are commonly used to resolve challenging interactions with patients emerged when I analyzed the material. Such methods were things like ignoring the troubling behavior, distracting the patient and thereby interrupting the challenging behavior, asking a colleague for help and lastly involving a formal third party.

Cooke and Baumbusch (2020) suggested that the work place environment is important for staff to feel that they can ask each other for help when the need arises. In my study I found that on one hand collegiality and emotional support from co-workers were very important to many of my informants, but on another hand it seems like asking for help in troubling situations could also be connected to a loss of legitimacy and authority among colleagues. Especially when one felt they might need to ask a formal third party for help such as a boss or the police. Losing one's temper also seemed to be connected to a certain loss of prestige among colleagues and my informants put a lot of emphasis on the fact that they had tried everything before resorting to asking for help or losing their temper. My informants didn't have a problem with asking colleagues for help when someone needed to get the other patients away from a troubling situation or when discussing a troubling situation after the fact but it didn't seem quite acceptable not to be able to solve troubling situations on ones own.

Crocker (2019) put a lot of emphasis on the need for solidarity among co-workers to be able to resist gendered structures in the workplace. I have not put any emphasis on gender in my study, as I found that my material provided sufficient interesting micropolitical troubles without also making a gender analysis. I fear that the study would have become too long and sprawling had I involved gender in my analysis as well. But as Crocker (2019) also points out, my informants have put a lot of emphasis on the need for support from co-workers. Crocker (2019) suggests that collegial support can stem from a shared experience as women and mothers as well as from a shared experience as low-wage workers. I think that Cocker (2019) might have a point, but from what I can tell from my informants, their collegiality seems to stem more from a sense of shared experience as low-wage workers than from gender identity, as not all my informants were women and none of my informants suggested that gender was considered when asking for help

6.2 Power in challenging interactions with patients

The power relations visible in the interactions between staff and patients in my empirical material were interesting in that it seems to suggest that the patients have a number of ways to claim some power back in the relationship. It also shows that the power balance can temporarily tilt toward the patient before quickly settling back into the favor of the staff. This might suggest that power relations can be very dynamic and constantly shift and twist without necessarily changing fundamentally.

In their study, Nimmon & Stenfors-Hayes (2016) explores the power relation between physicians and their patients. In this study I have explored the power dynamics present in care workers interactions with their patients too, but unlike Nimmon and Stenfors-Hayes (2016) I have focused on narratives of the experiences of nurses, nurses assistants and so on that have an arguably closer relationship to their patients than physicians in a hospital setting has. This might have enabled me to see different aspects of the power dynamics present in care worker- patient interactions than Nimmon and Stenfors-hayes did in their study. This doesn't make their study less valuable, but my study might contribute to a more nuanced understanding of the power relations inherent in the care industry.

Jervis (2002) writes in her study about the power relations between nurses and nursing assistants. She points out that nursing assistants often are the most numerous and have the closest relationship with patients, yet they often have the least power among the staff. Jervis

(2002) suggests that this creates tension among the staff which might very well be true, my study though, focuses more on the power relation present between staff and patients. My study suggests that patients have more power in their dealings with care workers than might be obvious at first glance. This power relation also seems to be very dynamic as Emerson (1962) hints toward, but in my study one can also see that the power relationships can twist and shift a good deal without necessarily changing fundamentally.

6.3 Feelings in connection to challenging interactions with patients

My informants described feeling a variety of emotions in connection with troubling interactions with their patients. A prevailing feeling that almost all of my informants describe was stress. Other feelings such as insecurity, shame and fear were also common in their descriptions of troubling interactions with patients.

Warming (2019), writes about emotions and the power relations connected to them that arise in the interaction between client/patient and the professional care worker. She focuses a lot on the emotional pressure staff can put on their patients, which is an important aspect of emotions in any relationship (Warming, 2019). I think that it is important to also acknowledge the emotional press staff can sometimes feel in their relations with patients as well though. It is important to recognize that troubling behavior takes an emotional toll not only on the patient but also on the staff and, as many of my informants point out, how important it is for staff to be able to get the emotional support they need after a troubling interaction with patients.

McAllister, et al.(2020) explored nurses' stories about working the night shift in their study. They suggest that to work the night shift the nurses need to be adept in interpersonal and psychosocial skills as well as having technical and physical competence (McAllister et al., 2020). I would argue, in light of my study, that care workers need to be adept in psychosocial and interpersonal skills regardless of whether they work the night shift or not. As my study suggests, emotion is present in interactions between care workers and patients regardless of time of day and to be able to navigate troubling interactions, empathy and sensitivity are crucial personality traits. To be able to prevent troubling situations from occurring, sensitivity is needed as many of my informants emphasized.

Shenk (2012) suggested in her study that emotionally invested care workers are crucial to quality care work, however I would argue that to be emotionally invested in ones work also increases the risk of feeling insecure, scared and so on when things don't go smoothly. It also increases the risk of feeling hurt when patients take a turn for the worse or die. This is not an argument against Shenks (2012) suggestion but I want to point out the need for an emotional support network for care workers if they are to get emotionally involved with their patients. My informants also pointed out the need for support from colleagues when things get out of hand and how important it is to be able to talk things over with ones colleagues and bosses.

Habel (2021), writes in her study about how working hours are viewed in the live-in care industry. She writes that the agencies have two contending and contradicting conceptions of working hours, some see working and leisure time as inseparable and some see leisure time as something personal and a valid demand from workers (Habel, 2021). This contending view points to something prevalent in the care industry that is that emotional and physical leisure time for the staff is seen as something secondary to the care of the patients. My informants pointed out that personal time is important after a troubling interaction with a patient as many confess to feeling drained, some to feel a bit scared or stressed out. This suggests that there needs to be room for staff to take a break or to talk to a colleague after a troubling interaction so that they can have the mental and physical fortitude to provide quality care to their patients.

As can be seen in this chapter a lot of time and care has been put into exploring and explaining the power relations between nurses and nursing assistants, the emotional investment appropriate in care work, different views on leisure time for staff and so on. My study on the other hand takes an interest in the complex relationships care workers have with their patients and especially what staff feel and think when troubling situations arise in these relationships. Although this study has focused on the micro-political interpersonal processes present in the relationship between care worker and patient, I recognize as Emerson and Messenger (1977) did, that a fully developed sociology of trouble also should consider macro-politics. Such macro-political considerations would for example inquire into how broader economic, political and social interests shape the frames of reference and the institutionalized remedies available when identifying and dealing with trouble (Emerson & Messinger, 1977). How society views sickness and medicalisation also informes how care workers would frame and deal with a patient considered troubling. It could be argued that the

medicalization of society leads us to "recognize" new forms of diagnosis and thus deal with troubling behavior in a different way. Furthermore, I would argue that to gain a deeper understanding of macro-political forces and societal issues, it is important to also understand how trouble begins in micro-political interpersonal relationships. The relationship between micro-political and macro-political processes can thus be seen as reciprocal. Micro- political processes are framed by the macro-political forces at play in society, but macro-political institutions are made up by people and are thus also shaped by interpersonal relationships.

6.4 Methodological reflections

The methods I chose for this study were semi-structured interviews and participant observations. I chose to combine these methods of data collection because I felt they could best help me answer my research questions. Another reason for the chosen methods was that I felt it gave me quite holistic material for the study as the semi-structured interview can give the interviewed person and me more room to discuss my questions and sometimes diverge a bit without losing sight of the reason for the interview. The observations were implemented as I thought they could give me a bit more insight in how care workers work throughout a normal day and it also gave me the opportunity to ask more questions as I got curious of the things I could observe and I could see things my informants not necessarily knew how to describe in an interview situation.

A potential problem with the method could be that the sample size is relatively small, only eight interviews and three days of observation. This might pose a problem as I might have missed things that could have been of interest to this study. However, by covering a variety of views present in the field one can argue that the generalizability of the study is enhanced (Larsson, 2009). Therefore it could be a potential strength of the chosen sample that both men and women of varying age and backgrounds are represented. The fieldnotes amounted to 6 pages in total and the interviews amounted to a total of 44 pages of text. A potential problem, however, could be that it is difficult to know the true breath of the variation and I might therefore have missed some viewpoint that could have been of interest to this study (Larson, 2009). I have also chosen not to put much emphasis on gender in this study as the informants didn't think their gender identity played much of a role in their interactions with their patients. I also felt that the study might have become too long and too sprawling had I taken gender dynamics into sufficient consideration in my analysis.

Considering the things discussed above it could be of interest for future studies to do something similar to this study but with a larger sample size. Another interesting future project could be to look at how gender identity might play a role in troubling interactions with patients.

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Bilaga 1

Intervjuguide

Samtycke och information om studien
Denna studie har som syfte att undersöka hur du som vårdpersonal hanterar/navigerar utmanande kontakter med dina brukare/boende samt vilket stöd du upplever att du får av kollegor och chefer. Din medverkan i studien kommer att vara helt anonym och du kan naturligtvis avbryta din medverkan när som helst innan publicering av studien.
Tack så mycket för din medverkan!

En vanlig dag
- Vad för typ av anställning har du? Heltid/Deltid
- Hur länge har du jobbat här?
- Vad har du fått för utbildning?
- Beskriv en vanlig dag på jobbet?
- kvällspass/morgonpass?

Utmanande samspel
- Har du upplevt någon brukarkontakt som extra svår att navigera?
- På vilket sätt upplevdes kontakten som svår/utmanande? Beskriv händelsen?
- exempel?

Hur hanteras de?
- Hur löser du situationer som upplevs som extra utmanande i din kontakt med brukare?
- Vad för känslor upplever du i situationer som du upplever som utmanande?
- Hur kände du efter att du lämnat den utmanande situationen?
- Pratade du med kollegor/chefer om den utmanande situationen?

Det formella
- Rapporterades din utmanande brukarkontakt?
- Hur?
- Blir det någon uppföljning? Hur ser den i så fall ut? Hade du velat ha annan intro till yrket?