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K309 Communication in Health and Social Care

K309 Block 3

The Person in the Process

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Contents

Introduction

You have reached a turning point in the course. So far you have been considering large-scale influences such as context, language, diversity and theoretical perspectives on communication and relationships in health and social care. You turn now to the individual, what the individual brings to the communication process and what influences the individual in that process.

There are different ways of trying to understand what makes for effective communication in health and social care.

Unit 8 addresses one approach that involves looking at attributes, dispositions and attitudes that the person brings to a communication process. The notion of core conditions offers a framework that has been widely used to understand these and the unit focuses on this framework to explore whether there are some generalisable principles that can be drawn out. Unit 8 draws explicitly on a *humanistic tradition.*

Unit 9 explores another approach that focuses on communication *skills.* A skills focus builds on the capacity of each individual to learn and develop some fundamental ways of interacting with each other. These ideas emphasise the expression of attitudes and attributes in behaviours and therefore draw on *behaviourist* traditions. Although the notions of *core conditions* and *skills* are from different schools of thought, they are so closely intertwined that Units 8 and 9 address both.

Unit 10 acknowledges that involvement in health and social care can be an emotional experience. Using psychological and sociological perspectives, it explores the emotional impact on the individual.

Unit 11 examines difficult encounters, exploring the broad interactional, organisational and ideological contexts that make some people and situations 'difficult'. It also looks at alternative approaches to handling encounters.

Unit 8

Core conditions

Prepared for the course team
by Anita Rogers

Contents

You will need

- Course Reader

  Chapter 19 'The necessary and sufficient conditions of therapeutic personality change' by Carl Rogers

  Chapter 20 'Compassion fatigue: how much can I give?' by Peter Huggard

  Chapter 21 'Developing virtue and the core conditions' by Anne Gallagher
- Anthology

  Extract 30 'The diving-bell and the butterfly' by Jean-Dominique Bauby

  Extract 40 'I didn't know how to help him' by Michele Hanson (optional)

  Extract 16 'What is a good doctor?'

  Extract 15 'Listening' by William Isaacs
- Audio 3, Band 1, Interview with Menachim Pressler

Learning outcomes

After studying this unit you should be able to:

- Demonstrate systematic and critical understanding of what is meant by core conditions and the socio-cultural origins of this theory.
- Critically discuss the role of core conditions in everyday communication in health and social care interactions.
- Analyse the effects on relationships of your own and other people's use of core conditions in interactions.
- Demonstrate reflexivity and reflective thinking in regard to developing the core conditions in practice.

Introduction

There are different ways of trying to understand what makes for effective communication in health and social care. One approach involves looking at attributes, dispositions and attitudes that the person brings to a communication process. The notion of core conditions, which you looked at briefly in your work on Carl Rogers and the humanistic perspective in Unit 4, is a framework that has been widely used to understand them. This unit focuses on the framework to explore whether some generalisable principles can be drawn out.

Another approach focuses on communication skills, which is the topic of Unit 9. These ideas are from different schools of thought and yet they are so closely intertwined that it can be difficult to separate them.

This unit takes an explicitly humanistic perspective, and examines three areas.

1 Some aspects of Carl Rogers' theory of personality change.

2 How the notion of the core conditions emerged from this theory.

3 How core conditions might be developed within this framework of thinking and acting.

This unit explores how core conditions might look in everyday practice in health and social care, and how they might impact on the nature of relationship and communication processes. To understand the role of core conditions it is also important to explore the relationship between core conditions and communication skills.

To summarise, this unit addresses the following core questions.

Core questions

1 What are core conditions and what is their role in helping you to communicate effectively?

2 How are core conditions situated in a socio-cultural context?

3 What helps or hinders developing and implementing core conditions?

4 How are core conditions and communication skills related to each other?

1 Disentangling the relationship between core conditions and communication skills

This section disentangles what the two concepts – core conditions and communication skills – mean and their relationship to each other.

1.1 Two ways of telling a story

Core conditions are necessary and sufficient for effective interpersonal communication. This emphasis suggests that identifiable conditions such as a helper's empathy, genuineness and positive regard are key to effective relationship building and effective communication. These 'conditions' take into account the circumstances of the relationship, certain attitudes and attributes the person in the helping role can bring, and how the other person receives these conditions. This framework, which has so powerfully shaped current expectations about effective communication in health and social care, comes from a humanistic tradition.

An emphasis on skills gives behaviours priority. Regardless of attitude towards the other person, the behaviour is what counts and behaviours can be learned, skills can be developed. Skills approaches emphasise behavioural change, assuming the process of relating interpersonally can be broken down into specific behaviours. Skills approaches do not necessarily account for qualities such as warmth and trust. Skill development approaches come from a behaviourist tradition.

1.2 Interacting processes

As you can see, core conditions belong in one kind of story and communication skills in another. Both are interesting and useful stories. Sometimes one story gives insights into the other and vice versa. Some aspects of the stories intersect. Possibly both are necessary for effective communication. Not only is it necessary to have conditions such as empathy, genuineness and positive regard present but, equally, conveying them requires a certain amount of skilfulness. In addition, developing skills may lead to enhancing core conditions and vice versa.

This unit does some of this disentangling for you, although you will notice a considerable overlap in language and terminology as you work through this unit and the next one. It is important to be clear what distinctions are being made and why.

2 What are core conditions?

2.1 Identifying underlying themes and attitudes

Activity 8.1 **Experiences of being helped**

15 minutes

In Section 1 the importance of both skills and attitudes or conditions to the helping process was noted.

Read the following two accounts. They are different in many respects. The first one gives an observer's perspective on how a situation involving a person with a learning disability was resolved. The second account gives a practitioner's view on how she attempts to relate to a client in a psychotherapy setting.

Make a few notes on the attitudes, qualities and behaviours the helpers seem to have in common.

Account 1 – Jimmy

Jimmy has a learning disability. He was born with a condition known as albinism, which means he has no pigmentation in his skin or hair and his eyes are very light sensitive. He has no speech but he leads people to the things that he likes and needs. Staff like him and they describe him with great affection. However, in the past, he was seen as obstinate and lazy, especially on walking trips to town when he would frequently sit down on the pavement and refuse to move. Often the trip was abandoned and they would have to return home. Staff were bemused, since they were usually going into the town for things that Jimmy liked such as a take-away, a CD or essential shopping that inevitably included goodies for Jimmy's sweet tooth.

A behavioural specialist spent time with staff and Jimmy interviewing and observing in order to understand some of the factors that might be involved in these incidents. Nothing very clearly emerged except these incidents seemed to occur on very sunny days, when all the staff were feeling great. Very soon it became apparent that Jimmy's light sensitivity meant he could not cope with the bright light and, possibly not being able to see clearly, he sat down on what he saw as safe ground – the pavement. When staff were able to understand how Jimmy was experiencing what they saw as a lovely sunny day and put themselves in his position, Jimmy lost the attributions of laziness and obstinacy. Instead they saw a man who felt unsteady and unsafe. Their anger and frustration turned to understanding and support. That is when Jimmy started to be known around town for his designer shades and not for his 'obstinate behaviour'.

(Source: Psychologist in a voluntary organisation for people with learning disabilities, interviewed for K309)

Account 2 – practitioner's view

To care for another person, I must be able to understand him and his world as if I were inside it. I must be able to see, as it were, with his eyes what his world is like to him and how he sees himself. Instead of merely looking at him in a detached way from outside, as if he were a specimen, I must be able to be with him in his world, 'going' into his world in order to sense from 'inside' what life is like for him ...

Psychotherapist in private practice

(Source: Mayeroff, 1971, pp. 41–42, cited in Egan, 1975, p. 86)

Comment *It seemed important to spend time, to understand how the person being helped was actually experiencing events. In Jimmy's case, the time and the focused attention on his situation led to an understanding of what his world is like for him. This helped to reach a solution to the difficulties both Jimmy and his staff faced.*

The next activity is an opportunity to explore your own experience of helping or being helped.

Activity 8.2 **Exploring your own experience of helping or being helped**

15 minutes

Take a few moments now to recall an experience in the context of health or social care, when you were either a helper or someone who was receiving help, which had a positive outcome. What was important about this experience and what made it memorable for you?

Comment *You may have remembered a time of crisis, the memory of which remains acute. The 'help' involved may have been very concrete and specific. As a helper or the person being helped, possibly some action was taken: for example, a pillow being smoothed, or treatment to ease back pain. When you reflect on your memories of what may have made such an encounter significant, you may have remembered how the action was carried out. You may have noted that a small gesture made a difference to you: someone placed a hand on your shoulder during a difficult time and you felt steadied somehow; perhaps you felt relieved when you were struggling to express something and another person came out with the right words that let you know they understood you; possibly you recall a time when someone thanked you for just 'being there'.*

What may bind your recollections and the accounts of Jimmy and the psychotherapist together are common themes involving some kind of communication between people: a valuing and *regard* of others. This can lead to a *commitment* to understanding the life world of other people, and a capacity to convey that understanding in a way that has meaning and impact. The staff working with Jimmy made an effort to understand what was going on for him, to put themselves in his position and to *respond* in a way that reflected their *care* and *concern*. The psychotherapist, too, describes this commitment that links care with a willingness to understand the world of the other. This coupling of understanding and action is often called *empathy.*


Activity 8.3

30 minutes

Coupling understanding and action: guardian angel or heartless oaf?

1 Read the extract from *The Diving-Bell and the Butterfly* by Jean-Dominique Bauby in the Anthology (Extract 30).

2 Put yourself in the patient's position and note where responses to him combined understanding and action and where they were the opposite.

Comment

The patient in the account calls the speech therapist a 'Guardian Angel'. This is because she (and the female psychologist) understand the importance of communication to him. They work hard to keep him in touch with the world by working out his needs from the tiny signals that he can give. By contrast, he views very negatively those who do not bother to do this. The doctor he describes does not make any effort to understand and communicate and one member of staff (the 'heartless oaf') shows so little empathy for the patient's situation that they turn off the television half-way through something the patient can enjoy – a football match. I can imagine the enraged reactions there would be if a 'big screen' in a pub were turned off half-way through a football, tennis or other match or event. How did you respond to that? I felt really cross for Jean when I read this – seeing the person is about 'putting yourself in their shoes' enough to meet their needs sensitively and this was one enjoyable thing he could still engage with. Was it really necessary to be rigid about routines and switch off? At the very least there could have been some kind of acknowledgement of what was being done and some conversation about it.

These attitudes and dispositions are related to the *core conditions*. Carl Rogers, an American humanistic scholar and the founder of person-centred approaches, first introduced the term (Rogers, 1957). You met Rogers' work on the core conditions in Unit 4, as part of your exploration of a humanistic or person-centred perspective on communication and relationships. In the next activity you will read one of his seminal articles on core conditions, which you first looked at as part of your work in Unit 4.

2.2 Humanistic perspectives and core conditions: theory and practice

In reading Carl Rogers' article you are being asked to make a leap from the examples occurring in everyday life and work in health and social care that you read in the accounts in Activity 9.1. This leap will take you briefly into the world of psychotherapy and personality change, in order to understand the origins of the notion of core conditions in a particular philosophy of human nature embedded in humanistic psychology.


Activity 8.4

1 hour

Core conditions: the necessary and sufficient conditions of therapeutic personality change

Rogers proposed that the core conditions were *the necessary and sufficient conditions* for therapeutic personality change. Read Chapter 19, 'The necessary and sufficient conditions of the therapeutic personality change', by Carl Rogers in the Reader. As you read, think about times, perhaps drawing from your recollections for Activity 9.1, when you were aware of the core conditions in an interaction. What were the circumstances and what happened? How does the notion 'necessary and sufficient' apply to these? Do you feel the core conditions are necessary to all effective communication?

Comment *I hope that you could identify some connections between your recollection of your own experience and the core conditions described by Rogers. Here are one tester's comments.*

> *I had the experience of someone treating me with respect, empathy, genuineness. They accepted what I was saying, and seemed to respect my point of view. I felt very relieved and understood. Other people around me at the time were trying to get me to see their point of view and to change my mind. They just didn't seem to listen or understand.*

Another tester made the following comments about his work.

> *In our day-to-day contact with people with difficult circumstances, we endeavour to provide them with support and/or information to resolve these or learn to cope. Nothing earth shattering, but often 'just being there' is all we need to do.*

You may have noted that the first tester emphasises how helpful it was to her to be accepted and understood. The second tester introduces an additional element to the effectiveness of the helping encounter – 'giving information'. However, both emphasise the importance of that quality of connection, or 'just being there'.

The core conditions came out of Rogers' search for a theory of personality change. The first two conditions he mentions are really 'setting conditions'. They set the context for the exchange. The client and the helper must be at least in minimal contact and the client must be in a state of distress or incongruence. Incongruence means that how a person thinks they should think and feel and how they actually behave is out of step, or incongruent, with what they really think and feel inside themselves. In addition, they may not even be aware of these disparate thoughts, feelings and behaviours.

The beliefs embedded in humanistic psychology underpin this idea of 'incongruence'. You have already reflected in earlier units on how various perspectives, including the humanistic one, are products of certain social and cultural contexts. Briefly, the humanistic perspective proposes that each individual has a real self, which if nurtured properly will grow and change in positive ways. For a variety of different reasons, an individual's real self and the ideas that individual has about how he or she should be get distorted and the person is said to be in a state of incongruence.

The following case study expresses a range of concerns encountered by a member of our course team in her work as a counsellor to people with vocational concerns. The case study will be used to explore Rogers' ideas.

Yasmin

Yasmin has been a nurse manager on a busy oncology ward for six months. She describes herself as 'born to be a nurse', and she cannot remember a time, even when she was a very small child, when she did not want to be a nurse. When she was offered the promotion she was pleased and saw it as a way to make more of a difference. However, six months into the new job, she is not happy. She loved working with patients, helping them to feel better, or least more comfortable, when she could. The new job requires meticulous attention to paper work, meetings, contentious resource allocation issues and confrontations with colleagues. She cannot really admit, even to herself, that she is not happy because this is what she thought she wanted to further her career. She

needs the money, her family is proud of her achievements, and she does not want to let them down. She blames her discontent on a possible low grade virus that she may have after a bout of severe food poisoning a few months ago. She is becoming increasingly snappy at work and her supervisor took her aside yesterday and recommended she see a counsellor through the Employee Assistance Programme at the trust.

Applying Rogers' theory of personality to this account, Yasmin seems to be in a state of incongruence. On the one hand, her real self, at an organismic and fundamental level, is drawn towards the kind of caring relationship she had with patients, where she felt she was giving her best. On the other hand, her 'self concept' is such that she sees herself as moving forward and achieving more in her career, and she has a lot invested in maintaining this idea of herself. Her organismic self and her self concept are in dissonance with each other.

Rogers comments on how this happens:

> By taking over the conceptions of others as our own, we lose contact with the potential wisdom of our own functioning ... We have in a very basic way divorced ourselves from ourselves.
>
> *Rogers, 1964, p. 163, cited in Barrett-Lennard, 1997, p. 105*

According to Rogers, if Yasmin's counsellor can successfully convey to her the conditions of empathy, genuineness and unconditional positive regard, as they explore the issues together, Yasmin will be able to find a satisfactory resolution and clarify and strengthen her organismic self.

We do not know how many times Yasmin met with the counsellor. It could have been once or for several sessions. It will be helpful to look at some of what happened from Yasmin's point of view.

Yasmin's account

I don't know what I expected from a counsellor. I just know that I was upset and worried, being told by my supervisor to go. I was so ashamed. I am sure I expected to be judged, have my failings pointed out, maybe told how to get myself together or, worse, told I was unfit. These were my fears anyway. It wasn't like that at all. First, he was quite warm and welcoming. Concerned, but not overly ... if you know what I mean. He seemed quite relaxed and comfortable with himself. He looked at me and gave me his full attention. I felt a certain amount of respect coming from him. He said:

'I'd really like to hear from you what it's been like these past few months.'

So, I told him what had been going on, not feeling well and all. He asked me how things might have changed for me over the past little while, and it seemed like he really wanted to know. I found myself telling him how much I enjoyed caring for patients and how, being a manager now, I missed the contact and the sense I was doing something helpful. Worse, it feels like as a manager I am expected to be tough with people. It's just not my way, but I guess I am sort of weak. And I hate the paper work. Things keep coming back to me, 'not quite right'.

He didn't say much but at one point, which, for me, felt like a real turning point, he said:

'It's like they're trying to make the icing on the cake all smooth, with no patterns or lumps and you're like a lump in the icing they keep trying to smooth out.'

We both laughed.

I said: 'Yes, that's how I feel.'

Suddenly I could see that I wasn't unfit, just different.

Yasmin seems to feel the counsellor's warmth and attentiveness. He is able to convey positive regard, which helps Yasmin feel respected and this allows her to open up. The counsellor did not judge her or give her advice that would have implicitly questioned her worth or her decision making capacity. The counsellor uses empathy to get to the heart of the distress Yasmin is experiencing and to convey his understanding in such a way that Yasmin's own perception of her situation shifts. He uses language that helps Yasmin feel comfortable and non-threatened. He shows an authenticity, spontaneity and genuineness, in his willingness and capacity to laugh with her.

There is no certainty about how Yasmin will ultimately handle the situation, or the decisions she will make, but at this point she has more clarity and growing confidence. Her understanding has moved from thinking she is short-tempered and unhappy about feeling poorly, to realising she does not fit in her current job.

Looking a little more closely at how the counsellor conveyed his understanding and care, and how this might have helped Yasmin, it is worth noting the following. Leslie Greenberg and Robert Elliott (1997), two psychologists who study empathy, suggest that the use of a relevant metaphor can help the client to feel within the counselling session the distress they experience about their troubling situation. The counsellor uses metaphor or *empathic evocation* with Yasmin to help her re-experience and bring new perspectives to her situation.

The counsellor uses *empathic exploration* to help her search around the fuzzy edges of her life experience at that time. This exploration is non-directive. The counsellor really follows Yasmin's lead, which in turn strengthens her self-confidence and self-acceptance.

Rogers says it is not the case:

> that the client-centred therapist responds only to the obvious in the phenomenal world of the client. If that were so, it is doubtful that any movement would ensue in therapy. Indeed, there would be no therapy. Instead, the client-centred therapist aims to dip from the pool of implicit meanings just at the edge of the client's awareness.
>
> *Rogers, 1966, cited in Barrett-Lennard, 1997, p. 110*

The counsellor uses *empathic conjecture*, that is he 'tries out' his understanding and attempts to clarify Yasmin's experience by offering information from his perspective. In suggesting a possible symbol – 'the lump in the icing' – he attempts to capture an aspect of her current experience. This conjecture gives form to an unstated but significant aspect of the whole of what is going on for Yasmin and brings some coherent meaning to it.

The core conditions are not simply friendly rapport, sympathetic encouraging and listening, or being warm and supportive. Nor do we see here any of several other modes of help, such as problem solving, analysis and interpretation. The core conditions are a specific and measurable complex of attitudes or qualities that include *unconditional positive regard*, *empathy* and *genuineness.*

The fact that Carl Rogers makes several radical claims may account in part for the powerful influence of the concept of core conditions. He acknowledges his own discomfort with such a revolutionary departure from previous traditions such as psychoanalysis and behavioural approaches. Rogers claims that:

1 These conditions come as a package. They are interrelated. If one gets left out, a positive outcome will not happen.

2 There is a universality to the core conditions.
- They apply to all types of client.
- They apply to all types of psychotherapy.
- They apply to all types of relationship.
- They are sufficient conditions for a positive outcome. All techniques and strategies from other traditions are helpful only to the extent that they act as vehicles for conveying the core conditions.

Rogers implicitly and explicitly focuses on the individual helper who expresses the three central conditions of empathy, unconditional positive regard and genuineness to the other person.

The theory and practice of person-centred counselling seems to emphasise verbal exchange and makes some assumptions about the nature and role of the self. This raises questions about the application of these concepts in other cultures. For example, according to Yuko Nippoda (2001), a counsellor practising in the UK, in Japanese culture silence is seen as positive, group belonging is of primary importance, and the ideas of self-exploration and self-actualisation are unheard of. Sections 3 and 4 say more about the cultural limitations of these concepts.

Carl Rogers' ideas have been developed and expanded over the years so that terms that were originally associated with therapeutic processes became common in everyday language. Gerard Egan (1975) was an important influence in developing and applying Rogers' ideas. In his book *The Skilled Helper* he couples attitudes or conditions with behaviours. In other words, having an attitude of respect towards someone does not automatically result in behaviours of respect. To let the other person know you respect them, you must behave in ways that convey respect. Developing the capacity to experience and express these attitudes is at the heart of many communication training and education programmes.

In Egan's view, to *respect* another means you value that person. You show respect and unconditional positive regard by your willingness to work with them, by assuming the other person's goodwill, by acknowledging their uniqueness, and the possibility of self-determination. Of course, deciding what is appropriate self-determination is a contentious issue in health and social welfare. Such decisions are influenced by the particular perspectives people use in their work and relationships. Examining these perspectives and their underpinning assumptions is one of your key tasks in this unit and in this course.

Empathy involves achieving an understanding of another person's world from their perspective, and conveying that understanding to them. Empathy is a complex phenomenon with multiple layers and facets. This unit focuses particularly on empathy as a kind of template through which the other core conditions can also be explored more fully.

Genuineness requires an awareness of your own 'in the moment' experiences, thoughts and feelings, and the capacity to step outside the 'role' of helper and behave openly and honestly.

Behaving in a way that expresses attitudes of respect and empathy is important

This unit has been exploring both the simplicity and the complexity of this constellation of attitudes known as the core conditions. The lists below of the qualities that seem to be associated with empathy, genuineness and positive regard is a useful way to start getting to grips with the notion. You can probably identify several of those key qualities in the case study examples.

Empathy	**Genuineness**	**Unconditional positive regard**
Compassion	Spontaneity	Warmth
Care	Authenticity	Respect
Concern	Responsiveness	Attentiveness

This may seem a lot to cover in what is a brief encounter: getting an appropriate and helpful balance can be tricky. However, if you look at the lists, these are everyday qualities that seem to pass between people, often without them being fully aware of it. If core conditions are a reliably helpful aspect of communication, what gets in the way of their practice? The next section explores this question.

Key points

1. Carl Rogers' theory of personality change, with its focus on emotion, the here and now, and the centrality of the core conditions, was a radical departure from the traditions of its time.
2. Rogers suggested that experiencing and conveying empathy, genuineness and positive regard in combination with setting conditions provides both the necessary and the sufficient conditions for building relationships and promoting personal change.
3. The concept of core conditions has been an important influence in understanding what makes for effective communication in health and social care.
4. Skills and core conditions are closely intertwined: core conditions can be conveyed only partly through behavioural skills approaches to communication, while skills themselves are not enough.

3 Why core conditions may be absent from communication

This section looks at what gets in the way of experiencing and expressing core conditions within communication and relationship processes in health and social care. You will consider three different possibilities clustered around the difficulties of crossing cultures and begin by exploring your personal readiness to understand and experience the world view of another. The world view which each person holds at any moment is a complex mix of assumptions, expectations, beliefs and ways of behaving that emerge from the various cultures that influence us. The term 'cultures' is used quite broadly here, to include more than racial, ethnic, class and other large-scale identities. The term 'culture' also acknowledges the norms, values, ways of thinking and working that arise from the type of work people do, the neighbourhoods they live in, the voluntary and other interests that engage them. Lena Robinson's chapter in the Reader, which you read in Unit 6, expands and deepens this perspective on world view, culture, assumptions and beliefs.

3.1 Crossing cultures: assumptions and expectations

In a world that brings us into daily contact with people from a variety of different experiences and cultures, empathy and related conditions can be a central bridge to understanding. Expanding knowledge about a person or about the specific features of their culture is an ongoing requirement of working in health and social care, so that we can recognise the person before us in both their uniqueness and as a member of cultures. Yet there are often barriers to experiencing and expressing such conditions as empathy that would help develop further our understanding and relationships with other people.

Activity 8.5 **Identifying assumptions and expectations**

45 minutes

As you read Molly's story, reflect on the questions below and note briefly (in a few sentences) your responses. You could also return to Jimmy's story in Activity 8.1 and consider the two together.

- When you interact with someone, what do you look for and respond to?
- Are there any people or patterns of working with people where developing understanding has been particularly easy or difficult?
- What would you do if you were a staff member working with Molly or Jimmy?

Molly – 1

Molly is in her early forties. She lives at home with her parents and attends a day care facility two days a week. She has great difficulty comprehending and expressing language and has been labelled as having a moderate learning disability. She loves the company of other people. Where everything is consistent and predictable, she is very capable but in different environments staff sometimes assume she is more capable. They are unaware of the meaning of her disability. For example, Molly and some of the others who attend the centre are about to collect supplies for lunch with a staff member.

"Molly! Get your coat. We're going to town now." Molly goes to the coat stand, puts on her coat and then stands still. "Come here Molly. I said we're going to town." Molly returns to the staff member. The staff often feel impatient with Molly: they ask her to do something and more often than not she stands there looking vacant.

Comment

As you read Molly's story perhaps you were reminded of your expectations about how people respond to you. You may find it difficult when they behave in ways you had not anticipated or that are contrary to your instructions. You may find it easier to work with someone, for example, who follows through on your directions.

One tester said:

> *I know that in the daily rush of trying to provide a good service for a number of people, it's easy for me to get caught up in getting the tasks done. I forget to take the time to sit down with someone and find out why they are acting in a particular way.*

Sometimes it is not clear why people behave as they do. It may be difficult to understand them. In this 'gap of understanding', there may be a danger of making personal attributions about what is going on. When there is non-compliance, as for example in the situations with Molly or Jimmy, it may not be unusual to fall into the trap of making negative assumptions. Sometimes a search for understanding may have to go further than understanding a social or a personal history. It may be that, even cognitively, people see the world differently.

So, regarding empathy and the core conditions, it can be important to look at personal and cultural assumptions and expectations about how other people ought to respond or behave.

Assumptions and expectations are slightly different but related phenomena. *Assumptions* are more concerned with what we *believe* is going on for another person. In Molly's situation, the staff were possibly making assumptions about her intentions, motivations and capabilities. *Expectations* are more concerned with anticipated outcomes. They are based partly on assumptions. If staff assume Molly understands, retains and can act on their instructions, they will expect her to follow through with what they believe to be appropriate behaviour. Expectations can be based on spoken and unspoken roles and rules of a particular culture. In Molly's situation, staff may see themselves as 'in charge' of Molly. Their job is to set the agenda for her activity. When they give her an instruction, they expect her to obey. So issues of power are embedded here too. Assumptions, expectations and divisions of power can get in the way of experiencing and expressing core conditions. For example, it may be difficult to have empathy or positive regard for someone who seems to contradict you deliberately. Paradoxically, bringing core conditions to the situation can further an understanding of the situation as was seen in the case of Jimmy in Activity 9.1. Becoming aware of the kinds of issues or patterns of behaviour that consistently annoy you or that you find problematic in some way can be useful in discerning what those assumptions and expectations are.

Becoming aware of cultural influences can be important too. Living in a culture that focuses on efficiency, strict routine and punctuality may lead to impatience with a person who seems to delay, for example.

Working together and making connections

Activity 8.6 **Gaps in understanding**

5 minutes

Read the following additional information about Molly.

Molly – 2

What staff do not know is that cognitively (that is, how a person interprets the information they receive) Molly can only process the first half of a two-part request. She simply forgets the second part.

- How would having this information possibly change your reactions to Molly?
- What would it have taken for you to find out this information?
- Make a list of the qualities you might need (such as curiosity), the procedures that might stand in the way, and one or two things you might need to do differently.

Comment *Finding out why Molly does not respond as she should might require you to suspend your assumption that she was deliberately being obstinate. You could follow your curiosity, wondering and experimenting with different ways of working with her. You would need to take more time to explore these, time that regular procedures and routines might prevent. Underneath it all, a humanistic view would suggest that Molly's intentions are good and self-preserving. She wants to do what is best for her and your role would be to explore how her responses in her view seem to be what she thinks is best for her.*

It is difficult to identify assumptions because they are so taken for granted that they often remain hidden from awareness. You may not be in the habit of questioning and challenging assumptions. Even though you may agree in principle that it is a good idea to do so, you may find it difficult to know how to do it. The next activity could be a useful starting point.

Interpretations involve ascribing or attributing intentions, motivations and causes of someone else's behaviour and they can arise from assumptions. Interpretations can also offer additional clues to assumptions that may be lurking.

Activity 8.7 **Assumptions, expectations and interpretations**

30 minutes

Keep a record for a morning of occasions when you or a colleague or friend spontaneously offer interpretations of someone else's motivations and behaviours.

These 'interpretations' might start with phrases such as: 'You're just doing it because ...'; 'Underneath it all he's really ...'; 'That's not really what she means ...'.

Note also the impact of these interpretations, whether you or someone else is the recipient. What kind of authority and evidence are offered to back up these interpretations? Who makes them?

Can you find one or two assumptions underlying the interpretations you identify?

Comment *You may have found this activity quite difficult to do at first. Interpretations happen so fast, they can be hard to identify.*

I noted that at times I make interpretations about someone's behaviour when I am really trying to 'guess' their motivations. Sometimes interpretations come from some knowledge, that is they are based on someone's past behaviours. At other times an interpretation is based on what I expect because of their role or position. And sometimes the authority or evidence comes from my own imagination, what I want to believe at the time because it is convenient or helps me save face.

Molly's and Jimmy's stories are two dramatic examples of a situation in which the world view of the individuals involved (Molly and Jimmy) was profoundly different from the staff's. To get to the bottom of their situations, the staff may have to suspend certainty, perhaps rigid opinions they had formed and their own, possibly unspoken, rules of intervention. In getting to understand another person's reality, you may need to have a certain amount of curiosity about what life is like for them, and to create a certain amount of space within yourself to receive that reality.

Sometimes the context or the circumstances of the situation do not seem to lend themselves to experiencing and expressing the core conditions. The next section explores how different ways of working may focus the interaction on different kinds of behaviours.

Key points

1 Cultural influences can create assumptions and expectations which sometimes remain hidden.

2 Identifying assumptions and expectations and putting them aside can create an opening for the core conditions.

3 Paradoxically, experiencing and expressing core conditions can lead to a new understanding that can in turn dispel assumptions and expectations.

3.2 Crossing cultures: different ways of working

It is helpful to pause here and remind yourself that the notion of core conditions originated in a therapeutic orientation that made relationships, and the building of a relationship between helper and the person being helped, central to a positive outcome. The idea of core conditions has been imported into people's everyday expectations about what makes communication effective. If part of the purpose of the communication is to build a relationship, as in a therapeutic or counselling environment, it is easy to see the link to the core conditions. However, if the purpose of the communication is some other task, such as the one in the next activity, what place do core conditions have in that communication? Sometimes there is a tension between the differing expectations that a relationship and task focus place on an encounter.

Jan, one of our colleagues, reflected on her recent experiences with various helpers at the time of her car accident. She not only describes what happened but also how she was treated, and what her reactions were to that treatment.

Activity 8.8 **Analysing an accident for different ways of working**

20 minutes

As you read through Jan's account, note your immediate reactions to the circumstances surrounding the incident. You might want to think about the various roles of the key people, their reactions and responses, and what you can derive from the account about the presence or absence of core conditions – empathy, warmth, positive regard, genuineness and respect.

The accident

Friday started off with a bit of space around it. It was clear, cold and sunny. My partner and I sat and talked together over coffee before starting off for work. We were passing the garden centre and the crèche, and then, without any warning, a large vehicle loomed towards us on our side of the road. We couldn't get out of the way. The impact was immediate and intense. The windscreen shattered, the bonnet buckled and another vehicle was impaled on ours. I saw shooting stars with the force of the impact. My partner and I looked at each other in disbelief. We were aware of each other and a feeling of exhaustion. I felt paralysed with anxiety. What had happened? I couldn't speak. My heart was beating so hard that I felt like people could see it outside my body. I couldn't really communicate verbally, so I was relying on others to communicate with me. Touch and tone of voice played a large part.

The emergency services arrive late and in large numbers. I am still in the vehicle. A police officer walks toward me. He doesn't open the car door, which will open, but instead he taps on the window and asks me if I am all right. No I'm not all right, but I'm not used to talking through panes of glass, so I just nod feebly and say 'Yes, I'm OK.' The fire service come. The firefighter opens the door. He kneels down. He holds my arm. He tells me that I'll be OK, that everyone is there to help. He tells me what everyone else is doing and that he is going to look at the chap in the car behind (we were hit from behind too) and that he'll be back. I say 'Thank you, thank you.'

The ambulance people arrive and touch me with thick plastic-gloved hands. They check my vital responses. I don't much like this. I'm a victim. They're dealing with a victim. They are dealing with just another victim. They talk about how to get me out, they talk to me about how to get me out, and they really try to go through the proper routine so I'm not damaged further, but they don't connect with me at all. Am I the wrong sort of victim? They know what they're doing, it's routine, but I've not been an accident victim before. I feel like a piece of meat, and I have no control and it feels like my fault.

Conversations over my head at the hospital are not reassuring. The sister needs to take control so she begins by telling the ambulance personnel that they have parked my trolley, on which I am strapped with full head brace, in the wrong area and they need to move it. Once she is out of sight they moan about never getting it right.

A doctor comes to examine me. He doesn't make eye contact or offer anything but peremptory assurance. He sends a nurse to run some tests. She knows what she is doing. She's done it lots of times before. She comments on the rubbish equipment that she has to work with and how much better some of the newer machines are. She tells me everything looks fine and she will show the traces to the doctor. I am in too much pain to hold a conversation. I don't seem to be the focus of attention and I begin to wonder why not. The sister reappears and tells me I am fine to go and that if I need to talk to her about anything that I can just call.
I need to talk to her NOW. I want to communicate the way I am feeling and I want her personal reassurance. When I needed help, when I couldn't ask for it, I expected her to understand, I wanted her to understand; and fill in the gaps in the communication I was experiencing.

Comment *Compare your reactions to the account with our testers' comments:*

- *There were so many people involved in this situation. I can remember being in a similar situation and being afraid that somehow I would be forgotten or abandoned. I was just so glad that everyone seemed to know what they were doing. There were some people who did stand out more than others. The ones who talked to me like a real person made a huge difference to my fear.*
- *For me, efficiency and competence are the most important things. I want to know that these people know what they are doing. I know that by their actions. I don't care if they talk to me.*
- *I found it interesting how much the person wanted to be acknowledged and how she made meaning in her own head of how they treated her. For example, she says, am I the wrong sort of victim? I noticed too, that the police, the ambulance people, the firefighter, the nurse, the doctor, all seemed to treat her somewhat*

differently. From what she says, the firefighter seemed to treat her with the most empathy, in that he took the time to be reassuring, tell her what was going on. It seems that he understood her need to connect.

The testers had different reactions to the accident case study and, when placing themselves in the same situation, each would have wanted different behaviour from the helpers. The first and third comments concern the importance of being acknowledged as a person, the reassurance that comes from a more personal or 'emotional' connection. The second comment emphasises the importance of knowing that the tasks are done with competence and efficiency. That tester cared less about the interpersonal communication.

The question that came to my mind, and maybe for you too, is can both the interpersonal communication and the task happen effectively at the same time?

Daniel Goleman, the author of *Emotional Intelligence*, acknowledges the need for connection and for a relationship dimension when he talks about the importance of emotion in health care:

> By now a scientific case can be made that there is a margin of *medical* effectiveness, both in prevention and treatment, that can be gained by treating people's emotional state along with their medical condition.
>
> *Goleman, 1995, p. 165*

However, he also suggests that the current climate is one in which relationship tends to be treated as a background variable.

The account of the accident illustrates this well. In that situation there is not much opportunity to set the context or develop relationships. Yet Jan has clear expectations about the relational element, and about (implicitly) the core conditions. She explicitly states she is relying on others to communicate with her and how 'touch, tone of voice' matter. She identifies for us clearly which interactions she considers are most helpful, and which are least helpful. For her, the quality of the relationship seems to be in the foreground while most of the helpers put the task in the foreground.

Different helping models may influence the expectations of helper and the person being helped. Many of the helpers seem to be acting according to a task-oriented model. In this model, the user/client/patient is passive and weak. The helper is the expert who provides treatment and other services. In Unit 2 you explored the impact of context that includes ways of behaving that we call professional. Procedures and protocols, routines and practices originate with both the individual and the institution. We might say a relational model or perspective influences the perspectives and expectations of the person being helped.

Activity 8.9 **How could people behave differently?**

30 minutes

Return to the case study in Activity 8.8 and consider how the various helpers might have behaved differently, even in small ways, that would have made a difference to Jan.

Comment

Jan was looking for a more relational approach: more warmth, a greater demonstration of empathy, and more genuine interest may have helped her to be less fearful and more reassured. It may have also helped in eliciting important information from her. For example, the police officer might have opened the door instead of tapping on the window, or explained why he could not open the door. A gentle touch on the shoulder and a smile may have helped. Similarly, the doctor

might have made eye contact. The nurse, instead of, or in addition to, commenting on the rubbish equipment, might have acknowledged how frightening and disorienting an accident like this can be.

Testers identified the firefighter as one person who seemed to be able to convey the core conditions. Showing the willingness and the capacity to 'tune in', to understand Jan's need for assurance, and to respond. This act of empathy is not a 'skilful technique' but demonstrates, rather, an approach or an attitude that aligns with Carl Rogers' original definition, which has two parts:

- *sensing the other person's experience*
- *communicating it.*

The firefighter's response seems to demonstrate another element in the cluster of core conditions: genuineness. He treats Jan as a real person, at least in her view. He knelt down. He held her arm. His gestures seem authentic and unique rather than prescribed by role or training. It is hard to imagine a training manual that would prescribe the sequence of kneeling down, holding her arm, reassuring her. His communication was concrete in that he told her specifically where he was going, what he was doing, what was going on. The communication here is both verbal and non-verbal. Person-centred and experiential theorists and practitioners suggest that the core condition of empathy is not an intellectual analytical process but a mind–body phenomenon in which the emotional reactions of one person (in this instance, the helper) correspond to and reflect the emotional reactions experienced by the other (the person being helped). If empathy is an emotional experience then it is also embodied. Empathy is a felt experience. It is only after this felt experience is accessed or brought to awareness that the second dimension of empathy can take place, the responding dimension that involves a verbal or non-verbal response or both.

Margaret Warner, a psychologist, has written about what it is like for the person receiving such a response:

> the sense of recognition that one has when one feels that another has grasped – in words, or in some other way – the essence of one's situation as it is currently experienced ... This kind of recognition is often accompanied with a sense of slight release or relief at being seen. At an everyday level, a person might feel this sense of recognition when someone notices that he or she has been waiting in line for service or if someone says: 'You look like you're tired of all this', when this is in fact true. Most people experience a fuller version of this experience of recognition at certain rare and valued moments in life.
>
> *Warner, 1997, pp. 130–1*

None the less, in Jan's account, for the staff attending to her medical needs, trying to empathise with her may have felt like a distraction. Some helpers may have hesitated to make further emotional connections, not wanting to intrude on her and possibly raise her anxiety. Some may have been fearful of raising their own anxieties by placing themselves 'in her shoes': a focus on the medical model allowed them to focus on the tasks.

Activity 8.10 **Compassion fatigue as one explanation**

45 minutes

Read Chapter 20, 'Compassion fatigue: how much can I give?', by Peter Huggard in the Reader. Write a few notes on times in your own experience when you may have avoided engaging with someone. Consider what you did instead of engaging. What sorts of things have you done for yourself to prevent this kind of compassion fatigue?

Comment

To be candid, there are times when I do not feel I have any more to give, and then even a meeting where I can just be with my own colleagues feels like a safe haven from the tough, sometimes irresolvable, painful problems that my clients are faced with and expect me to help them with every single day.

I have never been able to discover a real formula for preventing this. Generally, the old adages – take a break, or make some changes – work up to a point.

I have also discovered that, if I am honest with my clients about how I am feeling, not in an overwhelming way but perhaps just a few well chosen words, often they can be remarkably understanding and somehow the weight lifts a little.

Peter Huggard acknowledges that there is a relationship between a clinician's empathy and compassion and the quality of care. He notes that clinicians sometimes seek detachment to prevent burn-out. However, he distinguishes between the nature and the reasons for burn-out and compassion fatigue and makes several recommendations for prevention and treatment.

You could also read Extract 40 'I didn't know how to help him', by Michele Hanson in the Anthology. This article also explores the expectations placed on medical personnel to 'be tremendously intelligent, generous and never forget anything, when the reality is that they are often exhausted and overstretched.'

The account of the accident demonstrates that different people have different needs and ways of working, and these differences can sometimes create tensions. The incident raises questions about how realistic, efficient or necessary it is to have every team member caring in the same way. It also raises questions about whether the core conditions – empathy, genuineness and positive regard – are just one aspect or one alternative in communicating effectively, or whether they are more fundamental to all effective communication and should coexist with other modes of caring.

The next section challenges the legitimacy of applying the core conditions universally. How is it possible to feel unconditional positive regard for a person who abuses children or towards anyone who has committed a terrible crime? Is it morally and ethically acceptable to do so?

Key points

1 Tensions between the task and relationship elements of an encounter can lead to differing expectations and misunderstandings.

2 Core conditions can be experienced and conveyed in a variety of ways that have meaning for the participants.

3 Helpers sometimes detach from the relational aspects of an encounter in order to prevent compassion fatigue and burn-out.

3.3 Crossing cultures: a question of values

Values conflicts and moral and ethical dilemmas can arise in trying to experience and express the core conditions when one person's ethical and moral code and conduct violate another's. Lena Robinson (in Chapter 12 of the Reader) describes values as standards or principles to live by.

Richard Hazler is a psychotherapist and the co-author of a book called *The Therapeutic Environment* (2001). He describes his work with John, who has been in prison for several years for a series of serious crimes.

Activity 8.11

30 minutes

Trying to reconcile values and core conditions: we don't choose our clients

As you read about John's case, keep in mind the core conditions and how you might respond to him. What elements of your own world view, values and moral code might influence your responses? How might John's ethnicity affect the way you think about him?

John

John was a large black prisoner who kept very much to himself. His physique, scars and brooding look all gave the impression of someone from a very different world from my own, and the prospect of counselling him alone in a locked prison cell felt a particularly foreboding one. Yet, once in therapy, he shared a very quiet, peaceful and trusting side that did not match his looks at all. Which, then, was the real world – the real John?

John quickly made progress at opening up, trusting and looking for better ways to deal with his life. Encouraged by the progress, it was a shock when, after a particularly productive session, a guard who was normally friendly to me surprised me with his anger: 'Haz, you must be sick to try and help that bastard!' He turned quickly, emphasizing his disdain for me, and stomped away. What was going on here? A record-search showed that John was in prison for raping a 13-year-old and there were similar charges for other cases in several states ...

In our next session, before I had even said a word, John recognized the confusion in me. 'You found out about my past huh? Well, f*** you!' As he got up to call the guard and leave, I instinctively moved to stop him, although I did not know how I managed to do so or why. The words that came out were unplanned but honest.

Wait! ... I'm having trouble figuring out my own feelings, that's true. Maybe I'm not doing too well right now, but we've worked well together and you've helped me understand before. You can do that again. But I need your help to know you better and to be of more help. Give me a shot?

John was used to people's reactions when they found out about his horrific acts. The disdain in their faces, words and actions were too much for him to take, so he hid from people, both physically and psychologically. He despised himself for what he did when, periodically, he went out of control. But where could he turn for help? His actions were too despicable for people to show caring for him, or even for John to care about himself.

We discussed my reactions and John's own feelings about his behaviours, feelings that were many times more painful to explore than topics like how others felt about and treated him. These discussions helped to develop between us a positive therapeutic relationship that may not have made John into a model citizen, but did give him hope, new ways of looking at life, and more productive ways of interacting with others.

(Source: Hazler and Barwick, 2001, pp. 72–73)

Comment

Richard Hazler was able to let John know of his willingness to try understanding John's immediate thoughts and feelings. He shows a great deal of genuineness in revealing his own struggles and seems to elicit John's trust in doing so. He shows positive regard and respect in asking John for his help, and again a willingness to work with him. These conditions of empathy and positive regard let the other person know they are seen, that their experience is recognised in the moment by another human being. This experience of being recognised can lessen momentarily the feeling of being alone and isolated. There is often a slight sense of relief or release at being seen, which can lead to a clearer recognition of the person's own vaguely felt experiences and meanings. New ways of seeing things spontaneously emerge as if a fog has cleared. So the communicator of empathy provides a model for how people can relate to themselves and promotes a greater sense of safety and trust in the self. It is a process of validation, which says to the other: 'You are real and you matter.' The core conditions, including empathy, are portrayed here as morally neutral. Being empathic or respectful does not mean condoning John's acts, but it does mean respecting the fact that John's crimes are not the whole of him but only a part.

As you read this case study, you may have wondered why the author mentioned John's ethnicity: perhaps recalling your work on diversity and difference in Unit 6.

The mention of race and ethnicity raises several questions, for example why are black men overrepresented in the justice system?

So far this unit has explored the kinds of situations and dilemmas that may account for the absence of core conditions in communication and relationships. This included a look at personal readiness, appropriateness and different ways of working, and conflicts of values. Thinking about how it might be possible to develop the core conditions raises questions about their definition. The early part of the unit explored briefly the relationship between core conditions and skills. At this point you may have formulated a tentative response to the following questions.

- Are core conditions attitudes or skills?
- Are they innate qualities or can they be learned?
- How might you develop them?

The next section considers these questions because, in reaching some answers to them, it might be more possible to consider how core conditions can be developed.

Key points

1 Conflicts of values can present moral dilemmas about the role of core conditions.

2 Within the framework of a humanistic perspective, core conditions validate the person in his or her potential goodness and possible future, rather than specific, behaviours.

4 Developing core conditions depends on how they are defined

4.1 Core conditions: an interdependent constellation of knowledge and emotions

Think for a moment about times when you experienced the core conditions of empathy, genuineness and positive regard for someone else. Can you discern whether these are thoughts or feelings or both? Is empathy, for example, an intellectual understanding of someone else's situation, or is it an emotional response, 'a feeling with'?

Activity 8.12 **Being understood**

30 minutes

Consider a time when another person understood you very well. When it almost felt like they knew you better than you knew yourself, yet you felt uncomfortable, somehow exposed. You may be able to recall other times when someone understood you, and you felt something settle inside you. As a result, you understood yourself a little better, perhaps gained more clarity, and felt a little relief. What made the difference?

Comment

When I think about times when I have felt understood and had that sense of relief and clarity, I realise that the other person seemed to care about me, but without overly intruding or taking over. At other times, I have felt someone understood me almost like I was under a microscope – incisively. There was no caring and, at worst, I felt they were judging me unfavourably.

John Schlein (1997), who is a psychologist, talks about empathy as a kind of human intelligence that everyone has. He considers it a neutral capacity that can be used positively or negatively. He describes empathy as a guidance system that can get you to the airport but makes no decisions about what to do once you are there. Most people are more or less capable of a 'gut reaction' kind of understanding of others. Empathy, however, does not automatically mean caring. It is possible to understand someone else's world and use it uncaringly. Empathy in conjunction with care, compassion and positive regard is the kind of empathy that Carl Rogers suggested could be helpful in building relationships and facilitating communication.

Jerold Bozarth, a practitioner and researcher on person-centred approaches, says:

> It has been suggested that Rogerian empathy is primarily the purest way to communicate unconditional positive regard. Rogerian empathy is, in fact, inseparable from unconditional positive regard and I suggest that ultimately they are the same condition.
>
> *Bozarth, 1997, p. 82*

If empathy, and the other core conditions, are innate characteristics *and* skills, *both* intellectual understanding *and* emotional response, what are the implications for thinking about how to develop them?

The following activity looks at some thoughts developed by doctors.

Activity 8.13 **What is a good doctor?**

30 minutes

1 Write down the qualities you value in a doctor.
2 Read the accounts from the internet discussion 'What is a good doctor?' in the Anthology (Extract 16).
3 Add to your list any qualities that the participants in the discussion found helpful.

Comment

Some qualities I noted are: a genuine concern for patients; good communication skills; a willingness to listen; open-mindedness; readiness to be honest about uncertainties; openness to learning from people; humanity; rapport with patients. This is a tall order for any one person but clearly such qualities are important to patients. I had warmth and honesty at the top of my list.

One of the testers commented:

> *Before reading the Anthology extracts I put down warmth, gentleness, clarity about procedures – like getting test results – honesty about uncertainty, ability to pitch their talk to you at the right level – not dumbing-down and not over your head – interest in me as a whole person, willing to listen, give the impression they have the time to listen.*
>
> *After reading the Anthology, I added: referring to previous medical notes and learning from them; knowing what it is like to be a patient; keeping up to date with treatments; not patronising; courteous and maintains dignity.*

4.2 Development as practice

Anne Gallagher, lecturer and mental health practitioner, brings a moral and ethical perspective to the notion of core conditions and how they can be developed, as you will see in the next activity.

Activity 8.14 **The practice of virtue and the development of core conditions**

1 hour

Read Chapter 21, 'Developing virtue and core conditions', by Anne Gallagher in the Reader. As you read make notes in answer to the following questions.

1 What does being ethical mean to you?
2 How might an ethical view be related to core conditions?
3 What would it mean to 'practise' the core conditions?

As you read note that the author talks about core conditions in the context of person-centred counselling where the notion originated.

Comment

You may have said that being ethical concerns morality. You may consider that being ethical means treating others with honesty and fairness, balanced with compassion. You may also have acknowledged to yourself that it can be difficult to find the right balance between your own personal needs and views, and being open to others. Finally, you may have recognised that there may be no perfect formula for handling core conditions. Rather than reaching a final state of achievement, as Carl Rogers noted, people are always in the state of becoming or moving towards it.

Gallagher makes the connection between counselling as a form of help and the necessity that counselling is an ethical process. She describes a good counsellor as someone who has good intentions. She suggests the core conditions such as empathy and positive regard can be compared with virtues or morally desirable character traits.

Virtue ethics, as described by Anne Gallagher, acknowledges the important role that emotions play in defining the core conditions and, in her discussion of the doctrine of the mean, she suggests that the virtue of empathy, for example, rests between too much emotion (over-involvement) and too little (detachment). Her discussion highlights the idea of developing core conditions through practice as in the practice of a virtue.

Anne Gallagher's perspective is slightly different from the discussion in Section 1 about the interrelatedness of core conditions and skills. She addresses indirectly the skill/authenticity debate. She states clearly how unlikely it is that a person will always feel empathy, positive regard and genuineness in an encounter. Sometimes the best that can be done is to *act* 'as if'. However, it is better if a person *authentically* feels empathy and positive regard. This is better because authenticity leads to integration (integrity) within the person, which is more reliable, trustworthy, flexible and consistent at the same time.

You may recall from your work on Unit 3 that Deborah Cameron addressed expansively the debate between the discourse of communication as skilled behaviour and the discourse of communication as a characteristic of personality (Cameron, 2000).

You may agree with some of the virtue ethics perspective or even a large part of it. Alternatively, you may think it focuses too much on the individual, and does not acknowledge or allow for the fact that there is some kind of reciprocity at work in any encounter.

Gallagher suggests that virtues can become habitual through practice. Buddhist philosophy echoes the notion of development through practice. Although it is beyond the scope of this unit to compare and contrast Buddhist philosophy and spirituality with virtue ethics, it is worth noting that both draw attention to the importance of qualities known as core conditions. According to virtue ethics, these qualities are important because of a shared human condition: 'We demonstrate respectfulness on the basis of concern or even love of our common humanity.' Buddhist philosophy enlists qualities related to the core conditions in order to tackle 'self-cherishing' or self-centred attitudes. Malcolm Walley (1986), in a chapter on 'Applications of Buddhism in mental health care', describes one strategy for tackling a self-cherishing attitude, known as *the six causes.*

1 Noticing the interdependence of all life.

2 Meditating on kindnesses we have received.

3 Developing a strong wish to repay the kindness.

4 Giving rise to the development of heartfelt love towards anyone.

5 The development of great compassion, which arises when we contemplate the sufferings of those we care for. To appreciate their problems, difficulties and so on leads to the sixth cause.

6 Abandoning the self-cherishing attitude.

Both Gallagher and Walley, as they discuss a western orientation to spirituality in virtue ethics and an eastern Buddhist view, respectively, underline the centrality of practice that requires intention, meditation and repetition.

We shall pause here so that you can consider your own experiences and ideas of practice.

Activity 8.15 The meaning of practice

30 minutes

Think about what practice means to you. Consider a time when you set out to learn something quite new, or perhaps you wanted to improve on something you already knew. Perhaps you were learning a new skill at work, or practising a language before going on holiday.

- Did you have a clear idea of what you were practising?
- Why were you practising it?
- How did you know you were on the right track?
- What were the outcomes?

Comment

What came to my mind first was that practice involves some kind of discrete learning: in yoga, learning the various postures. I had to understand what I was meant to practise. Sometimes, because I did not understand clearly in the beginning, or because of how complex it was really, practising helped me to get further clarification and then modify. So feedback was coming either from myself (this does not work or seem right) or from others, or both.

I had to be intensely focused and in the beginning I often felt clumsy. Later I became more comfortable, and the movements felt natural to me. I could just 'be'. Sometimes I had to let go of preconceived ideas I had about how I was supposed to look at, or feel or even think about the outcome.

Another kind of practice came to mind too, such as nursing practice, or medical practice, or social work practice. This kind of practice involves being initiated into and participating in a particular world that includes a lot of its own language, ways of relating to people, and ways of working.

During the early stages of my counselling practice, I was sometimes confused and frustrated. I wanted things to be more simple. To really become involved in a community of practice requires a large commitment to learning, understanding, trying things out, getting feedback, repetition, putting many other things aside.

There are parallels here with developing the core conditions. They are complex, multifaceted phenomena, which are at the same time intangible. Yet developing them through practice requires being able to identify important components.

Activity 8.16 Listening

45 minutes

Read Extract 15 'Listening' by William Isaacs in the Anthology. He picks up on the theme of listening and developing the capacity to listen. You will explore listening as a skill in Unit 9. Here, you are asked to consider listening as part of an attitude with which you approach other people.

Choose one encounter in which you become involved in the next day or two. Note down:

1 How much you listen.

2 What other thoughts are going through your head while you are 'listening'.

3 How many times you think you know what the other person is going to say before they say it.

Comment *You might have noted in this reading that Isaacs refers to the importance of developing self-awareness. Listening to yourself and your own reactions requires developing an inner silence that seems reminiscent of meditation practices in Buddhism, for example. Listening effectively requires 'slowing down the process' to allow space and time to reflect.*

To summarise the key points of Isaacs' article:

- *Be aware* of your own thinking and how it can get in the way of the experiences within yourself and others. Grasping these internal and interpersonal experiences is the foundation for the core conditions.
- *Challenge and suspend assumptions.* Early in this unit you explored your own assumptions and expectations when you considered the cases of Molly and Jimmy.
- *Stick to the facts.* Be able to discern the difference between inference, assumptions and beliefs.

Key points

1 Controversy about how to define the core conditions can make it difficult to know how to develop them.

2 Eastern and western philosophies offer some consensus about their nature and role and how to develop them.

3 Clear intention and the development of self and other awareness are key to developing core conditions.

5 Towards a different view

Humanistic perspectives and, by association, the definition, development and practice of the core conditions have been criticised for several reasons. By focusing on immediate 'here and now' personal experiences, humanistic approaches have been criticised for neglecting to take into account the wider context that inevitably influences the individual experience.

Humanistic approaches have also been criticised for failing to address issues of power, such as the imbalance of power that may be embedded in a 'transmission' model of communication inherent in a traditional provider/service user relationship. The relationship has been represented as unidirectional with the provider delivering the conditions of help while the service user, client or patient is a more passive recipient. You had the opportunity to examine how these imbalances are constructed earlier in the course. In Unit 4 you read a chapter by Helen Jessup and Steve Rogerson, social work educators who have developed an approach that couples empathy with critical questioning. They help clients locate themselves and their difficulties in a wider context and support them in exploring more fully the sources of constraints and power that are embedded in social systems. As you explored in Unit 4, humanistic psychology developed within and reflects a socio-cultural context that privileges the individual, the notion of a self, self-reliance and autonomy. Regarding the core conditions and the practice of humanistic forms of helping, acknowledgement of the mutuality, the reciprocity, the co-creation of conditions has been sacrificed in the past to an emphasis on method. This focus appears to ignore how empathy and core conditions may be constructed between and among participants in the interaction. Yet you have probably had experiences of working or playing in a team where you felt that being 'in tune' with each other, by being open, respectful and caring, you could perform at your collective best. Reflecting on these experiences can lead you to a greater appreciation of how core conditions are co-created.

Bozarth (1997) comments that one of the greatest sources of misunderstanding of the person-centred approach is focusing on how to do it. He acknowledges that one of Rogers' earliest and greatest contributions was the development of a way to communicate empathy, for example, through the reflection processes, in order to test his understanding with the client. Carl Rogers himself moved away at an early stage from a focus on method, to talk more about attitudes and, later, about the relationships.

A great deal of innovative thinking about and exploration of the core conditions continues in the disciplines of therapeutic and organisational psychology. The dialogue processes that form a foundation for the learning organisation emphasise the co-creation of meaning among groups of people. Dialogue suggests that in a group or team interaction, if participants can 'suspend' their own assumptions and patterns of defensiveness, they can enter into a state of genuinely thinking together. Eventually a team can achieve new insights that might not have been available to individuals on their own.

David Ryback (2001), a consulting psychologist, compares empathy at its best with improvisational jazz. He quotes Wynton Marsalis (2001), a well known jazz musician: 'Jazz music is about communication and connection.' While jazz may not be your preferred music, you may recognise much of what Ryback is saying when you listen to and think about your own musical preferences. Ryback draws the following parallels.

Music can be about communication and connection

1 The invitation to improvise, in jazz, among the musicians; in therapy, between therapist and client. As Rogers (1986) put it, "In person-centered therapy, the person is free to choose any direction."

2 Progress of possibilities continues until there is a cohesive theme – in jazz, a shared melody; in therapy, an entrainment of body and mind in both individuals. Rogers (1980) again: "being sensitive, moment to moment to the changing felt meanings which flow in this other person".

3 Such openness leading to togetherness requires the combination of both skill in technique and a creative openness. In jazz, musical technique; in therapy, the therapist's skill in providing the underlying structure ...

Ryback, 2001, p. 78

Openness to, and mutual respect for, ongoing processes leads to something new rather than mere repetition: in jazz, response to one another's unique creativity; in therapy, the therapist's openness to new learning by listening for correction in building mutuality of effect, daring to go beyond mere repetition. In Rogers' words, 'a directional tendency inherent in the human organism – a tendency to grow, to develop, to realize its full potential' (1986, p. 197).

Activity 8.17 **Interview with Menachim Pressler**

30 minutes

Because of their very nature, the core conditions can only be partially grasped verbally. So this unit concludes with an interview with Menachim Pressler, the pianist with the Beaux Arts trio, on Audio 3 Band 1, which you should listen to now.

Comment *The comparison highlights how flexibility, sensitivity, openness, respect, and a sharing of emotion can lead to a mutuality of responsiveness from which something new and different can emerge.*

Pressler speaks eloquently about how the co-creation of music rests on the interplay of empathy, positive regard, genuineness and openness:

> *It felt wonderful being a part. An important aspect is how much can you conquer your ego and become part of a group. How wonderful it is to share success and how helpful it is to share defeat.*

Key points

1. Humanistic approaches have been criticised for an individualistic focus and a lack of attention to important contextual influences and power imbalances.
2. Shifting perspectives on core conditions take into account the co-creation of conditions, relationships and communication.
3. Using different media such as music to reflect on core conditions and relationships can bring new understanding to the nature and development of core conditions.

6 Conclusion

The humanistic theory of personality and change, also known as a person-centred approach, was represented as a radical departure from the therapeutic and helping traditions of the times, emphasising the importance of the relationship that the helper can provide. The notion of core conditions acknowledges conditions that are necessary and sufficient to building effective relationships. It remains one of the most powerful and influential contributions from the humanistic tradition to current everyday expectations about what makes for effective communication in health and social care.

Unit summary

There are continuing debates about whether core conditions are skills or attitudes, and they may indeed be a combination of both. This debate is important because it influences perspectives on whether core conditions are always appropriate and helpful to the communication at hand. In exploring what gets in the way of experiencing and expressing them, personal, situational and moral dilemmas reveal themselves. Determining whether core conditions are attitudes, attributes or skills has some bearing on how to develop them.

This unit explored core conditions from this perspective, relying on experience in health and social care and research that acknowledges their complexity and multifaceted nature. They involve intellectual, emotional and embodied experience. Developing them requires intention and practice, of the sort that requires the development of self-awareness, other awareness, and communication capacities. Unit 9 focuses primarily on the skills of communication that include communication of the core conditions.

Humanistic and person-centred perspectives have been criticised for perceived biases that disregard contextual influences and power imbalances. However, new and shifting perspectives recognise increasingly the mutuality, reciprocity, and co-creation of conditions and meaning among all participants in interactions and relationships.

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Unit 9

Communication skills

Prepared for the course team by
Ann Brechin and Janet Seden

Contents

You will need

- Course Reader

  Chapter 22 'Are there universal human being skills?' by Richard Nelson-Jones (optional)

  Chapter 23 'Counselling skills in social work practice' by Janet Seden

  Chapter 24 'Disability and communication: listening is not enough' by Sally French and John Swain

- Anthology

  Extract 18 'Moments in time' edited by Ann Brechin

  Extract 17 'One "day" in the life of a hospital out-patient'

  Extract 20 'Counselling for toads' by Robert de Board

- Audio 3, Band 2 'Skills in action'

Learning outcomes

After studying this unit you should be able to:

- Demonstrate knowledge and critical understanding of theoretical frameworks of 'communication skills' and their development in health and social care practice.
- Apply theoretical understanding of 'communication skills' to personal practice and experience in health and social care settings.
- Use ideas and approaches such as 'appreciative inquiry' to reflexively explore and enhance communication skills in your own practice.
- Identify and explore helpful and harmful communications skills and ways to improve practice in health and social care settings.

Introduction

A moment in time (1)

It is time for a cup of tea in the lounge of a residential care home for people with dementia. About 12 people share this part of the home and six are in the lounge at this moment. Janice is sleeping in an armchair and wakes to hear her neighbour being offered a cup of tea. 'Cup of tea for you, Dora?'

'Where's my tea, then? Why am I not getting any tea?' Janice demands. Janice angers quickly and seems to see the world as set against her. Her instant response, which is angry and complaining, is very characteristic. I look round (visiting my father at the other side of the room) feeling for the staff and feeling in myself the slightly irritated desire to rebuke her for her petulance. 'Here is your tea, Janice,' I instinctively want to say. 'Why do you think we would have forgotten you? You were asleep!'

Instead the male volunteer carer, Jim, who is nearest her, responds with delight to her waking. 'Hello, Janice,' he says warmly. 'Have you woken up now?' He crouches down by her chair, smiling at her.

'Hello,' she says.

'Have you had a nice sleep? How are you feeling?' All said warmly with a smile of greeting and relaxed eye contact.

'Hello' – she smiles and reaches out towards him – 'Give us a kiss!' She kisses his cheek – once and then again. 'Ooh, you're nice,' and she laughs in delight.

'Would you like a cup of tea, Janice?'

'Ooh, yes please.'

(Source: Ann Brechin, personal experience)

This unit explores a way of looking at communication that focuses on skills. The starting point is to look at what people *actually do and say* in communication that seems helpful. This draws partly on a behavioural approach (see Unit 4). Briefly, it proposes that as no one can know what is or is not in someone else's head, why not focus on what *can* be seen by looking at how people act? The 'cup of tea' incident, observed by one of the authors, seems to be an excellent example of communication skills *in action.*

Unit 8 drew on humanistic theory and introduced the concept of core conditions. As you have seen, this is also a way of trying to capture the essence of helpful communication. Essentially, the core conditions involve certain key orientations or dispositions residing within the individual: towards empathy, genuineness and unconditional positive regard. These may be seen as 'virtues' in ethical terms. What seems to be achieved by the presence of core conditions is the facilitation of communication, negotiation and understanding.

This unit considers communication *skills* as the other side of the coin from *core conditions* and addresses the debates suggested by the following questions.

- Are good communication skills simply the manifestation of core conditions?
- How, in effect, do you 'do' empathy?
- How do you convey 'genuineness' or 'unconditional positive regard'?
- Even if the disposition is there, do the skills inevitably flow? Conversely, can skills be developed and can they promote better communications in their own right?
- Can improved skills perhaps even prompt empathy, unconditional positive regard and genuineness?

This unit engages with the interrelationship between the two theoretical approaches. More will also be said about contexts, meanings and co-constructions, using a social constructionist approach (see Unit 4).

To summarise, this unit addresses the following core questions.

Core questions

1 What is meant by communication skills in the context of health and social care?

2 How can your own (and other people's) skills be scrutinised and developed in a non-threatening way?

3 How can a balanced approach to improving skills be achieved, recognising the significance of context as well as taking responsibility as individuals?

1 What is meant by communication skills?

1.1 Everyday skills

Quite ordinary, everyday skills can sometimes produce very special moments of communication. Later in Section 1.2 there are some more moments in time which, like the 'cup of tea' moment, are helpful in thinking about what happens when communication works well. What do people actually do to 'oil the wheels' of human exchange in a helpful way? Equally important, what do people do that gets grit into the system, causing unpleasant consequences and sometimes complete breakdown?

In dictionaries 'skill' is sometimes simply defined as 'the ability to do something well'. This definition might be enough for some practical skills but communicating and relating skills are a little more complicated, because of what exactly the word 'well' means in this context. Whether a communication is skilful, as you saw in the 'cup of tea' example, depends on how it works in the situation and on the attitudes that are conveyed to the other person by the words and actions. This unit suggests that skilful communications enhance the other person's experience and ability to respond in some way and they can be observed and learned from.

So, as authors, we see developing and improving communication skills as an important professional challenge and responsibility. At the same time, service users as well as service providers are part of any communication process and bring skills to bear on the exchange. It is a two-way process. Some examples from health and social care settings and relationships are used here to enable you to think about effective and successful communication skills in such contexts. However, there is also talking to do about something more fundamental: the human capacity to communicate with other human beings.

Richard Nelson-Jones (2002), a well known writer on communication skills, asks 'Are there universal human being skills?' His answer is a qualified 'yes' as he considers how little is really known about how to identify, cultivate and share what might be seen as desirable and universal skills. If you want to read about his ideas in full, his paper is reprinted in the Reader. Rather than thinking about such skills as if they lie in the realms of some special professional expertise, this unit will constantly remind you that they can be commonplace. Where specific impairments impede communication, amazing ingenuity demonstrates the depth of human motivation and the capacity to communicate. Most of the basic communication skills you have are shared by almost every other human being on the planet. These are the skills that have enabled humans to co-operate, and to compete, with each other to develop great civilisations, science, literature, technology, art, medicine; to make war and to make peace; to travel and to learn.

This is not to suggest that communication skills are entirely *innate*. There may be an in-built capacity and predisposition in all humans but the particular way in which each individual communicates is also shaped by experiences, learning, choices made and the cultural environment. From infancy, babies learn to modulate their crying or requests for food, to influence, instruct or reassure others around them, and to share their ideas and intentions. The way in which babies communicate with their first carers has been observed in detail by child development researcher Lynne Murray and her colleague Liz Andrews, a health visitor and counsellor, in partnership with the Children's Project founded in 1993 to support parents. Their book *The Social Baby* (2000) shows in pictures how from the start babies have complex psychological lives and make social responses to the people who care for them.

The social baby: 'Let's talk'

Judy Dunn, another expert in child development, suggests that the influence of the family as a system is very significant (Dunn, 1996). Each child's environment is unique, even in the same family, because parents relate differently to each child in response to that child's temperament and position in the family. Position in the family and relationships with brothers, sisters and friends are also important, but exactly how each person is influenced remains unique to them.

In an interview with Anthony Clare for the series *In the Psychiatrist's Chair* on BBC Radio 4, Jimmy Savile, the DJ and broadcaster, said he thinks he learned to listen and be interested in people through the experience of being the seventh child in the family.

> I was always interested in people, 'cos when I was very, very young, being the youngest of seven, I had big ears and no mouth because nobody listens to you when you're the youngest of a family anyway so you finish up listening a lot. I used to think how strange this person was from that person and then I'd listen to the folks or brothers and sisters talking about them afterwards and it all went into a big jumble of a computer [meaning his head]. We didn't have any money for hobbies of any sort so it would appear, I don't know, but it would appear that people finished up almost as a hobby.
>
> *Clare, 1992, p. 247*

Anthony Clare's approach as a psychiatrist looks for psychodynamic patterns and experiences from early childhood and tries to see below the surface to what the underlying anxieties and defences may be. He expects there will be patterns that are firmly rooted in the past and will lead to some consistent styles and qualities in adulthood.

As human beings go on developing throughout childhood, their adult lives and their emergent social and communication skills change and are refined. Developmental psychologists Michael Rutter and Dale Hay (1996) show how children learn their styles of communicating, ways of relating to other people, cultural and social behaviours from their earliest and subsequent carers. This happens naturally as children discover what is effective and what is considered

acceptable within the bounds of their families and their wider social and cultural experiences. In the 1970s and 1980s social learning theorists, particularly Michael Argyle, built an understanding of how such social skills develop and can be modified (for example Argyle, 1969, 1988, 1991; Argyle and Cook, 1976).

1.2 Noticing other people's communication skills

In order to build on their natural propensity to learn, adults need, first, to remain open to noticing their own and other people's skills; second, to be prepared to be open to new ways of doing things; and third, to be willing to learn from what is noticed. Emergent skills depend on learning by observing and reflecting on what seems to work well between people in all kinds of settings, cultures and walks of life. The first activity involves thinking of an instance when you were struck by something special in a communication between people.

Activity 9.1 **Noticing other people's communication skills**

20 minutes

First, think of a 'moment in time' when you were struck by someone's skill in communicating in a particularly effective or facilitative way. This need not be in a health or social care setting. It can be any moment when someone communicated with you in a way that you really appreciated, or it could be an interaction you observed between other people.

Next, write down a brief account of what happened. Be prepared for this to be an emotional experience as such moments can be powerful and touch you deeply. Revisiting them can reawaken feelings you had at the time. On the other hand, you may choose an example where clear and helpful information was offered with little emotional overlay.

Comment

The 'cup of tea' experience described at the beginning of this unit was such a moment for Ann Brechin. You will return to your moment and others again in Activity 9.2, to reflect further on them and to draw out the skills that may be involved. For now, read the examples below from the authors and course testers who did this activity. There are fuller accounts of them in the Anthology. There is no easy formula to apply to decide what will be especially effective or facilitative. It has to work in that moment at some level between the people involved in the communication: 'at some level' because something may register and be held in the memory to be revisited and to become more significant later on.

A moment in time (2)

A grandmother takes time on a train to really play with her granddaughter. She is touchingly responsive and engaged. The granddaughter loves it.

(Course tester)

A woman is speaking at the funeral of her friend, a white woman who had been actively involved in the fight against apartheid in South Africa. She begins to cry. A black African woman in the congregation begins to sing gently. Others join her – and the singing carries a message of sisterhood and support. The speaker smiles her gratitude.

(Ann Brechin)

A lecturer holds an audience spellbound. The delivery is clear, concise and wonderfully interesting. Questions are handled with clarity and the answers are relevant and illuminating.

(Course tester)

A neighbourhood office adviser in a drop-in centre has a visit from an elderly grandmother. She has a traumatic tale to tell involving a hit-and-run accident in which her two-year-old grandson was killed. The adviser remains very still and listens quietly, asking her only from time to time if she is all right. The woman is able then to tell her tale in full and explain her daughter's needs in her own way.

(Course tester)

A father with advanced Alzheimer's disease suddenly creates a channel of communication with his daughter. He holds her gaze and tells her essentially that he loves her and wishes he could have 'loved better'. After his death, she wishes she could have given him something back in return – to have acknowledged his message more than she did. Her daughter helps her to see that perhaps she did not have to respond. The message was his gift and all she had to do was to receive it.

(Ann Brechin)

You were asked to think of examples of strikingly facilitative or effective communications that happened in a real situation in your experience. The examples above and those you have chosen involve a normal range of human communications. In themselves they are probably not particularly unusual.

Such ordinary or special 'moments in time' help to mark out what is a skilful communication. Human beings talk, write, touch, look, signal, sing and listen in varying combinations. The way this happens for the recipient of the communication can be skilful, helpful and facilitative or, conversely, negative and disempowering, or a mixture. Such behaviours and 'moments in time' are public and observable. A behavioural approach would suggest that this is where the focus should be in order to understand and learn more about communications.

Activity 9.2 Effective and facilitative communication skills

40 minutes

Look back at your examples for Activity 9.1, and those in the comments. You could also look at the expanded versions of 'Moments in time' and scenarios 2, 3 and 5 in 'One "day" in the life of a hospital outpatient' in the Anthology (Extracts 18 and 17).

Identify what made these communications effective and facilitative. Try to avoid slipping into describing them in terms of core conditions or attitudes. Note down what people did or said that seemed important.

If you find this difficult, you will not be alone. Try to note why it is so difficult. It is more important that you take time to reflect on this task rather than draw up a coherent list.

Comment *Course testers arrived at the following conclusions, although they are somewhat overlapping.*

- *Giving time and attention: attending, listening, talking, making eye contact, expressing interest and concern through what is said, or sung, or by body language.*
- *Being non-intrusive, e.g. just being there, listening or singing.*
- *Being fully present and focused in that moment.*
- *It was the appropriateness of the behaviour, however, in the particular context and relationship that seemed most important.*

We found ourselves referring to the following.

- The ability to judge sensitively *how to react to support or facilitate or reassure (the African woman singing, for example).*
- The ability to show understanding and empathy *(the neighbourhood centre adviser).*
- The ability to be responsive *to what is asked or offered (the grandmother, for example).*
- The ability to tune in *to a person's wavelength – sensing what they want and need in this context (the lecturer, perhaps).*
- The ability to offer actively *(the message from the father, and the message from the daughter – both offered gifts).*

These are not complete accounts of skills; there is a fuller analysis in Section 2.2, where you will find guidelines for developing effective and facilitative communication skills. What was interesting here, and what you may well have found interesting too, is that evaluative descriptions are used to try to capture the skills. Driving a car is an overused analogy but it is quite apt in this context. The skills needed are not just managing the clutch, accelerator and brake but, essentially, those involved in judging the road conditions and interpreting the intentions of other drivers and pedestrians appropriately. Communication skills also can only really be accounted for in terms of their appropriateness in time, place and context. Even eye contact, a silent presence or listening can be deeply intrusive and unwelcome if you just want to be left alone.

Listening can be deeply intrusive and unwelcome if you simply want to be left alone

To recap, skills are often defined simply as the ability to do something well, but this really does not go far enough for communication and relationships. Different people may have different ideas about what they experience as 'helpful' or 'effective', depending on the situation. Staying silent and leaving someone the space to speak can be very useful. On the other hand, if the listener

stays silent and does not give any feedback to a person talking, it can feel uncomfortable. Perhaps effective communication skills are most easily defined as *skills that enhance the other person's capacity to communicate – to be heard, to understand and to be understood in return*.

1.3 Noticing our own communication skills

Making judgements about the success or appropriateness of communication skills is always tricky. At best you will have access to only one side of the story. Feedback from other people and careful reflection on how others experience you is one way of judging what sort of communication was 'skilful' and what was not.

Activity 9.3

This activity is ongoing, but start by setting aside at least four sessions of 10 minutes this week

Diary of communication skills

First, keep a diary where you note your own use of communication skills at home or work over two days.

Choose a particular exchange and make a note of some of your precise words and actions if you can. Note how the other person responds. If possible, it is best to do this immediately.

Now imagine yourself on the receiving end of the exchange and reflect on how you would respond to yourself.

If you can, sit down with someone who knows you reasonably well. Ask them for some feedback on your communication skills, including areas to improve.

Make a list from this of which communication skills you think you have and which ones you might develop.

Comment

This can be a surprising and challenging experience. You can suddenly hear yourself in quite a different way. Ann tried an activity like this many years ago and she says:

> *I asked myself 'Would I turn to myself for help if I were in distress?' – which led me eventually on to a path of self-development through counselling and extensive reading and reflection. I was so shocked to realise that I most certainly would NOT want my rather judgemental, problem-focused approach AT ALL. I thought I was trying to be helpful! My children tell me I'm much nicer now!*

You will need your communication diary again later in this unit. In the meantime, try to keep going with it and raise your own awareness of the skills you use. You could ask yourself from time to time whether your skills in communicating enhance the other person's capacity to communicate – to be heard, to understand and to be understood in return. As you work on this, you may find yourself focusing more on trying to understand the other person's perspective and situation than on your skills. This would be an essential part of a process that enables you to judge the appropriateness of anything you say or do more effectively.

As Deborah Cameron suggests in Chapter 7 in the Reader, skilled communication depends on an understanding of the context and the relationships involved in a particular communicative event:

> Attempts to promote 'better communication' will not succeed unless they are based on an understanding that all human communication is necessarily embedded in social contexts and relationships. Since these are complex and variable, there is no single 'right way' to communicate, no universally applicable 'magic words', and no quick fix for every problem. 'Skilled' communicators are those with the resources (linguistic, intellectual and experiential) to reflect on the context and the relationships involved in a particular communicative event, and in the light of that reflection, gauge the effects of different ways of interacting. Without this deeper dimension, communication skills training becomes a superficial exercise, of little benefit either to trainees themselves or to the recipients of their professional attentions.

Some practitioners, who are part of a Community Mental Health Team, talked to us about their use of communication skills in their work. They were asked how they would describe the skills they try to use and how far they would see their skills as being embedded in the wider context of relationships. They were also asked about how they learned and developed their skills.

We also talked to Jill, the service user you met on Audio 1, about what she would look for in terms of good communications from members of such a team. Like many service users, she values being treated with 'respect'. Therefore, it is worth spending a few minutes (before you hear Jill again on Audio 2 and listen to the Community Mental Health Team members talking about their skills) to think about what is meant by the word 'respect'. It is a little word that can carry many layers of meaning. Annette Browne (1993), writing in the *Journal of Advanced Nursing*, suggests that respect is an ethical principle underpinning humane and sensitive caring. She also describes it as an attitude that is shown by practitioners being sensitive to the human dignity and uniqueness of each person, accepting their right to self-determination by accepting the other person's values and feelings as being valid. In Browne's view the word 'respect' carries a range of ideas along with it. This includes understanding and valuing each person's unique cultural background and what is understood by 'respect' within that culture. Browne also argues that respect must be 'conveyed' to the other person through non-verbal messages, verbal messages and the practitioner's actions. A skilful communication will convey that underpinning 'respect' to the other person. 'Respect' is a word that includes thinking about your own and others' values, beliefs and attitudes.

Activity 9.4 Communication skills in practice

1 hour

Find Audio 3, Band 2, 'Skills in action'. Before you listen write down the following headings at the top of a piece of paper. (You could draw four columns with one heading at the top of each column.)

- Practitioner
- Skills used and purpose
- How skills were learned
- How skills might improve

1 Now listen to Jill the service user again. Note down on a separate sheet of paper what makes a good practitioner for her. Include her ideas about respect.

2 Next listen to each practitioner and make notes under the headings on the first piece of paper. You may need to listen twice as there is much to note.

Comment *Your notes might include some of the following points. If you missed any of them it is worth listening to the audio again.*

1 *Jill says she values a relationship with practitioners of 'mutual respect'. She means she has built trust with her psychiatrist and one social worker in particular because, while they have kept the professional boundaries ('a line') with her, she has felt treated as an adult and enabled to keep her dignity as a person. She says when you are vulnerable trust is important. She also values reliability in the professionals she has worked with.*

2 *The practitioners are also aware of the need to be sensitive to service users' concerns and to use their skills to build trust.*

Lynne uses social skills to put people at ease and then manages the time to enable service users to talk and share their view of their situation. To draw people out she uses empathy and repetition, trying to avoid questioning. She leaves space and stays silent so that she does not interrupt the narrative or the way the other person expresses their concerns. In the second half of the meeting she does use questions to obtain the information she needs to provide the service. She wants to build rapport and trust and thinks sensitivity and empathy do this best. She always tries to listen carefully to the feedback from the service user and to respond to this as she goes along. Lynne learned her social skills from her parents and work experiences but has since benefited from professional and counselling training, supervision and sharing with colleagues.

Chris talks of influencing people and diffusing difficult situations, so that he can help patients and the team to manage and support mental illness. He learned his communication techniques through his medical training and experience, but is very aware that such skills need refreshing and reassessing on a regular basis.

Siân uses verbal skills but is very alert to non-verbal language, so that she can put people at ease and be sensitive to the non-verbal messages they may give about how they are feeling. Siân says skills of communicating are learned early in life, but that they are 'fine-tuned' on the job through training and experience.

Carly is very sensitive to the disadvantages that the service users experience. As well as other skills, she uses advocacy and assertiveness to try to improve people's situations and make sure they are heard. She brings a high awareness of social inequality from her own background and has improved her skills through training. She says that 'ongoing reflection' is very important indeed in thinking about how to develop and improve practice.

Denise works at being calm and approachable. She uses empathy to reassure people when they are anxious. She treats people 'as I would like to be treated' and has a flexible approach to the different styles of others. She has learned from other people 'on the job' and now feels able to help others learn. Maintaining confidentiality is important in her role.

The Community Mental Health Team members identify many skills, but you probably also noticed they maintain a high awareness of the context and appropriateness of their actions. Many of their service users are ill or distressed, so they need to be very sensitive and careful to communicate as skilfully as possible to enhance the service users' capacity to communicate and to tell their own story as they see it. Much of the time they use their own skills to enable others to be heard and to respond.

Key points

1. Everyone develops and uses communication skills as a part of normal human interaction and relationships. In this sense such skills are commonplace – and largely universal.
2. Reflecting on positive communications when interactions seem particularly effective can yield some rich descriptions of a wide range of types and styles of communication skill.
3. For communication skills to be effective and facilitative, they have to be ways of interacting that are appropriate in the time, relationship and context in which they occur.

2 Identifying 'helpful' and 'harmful' communication skills

2.1 How not to do it

In the next section the exploration of what makes for effective and facilitative skills is taken a little further. First, however, partly to demonstrate how *not* to do it, there is an example of the impact of poor communication skills. It is difficult to give negative examples, as it seems to point an accusing finger at a whole group of people – in this case, midwives. As authors, we are concerned not to offend anyone and, by way of justification for using this example, we would make four points. First, it did actually happen. Second, it happened 30 years ago. Third, there are still numerous examples of poor communications and practice across all professional groups – just ask any service user. Fourth, it is a compelling example that illustrates some important points.

Activity 9.5 **Harmful communication skills**

20 minutes

The following account describes an interaction that felt very unhelpful to a young woman. What would you identify here as features of potentially harmful communication skills?

Note down what the midwife says or does, or fails to do or say, that so upset the young woman.

Would you agree that such patterns of interaction could be harmful?

A bad moment in time

When my first baby was born I was at home by myself during the first few days I returned from hospital. I was feeling confident and happy, enjoying the new experience. Both my partner and my mother had full-time jobs, so that while they were available from time to time, during the day at least my new daughter and I were alone. I was content, if tired and busy.

One morning the midwife called. She sat down and started to pry. Where was my husband? Surely he was not at work when I had a new baby in the house? Where was my mother? She told me that when her daughter Susan had a baby she had taken two weeks' leave to go and stay with her and help and advise. Susan had been so pleased, and the baby had come on so well.

Next, she said she did not think my PVC baby-changing mat was a good idea: too much PVC near the baby's skin and why hadn't I a handy pile of newspapers ready to wrap up and dispose of the contents of dirty nappies? I usually put a cotton sheet over the PVC changing mat anyway, but she did not stop to ask.

More advice followed. 'I wouldn't let her suck her hands if I were you. Haven't you any mittens to stop her scratching her face?' Then it was 'Why don't you turn up the central heating then? We don't want baby dying of hypothermia do we?'

Finally she went, and I sat down exhausted and cried. I had been tired but happy half an hour before. Luckily, the friend I phoned to cheer me up was at home. She came round for coffee, reassured me about my care of my baby, and said she understood just how 'invaded' I had felt at a vulnerable time. I felt restored.

Later, with my second and third babies, I had much more positive experiences of health professionals. This unfortunate experience proved to be an exception.

(Source: Janet Seden, personal communication)

Comment

The course testers variously commented that the midwife seemed to be:

- *bent on finding fault*
- *interrogating the young woman*
- *not listening at all*
- *taking no interest in the person*
- *offering no support*
- *asking judgemental questions*
- *offering nit-picking criticisms*
- *not enabling*
- *imposing her own values*
- *not respecting the person's views*
- *undermining her confidence*
- *moralising*
- *imposing her own experience.*

Perhaps the midwife had a reasonable agenda of concerns and questions that formed her mental checklist. Was this young woman adequately supported or isolated? Was she sufficiently aware of skin care, temperature control, hygiene or the risk of scratching? The concerns felt appropriate to the midwife, but the way she passed them on did not seem appropriate to the person on the receiving end.

Psychodynamic theory (see Unit 4) would suggest that some of these messages might be unconscious – outside the awareness of the communicator. Their impact may be felt at an emotional level, as in this example, and may or may not be understood. At the time this young mother may have wondered why she felt so undermined and distressed by this 'professional advice'. The message was, 'You and your family are inadequate and incompetent.' Being able to laugh at it probably saved her as she talked it through with a supportive friend and regained her confidence and self-respect. Others might not have been so lucky and such communications can be very harmful, particularly at a vulnerable time.

Essentially this midwife did not display any of the core conditions. Being genuinely non-judgemental, showing positive regard and genuine presence in a relationship may be dispositions that people *feel* they are achieving, but their words and behaviour sometimes carry a different message.

We shall return to this midwife briefly near the end of the unit to ask, 'What might have helped to develop her skills?'

2.2 How to do it better

There is now much common ground among writers about the kind of communication skills that are helpful when used well. Some of the best known writers on 'people skills' are Gerard Egan (1990), Michael Jacobs (1982), Richard Nelson-Jones (1990) and John Heron (2001). Each of them shows how the communication skills for building relationships and working effectively to help other people can be learned. Becoming a psychotherapist requires a long, intensive training in understanding the self and others, and learning the skills and techniques to manage therapeutic processes. Starting to become a better communicator in daily work and conversations, however, is not that hard. Often it begins to happen just as a result of paying more attention to how, what and when you do or say something. It also happens as a result of noticing and learning from other people's responses to you.

In the next activity you are introduced to counselling skills. Unit 8 introduced you to core conditions, which also stem from counselling theory and practice. In his book *Counselling for Toads*, Robert de Board builds on a more explicitly psychoanalytical tradition. The assumption is there are particular skills and techniques that are necessary to assist the process of self-development. You will not be surprised that there are considerable areas of overlap when drawing out the implications for effective and facilitative communication.

If you are not familiar with the original book and characters on which de Board's book is based, you should be aware that, with its animal-based characterisations, it is a vehicle for poking gentle fun at the male English upper-class establishment of the day. It does, therefore, have a context, despite being based on fiction and imaginary animals.

Activity 9.6 **Counselling for toads**

50 minutes

Read the extract from *Counselling for Toads* by Robert de Board in the Anthology (Extract 20) and enjoy the account of Toad of Toad Hall's counselling sessions.

Identify the skills that the Heron uses in these encounters and the impact they have on Toad. If you check back, you should find they cover some of the same ideas you heard about on the audio 'Skills in action'. Here they are pulled together for you in a different way.

Comment

We drew up a list and added to it to form the guidelines in Box 9.1. You are not expected to have produced a lengthy account like ours, but you could compare your notes with the points we make.

Box 9.1 Guidelines for developing effective and facilitative communication skills

Active listening

Active listening means giving the other person full attention and, if possible, not interrupting. This may be for a brief momentary exchange or a much longer conversation. The active listener offers small responses, nods and other signs of attending, but speaks little. At the same time as listening to words, the listener may also try to gauge how the speaker is feeling. If the speaker falls silent, pauses are left to give the person time to gather their thoughts and continue speaking. The listener's activity is focused on encouraging the other person to talk. This gives the person who is talking a chance to clarify their own thoughts and feelings.

Responding and respectful talking

Knowing how and when to respond involves skilled timing. When a person needs to talk, small prompts and an accepting manner are all that is needed. However, being left to talk for too long with no input from the listener can feel difficult. The person who is talking can start to feel anxious and out of control. Also, they may be unsure how safe it is to share thoughts with the listener and want some positive verbal reassurance that they are understood. Lynne, the occupational therapist on the audio, gives an example of when she did not actively respond and left the client, as she says, 'in the void'. She also gives a more positive example of when she responded and it worked well for the client. If you cannot remember these two examples it would be useful to listen to them again.

Sometimes you may, because of your role, want to impart quite a lot of information, and to talk and explain rather than listen. This needs to be carefully done, listening while talking and watching for the impact of what you say. It helps to take time to ensure that the person is receiving and understanding you. This saves wasting their time and yours. You could check by asking 'How does that idea seem from your point of view?' 'Is this what you were expecting me to say?' 'How do you feel about that?' 'Do you have questions at this stage?' In a sense, respectful talking is about continuing to listen while you are talking. You can listen with your eyes as well as your ears to see how you are being received. Siân, the community psychiatric nurse on the audio, describes how this observation of and response to non-verbal cues is very important in her work.

Paraphrasing

This is the skill of capturing what a person has said, using different words. It is a very useful way of demonstrating that you are listening carefully and of checking that you understand accurately as you go along. It is arguably the skill that underpins or demonstrates empathy. If paraphrasing is used carefully and sensitively, it enables the other person to clarify his or her own thoughts. At the same time, the person who is responding is keeping focused, avoiding giving advice and judgement, thus creating space for the other person to come to their own conclusions.

Summarising

Summarising is the ability to reflect back on perhaps quite a long spell of listening, or interviewing, or interaction and activity, and sum up what has been said and agreed. Summing up every 10 minutes or so is also useful to help clarify the process of a long interview or intervention. Few care jobs can be done well without this ability. It is always useful to summarise what has been agreed and will be written down with the person before writing your own version on a record, for example.

Questions

Most people know how to ask questions, but the skilful use of questioning requires thought. Inexperienced workers often 'fire' a string of questions at a person they have to interview. Closed questioning like this is associated with courts, parental figures and tests at school. It tends to put people on the defensive. Questions are often needed simply to elicit necessary information. You might explain: 'In order to help I am going to ask you a series of questions. This is going to be the quickest and simplest way for me to find out.' Filling in a form for a client is an example of where this approach is used.

In other kinds of conversation, perhaps where you are exploring someone's feelings or options, it is much better practice to use open questions, which begin with words such as 'How?' or 'When?' 'Why?' is often a very challenging question and best avoided if possible. Open questions provide an opportunity for people to respond from their own agenda. Practitioners who carry out interviews about abuse, or other sensitive issues, need to become very skilled in using the kinds of question that do not lead or put words into people's mouths. In these circumstances it helps to be skilled at rephrasing questions and using a formula such as 'Tell me about the day that ...' or 'Could you describe ...?'

On the audio 'Skills in action', the members of the Community Mental Health Team made a point of saying they were careful to encourage the person to give their own narrative or version of events. Did you notice they also managed the time that was available for the meeting? Lynne, the occupational therapist, said she left the first half of any interview free for narrative but used questions more in the second part because she needed to have practical information in order to help the person.

Facing up to conflict

Sometimes exchanges between people become heated and angry. It is hard to see how this can be avoided when feelings are running high, clients are upset and professionals are taking actions they disagree with. Care workers have to be able to handle giving unpleasant news; nurses may be faced with angry relatives; service users may find themselves up against cross and stressed professionals. It is possible to become skilled about accepting anger, but still challenge what is happening without being unnecessarily confrontational (Heron, 2001). In care work where residents and staff live together, handling the tensions and confronting the issues that arise are ongoing tasks. Workers in residential homes for children have to become skilled at talking honestly about issues of behaviour and the rules the home has for community living. Chris, the psychiatrist on the audio, often has to diffuse difficult situations.

Assertiveness

This is a particularly useful skill in facing conflict. Often the first skill to learn is coming to terms with your own feelings. That way you are more likely to stay calm and thoughtful. Your words need to be chosen so that they do not become blaming, moralising or judging, or placating in a way that avoids the issue. Assertiveness is very different from aggression. It is about being comfortable about expressing your view or your needs while remaining open to listening to the other person. You continue to respect them, while also respecting yourself. Carly, the social worker on the audio 'Skills in action', identifies how she needs to be assertive to advocate for services for her clients or to put across a social perspective on their illness. Robert Bolton (1986) has written a good chapter on assertiveness.

If this seems a rather long list of skills to practise, just start at the top. It is easy to underestimate the challenge and the power of active listening. (You may remember how important this is from the article by William Isaacs in the Anthology, which you read in Unit 8.) Just listening to a friend's account of a holiday, without interrupting every second sentence to tell them how you did something twice as exciting or why you would never go there, can be a highly valued skill. Start by listening attentively, using small responses to show that you are focused on the speaker, as suggested in our guidelines. Then move on to practising other skills, perhaps responding or

paraphrasing. In your diary note what this is like and how other people respond. This can feel a very self-conscious exercise at first but, if you can be self-aware and reflect on feedback from others in this way, you will begin to develop better skills. Active listening is the foundation of developing more skilful communications and is even more important when a person has something painful or personal to relate.

Dorothy Rowe, a psychologist and psychotherapist, wrote in her book on depression:

> In listening to another person's story we are, in effect, bearing witness to that person's existence, courage, suffering and pain. We open ourselves to the anguish of witnessing another person's suffering. Sometimes we can relieve our own anguish by hastening to cure the person's pain and to put right what has gone wrong, but so often there is nothing we can do. Then we have to be able to face our own helplessness and not preserve a glorified image of ourselves and reduce our pain by denying the other person's truth.
>
> *Rowe, 1983, p. 194*

It is hard to listen and accept how the situation is for the other person without trying to reject or modify it. Sometimes it is only human to say 'No, no, you mustn't take it personally', or 'Oh I know, my mother had that too but she's better now', or 'Well, what you need to do is just tell them', or 'Don't worry, you'll be all right soon'. It is quite hard to resist such reactions but, when you do, it is amazingly powerful.

The writer Oriah Mountain Dreamer puts it like this:

> I want to know if you can sit with pain, mine or your own, without moving to hide it or fade it or fix it.
>
> *Dreamer, 1999, p. 1*

Try noticing when someone does it for you and how validating and respectful it feels to be *heard*.

Activity 9.7 Your communication diary

30 minutes

Return to your diary. Look back over your notes so far and see whether you can identify points where you used any of the skills listed in our guidelines. If you have not made any entries, think back over the last day or so and make them now.

If you feel comfortable with the idea, see whether you can extend your use of these skills in your everyday communications. If you are in a health and social care context, whether as service provider or user, look for opportunities there too. Write them up in your diary.

Comment

If you are struggling with your diary, read some of the earlier guidance again and keep trying in your communications with other people to put yourself in their position. Practising saying phrases out loud and imagining them being said to you can be surprisingly helpful, although it sounds so artificial. A role play or a recorded conversation can be helpful too. Note down what seems to 'work' for you and other people and build on what you identify as helpful communications. There are plenty of other sources of more detailed discussion than we can offer here: for example, Robert Bolton's People Skills *(1986), Janet Seden's* Counselling Skills in Social Work Practice *(2000), or one of the other books in the Counselling Skills in Practice series published by Open University Press.*

The suggestion at the end of Section 1.2 that the outcome of effective and facilitative communication should be *to enhance the other person's capacity to communicate – to be heard, to understand and to be understood in return* is a useful reminder. You cannot communicate successfully just by deploying skills. Skilful communication depends on being sufficiently sensitive to the other person or people and the wider context, so that you can successfully engage with them. If you think back to Jill, the service user on the audio, she emphasised the importance of respect. By this she meant the way two particular practitioners treated her as an adult whose views counted, and saw her as a person with strengths and a contribution to make to the lives of others, as well as someone with an illness who needed support now and again.

Key points

1 Helpful or harmful communication skills can enhance or diminish other people's capacity to communicate.

2 Harmful communications can undermine self-esteem and disempower. Harm may not be intended but a failure to recognise and respect the other person's perspective and context can be damaging.

3 Helpful communication skills promote the capacity of the other person to be heard, to understand and to be understood. They promote and empower the other person without disempowering the skilled communicator.

3 Improving skills

3.1 Appreciative inquiry

The focus now turns to how people can develop their skills. So far this unit has taken a somewhat traditional approach to learning. We have pointed out and illustrated some negative and some positive examples and have suggested that you might work on developing your skills according to some guidelines we drew up. In many ways this is quite a didactic approach. It suggests that there is an accessible body of expertise that can then be passed on to you. This puts you in a less powerful position than the authors and you are expected to follow the advice given. As a model for effective and facilitative communication in itself, this is only part of the story, as you are also active in your own learning.

A rather different approach is suggested by *appreciative inquiry*. This approach has emerged from the world of organisational change. Appreciative inquiry was first written about by the American authors David Cooperrider and Suresh Srivastva (1987). Their work was then further developed, for example by Gervaise Busche (1995). It provides an alternative to problem-based approaches by seeking out the positive stories. The approach has now been used in research looking at the development of human services. Jan Reed and her colleagues, for example, formed an inter-agency research group in Newcastle to look at the co-ordination of discharge services for older people (Reed et al., 2002).

Activity 9.8 **Exploring appreciative inquiry**

1 hour

Go to the K309 course website. Look at the list of websites for Block 3 and find the following links. First go to www.newparadigm.co.uk and note down the approach that appreciative inquiry takes to solving organisational problems. Next go to www.solworld/org/downloads/AISF1.doc and note what appreciative inquiry and solution-focused therapy have in common.

Comment

Appreciative inquiry is an approach which suggests that identifying and appreciating the best in an organisation's life enables people to build on strengths and replicate best practice to bring about change and development. In solution-focused approaches to helping individuals, the helper works with a person to identify their past coping strategies and ways of solving difficulties so they can use them in the present. Both sets of ideas emphasise looking for what works well, learning from it and repeating it. Here we use this approach in relation to developing skills.

Appreciative inquiry starts by assuming that people very often hold the most important seeds of knowledge, understanding and skill within themselves. Then it proposes a process that can help to identify and draw that out. The next activity takes you step by step through such an approach. Bear in mind it takes time to do this properly and it is best shared in discussion with at least one other person. You do not have to choose a process that involved you directly, nor need it be about communication. However, for our purposes here, that would be best.

Activity 9.9

Ideally allow at least 2 hours for this with breaks. In a small group or workshop you might spend longer

Conducting an appreciative inquiry

1 Think of an occasion when you felt some communication you were involved in had gone really well. This could be an example from your communication diary or one you drew on in Activity 9.1. The 'cup of tea' incident described earlier is used to illustrate the process in our activity comment.

2 Next, describe or write out what happened in your own words. Note down what felt so good about it.

3 Now reflect on how this moment was achieved. What skills, abilities and strengths do you have that contributed to that process? How did other people play a role, and what role?

4 Then ask yourself how you were able to do that. Did someone show you or teach you? Did it have any family origins?

5 Finally, what encouraged or enabled you to develop and demonstrate those skills, abilities and strengths at that time and in that context? Note any particular contextual factors that contributed.

Comment

The 'cup of tea' story surfaced in Ann Brechin's mind when she was looking for an example of a communication that went well. It is not her story, but she was there. Ideally, she would go over this account with Jim. Ann's appreciative inquiry of the moment is as follows.

1 Asked to describe it, I produced the account by trying to tease out a sense of what seemed to happen. What is it about it that felt so good to me? Asked that, I might focus on the way it changed something potentially upsetting into a warm and positive interaction. I might point to the positive consequences not just for Janice, but for the others around at the time – the other residents, staff, visitors, me (it certainly lifted my spirits). I might dwell on what else could have happened if Janice had been 'told off' for her rudeness instead. I think it also felt good because Jim was so inexperienced and had been so hesitant and unsure a few months earlier.

2 Asked to consider how it was achieved, I might point to the way the cross reaction was 'allowed'. I would certainly identify the importance of the warmth and contact with Janice as a person welcomed back into the waking world out of her drowsiness. I might guess at how easily she might feel confused and vulnerable on waking and react by 'hitting out' verbally. Jim uses empathy to appreciate that Janice has just woken up from a sleep. She has reacted crossly and perhaps needs someone to reorientate her to what is happening around her. He also gives her the attention she wants. He uses body language positively, crouching down and smiling, so that he does not seem threatening. I might describe the moment of contact that was established as being a moment of being in touch. I could suggest that she was given time and space and respect in which to come to herself and to feel good. I also note that others around support this by non-intrusion. I felt irritation, but said nothing. Nobody rose to the implicit challenge of Janice's complaint and that was important too.

3 Stepping further back, and asked what made it possible for this to happen, I would want to know how Jim learned to respond in this way. Did it just 'come naturally' to him – a style learned in childhood perhaps – or had he received some specialist training? What were the features of the situation that facilitated such a response from this carer? I could answer, or at least hazard a guess, as I knew this care home well and had seen this male carer start out as a volunteer visitor, unsure and hesitant, some months before.

4 *Thinking about contextual factors might take me to supportive staff, a regime of respectful care, a care home based on Tom Kitwood's training (Kitwood, 1997) and his concept of 'positive person work'. I would have to talk to Jim further to find out about other influences, ideas and experiences that might have led to his skilful response at that moment in time.*

How did you get on with your own appreciative inquiry? Ann's experience of this in a workshop convinced her that it is a valuable technique to aid personal and contextual exploration and learning.

3.2 Recognising our own inner resources

The writer Jafar Kareem quotes an Indian man telling her:

> I am a Brahmin, I am a Punjabi, I am British and I am an Indian. I am all those four together and that is what I want you to write in your file. Whenever I speak, all those four speak from inside me.
>
> *Kareem, 1992, p. 34*

Human beings carry their experiences of growing up inside them and this informs the way they communicate and relate with other people. Sometimes this comes from a particular emphasis at a point in time. For example, Clare Elliott says:

> Each culture emphasises some aspects of personality over others. For instance, in the USA individuality is admired ... In Japan, on the other hand, loyalty to the group is important, and therefore good behaviour and obedience to the rules are emphasised.
>
> *Elliott, 1992, p. 19*

Over time, ideas change, cultures change, merge and cross over with each other, and cultural influences are then more complex, as Jafar Kareem's example shows. Perceptions and expectations about gender and age differences and balances of power in relationships also alter. For example, until the late 20th century parental rights over children's lives were largely unquestioned. Today the Children Act 1989 talks of parental responsibilities and children's rights. Everyone is a product of a history and of socialisation, including education, family, and neighbourhood or locality. Psychotherapists Colin Lago and Joyce Thompson (1997) argue that understanding these developmental processes in others and the self improves counselling and communication skills in relationships.

Contextualised experiences, arising through interactions with others, also lead people to their particular 'take' on the world. A social constructionist view would suggest that we co-create the meanings and understandings we come to hold. (See, for example, Shotter and Gergen, 1989; McNamee and Gergen, 1992.) These meanings and understandings then influence our future experiences, because they become our personal theories of what life is about. Thus emergent beliefs about and experiences of culture, relationships, family, roles and expectations, and education or training can be thought of as the inner resources each person brings to any new or ongoing encounter.

Every person carries a rich and powerful set of such resources. These may lead to fixed ideas about the self and others: 'I've always had bad luck'; 'People tend to ignore me'; 'I've got this sense of determination from my mother, so I'm a

fighter'; or 'I tend to expect the best of people.' These beliefs, or 'fixed narratives', are nevertheless potentially open to change as new situations and challenges arise. In other words, we can all learn and, as this happens, new learning is added to the bag of resources ready to influence the next encounter.

In any communication, of course, the other person draws on his or her own resources – and personal narratives. It is a little like recognising that the other person is using a slightly different language where the meanings of some familiar-sounding words and expressions actually have different connotations. When someone says, 'I don't know what you're getting so upset about', it can be meant as a criticism: 'There's no reason for you to be so upset.' However, there is more truth in the words themselves – the person really does not know. The struggle to make sense of what each party means can be helped if they are willing to work towards decoding the meanings together.

The next activity is based on an account of failures to understand differences in meaning stemming from very different sets of resources. It describes the efforts of a hospital social worker to facilitate communication, which had broken down, between a patient and a consultant.

Activity 9.10 Decoding the meanings together

30 minutes

Read Chapter 23, 'Counselling skills in social work practice', by Janet Seden in the Reader.

Make a few notes about the skills the hospital social worker used in responding to both Mr Mistry and the doctor.

Then see whether you can construct a sense of what her personal narrative might be. Might it have changed at all as a result of this experience?

Comment

The skills are drawn out clearly: active listening, presence, summarising, respectful talking, empathy, questioning, facing up to conflict, and assertiveness perhaps.

What did you think the social worker's personal narrative might be? Perhaps she saw herself as someone who liked to be facilitative, who had the capacity to get in there and make a difference. She seems ready to challenge what she sees as injustice and judgementalism in others. She has perhaps a negative opinion about doctors and sees the importance of working with rather than against this doctor. She expects that language difficulties, prejudice, and different cultural beliefs and expectations may be contributory factors. Her predominant narrative is perhaps that by trying to understand each of their perspectives better, she may be able to facilitate a dialogue and resolution. This is a powerful belief system to hold, especially as it is backed up by the necessary skills.

What could she have learned? This probably reinforced her fixed narrative. It may well have built up her confidence; her story may now tell her that she can challenge powerful people if she goes about it the right way. She may also believe that doctors can shift their perspectives too.

It would have been interesting to conduct a process of appreciative inquiry with that social worker. There might be more to draw out about the basis of the skills she used, where they came from and how she felt enabled to work in this way. What else and who else in the situation and in her wider context contributed to this process? An appreciative inquiry approach would explore and expand her narrative.

3.3 Pushing at boundaries

Without the intervention of the social worker Mr Mistry's situation would probably not have been resolved happily. Communicating across difference can be very challenging. Everyone is inevitably limited in their capacity to understand where other people are 'coming from' in their communications, although they can try working at it. However, people can be pretty poor at understanding their own bag or supply of inner resources. The social worker may have been reasonably self-aware, but there could have been some influences that would remain hidden from view, even to her. We think that we behave, react and communicate as we do simply because that is how we are: 'That's just the kind of person I am', we say. 'Anyone would have done/said/felt the same in the circumstances.' Digging a little below the surface suggests that these convictions are very misplaced.

Psychodynamic theorists (see Unit 4) suggest that everyone carries among their inner resources emotional hurts, anxieties and shame, which they successfully hide from themselves most of the time but affect the way they interact with other people. The defences people may erect to stop these feelings being exposed can make them less able to be fully present and comfortable in communications with other people. Unit 10 picks up on the issue of emotions and takes it further. For now, it is enough just to make the point.

Where there are boundaries of perceived difference, as well as boundaries in the form of defences against perceived risks, communication is likely to be seriously compromised. Janet Seden suggests in her account that Mr Mistry's doctor, and perhaps Mr Mistry too, had both kinds of boundary to contend with. They carried prejudicial assumptions, seeing each other as different and alien in some way, and they both had in-built defence structures to protect themselves. From those positions the likely outcome is conflict and avoidance. Language

barriers here were part of the story but, without the mediation of the social worker, the motivation to bring in an interpreter would not have been there, nor would it have been sufficient to overcome the resistance.

The next activity explores communication across difference in the context of disability. Here too the sense of boundaries is strong. It is not only a question of addressing the need for flexible communication skills, it is also an area where a reluctance to engage fully across difference can be compounded by personal defences about disability.

Activity 9.11 Reaching and learning across difference

45 minutes

Read Chapter 24, 'Disability and communication: listening is not enough', by Sally French and John Swain in the Reader. They discuss how disabling 'normal' communication skills can be. As you read, identify what the authors suggest could improve communication skills where there are differences to be bridged.

Comment

The key message here is about the importance of being sensitive to the other person and responding accordingly. They show how you need to think carefully about what may facilitate understanding (both ways) and, if you are not sure, then you should try to find out. Asking may be appropriate or it may not, but it is essential not to make assumptions. Be prepared to learn – and be prepared to spend time trying to develop your skills and awareness.

French and Swain also suggest that listening to disabled people has to be collaborative, so that the disabled person has more power. There needs to be a willingness to remove barriers and care workers need to be flexible in responding to the person's experiences and feelings in a genuine way.

Specialist skills or an interpreter may be necessary so that the person can properly say what their view is. If you have a visual or hearing impairment, you will know only too well how much skill and effort is needed to engage in communication effectively with other people. It is not too much to expect that people without such impairments should make some effort to extend their capacity to communicate with you. French and Swain challenge professionals to be sensitive, flexible and participatory in their approach to communication.

What about the midwife we met earlier? What might have helped her to shift to become a better communicator? Did she convey respect for the young woman's ideas about looking after a baby? We have looked at skilful communicating in this unit as a process that requires an awareness of the wider context, sensitivity to the other person's life world, and a readiness to be reflective about understanding yourself. It sounds a tall order for that particular midwife – and for many of us. However, if we return to a focus on the skills guidelines in Box 9.1 – maybe some basic communication skills training could have had an impact. She might have shown an interest by listening. She might have started by asking 'How are things going for you?', which could have begun the discussion on quite a different footing. From then on it would have been a different kind of learning experience for them both.

There are many ways in which people can learn and change and, despite the complex contextual and personal issues underpinning effective communication, developing some quite simple communication skills can be a powerful starting point.

Key points

1 Taking responsibility for appreciating and developing your own skills can be enabling for you and for other people. A technique such as appreciative inquiry can support and develop understanding of personal skills in its wider context.

2 Many interacting influences (resources we accumulate and carry forward) play a part in how we each communicate with other people. The more we understand these influences, the more effective we can become.

3 Other people are different. Working across boundaries challenges our fixed narratives about others but also about ourselves.

4 Conclusion

Communication skills are hard to pin down and to distinguish from concepts such as core conditions. They draw on different theoretical bases but often address similar questions. Here we took a skills focus and proposed that the effectiveness of communication skills lies in enhancing the other person's capacity to engage in the communication process. It is possible to identify and describe some core skills that are used in communicating successfully. These include concepts such as active listening, summarising and assertiveness among others. This unit proposed that such skills can be enhanced by increasing awareness, monitoring, reflecting, and seeking out and responding to feedback.

However, a recurrent theme was the *appropriateness* of the skills in context. In addressing this we saw that sensitivity to the other person's situation and perspectives is important. Equally important are awareness and reflection about your own issues. Exploring how such sophisticated skills can be developed suggests a number of potential strategies. Appreciative inquiry is a process that addresses the actions on individuals in wider social, organisational and cultural contexts. It also enables the individual to identify and build on positive experiences. As a facilitative process, it seems to mirror many of the core requirements of effective communication processes.

Communicating at all involves communicating across difference, with another person whose world of experience you cannot access directly. Sometimes such differences are more challenging and complex. Taking responsibility for trying to cross such boundaries can also be personally challenging. Essentially, this unit argued that developing effective communication skills requires us to address such personal issues and to develop our self-awareness. At the same time, however, it accepts that a simple starting point with the development of some core skills such as active listening can be just as powerful a starting point and can have a significant impact subsequently on the individual's self-awareness and respect for others. This unit took the optimistic view that change and learning are ongoing, despite our propensity to develop fixed narratives about ourselves and others, and that this provides a foundation for us each to work towards improved communication skills.

Unit summary

This unit suggested that a focus on skills can be useful for the following reasons.

The presence of core conditions may not in itself translate into skills. It can be helpful to monitor and develop skills too.

Improving skills through practice and reflection can promote the presence of core conditions.

Increased awareness of skills in the self and others – and in exchanges between people – creates opportunities for improved practice and personal development.

Examining the detail of skills within contexts focuses attention on diversity and difference: for example, communications where disability has an impact or where cultural or gender difference impacts on expectations about mechanics, style, and rules and techniques of communication.

Skilful communication can be used to enhance the other person's capacity to communicate, to be heard, to understand and to be understood in return.

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Unit 10

The emotional impact of communicating and relating in health and social care

Prepared for the course team by Anita Rogers
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Contents

You will need

- Course Reader

  Chapter 25 'Caring presence: a case study' by Joan Engebretson

  Chapter 26 'The sociology of emotion as a way of seeing' by Arlie Hochschild

  Chapter 27 'Divisions of emotional labour: disclosure and cancer' by Nicky James

- Anthology

  Extract 38 'The short life and death of Joe Buffalo Stuart' by Alexander Stuart and Ann Totterdell

  Extracts 21, 33, 39 'The memory bird: accounts by survivors of sexual abuse'

- Audio 3, Band 1 'Coping with emotions in health and social care'

Learning outcomes

After studying this unit you should be able to:

- Demonstrate systematic and critical knowledge and understanding of the emotional dimension of interpersonal communication and relationships.
- Reflect on the role of emotions in your own practice and experience of health and social care.
- Draw on and critically evaluate different approaches to the role of emotions in communication.
- Demonstrate how greater awareness of the significance of your own and other people's emotions could enable the development of practice in health and social care.

Introduction

This unit seeks to develop your critical knowledge and understanding of the emotional dimension of interpersonal communication and relationships. It does this by getting you to reflect on the role of emotions in your own practice and experience of health and social care relationships and by inviting you to draw upon and evaluate critically the different approaches to the role of emotions in communication. In doing so, you will be able to demonstrate how a greater awareness of the significance of your own and other people's emotions could enable the development of practice in health and social care.

Although the unit focuses on the issues of emotion, it does not advocate an unbridled approach that says 'I've got to get it out of my system *at all costs*'. Rather, it suggests that, in health and social care relationships, the individual, the organisation, even wider society, all have a mixed or ambivalent relationship with emotion: its presence or absence, the way it is expressed or not expressed, what a person should or should not feel, and who should express what and when. It also raises issues about what it means to care and whether caring can be separated from emotion. Moreover, it considers how much *emotion work* and *emotional labour* (terms which are explored later) have been taken for granted and undervalued.

While commonsense ideas of emotion might regard emotions as natural because of their location in bodily experience, this unit will enable you to tackle and better understand these issues theoretically. In addition, you will explore how the interplay of psychological and sociological perspectives impacts on an understanding of emotion. A psychological perspective suggests that emotions are pre-existing internal states to be expressed. In contrast, a sociological perspective (of which social constructionism is a variant) suggests that there is a two-way relationship between emotions as individual experiences and the wider culture. Thus, according to social constructionism, emotions are a product of social interactions and discourse rather than being merely reducible to biology.

In drawing upon these two academic perspectives, this unit will explore how individual and social worlds exist in dynamic and contradictory tension and how these create the world of health and social care.

To summarise, this unit addresses the following core questions.

Core questions

1 What is meant by emotions in the context of health and social care work?

2 How are identity and sense of purpose related to emotions?

3 What is the significance of emotional labour and emotional work to everyone involved in using and providing care services?

4 What are the costs involved?

5 What are some of the individual and organisational attitudes to emotion work?

6 What is the relationship between stress and burn-out, on the one hand, and people's attitude to and handling of emotion, on the other?

7 What are the implications for support and supervision?

1 Emotions in care work

1.1 Looking at the cost

Emotions are a significant force in health and social care. They engage service users and staff alike and consume effort, energy and investment. Many interactions and involvements in the work and experiences of care services are emotional, sometimes highly emotional. These 'emotional' involvements require an investment of energy and effort. The following activity suggests that there is a *cost* to emotional investment.

Activity 10.1 **Looking at the cost**

1 hour

We asked people involved in health and social care about the emotional dimension of their practice. Below is a summary of the account of a former care worker, which gives a retrospective account of her own experience of work over time. As you read it, please note down:

1 What emotions the person expresses.
2 Any emotions that emerge from you.
3 The unspoken, 'tacit' emotional rules that go with the role of care worker.
4 Any relationship you see between the worker's emotional life and her idealism and sense of purpose.

Emotions in care work: a care worker's account

I remember when I was involved in intense one-to-one contact with clients ... many each day. I began to feel that I was somehow the instrument, the tool that my very being was on the line every minute. The work required my undivided attention, following all the nuances in my client's verbal and non-verbal communication. I struggled to find the appropriate and helpful response at every turn because I was always acutely aware that these people had been trampled on so many times. Often I couldn't offer them anywhere near what they needed in concrete resources. At times all I could offer them was myself. I really do believe that many people find themselves in trouble because nobody cared.

I couldn't talk to anybody about it. I knew I would get 'social worked', colleagues telling me I was over-involved. Or, they would blame the client. 'Well, they got themselves into it anyway' type of thing. Or they would have a moan: 'Yeah well, we all know the system is lousy.'

So I was using my self and I felt used up. I envied people who could stand behind their knowledge, like an engineer, or behind their craft and not have to put their 'self' forward. I began to feel that each person I encountered wanted something from me urgently, and after a while it could have been somebody I met for two minutes in the hallway ... I felt they were taking another chunk out of me. They needed, wanted a piece of ME: not information, not an injection, not a referral, but a piece of me. I would start avoiding phone calls from some of my favourite clients, especially if I didn't have any more resource to offer. These were people who really did appreciate what I tried to do. I was idealistic. I wanted to

help. But I couldn't do enough or enough that mattered. I would go home feeling stripped bare.

My children tell me now that I looked after them well in a physical sense, but I was absent emotionally.

Comment

You may have identified with some of the emotions in this account, perhaps the frustration or the emotional 'overload'. Or you may experience things differently, either because you react differently or because your particular work situation is different.

We asked three course testers – a nurse on a surgical ward, a psychotherapist/drugs and alcohol counsellor and a care manager of a residential unit – to comment on the care worker's account.

You might have noted some of the issues that are highlighted in the account. For the care worker, the job and how she did it seemed to be wrapped up with her ideals and sense of identity. Both the care worker and the nurse also alluded indirectly to 'tacit rules': unspoken rules about how helpers should handle their own and other people's feelings in the workplace. The case study raises questions about the type, level and nature of support, training and supervision that is necessary to sustain this level of emotional work. The psychotherapist/drugs and alcohol counsellor referred to the degree of emotional demand that this work makes on him, and the lack of outside recognition and appreciation. The care manager took a slightly different view and commented on the need for self-awareness and personal boundaries and, although not stated explicitly, she drew upon a discourse that places responsibility for stress strictly on the individual.

If costs were the only aspects of care work, people would not engage in this area of employment. There are then also several benefits to such work and these are explored in the next section.

1.2 Looking at the benefits

Rewards also come with people's emotional investment in health and social care. These may take various forms; however, rewards often reinforce people's continuing engagement in the work. You may feel that the language of 'cost' and 'benefit' is a rather cold and pragmatic way to approach the topic of emotion. You may also notice that the language of reinforcement has embedded assumptions drawn from a behaviourist perspective, which was explored in Unit 4.

In the next activity you will consider an account that contrasts with the one in Activity 10.1. It highlights the rewards or benefits that may accompany experiences in health and social care.

Activity 10.2 **Looking at the benefits**

1 hour

Read Chapter 25, 'Caring presence; a case study', by Joan Engebretson in the Reader. This is an evocative reading that you may find distressing as it involves the death of a child. It is an account of a single event in the work of a student nurse. This is an example from an American setting and raises issues about the additional complexities of caring in a multicultural environment.

Comment

The chapter elicited different responses from the course testers. One person cried, another commented on the 'gift' in the form of support she received from a nurse who stayed long after her shift was over to help the woman who gave birth. Yet another felt empathy with Mrs Q's feelings and also cried when reading of the baby's death but also suggested that she found it useful to find an opportunity to talk about how she feels in situations like this.

The testers' responses highlight some of the ways in which responses can differ depending on individual memories and associations and the availability of support. The account also highlights how emotionally potent the actual experiences are for the people involved. The environmental support, and the 'culture' of acceptance, care and respect for the emotional aspect of the event, were pivotal in determining the quality of the experience for Brenda and possibly the subsequent memories and associations she carried forward into her life.

Clearly, events that happen in care agencies often touch everyone present deeply. This is particularly so in an experience involving the death of a child. There is another account written from a parent's perspective in the Anthology. It explores further the issues of explanations and managing emotions. You could read the extract by Alexander Stuart and Ann Totterdell (Extract 38) now or at the end of this unit.

1.3 Comparing and contrasting costs, benefits, purpose and motivation

People who do caring work have a mixture of motives for doing so

The next activity suggests there is a relationship between costs, benefits and the sense of purpose and motivation that underlies people's choice to involve themselves in caring for others.

Activity 10.3 Comparing and contrasting costs, benefits, purpose and motivation

45 minutes

Look again at both the account of the former care worker in Activity 10.1 and your notes and reflections on Brenda's experience in Activity 10.2.

Make notes on the following points.

- Compare and contrast the costs and the benefits to the emotional investment each of the practitioners made.
- Think about how their sense of purpose, motivations and ideals were tied up with the emotional investment each of them made.
- Consider briefly some of the personal and contextual elements that may have made a difference. These might include, for example, the type of support and supervision that was available, the expectations placed on each of them by colleagues, the length of time they had been in the role, the attitudes of each workplace about the appropriate handling of emotions.

These are quite demanding issues. Attempting to respond to them will help provide you with important links between emotion, motivation and the context.

Comment

This is what one course tester said.

> *In both accounts the workers are involved and invest emotionally in their work – the first over a long period of time, the second over one day. In the first account, the worker felt burnt out, in her words 'used up'. She began avoiding contact with clients and even everyday encounters with others began to feel like too much and her children found her 'emotionally absent'. The cost is less obvious in the second account – perhaps initially a feeling of inadequacy and being uncomfortable at being so intimately involved in another person's pain. She probably felt drained at the end of the day. The rewards for both, apart from being paid and being in a socially valued job, would be a sense of fulfilment at being with another person in their time of need – feeling that what they did and their presence made a difference in the life of another. Brenda describes her day as having a profound effect on her and reaffirming her decision to go into nursing. I wonder – could the first care worker also point to days like Brenda's that affirmed her career choice for her?*

You also may have considered that the first account describes a practitioner's involvement over several years, while the second one is about a single event in which the key practitioner is a student. You may have observed that the first account describes the erosion of emotional energy that happens after many years of work in unrewarded and under-resourced circumstances. The second account describes high drama, where the whole environment participated in the intensity of a life-and-death event, whereas the environment in which the care worker practised seemed less supportive and more jaded. You may also have noticed that both practitioners had the desire and the intention to give their emotional energy as part of the caring process, while also seeking some fulfilment and satisfaction from that effort. One achieved it, the other did not. The care worker's expectations did not match the possibilities for fulfilment, while the student nurse could recognise that her presence was the most valuable offering she could make. The two accounts highlight similarities and differences in the following respects.

- *The significance of the practitioners' sense of purpose, identity and expectations to their emotional investment.*
- *The role of support and supervision in the emotional dynamics of the workplace.*
- *The ways in which emotions are validated or suppressed in the interaction between individual and organisational attitudes, and the ways in which this is expressed verbally and non-verbally through practices and procedures.*

The next section begins to explore the ways in which different theoretical perspectives bring into question both the origins and the meaning of emotions. This has implications for how emotions are handled in health and social care.

Key points

1 Emotions are significant, complex and sometimes unacknowledged factors in many activities in care work.

2 There are both costs and benefits to any emotional investment.

3 How the environment handles emotion can have an impact on the people involved, possibly determining levels of motivation, commitment and long-term associations and memories.

2 Different theoretical perspectives: definitions and implications

In order to understand the different theoretical perspectives on emotion, it is necessary to answer the question 'But what are emotions really?' This question is important because *how* emotions are defined can affect significantly how they are handled. For example, one definition of emotions suggests that they are innate and universal forces. This might lead us to conclude that emotions are the same for everybody in the sense that they are independent forces beyond an individual's control. A biological or physiological approach to emotions might also suggest that they represent a state of arousal – a form of neutral energy. It is, therefore, the meanings given to these neutral energies by culture, context, the individual, group or wider society that, subsequently, determines actions and responses.

The cognitive psychologists Mick Power and Tim Dalgleish (1997) examined the possibility that when feelings are labelled or named, such as the emotions of joy, sorrow and love, they assume social significance or meaning and then become subject to cultural and political forces. In contrast, the sociologist Jeff Hearn (1993) suggests that if we adopt a discursive analysis, this enables us to explore the issue of emotion within the context of gender and power. Seen from this perspective, emotion is not simply a physiological experience; rather, how we deal with emotions can be understood in a variety of socially constructed ways. Thus Power and Dalgleish point out that disgust is classified as one of the five basic emotions along with anger, sadness, fear and happiness. Dawn Freshwater and Chris Robertson (2002) note that disgust at a basic level invokes recoiling from something unpleasant. (You might already have noted that what produces 'disgust' in an individual is subject to social and cultural variation.) However, as Power and Dalgleish point out, in social contexts, disgust can also act as a social control mechanism as this particular emotion is one of the most powerful ways of transmitting cultural and moral values.

Beware, too, of taking at face value the idea that there are five basic or primary emotions. As Thamm (2007) notes, scholars from Aristotle onwards have tried to isolate which emotions are 'basic' with varying results. The Enlightenment philosopher David Hume argued that there are merely two, while Aristotle argued for 15. It is this problem of identification, added to the fact that not all emotions are necessarily present in all cultures, that leads social constructionists to challenge the idea that there are any 'basic' emotions.

Activity 10.4 **The memory bird**

45 minutes

Read the accounts in 'The memory bird' in the Anthology (Extracts 21, 33 and 39), which were written by survivors of sexual abuse.

Choose three accounts and note down the emotions each person experienced and whether they could express them.

Note what blocks there were to doing this and whether this was experienced as helpful or not.

Comment

For most of the writers, 'telling' or 'talking about' their experiences was very emotional for them and it was made more difficult by the way other people 'blocked out' or denied the emotions they were expressing and even their realities. Emile Bird (extract 1) finds expression of emotion through dance and dreams. In extracts 2, 3, 4 and 5 the lack of empathy and the insensitivity of professionals increases the hurt and

pain the women had already experienced but have 'survived'. Extract 6 shows how 'labelling' and putting people's emotional experiences into culturally or medically defined boxes can make it difficult for a person to define their own truths and realities. As noted in Unit 4, psychodynamic perspectives emphasise that the unresolved or unexpressed emotions can cause difficulties for individuals who want their emotional experiences acknowledged and accepted. This is why there is such a focus in psychodynamic literature on helpers being open to their own emotional experiences as well as other people's.

Thus, psychodynamic and humanist theories make the exploration of emotion a priority and suggest that unresolved emotional issues are the heart of many interpersonal difficulties. As you noted in Unit 4, psychodynamic theories place great emphasis on the resolution of emotional difficulties in the present that have originated in early childhood: the therapeutic focus, therefore, is on resolution of the childhood problem. In contrast, humanistic theories are mainly concerned with emotion in the context of the 'here and now' life situations and emphasise individual responsibility for action and personal control. The implication for this view might be that 'bottling up' or surprising emotions is harmful and they must be 'let out'.

This section explores further psychological, sociological, political and historical explanations of some current attitudes towards emotions in health and social care. These include gendered and cultural perspectives in the experience and expression of emotion. This exploration then leads to an analysis and critique of the balance between individual and collective points of view at the end of this unit.

Activity 10.5 The sociology of emotions

1 hour

Read Chapter 26, 'The sociology of emotion as a way of seeing', by Arlie Hochschild in the Reader. She explores one episode or 'grain of sand': a young woman's emotions on her wedding day. Using this illustration as a platform, Hochschild explores the social and cultural constructions of love; the merging paradoxical relationship of love, marriage and the family; the increasing tendency to manage feelings; and how the act of managing feelings partly creates feelings.

As you read the chapter, make some notes on what Hochschild says about:

- How feelings can be the result of social and cultural influences.
- How a cultural dictionary plays an important role in determining what people feel.
- How emotional culture and the social context may contradict and present a paradox.
- How emotions can take on the properties of capital leading to emotional management.

Comment

The chapter may have prompted you to identify some of the elements that brought you to the particular feeling you had in a given circumstance. Perhaps you thought about your expectations, the emotional dictionary about what is permissible, the costs and benefits of feeling what you felt. You might have thought about alternative feelings you could have had. Working within health and social care highlights some of the tensions between psychological and sociological perspectives on emotion and prompts critical reflection on three important issues. First, the relationship of emotion to care work as expressing something 'deeper, more instinctive' which relates to values, beliefs

and commitment to life choices. Second, the role that cultural conditioning plays in the way we understand and experience emotion and, third, the role that language plays in the way emotions are perceived and handled.

2.1 The management of emotions

You studied the significance of context in Block 1, Unit 2. You may remember how people make sense of and give meaning to the world around them, their experiences and even their emotions by placing them in a context. Garfinkel (1967) refers to context as an 'index' and his theory of 'indexicality' refers to the process through which people make sense of any object or activity by considering and interpreting the context within which that object or activity is based. According to Garfinkel's interpretation of reality, in their everyday lives people take account of their feelings or behaviours with reference to a particular context or situation. Using indexicality, people become skilled at negotiating and communicating within different social situations and this helps maintain order in the messiness of emotional reality.

This process of indexicality not only explains why people feel the way they do but also helps bring order to the management of their emotion. Think about Engebretson's case study in Chapter 25 of the Reader (Activity 10.2). Consider how both Brenda and the other nurses 'indexed' the last hours of Mrs Q's baby in order to support her and manage their own feelings. Although staff were ostensibly going about their usual medical routines checking, assessing and monitoring all the babies in the unit, they observed unspoken 'rules' by not intruding into the space where Mrs Q, her baby and Brenda sat unless it was absolutely necessary, they moved more slowly and with care, they took care to reduce the noise, spoke softly to reduce the hectic atmosphere and created what Engebretson describes as an 'aura of dignity' (p. 283).

Similarly, the sociologist Erving Goffman (1959) developed the 'dramaturgical approach', which provides a useful conceptual framework for understanding how emotions are managed, particularly in health and social care contexts. Goffman characterised the social world as being rather like a drama (hence the term 'dramaturgical approach') in which everybody has a role or part to play. Individuals put on a performance (which includes managing their emotions) in order to manage the views of impressions that other people have of them.

For example, I, Eileen Oak, remember when my father (who died in 2003) was diagnosed with myeloid leukaemia and the consultant came to tell him that he had only three weeks to live. He made eye contact and showed my father the charts pertaining to his test results and spoke in quiet, unemotional, matter-of-fact tones. In this way you could not tell whether the consultant was angry, stressed, happy, sad, indifferent or even fed up (as presumably this unpleasant task was a regular part of his role). It was simply that the consultant was playing a professional role and this was how he managed his emotions and conveyed what he thought was the right impression associated with his role.

Key points

1 Sociological perspectives suggest that the ways in which emotions are defined and handled are determined by cultural contexts.

2 A psychological perspective treats emotions as innate, internal and independent entities and believes that unrecognised and unexpressed emotions can be problematic.

2.2 History, gender, culture, power and emotion

Unit 7 referred to the role of the body in communication, specifically the importance of touch in 'emotion work'. It cited Julia Twigg (2000), who refers to the ambivalent nature of care work due to its association with the body and dealing with difficult areas and taboos. In western society, emotions, because of their association with the body, are often treated with mistrust, or fear of being out of control or being associated with the baser, animal side of human nature. Since the beginning of the periods of Enlightenment, there has been a long history in European and American cultures of privileging the mind over the body or reason, and science and technology over emotion.

The work of feminist scholars and theorists has explored the development of the dichotomy of mind/body and its close link with another dichotomy – male/female. A particular consequence of women's association with emotion has been their secondary status within western culture. Jean Achterberg (1991) traced the turbulent history of women's involvement with health and as lay healers through the ages. She asserted that the contradictory and contested nature of women's voice and power is linked to the belief system of a culture that determines who has power and honour.

Drawing on several anthropological studies, Achterberg describes the erosion of women's influence and power in health care as beginning to take place before the common era. The emphasis of the Age of Enlightenment on reason over emotion and the privileging of science and technology in health care reinforced that erosion. The contemporary world of health and social care continues to experience this 'split' between masculine reason and feminine emotion.

> 'Woman as healer' is antithetical to the cosmological structure that binds the Western world. Throughout civilization, scientific, civic, and ecclesiastical bodies have closely watched the activities of women healers. Vigilance has been followed by legal restraint, persecution and finally by the enactment of laws and customs that prohibit women from practicing publicly.
>
> *Achterberg, 1991, p. 3*

According to Achterberg, what has prevailed through the ages is the myth that associates the beliefs, behaviours and capacities of women with intuition, nurturing and compassion, together with the idea that these capacities are separate from the work of curing. Since the 19th century, 'curing' has become aligned with scientific rationality (Meyerson, 1998). So we can begin to see emerging the historical, cultural and gendered story of the current ambivalent relationship with emotion in the work and workers in the caring professions.

In a similar vein, Jeff Hearn (1993) is a British sociologist who writes about masculinities and emotions and Debra Meyerson (1998) is an American feminist scholar who studies emotions in the context of medicine, organisations and stress. Both Hearn and Meyerson suggest that emotions are often identified within the discourses of gender. They assert that in the cultures in which men dominate, men are 'constructed' as unemotional relative to women. However, Hearn points out that such a crude dichotomy to describe the differences between men and women is too simplistic because he challenges the idea that it is possible to give a watertight definition of emotion. Rather, he suggests that it is more important to understand how the idea of emotion is used. In relation to

this point, he suggests that men are far from unemotional, but they are expected to display different emotions from women:

> An alternative construction is that men are too emotional, too much out of control (or indeed too much in control) especially when it comes to anger, sexuality and violence.
>
> *Hearn, 1993, p. 143*

Meyerson claims that gender is the 'axis of relations and power'. She and Hearn are united in the view that men have dominated the *organisation* of health and social care. Men's presence in the organisation of these arenas symbolises organisation; organisation symbolises power and this includes power over emotion and emotion work.

Of course, gender is not the only factor that mediates emotion. As suggested in Unit 6, other factors such as age, ethnicity and status play important roles in determining who controls and expresses emotion.

2.3 Emotional labour and emotion work

Recent work on the concept of emotional labour has illuminated how the historic, cultural and gendered treatment of emotion plays out practically in the arenas of health and social care.

According to Hochschild, an individual's ability to manage emotion is based in her or his expectations of others. One might ask oneself, how should I behave in this situation? In this way, emotions are not fixed, but open-ended, and

subject to social context and to social control: there is nothing 'natural' about emotion here. The social context typically includes the expectations that derive from a person's role in society. The most significant aspect of Hochschild's theory is that emotion is interpreted in part as a commodity so that, in certain occupations, the emotional response of the employee is part of what is being sold. Certain occupations demand particular emotional responses, which might include the expression or suppression of particular emotions. Therefore, individuals have to make judgements about what emotions it is appropriate or inappropriate to express. This is what Hochschild called acting, and she distinguished between two types: 'surface acting', usually associated with body language and which includes such things as sighs, shrugs and facial expressions, and 'deep acting', which refers to a response that induces real feelings.

The article by Hochschild you read in Activity 10.5 emphasises the social and cultural influences on feelings and how they are defined. She argues that the paradox between social context and emotional culture can lead to acts of emotional management defined as 'an effort by any means, conscious or not, to change one's feelings or emotion' (Reader, p. 253).

> [Emotional] labor requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others – in this case, the sense of being cared for in a convivial and safe place. This kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality.
>
> *Hochschild, 1983, p. 7*

Since Hochschild's research, other scholars in the field have defined emotional labour. A nurse educator, Nicky James, comments further on emotional labour:

> The phrase 'emotional labour' is intended to highlight similarities as well as differences between emotional and physical labour, with both being hard, skilled, work requiring experience, affected by immediate conditions, external controls and subject to divisions of labour ... Emotions that are not acknowledged – whether our own or those of others – may be denied or suppressed, but full emotional labour involves working with feelings rather than denying them ... Emotional labour is an integral yet often unrecognized part of employment that involves contact with people. ... [Many researchers] have noted that although male-dominated professions, such as medicine, may define the limits and action of emotion for other workers and clients, the problems of dealing with emotional control are primarily located through others.
>
> *James, 1993, pp. 95–6*

You may want to consider at this point whether emotion work and emotional labour are the same. Everyone involved in the worlds of health and social care, whether as service users or as providers of care, probably engage in emotion work. Experiencing emotion and expressing emotion, in whatever ways they are constructed, involves some kind of effort. The term 'emotional labour' as it is defined in research in health and social care has additional dimensions. It involves the skilful management of emotions in an employment setting.

Activity 10.6 **Bill – a case study**

15 minutes

As you read the following case study, make notes on what kinds of emotions seem to be in play here. Who expresses them and how?

Bill

The nurses told me the night before not to get worried. Bill would be in intensive care and I'd see all these machines and everything. But not to worry that was normal. They warned Bill as well. Well when I went in the afternoon ... he was sitting in a chair. And I thought, that's odd. And I said to him, 'Have you had the operation?' 'Yes' he said ... He said, 'Well I can tell you they found something, but don't say anything' ... Well me and my son went in [to see Sister] and sat down. And she said that she was very sorry to tell us there was nothing they could do for Bill. They had operated, they had put this tube in, and he'd think he was getting better for a while because the food will pass through. She said, 'I'm afraid we found a growth at an advanced stage.' She wasn't supposed to have told me. ... Anyway it didn't sink in what she was saying. I'd been told by all the doctors, no, no, no [i.e. it's not cancer]. And my son was cringing because he knew that she wasn't supposed to tell me.

I think he'd gone and had a word with one of the doctors without me and Bill knowing. And this particular doctor had said to my son Robert ... 'Don't tell your mother. The surgeon has to see her himself.' And my son and I came out, and I didn't say anything to Bill, naturally, and he was all right.

When Sister finished with me a doctor walked in. And one of the staff nurses said, 'Did you do Bill Jenkins' operation? This is his wife and son.' And the doctor said, 'I can't tell you much about it because the surgeon will have a word with you, he'll explain better than I can. But I don't want you to think things are worse than they are.' You see, they're still telling me now that everything is all right, but meanwhile, the Sister had already said ... but I didn't say anything.

So I went back up but my son followed the doctor ... and they went into his room. And my son said, 'You're holding something back and I want to know what it is.' 'Well, you see, I'm not supposed to tell you in front of your mother,' the doctor said ... I just don't know why, I was his wife, I should have been told. Perhaps they thought I couldn't take it, I don't know ... We came out of the hospital and my son said, 'Now look Mum, don't go thinking the worst, don't go thinking now there's cancer there.' He said, 'Dad's going to be all right.' Now he is saying this because of what the doctor had told him. 'Well, anyway,' I said, 'whatever it is, the surgeon will tell us tomorrow.' We went in the following day. Fortunately Bill didn't see me. We went round to a little place to see the surgeon. He said he'd operated and fixed this tube in and that there was a huge growth by the side of it. And he said, 'I'm glad I've proved myself right, but I'm sorry that he's got cancer.' He said, 'I felt it all the time, but it wasn't showing up on the X-rays.' So of course when they operated they discovered it was more than there, it had risen right up, the cancer, gone right up. And never a pain but terrible discomfort. ... I still couldn't believe it. My mind was blank. And yet, looking back, I had a feeling there was something ...

Mrs Jenkins, aged 67, widow

(Source: James, 1993, pp. 94–5)

Comment *Note that emotions are hardly mentioned in this account. Yet most people who have had a serious illness or a relative with a serious illness will know the intense feelings of fear, worry, disbelief and frustration that accompany such a situation. You may be asking where they are in this account.*

The following activity will help you to address this question.

Activity 10.7 **Divisions of emotional labour: disclosure and cancer**

1 hour

Read Chapter 27, 'Divisions of emotional labour', by Nicky James in the Reader. As you read, make notes on the following.

1 What elements of context form the divisions of emotional labour?

2 In what ways is disclosure a negotiated process?

Comment *James considers that the term 'division of labour' is helpful in understanding that there are a whole range of people involved in disclosures around cancer. She lists these people and argues that each one will have different feelings about cancer and will manage emotions differently. Furthermore, despite the hierarchy within the system of health care and the formal duties of disclosure that rest with the consultant, it is those people who have to manage the intensity of emotion on a daily basis who carry the greatest burden of emotional labour.*

Certainly, the division of emotional labour is part of the process of negotiation, but at its simplest disclosure of diagnosis is not a one-off event. The history of cancer as a metaphor for death, individual experience and the way in which the news about this disease is given and by whom all affect the way that it is understood and managed. Not only do care staff set the context within which feelings are managed, but also people with cancer and their family and friends continue to perform the ongoing work of emotional management. People with cancer are not passive recipients of bad news. As James's study illustrates, individual roles can be subject to individual negotiations.

James argues that the health care staff have a key role in shaping the division of emotional labour because they have control over the context through routine and ritual, unwritten rules, status and organisational role. The use of space and time, control of knowledge, and gender-divided labour all shape who is permitted to say what to whom and how feelings are expressed. You have already explored some of these contextual elements, such as the use of space and time, in more detail in Unit 2.

The consultant shaped the emotional agenda through his technical knowledge and assumed role in giving the diagnosis. Until the nurse gave the family information against the rules, the consultant's agenda pre-empted discussion of any authentic emotions associated with a diagnosis. All except the sister silently collaborated in secrecy and denial. All staff were involved in 'keeping the lid on' and avoiding emotional outbursts.

James also makes the case that role and status provide control of the emotional agenda. The emotional labour that results from that agenda is carried out by those with less status and power.

The next activity builds on the work you have been doing on emotional labour and introduces the notion of everyday 'talk' about emotions in care environments.

Activity 10.8 Looking for clues to emotional attitudes in everyday talk

45 minutes

During a brief period of time, perhaps a morning or an afternoon, look for clues to attitudes in everyday talk in the care setting you are most familiar with.

You may want to consider you, your fellow service users, co-workers, friends and/or family members.

1 In what contexts are emotions talked about?
2 Note which emotions are privileged in talk by whom and when.

Comment

One course tester who works in social care responded with the following table.

In what contexts are emotions talked about?	How are they expressed?	Who expresses them?	Which emotions are privileged? By whom?
Discussing clients	Through speech, body language	Members of staff	Sadness, happiness (colleagues)
Interviews with clients	Through speech, body language, facial expressions	Members of staff, clients	Crying, anger, annoyance (by clients) Sympathy, reassurance (by staff)

This tester seems to suggest that in her workplace emotions are the subject of 'talk', both with colleagues and with service users. It is difficult to determine any clear discernment between differential or deferential expressions of emotion. However, even in this small example, there is some suggestion that 'clients' are seen to 'privilege' the expression of anger and annoyance, while 'staff' privilege 'acceptable' or appropriate emotions such as sympathy and reassurance.

This response may leave you wondering what happens to the possible anger and annoyance that staff may experience.

The next activity explores how one group of service providers deals with these emotions.

Activity 10.9 Coping with emotions in health and social care

40 minutes

Listen to Audio 3, Band 2 'Coping with emotions in health and social care'. This explores what three nurses – two women (one of whom is the head of the department) and one man – say about the role of emotions in that setting and how they cope.

This is a rich, 'live' resource that picks up on many themes discussed in this unit. The nurses mention a whole range of emotions that occur during their daily work. They talk about vocation, how they have chosen the work, and what it means to them. They discuss the tensions between getting the task done and the feelings they have at a given moment, and the tough choices and decisions that have to be made. They talk about how care is constructed and expressed in different ways depending on the setting, and the emotional flexibility that is required.

As you listen, make notes in response to the following questions.

1 Which emotions are expressed more often than others?
2 What kinds of situations seem to trigger an emotional response?

3 How do the various staff manage their emotions and what is their role or position in the department?

4 How do the various staff cope with emotion?

Comment

All three practitioners – Claire, Norman and Sister Christine Edwards – describe an intense focus and concern for the wellbeing of their patients. Claire describes herself as a very emotional person. However, you can hear in the interview how she tempers her emotion and continually exercises judgement about the 'appropriate' expression of emotion. Sister Edwards, who has worked abroad for many years, describes cultural differences in the way emotions are handled. For example, she describes Americans as being more inclined to put their emotions on the table and sees that as quite constructive and wishes she could be more that way. She also describes the difference in expectations from patients about her level of personal involvement being a practitioner in a small Welsh community.

Norman also highlights the emotional adaptability required in moving between a military culture and the culture of this community. Caring is expressed differently. Norman mentions the division of emotional labour when he says that the consultants and doctors tend to leave much of the emotional work to the nurses.

The division of emotional labour was apparent in the way emotional expression and support were constructed in the department. Claire and Norman felt they could turn to Sister Edwards for support; she seemed to feel it necessary in her role as leader to control her own emotions. Her major source of support is outside the workplace.

Is it possible that the role of department head aligns Sister Edwards with the masculine construction of emotion?

Key points

1 Emotionality – that is, the experiencing and expressing of emotion – is effortful.

2 Managing or regulating emotion adds an extra layer of cost.

3 Emotion work and emotional labour are unacknowledged, undervalued and unappreciated.

4 Attitudes towards emotion and handling emotion are subject to power structures, and are often gendered.

2.4 The tensions of paradoxical 'feeling rules'

Dawn Freshwater and Chris Robertson (2002) write about how the gendered discourse reinforces a continuing dual view on emotions. They represent a psychological view of emotion as a force that must be expressed and describe emotions as the 'Cinderellas of the psyche' (p. 5), the poor cousins of rationality.

The presence of emotion has been seen as a barrier to thinking, but a psychological, psychotherapeutic perspective suggests that, on the contrary, bypassing difficult emotions demands an enormous investment of energy.

Both psychological and sociological perspectives have encouraged increasing attention to defining emotion, and to the role and the impact of emotions in the work of health and social care. None the less, the average workplace presents a far from unified view about expectations concerning the experience and expression of emotion. Table 10.1 gives some examples of typical 'talk' reflecting underlying attitudes and beliefs and 'feeling rules'. Hochschild (1983) provided early discussion about feeling rules, which has been advanced by the work of some of the researchers and writers drawn on in this unit, such as Hearn (1993), Smith and Gray (2000) and Fineman (1995). Feeling rules are the rules of a given culture that tell people how they should handle emotions and feelings and perhaps even what emotions they should experience. These 'rules' are often unspoken but are conveyed through the usual mechanisms of culture, such as rituals, processes and procedures. Culture can be quite local, such as the culture of an organisation, or broad, such as national culture. Emotional labour involves explicit feeling rules that have been part of the professional helping world for a long time. For example, clergy are expected to show compassion; probation officers are expected to work sympathetically with clients.

Table 10.1 Paradoxical feeling rules

Emotions are important and useful	Emotions get in the way of the work
Emotions alert us to different ways of working	It is important to keep professional at all times
There is a therapeutic benefit to developing interpersonal relationships	Showing emotions is a sign of weakness and can upset the patient or client
Talking about emotions is part of the job	You cannot afford to let emotions get the better of you when you are trying to allocate resources
You can communicate with a patient just by looking at them and taking their hand	Doctors are trained to put their feelings aside to do the real work of medicine
They will feel better talking about their worries	Feelings can get in the way when you are trying to make a diagnosis of a patient

(Source: adapted from Smith and Gray, 2000)

Table 10.1 juxtaposes feeling rules that say emotions are important and useful resources with feeling rules that say emotions get in the way of the work at hand. The realities of any given workplace can also be more subtle and mixed, as you will see in the next activity.

Whether your workplace encourages or discourages discussion about emotions, the routines, rituals, structures and processes often stand in the way of supporting emotion work. How the workplace discussion about emotion is handled impacts on service users and staff alike, as the account in the next activity demonstrates.

Activity 10.10 Tension and conflict

20 minutes

Read the account below of one day in the life of a nurse. It is taken from a report on emotional labour in nursing by Pat Smith and Benjamin Gray (2000).

A nurse's account

I felt I had let patients down most of the day ... I came away just feeling that it was a horrible day and I had to sit back and reflect on what areas I did do that day ... We had another admission and there was a woman dying ... The woman had not spoken to her family for about two years ... I had to work through the emotions on the phone with the woman's daughter and also go back to the carer and talk about it as well ... Bring them back together ... So I went back to the daughter and she seemed willing to come in. I walked her daughter in and she sat there ... and gave her a big cuddle and my eyes just filled up ... I just felt totally behind with everything again and that is why I ended up thinking it was a terrible day ... I did go to the nurses' station but there was so much going on ... They were kind of with me ... But everyone was so busy and had to get on with their own work ... I never understood it but I am just wondering if those pent-up emotions over the busy periods are not being dealt with and that is manifesting itself as conflict with teams and just general anxiety and stress retention.

(Source: Smith and Gray, 2000, p. 65)

Keeping in mind Table 10.1, make notes in answer to the following questions.

- What points of tension and conflict do you see in this account?
- What mixed messages did the nurse receive from her work environment?
- What are the costs or benefits of emotional labour?
- What theoretical perspectives can you see you in the nurse's belief system?

Comment

The nurse felt compelled to respond to the circumstances with immediacy and emotion. While she could acknowledge the benefits of her emotional labour investment (for example the reunion of the mother and daughter), that investment seemed to be diminished because of all the other work responsibilities and pressures that were left behind. She had a sense of support from other people, but they were too busy with the running order of the day to offer her effective support. She reveals a psychodynamic perspective when she reflects on the possible ripple effects of denial and repression as she is left with the emotional residue of the situation.

So, here is an example of how what people say is important can differ from or contradict what they actually do, and some of the implications of those contradictions. Emotion work, emotional labour and emotional involvement may be acknowledged or even invited as important elements of care. However, the real way things get done around here reveals the structures, processes, expectations and ways of working that diminish or prohibit the valuing of emotion work.

Hochschild's work on emotional labour exposed another fundamental contradiction: the dilemma of paying people to offer emotional care, which blurs the divide between authenticity and sham. This raises again the issue of whether care can be separated from emotion.

2.5 Policy's contribution to shaping the emotional environment

Unit 3 explored the role of policy in shaping communication and relationships in health and social care. This section touches very briefly on the role of policy in shaping emotional demands. Policy has dictated new approaches to 'befriending patients'. Partnership working with clients and user involvement require the development of interpersonal relationships. This intensified requirement to form interpersonal relationships may blur boundaries and increase the possibility of emotionality. Within these relationships workers may be asked to do 'surface acting' or 'deep acting', terms introduced by Hochschild (1983) in her early work.

The professional 'demeanour' is part of 'surface' and 'deep' acting

Workers may be asked to do some of both. Surface acting involves playing a role: smiling, talking and behaving in ways appropriate to the culture of that workplace, whether workers feel that way or not. Deep acting requires workers to experience genuine positive regard, and to suppress negative emotions and behaviours, while clients, users and patients have no obligation to repay staff emotion through reciprocal displays of emotion.

People engaged in surface acting can maintain a healthy detachment which fails when they no longer have control over the pace of work. In other words, the mask cracks when the tension between inner feeling and outer display becomes too great. Behaviours that may be labelled as signs of stress can result. For those involved in deep acting or, indeed, in authentic emotion work, feelings can take over all other private feelings. People eventually become deadened, losing the capacity to feel and respond emotionally, demonstrating what is often called *burn-out*, as in the former care worker's account at the start of this unit. So, in situations where the demand for emotional labour outstrips resources, stress and burn-out may occur.

Doing additional emotion work through deepened and increased contact and emotional labour by selectively presenting emotion, or negating emotion, are not just matters of individual choice or personal decision. They are also social matters as emotions are regulated by health and social care services. While there are paradoxical feeling rules, which in and of themselves cause tensions and strain, the call to increase emotion work and emotional labour within current conditions may contribute to stress and burn-out.

Key points

1 There are 'tacit' or unexpressed 'feeling rules' in many environments about the role of emotions.

2 These feeling rules can be contradictory and confusing.

3 Complying with feeling rules requires emotional labour and when demands for emotional labour outstrip resources stress or 'burn-out' may occur.

2.6 Stress and emotion

There are costs associated with emotion work and emotional labour. 'Stress' is a label often given to the personal costs exacted by emotion work and there are many different definitions of it. Defining the nature and the causes of stress is problematic. For example, stress can be seen as a physiological response to environmental conditions.

Often an individual becomes aware of these physiological responses through emotion. These responses are given emotional names such as anxiety, anger or depression. These 'emotional' responses may lead to behaviours that are not within the individual or organisational 'norms' and can lead to a 'diagnosis' of stress. Some of the literature suggests that stress occurs when the demands of the environment outstrip the resources available or when the demands of emotional labour outstrip personal resources, as Arlie Hochschild (1983) and Pam Smith and Benjamin Gray (2000) have noted. Others emphasise the role of cognitions or thoughts in the creation of stress, including cognitive behavioural psychologists such as Aaron Beck (1993) and Richard Lazarus (1966, 1991), and positive psychologists such as Martin Seligman (1998). Sociologists such as Stephen Fineman (1995) and Tim Newton (Newton et al., 1995), whose views are explored in the following sections, take an interpretive approach to understanding stress. In other words, 'It all depends on how you look at it.'

In the next activity you will consider the issue of stress in relation to your current environment, whether in your own home or the workplace, and whether you are currently a service user or a service provider.

Activity 10.11 **Defining stress**

5 minutes

Pause for a few minutes and think about 'stress' and what you mean by stress in relation to your current environment. As you will notice in the following comments, it does not have to be a work environment but any environment in which you are involved in a care role.

Comment

A course tester gave the following response.

> *Stress is a form of physical or emotional strain that can vary by degree and over time. Stress is a necessary part of life but becomes a problem when it becomes distress.*
>
> *To me, stress is when too many demands are made of me – more than the resources I have to offer. But it is not always down to work – having young children, relationship difficulties, family problems, financial worries, health worries, all take their emotional toll as do lack of sleep, interpersonal difficulties at work, neighbourhood disputes. Then add to these an emotionally demanding job. This is when the demands can outstrip*

the resources. But I think it is about managing the demands whether they be about work or other areas of life – learning to meet challenges rather than dealing with them ostrich style, 'head in the sand', as I tend to do, learning to say no, to delegate, and to find the support I need.

This tester talks about stress resulting from an overload of activity without sufficient resources to handle the demands. I found it significant that the demands are not all quantitative. Several demands mentioned are 'emotional' demands such as worries and interpersonal difficulties. I also found it significant that the tester reveals a completely individualised perspective on handling stress: that is, he sees it as his personal responsibility to manage the stress; better still, to prevent stress by learning to say no, delegating and finding support. However, you may know from personal experience that it is not always possible to say no, to delegate and to find support. Power, status and role – they all have a bearing on whether you have the capacity to manage your stress in these ways. Finally, the tester suggests that stress is something to be avoided.

Different environments handle stress differently. In the context of health and social care, environments generally recognised as highly stressful include child protection work and working in an accident and emergency department. What is it about these environments that defines them as stressful? Meyerson (1994) examined attitudes to stress and its management in two different social work settings. Social workers who worked in an acute hospital setting treated stress as an aberration, pathologising and individualising it, so that a person suffering stress 'was not taking care of himself properly', or 'got too involved', had to take sick leave, or go off site for stress management training.

Social workers in a community setting perceived stress as part of the normal ebb and flow of difficult interpersonal work and treated a person suffering stress with understanding, concrete support and, rather than excluding the person from the workplace, developed flexible ways of working.

Activity 10.12 Stress in the workplace

20 minutes

Take a few minutes to consider how stress is handled in the workplace. You may not currently be in work but you might be a service user, for example. However, if you have had encounters with people who are involved in the workplace you may be able to discern how people talk about stress and people who are suffering stress. You may even have some clues from conversations about how a workplace accommodates stress. Who defines what is stressful? Who defines stressful or stressed behaviour? Alternatively, if you are not in work, examine your home environment in the light of these questions.

Comment

You may have noted that if someone behaves in a way that signals they are suffering from stress, they may be treated with less respect than usual. For example, they may be challenged more about their workload, to see if they are pulling their weight. They may be more irritable and in turn generate irritable responses. They may not be able to focus on tasks and may exasperate others. If a person is visibly overworked or has a particularly difficult workload, these behaviours may be attributed to stress. Some workplaces may make a concerted effort to attend to this. Others will continue to push the person. Some workplaces, through their policies and procedures, may accommodate stress very generously, granting 'stress leave' once a person has reached the point of not being able to function day to day.

Stephen Fineman (1995), a researcher on emotions in organisations in the UK, notes that different stakeholders define stress differently. Management may see stress as a maladaptive person/environment fit. A union may define stress in terms of poor working conditions, lack of control over work, or overload. Both these perspectives define stress in terms of where to place responsibility for it. Fineman proposes that, in general, the current stress discourse emphasises individualism, masking the power inequalities embedded in existing social and organisational structures. In other words, the stress discourse lays the blame primarily on the individual rather than relating stress to their class, 'racial' or gender position. The stress management discourse rearticulates tacit rules of emotional restraint at work and stress management practices reinforce the privatisation of emotion. The following case study exemplifies the individualisation of stress, the rules of emotional restraint, and what happens when someone without power, status or support breaks them.

Activity 10.13 Teresa

15 minutes

The account below is a composite of real-life situations that a course team member witnessed recently. Read it and make a note of the possible 'stressors' in Teresa's life. Note how she handles her situation and the events surrounding her. Note also the attitudes expressed in the workplace and how the workplace handles her stress.

Teresa

Teresa arrived from a central African country 18 months ago. She and her husband and children joined a larger extended family who were already in the UK. She had been trained as a social worker, one of the few in her country at the time, but was not qualified in the UK. She found a job as a carer in a large group home for people with severe learning disabilities. Many of the members of the home exhibited challenging and aggressive behaviours too. The home has a staff of 22 people and three are from her region in Africa. The home has tried to be pro-active in complying with equal opportunities mandates. Teresa and the other staff from her country are hired because they are very able and caring with clients. They also have a 'reputation' for sometimes being overly involved emotionally, being somewhat unreliable (extended family commitments cause them to be absent from work), and lacking in follow-through with the occasional paperwork required. Other staff pass on this 'reputation' from time to time over coffee and cigarette breaks. Although Teresa speaks English, there is terminology she does not understand and rapidly changing procedures she is unfamiliar with. There are staff meetings on a regular basis to update staff on changes. She has missed some of these meetings because of her husband's illness. (Her husband has been ill for several months and they have two small children.) She is too embarrassed to ask for explanations from other staff, not wanting to draw attention to herself and her vulnerability. No one has offered to fill her in on what she may have missed. She does not know that others are experiencing the same confusion about procedures.

The event in question occurred with a client with whom she had built a trusting bond. On this occasion he began to exhibit some aggressive behaviour. She felt she could handle it. However, a more senior staff

member, who had been newly trained in a procedure, came in and took over, administering a restraining procedure (tie down) with this client. Teresa became distraught and had to be escorted out. She has been asked to take leave to sort herself out.

Comment *You might have noted that Teresa does indeed have many 'stressors' in her life both at work and at home. In addition to the real demands on her time and energy, there are cultural and language differences. There is the undercurrent of covert prejudice whereby other staff take a 'wait and see' attitude with her. No one offers to help her out, to empathise, or to anticipate gaps in her knowledge. Given her role within the organisation, she seems to have very little power and she commits the ultimate violation by 'over-reacting' to the 'tie down' procedure. Her stress is her problem to sort out.*

The comments in Activity 10.11 provide a very explicit example of how pervasive an individualised view has become in the contemporary discourse on stress. You may want to consider what latitude and power Teresa has to 'say no', 'to delegate' and 'to find support'.

Again, Tim Newton (Newton et al., 1995), an educator and researcher on stress, and Stephen Fineman (1995) have noted that stress management practices in many organisations take place largely in 'off-stage' arenas, either through creating confidential areas at work (counselling), or through 'supportive training environments' (for example learning progressive muscle relaxation), or through private practices such as meditation. The stress discourse and the practice of stress management do not challenge emotional codes: those tacit, powerful rules about the expression of feeling and emotion.

The prevailing individualised stress discourse does not suggest that part of the problem of stress may be that individuals are expected to maintain tight emotional control at work. It does not suggest radical alternatives: for example, that people should vent their feelings at work or be encouraged to share them. Part of the problem may be that challenging emotional codes also means thinking about power relationships. As Newton and Fineman have noted, the current stress discourse does not suggest that people should organise and express their feelings collectively. This ignores the interactionist view that people *collectively* create and are created by their environment.

The collective construction of coping

You have been exploring how stress is made an individual matter, rather than a collective problem. Some of the means and methods of coping with stress and anxiety are done collectively. However, the coping mechanisms themselves, while created collectively, can then cause stressful circumstances for individuals.

The studies by Menzies Lyth (1988) have been cited repeatedly as ground-breaking analyses that demonstrate the collective construction of coping. Isobel Menzies Lyth, a psychodynamic organisational consultant, explored the work of nurses in hospital settings and identified 'underload' as a form of work organisation that evolved to help staff cope with anxiety. Rather than individualising stress, she saw underload, resulting from routines such as doing tasks in a ritual manner, as an unconscious collusion in which nurses collectively created a work environment that helped them contain and control their anxiety. In other words, tasks were distributed in such a way that they

required the individual doing them to take on little or no responsibility, nor did they require or indeed allow the individual to form any kind of significant relationship with a patient. In other words, tasks were distributed to minimise the anxiety-producing elements of the work.

Work in the world of health and social care is intense and intensely personal. Often it involves interpersonal relationships with people who are in some kind of distress. However a person handles them, emotions are involved in this work and one of the key emotions is anxiety. A client or patient may have a condition or situation that mirrors the greatest fears of those who are charged with helping them, or a service user might remind a worker of painful but unacknowledged experiences in her past. A client's story could be similar to or identical with yours as a worker, and you may wonder, for example, whether he has eavesdropped at your door as you talked to the probation officer about your son, or the manager of the care home about your mother's aggressive behaviour caused by her Alzheimer's disease. Without a great deal of self-awareness, and without the time and tools for dealing with personal emotions, it is possible to become overwhelmed by anxiety as a worker in care services. In a fast-paced environment, there may be little time, fewer resources, and unfriendly attitudes about focusing on the worker's emotional life. Just because emotions are ignored or repressed, it does not mean they go away. Instead, both individually and collectively, ingenious ways are created to manage the anxiety, to 'contain' dangerous and uncomfortable emotions. One of the ingenious methods is to create and use bureaucratic structures as a defence against a sense of helplessness. The next section explores the work of Larry Hirschhorn, a psychodynamic theorist and organisational consultant.

2.7 A psychodynamic perspective on the interaction of emotions and bureaucratic practices

Larry Hirschhorn (1988) identifies the central role of anxiety in explaining the 'organisational behaviours' that people demonstrate. The next two brief accounts are from an article I wrote in which I use Hirschhorn's perspectives to examine what happens to the emotions of the people in the two encounters (Rogers, 2001).

As Hirschhorn points out, when people become anxious in their work, they may disconnect from each other empathically and relationally, setting up a chain of anxiety.

Activity 10.14 Chain of anxiety

30 minutes

As you read the following accounts make some notes. The first account is from a colleague in social care and the second is from my personal experience.

In the first account consider what prevented the district supervisor and the psychologist who had 'built up a relationship of trust' from discussing their concerns with each other openly.

What did you think of the way the nurse handled the patient's concerns in the second account?

The psychologist and the social workers

A psychologist in a rural region of the UK has had a consultancy relationship with the Ministry of Health for 12 years, during which time she has maintained a continuing contract. Over the years she has built up a relationship of trust with social workers who are involved with her caseload. This relationship has allowed her privileges such as direct access to client files to get necessary information related to her speciality. She recently hired an additional person to handle the increasing workload of her practice with learning disabled children and adults. Shortly after she hired the new person into her practice, the psychologist learned from the district supervisor that she will no longer have special privileges such as access to files in this manner. She learns that as part of a new 'procedure', the social workers will provide written summaries to her and her employees. The supervisor refers to the ethical code of confidentiality to provide a rationale for the revised procedure.

The psychologist accepts the decision on the surface, but privately expresses hurt, anger, and erosion of trust built over the years. In addition, she is frustrated with herself for having these feelings, thinking perhaps 'she is taking things too personally' and hasn't considered expressing any of these feelings to the key players. She 'does not want to risk making a fool of herself'. None the less, she says: 'Yes, we will work with this new procedure; we have to, don't we? But ultimately the client will get diminished service because I need to be able to look at the raw data to get the relevant information I require, rather than have a summary report from people who are not specialists in this area. My relationship with these workers and the department will never be the same.' The psychologist later learned that the wife of the person she hired, who also worked with the same groups of people, had a questionable reputation with the social workers.

(Source: adapted from Rogers, 2001)

The nurse and the academic

At a large university in the UK, a member of the faculty pays a visit to the campus health service which he had scheduled the day before. He recognises he is profoundly depressed, barely able to carry on with his daily functions. Upon his arrival, he is told that the resident nurse in the campus health service only has half an hour to give to him, because she is off to a meeting. He is escorted to the examining room in the Portakabin® where the health service is located, where the nurse asks him about his symptoms. Aware that his time with her is short, somewhat confused by her interruptions, he cuts his description short, feeling foolish and an imposition. The nurse, assuming 'the stress' as she calls it and depression are job related, although she did not ask directly, gives him a mini-lecture over work, and suggests he has 'a little lie in tomorrow morning'. And go to his family doctor. She discloses that even she feels guilty if she goes home directly after a meeting that ends at 4.30 off the campus. She concludes by telling him that a young faculty member, not unlike him, recently dropped dead unexpectedly. 'You know the university will replace you in 15 minutes.'

(Source: adapted from Rogers, 2001)

Comment *The following discussion considers these issues:*

- *How the 'helpers' use bureaucratic procedures to 'cover up' their feelings.*
- *What feelings they are covering up.*
- *Why might they be doing this.*
- *What the result was.*

After the two encounters described above, the vulnerable people – the psychologist and the faculty member – were left questioning the reality and validity of their emotional worlds for, within both encounters, bureaucracy and 'helper' (the district supervisor and the nurse) interact to leave care, emotion and nurture out of the relationship.

Using Hirschhorn's perspective, my observations are that when people become anxious about their work, about their dependency on others, exacerbated by increasing uncertainties in the working world, they cling to procedures and routine behaviours, turning away from the relational and from each other. They also step out of some of the unarticulated expectations of their roles. In the first account you may have noted, for example, that the district supervisor stepped out of the expected, but unarticulated, role of negotiator and facilitator of a multidisciplinary team, away from her role as helper and leader to the team. Procedure stands in for the real purposes of the work.

> Bureaucratic practices, the basis for much of modern organization, are too frequently disguised forms of social defense. Parading as efficient procedures, they actually waste resources. Excessive paper helps contain the anxiety of face-to-face communication; excessive checking and monitoring reduces the anxiety of making difficult decisions by diffusing accountability.
>
> *Hirschhorn, 1988, p. 3*

In Unit 4 you were introduced to the work of Melanie Klein, who is associated with the development of object relations theory, a particular branch of psychodynamic theory. You may recall that Chapter 30 in the Reader by William Halton is a useful summary of Klein's ideas. This approach highlights how people use one another to stabilise their inner lives. Projective identification, as you may remember from your work on Unit 4 (and in particular the Anthology article by Hinshelwood), is a mechanism for depositing unwanted feelings in another person's feeling system. You might have experienced entering into an encounter with someone feeling fine, and coming away from it feeling anxious and unsettled and not really knowing why. In the first account, the psychologist could articulate feelings of anger, disappointment and frustration, but could only indirectly allude to anxiety and shame that her own ethical behaviour was in question with the removal of what had been her privileged access to files. She could not recognise these feelings within herself because she did not really understand that she should be feeling them at all. The district supervisor's staff had ethical concerns about the wife of her new employee and, by association, with the psychologist's new employee himself. The district supervisor's staff were pressuring her to tighten up procedures. However, the supervisor's unconscious anxiety, especially about having previously 'bent the rules' on the basis of her favoured relationship with the psychologist and her inability to articulate her concerns directly to the psychologist, caused her to 'deposit' her anxiety on the psychologist. The psychologist was left with unaccountable feelings of shame and uncertainty.

The second account hints at the guilt of the nurse who 'leaves early', the diminished sense of worth and efficacy, working in a health service that exists on the physical margins of an institution, which reflects how little it is valued

'where half the faculty are on Prozac'. The devalued helper 'deposits' a sense of worthlessness and feelings of abandonment in the faculty person's feeling system. Note her dismissive attitude to the faculty member's concerns.

So, staff may collude with structures to handle their own emotions. These manoeuvres do not eliminate emotion. Instead, they distort, manipulate and redirect emotion. For example, the psychologist questioned the appropriateness of her own feelings and the legitimacy of expressing them. Emotions, instead of being valuable prompts to constructive communication, become things to be buried and hidden away.

Key points

1 The stress 'discourse' is a prominent way of explaining problematic emotions.

2 The current stress discourse makes stress a personal responsibility and a personal problem.

3 Both psychological and sociological perspectives suggest that stress is also a cultural and an organisational phenomenon, created and played out collectively.

3 Conclusion

This unit explored emotional impact, which is the role of emotions in the context of working life.

You considered:

- the emotional roots of your vocational choice
- the historical, cultural and gendered treatment of emotions
- concepts of emotional labour and emotion work
- how social, cultural and gendered relationships to emotion create divisions of emotional labour
- the paradoxical feeling rules of work in the helping world
- the value of emotional labour and its personal cost
- the construction of stress
- the dynamics of anxiety, organisational structures and the impact on the caring relationships of care.

This unit began with an experiential exploration of emotion, to give you the opportunity to reflect on a range of emotional experiences and situations that you may encounter in your involvement in health and social care. This unit then explored through two different perspectives – the psychological and the sociological – how emotions are defined and what the implications for each of those perspectives might be. Looking at emotion in the context of history, gender, power and culture reveals the variability in how emotion is defined and handled and begins to critique the divisions of emotional labour. Considering the relationship of stress and emotion brings in an organisational dimension, which is the focus of Block 4. The relationship of emotion to health and social care is a complex one, without easy pathways or solutions. None the less, heightening your awareness of these complexities, perhaps challenging your assumptions, can lead to some choices and alternatives about how to handle the emotional world of health and social care.

Unit summary

Emotions are a significant factor in many activities in caring and there are costs and benefits to any emotional investment that takes place. The way the environment handles emotion can have an important impact on the individuals involved. Sociological perspectives suggest that how emotions are defined and handled is determined by the cultural context. For example, attitudes towards emotion and handling emotion are subject to power structures, and are often gendered.

A psychological perspective treats emotions as independent entities within individuals and proposes that unresolved and unexpressed emotional issues are at the heart of communication and relationship difficulties.

Emotionality, which involves experiencing and expressing emotion, takes much effort and managing or regulating emotion adds an extra layer of cost, especially when undervalued and unappreciated. There are 'tacit' or unexpressed feeling rules in many environments about the role of emotions, which can be contradictory and confusing.

Complying with feeling rules requires emotional labour and, when demands for emotional labour outstrip resources, stress or 'burn-out' may occur. The stress 'discourse' is a prominent way of explaining problematic emotions and the current stress discourse makes stress a personal responsibility and a personal problem.

Both psychological and sociological perspectives suggest that stress is also a cultural and an organisational phenomenon, created and played out collectively.

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Unit 11

Difficult helping encounters

Prepared for the course team by Linda Finlay

Contents

You will need

- Course Reader

  Chapter 28 'Rediscovering unpopular patients' by Martin Johnson and Christine Webb

  Chapter 29 'Steven' by Valerie Sinason

- Anthology

  Extract 22 'Donna'

  Extract 23 'Telling other people' by Ann Richardson and Dietmar Bolle (optional)

Learning outcomes

After studying this unit you should be able to:

- Demonstrate systematic and critical knowledge and understanding of:
  - the way in which social evaluations arise in practice and how they are accounted for theoretically
  - the implications of particular discourses and the impact of disempowering practices and labelling.
- Analyse how difficult helping encounters between individuals are set in broader interactional, organisational and ideological contexts.
- Demonstrate awareness of how you would respond constructively to difficult encounters, including those involving conflict, anger or abuse.
- Demonstrate reflexive awareness of the impact of difficult encounters on yourself and on other people (including service users, carers and other workers).

Introduction

Practitioners and carers face difficult encounters every day. Almost every encounter is 'difficult' in some way: they can be challenging at both a personal and a professional level. Sometimes helpers face situations that are so physically or emotionally demanding they feel 'sucked dry' or personally threatened in some way. They can also be challenged in terms of their skills. Confronted by the complex needs of service users, they struggle to find the 'right' approach, or one that is at least workable.

Practitioners and carers have to routinely cope with stress and pressure. They must deal with the emotional assault of working in environments and institutions geared to helping people who have challenging problems, needs and behaviours. They may have to face situations they would prefer to avoid. Sometimes 'helping' can be part of a bigger problem or it can generate different sorts of difficulty. For example, much violence, anger and pain can result when social workers act to take a child into care: a situation which has probably been prompted by violence, anger and pain. As Jeffrey Kottler, a psychotherapist, recognises about his work:

> Some of the perils a therapist encounters are an implicit part of the job ... Just as ... a soldier would not be surprised to find people shooting at him during a war, a therapist accepts the dangers of getting close to people for a living.
>
> *Kottler, 1993, p. 115*

Kottler goes on to suggest that certain clients tend to create the most difficulty and stress for therapists. Drawing on his own experience and the wider literature, he then constructs a list of 'difficult client groups'.

Before reading Kottler's list, take a few minutes to consider what makes a person 'difficult' for you. Feel free to think in terms of your experiences as either service provider or service user and what occurs to you when you think of 'difficult clients' or 'difficult professionals' or 'difficult students', etc. – whatever suits your situation. Several factors may come to mind. What makes people 'difficult' for you might concern their individual characteristics, your relationship to them, or perhaps the situation itself. The way you see yourself

and your own preferences may be a consideration. For example, you may be uncomfortable with labelling and prefer to think about people in primarily positive terms. Some of Jeffrey Kottler's categories are as follows.

- Clients with hidden agendas (workers' compensation or court referrals)
- Clients who ignore boundaries (chronic lateness or missed appointments)
- Clients who refuse responsibility ("you fix me")
- Clients who are argumentative (hostility, skepticism)

[...]

- Clients who push the therapist's buttons (bring up his or her unresolved issues)
- Clients who are countertransference objects (remind the therapist of persons from the past)
- Clients who are impatient ("fix me quick")
- Clients who are literal and concrete (unable to access or express internal states)
- Clients who feel hopeless (actively suicidal)
- Clients with poor impulse control (offenders, substance abusers)

Kottler, 1993, pp. 123, 124

Kottler follows up this list with an emotional appeal:

> As therapists [or practitioners or carers], we see the most perverse, bizarre, sometimes even the most evil parts of human existence. We are constantly exposed to cruelty, conflict, deception, manipulation, cynicism, mistrust, and betrayal. We see people at their absolute worst. We are privy to their most secret, hidden selves. We are the folks delegated to pick up the pieces after disappointment, divorce, or death.
>
> There are clients we encounter whose main purpose in life seems to be making others miserable. They are schooled in the intricacies of sociopathic, narcissistic, hysterical, or borderline behavior. They know just how to get underneath our skin, and they feel most fulfilled when they succeed.

> All through the rage and despondency and conflict we are supposed to remain unperturbed. The sheer energy it takes to stay calm and in control in the face of such behavior is a major drain on our resources.
>
> *Kottler, 1993, p. 124*

Activity 11.1 **Responding to Kottler's list**

5 minutes

Reflect for 5 minutes on what Kottler is saying and your own reactions to his words. Are there any parallels between your list and Kottler's? Are you sympathetic: do you agree with him that certain clients (service users) are particularly difficult or stressful to work with? Or are you offended by his words and attitude? You might like to respond here both as a helper and as a service user.

Comment

My response was mixed. Speaking as a psychologist and a therapist, I can empathise with part of his message. Kottler is expressing his pain in the face of dealing with people who have very challenging emotional problems. However, I also feel he sounds too negative. Certainly as a service user I would not like to be labelled in this way. I think that we all respond differently and what may be felt as 'difficult' by one person may not be by another.

Identifying 'difficult clients' as Kottler has done raises several questions. Kottler is rather focused on negative characteristics, which are seen to reside *within the individual* clients. However, is that the whole story? Surely the problem does not always reside in the client? It may be their situation that is difficult. Sometimes it is the professional who is 'difficult'. Other times maybe both the client and the professional are difficult. It is important to get away from simplistic analyses and to think about the particular people in particular relationships. For instance, Kottler is also saying something about the therapist's capacity: for instance, 'unresolved issues' (therefore 'buttons to push') will differ from therapist to therapist and from person to person. Also, what is experienced as difficult may depend on the situation. Kottler is talking about what creates difficulties in the therapy context. These could well vary in other contexts: for instance, in a social care context where people have multiple disabilities and needs.

Activity 11.2 **Donna speaks about therapy**

30 minutes

Read Extract 22 'Donna' in the Anthology. Note down or highlight what Donna considered to be 'difficult' in her meeting with a therapist.

Comment

I noted that Donna felt vulnerable and that, because she is a black woman who has experienced racism from a predominantly white society, she is very aware that the kind of therapy on offer might not be helpful for her as a black woman. Her concern is that she will be disadvantaged and 'shut down' by the processes of talking. Donna took a risk and was open about her concerns but there were times when she just 'didn't know where she [the therapist] was coming from'. Language was also an issue because the therapist did not understand 'Black English'. For Donna it worked out reasonably well, but only because she used her 'personal power' to help the therapist meet her at a human-to-human level. The difficulties between them and the concerns Donna had about asking for help depended not only on personal factors but also on social ones.

While practitioners and carers may routinely experience difficulties in their work, what is perceived as difficult depends on both *personal* and *social* factors. In Unit 10 you engaged with a similar discussion about the role of emotion in helping relationships. You saw how emotion can exact a personal cost. You were encouraged to be reflexive about your own emotions and to be aware of ways we might better 'handle' these and the emotions of others. You also began to explore how experiencing and expressing emotion should be seen in a broader social and historical context.

Expanding on these themes, this unit explores two different approaches to – or two different 'takes' on – the idea of difficult helping encounters. Section 1 aims to get you thinking more theoretically about the notion of 'difficult' encounters and what that means. You will appreciate that this is not straightforward. Difficult for whom? In what way? What is difficult for one person will not necessarily be for another. To explore the different meanings involved, you will focus specifically on the kinds of individuals who sometimes are seen as 'difficult'. There is a discussion on how labels such as 'difficult patient' often carry with them some moral or social evaluation. Here there is an explicit link back to your work in Unit 7, when you examined the impact of discourse and labelling. As in Unit 7, this unit takes a social constructionist approach, discussing how *social evaluations* are complex and involve multiple meanings which emerge in different contexts, with different individuals.

Section 2 takes a more practical, applied approach. While acknowledging the problems inherent in labelling individuals and situations 'difficult', this section acknowledges that some people or some situations are *experienced as difficult*. A range of issues are explored through four case studies of difficult helping encounters. These examples act as 'windows' into different sorts of problem situation. After each example, you will examine the complex range of issues raised about the individuals concerned and the organisational or institutional context involved.

There is no simple set of rules about how to handle difficult encounters. Rather, this unit is designed to set you thinking reflexively about possibilities and the potentials within different situations. Equipped with greater self-awareness, and understanding of the resources within organisations, we can both recognise and minimise the more problematic aspects of difficult helping encounters. To summarise, this unit addresses the following core questions.

Core questions

1. What do we mean when we say a person is 'difficult'?
2. How and why do social evaluations arise in practice?
3. What factors are involved in creating difficult helping encounters?
4. How can the more problematic aspects of these difficult helping encounters be minimised?

1 The 'good', the 'bad' and the 'difficult': labelling and social judgement

1.1 Making judgements

As was made clear in Unit 7, practitioners and carers make personal and professional judgements all the time. Some of these judgements, perhaps inevitably, involve moral and/or social evaluations of service users. For example, sometimes comments are made about a person's appearance. Making judgements is also built into practitioners' jobs: for instance, when a social worker assesses that a parent is abusing their child.

Activity 11.3 **Making judgements or being judged**

5 minutes

Consider the concept of moral and/or social evaluations further. (Do not worry too much about distinguishing between them at this point.) Write some notes on the following questions.

1 Can you think of three examples of ways we describe other people that involve such evaluations?

2 Do you agree these can be, and are, applied to service users?

3 Can you think of an occasion when you felt yourself morally or socially judged as a service user?

Comment

Calling a person 'a nice girl' or 'an overly anxious mother' or 'a pervert' involves making moral judgements (that is, implying good or bad behaviour). These are also social categories as they depend on social definitions of what is 'appropriate' or 'normal' behaviour.

I would agree that judgements like these are made all the time, both consciously and unconsciously – even when practitioners are trying to be 'non-judgemental'!

I suspect that sometimes I am seen as being 'very demanding', for instance, when I see my GP and push for answers or action.

Often the moral or social evaluations made are quite *subtle* and implicit; they are expressed in such a way that we take the judgements for granted. It is only when we reflect on them, or hear an alternative account, that we may begin to think more deeply and critically about what is being said, and why, taking into account the broader context.

Consider the following two accounts. First a child psychiatrist writes about the mother of Wendy (aged 8), a 'difficult' child with severe learning difficulties. Then Wendy's mother gives her version.

Competing versions of evaluation

A psychiatrist's description of Wendy's mother

I found mother to be evasive and at times I thought she was deliberately covering up information. For example, she did not know anything about her husband's experiences in early childhood and subsequently let slip that [the] paternal grandfather was a very critical man and this has influenced her husband's attitude towards Wendy ... She [the child] has

no speech, she does sign for some objects using Makaton [sign language]. She is restless and ritualistic and does not sleep properly ... She is incontinent and I was quite surprised how mother seems detached, leaving her in a smelly condition throughout the consultation until I prompted her. I found the mother detached and flat in her mood.

An account written by Wendy's mother

She [Wendy] climbs, jumps at windows, pulls out plugs ... She seems to have tremendous mood swings, going from being completely wound up, almost wild to violent bouts of crying for which there is no explanation ... She is still suffering terrible diarrhoea ... and has had to be cleaned 3–4 times a day for the last 3 years ... Wendy is so demanding that I am concerned about the other children. I feel I have no time for them and that they are really suffering, not only from this, but from the stress of living with a child who is so unpredictable ... Wendy is a very confused little girl who desperately needs help. We love her.

(Source: adapted from White, 1997, cited in Taylor and White, 2000, pp. 14, 15)

Activity 11.4 Two competing versions of evaluation

15 minutes

After reading the accounts, make brief notes about any moral or social evaluations that are being made about Wendy's difficult behaviour and her mother's responses. It is perhaps not surprising that Wendy's mother and the psychiatrist offer different accounts. Note the way they mobilise different sets of 'facts', as they each try to persuade the reader to support their own perspective.

Comment

There are several different ways you could respond to and interpret these two accounts. Taylor and White make the following analysis of the psychiatrist's judgement about the mother.

> *the mother is, in a number of ways, considered to be at fault. There is a common-sense presupposition that wives know in detail about their husband's childhoods and because she denies any such knowledge, whilst making some statements which appear to contradict this, the mother becomes defined as evasive. The description of the child's 'smelly condition' serves to reference the mother's culpable neglect of her parental duties.*
>
> *Taylor and White, 2000, pp. 14–15*

In contrast, the mother's account is seen as 'a powerful account in which the mother refers to her commitment to the child, and also talks about her fears for the other children' (Taylor and White, 2000, p. 15). Instead of presenting herself as 'neglectful', the mother positions herself as a caring, attentive, if exhausted, mother.

The fact that health and social care workers draw on a range of judgements and social evaluations when representing service users is not, in itself, the problem. Rather, it lies in determining how stigmatising and disempowering these judgements might be, and whether they are based on evidence. You need to ask when and how they emerge and what consequences they might have. The definitions of Wendy's behaviour and her mother's responses could have some critical consequences. For instance, Wendy could be seen as being 'at risk' of

Health and social care workers routinely make social evaluations

harm and possibly even taken into care. Alternatively, Wendy's mother may be seen as the person 'at risk' of exhaustion and she might be offered additional support to help with Wendy's difficult behaviour at home.

This discussion on practitioners and carers making judgements is very relevant when considering representations of the 'difficult' service user or when referring to a 'difficult' encounter. What do we mean? Difficult for whom? In what way? Who defines what and who is difficult? To explore the different meanings involved, the focus in this section is on the way people become represented as 'difficult' and the values that underlie such labels.

Specifically, I have drawn on the research and extensive literature that is available on representations of 'good and bad patients'. This literature suggests that service providers routinely make social evaluations of service users in different ways. In the process they can be seen to both 'label' others and to perceive them in positive or negative terms. You may remember from Unit 7 that making evaluations is not in itself problematic. For instance, identifying a parent as an 'abuser' may help to save a child in the future. The key questions are how benign or pernicious these evaluations are and what they are based on. Does using labels invite service providers to forget the individuals behind the labels? Does the way they evaluate others carry critical consequences? Can the evaluations be experienced negatively? By asking and reflecting on these questions, I hope that you will gain awareness of the implications and likely results of particular social evaluations.

1.2 Professional use of labels

Activity 11.5 Labelling service users

10 minutes

Before looking at the research in this area, can you think of different ways in which service users can be labelled? Try to answer this with specific reference to your own service. Are there particular labels you can think of which are used frequently or even routinely? In your opinion are these labels problematic?
To help you get started you might find it useful to refer back to the examples of Molly and Jimmy in Sections 2 and 3 of Unit 8. Here practitioners ran the risk of making assumptions that could potentially result in negative labelling. Spend up to 10 minutes on this activity.

Comment

In the medical context, labels in the form of particular diagnoses are frequently, and often helpfully, used. They can become problematic, however, when the person behind the label gets lost: for instance, when medical staff refer to 'the coronary up from A&E' or 'that epileptic'. In other health and social care contexts labels about people's personality and behaviour are often heard: for instance, 'She's a sweetie' or 'She's just an over-anxious mum' or 'He's a scrounger' or 'He's a manipulative, smooth-talking, game player'. Whether these types of label have a negative impact depends in part on how the message is meant. Calling a person 'senile' or 'stupid' or 'demanding', for instance, can have negative consequences, particularly when people start believing in, and acting on, the role or behaviour the label implies. If labels cloud accurate assessments or stop practitioners seeing a person's strengths, then it is a problem.

Numerous studies over the last 40 years have highlighted how health professionals tend to categorise service users, applying a range of labels and evaluations beyond more straightforward diagnostic categories (see, for instance, the review by Kelly and May, 1982). You encountered the ideas of the renowned sociologist Erving Goffman in Units 4 and 8. His classic works include the book *Stigma: Notes on the Management of Spoiled Identity* (1963) which takes up this theme. He shows how patients, once negatively labelled, become stigmatised. The labelled individual is then seen to respond accordingly and the problem is aggravated. Figure 11.1 represents something of the vicious cycle involved. In mental health settings, for instance, a patient labelled 'violent' and responded to as such is likely to become more violent.

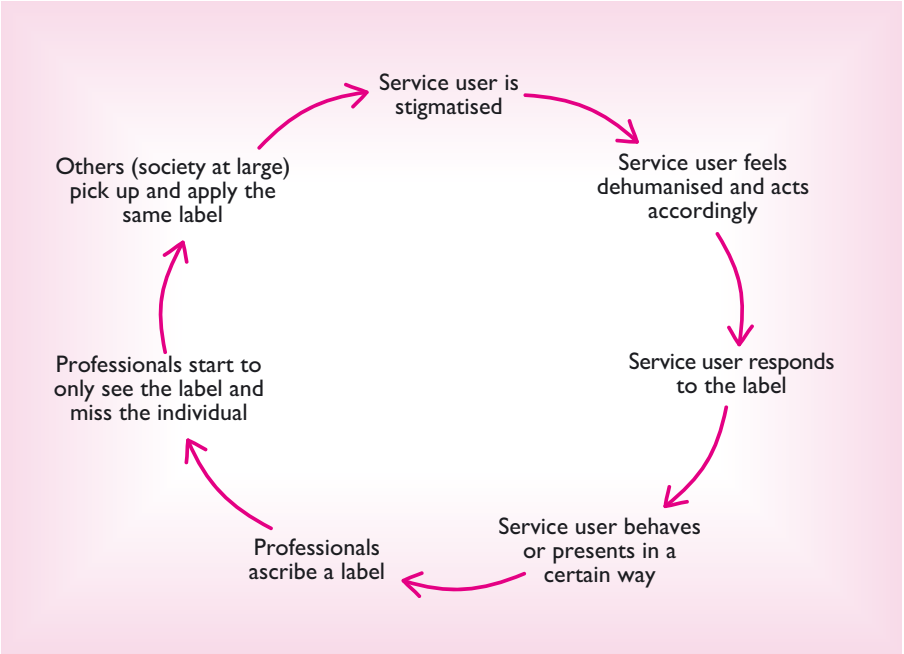

Figure 11.1 The vicious cycle of labelling: when the labelled person is seen to respond appropriately to the label, the problem is aggravated

Other research (for instance, contemporary work on 'social representations') casts doubt on the idea that the use of evaluative labels is in any way simple or predictable. Instead, professionals use multiple, often contradictory evaluations. Moreover, the labelling process is not just one-way – service users can invite certain labels. For instance, the label 'layabout' may contain a grain of truth. However, Martin Johnson and Christine Webb (1995), two nurse educators, argue that social evaluations are not tied to service user traits (for instance, relating to social class); rather, evaluations *vary between individuals given their relationships and different contexts.* Robert Dingwall and Topsy Murray (1983), who researched how patients are categorised in accident and emergency departments, suggest categories are fluid and that initial evaluations can change: for example, a patient who starts off as 'deviant' can be reclassified as 'clinically interesting' or 'a refreshing break from the routine'.

Beyond labels and categories, the research generally shows how moral evaluations are commonly involved in the way people are represented as being 'good' or 'bad' patients or clients. The literature (for instance, Finlay, 1997) suggests that 'good' patients have the characteristics of being co-operative, appreciative of their treatment, cheerful and uncomplaining, however ill they are. They allow staff to practise their skills or specialities and they usually get better. Bad patients are demanding, uncooperative and ungrateful. They make staff feel ineffective and tend to be condemned by them.

When Felicity Stockwell, a nurse herself, first pointed out that moral evaluations occurred in practice in terms of there being 'popular' and 'unpopular' patients, it created a stir (Stockwell, 1984). Some nurses denied that they were so judgemental, arguing that they strove to be positive and to treat their patients as 'individuals'. The next activity is an opportunity for you to reflect on your own practice in this area.

Activity 11.6 Moral evaluations

10 minutes

Reflect on your own practice, or on the practice of those in your community, in relation to the kind of moral evaluations mentioned above. The research suggests that service users would not explicitly be classified as 'good/popular' or 'bad/unpopular'. On the other hand, if you are a practitioner, are you aware of having 'favourites' – people you particularly enjoy working with? Are there also certain service users who make your heart sink when you have to work with them? Alternatively, as a user, have you dealt with some 'difficult' professionals? Can you be honest with yourself here even if you would not publicly admit such feelings? You will return to this topic in Activity 11.8.

Comment

Here are three different responses from testers who answered this question, followed by my own response.

- *I definitely have a few favourites and, yes, they do tend to be cheerful and have a quirky sense of humour. They're also quite courageous and brave, coping as they do with such difficult problems.*
- *I really don't like these questions. I think it's wrong to see people as 'good' or 'bad'. We should value everyone and treat them as individuals. You can always find something good in everyone. This is what being a caring helper is all about.*
- *I hate admitting it but I do have some 'heart sink' clients. They tend to be the ones who I can't communicate with well – the ones who don't respond. And that makes the job much more difficult to do. So I can see what you mean when you say 'bad patients' make you feel ineffective.*

I believe all of us, inevitably, have both positive and negative responses when we work with other people. Given this, I think it is important to critically examine these responses to separate out the relatively harmless evaluations from the more damaging ones. It requires a commitment to be honest with yourself and to be able to talk openly about these uncomfortable issues in your work settings. Being aware of the research in this area is a good start.

Health and social care research (and, indeed, research in other contexts such as education) suggests that moral evaluations are made because practitioners are forced to judge the social worth of people in order to balance competing claims on time and resources. Evaluations such as 'good' and 'bad' often relate to the practitioners' work load: good clients make work easy; bad clients obstruct and create difficulties (Duff and Hollingshead, 1968). Smith (1992) among others notes that young nurses prefer patients in their own age range as they make fewer physical demands and are more responsive socially. In addition, slotting patients into convenient categories such as 'difficult' allows nurses to distance themselves emotionally and so cope better with their work load. Kelly and May (1982) attribute nurses' definitions of patients to the way they legitimise (or not) the nurse's role (that is, an appreciative patient confirms the role).

The key point is sometimes people are *perceived* as difficult because they are 'different' with regard to their illness, class, behaviour or appearance. The evaluations that result from this perception carry critical consequences with them. In most cases, the evaluations applied can be important in stigmatising, stereotyping and disempowering the individuals concerned. For instance, Julius Roth (1972) noted that rehabilitation patients typified as uncooperative or abusive were promptly discharged. A more up-to-date example is how private care agencies can legitimately exclude certain 'difficult' clients from their books, citing insufficient resources as justification.

Activity 11.7 **Rediscovering unpopular patients**

30 minutes

Read Chapter 28, 'Rediscovering unpopular patients: the concept of social judgement', by Martin Johnson and Christine Webb in the Reader. The authors are nursing academics and they report on research done specifically in the nursing context. As you read, try to identify at least two key points they make about labelling and social evaluation.

Comment

Johnson and Webb discuss several points and it is worth dwelling on some of them further. Three points stand out:

1. *Service users are often routinely evaluated in terms of their social worth, for instance in nurses' expressions of 'good and bad' patients or 'popular and unpopular' ones.*
2. *There are no straightforward criteria of likeability or unpopularity. Johnson and Webb (1995) point out that one person may perceive a service user as 'difficult and unlikeable' while another may see them as 'interesting and challenging'. In addition, such labels are often applied ambiguously, contradictory opinions being expressed at the same time. Some service users may be 'difficult and demanding' and yet be perceived positively.*
3. *Social evaluations of other people are socially constructed (see below). Johnson and Webb argue that social evaluations are not necessarily tied to particular traits that people do or do not have (e.g. related to class or diagnosis). Instead, evaluations are seen to be negotiated in particular social contexts (e.g. depending on the people and department involved).*

Each of these three points are discussed more fully in Sections 1.3 and 1.4. Here, I draw on my own research into how another professional group – occupational therapists – perceive their patients or clients (Finlay, 1997). In this qualitative research study in-depth, relatively non-directive interviews were used to access the therapists' individual, as well as their shared (collective), meanings. My findings were similar to Johnson and Webb's (1995), and mirror the *representations* of 'good' and 'bad' patients identified in other research.

Contemporary social constructionist research has largely moved away from labelling theory towards the idea of 'social representations' and the importance of 'discourse'. (You met a version of this idea of representations in Section 3 of Unit 5 about the use of disempowering discourses. See also Section 2.4 on 'positioning' in Unit 7.) Social constructionists argue that people understand the world through collective ideas and images, which are widely shared across members of a social group. Social representations come into practice by people 'soaking up' the different discourses and ideologies that exist in the wider culture. Research has shown how racist 'talk' reflects broader patterns of power and inequality (Wetherell, 1996). An example of this is how asylum seekers are represented by some sections of the media as 'untrustworthy scroungers'.

To give another example, when AIDS was first identified in the UK in the early 1980s common representations linked images of 'impure foreigners' and 'deviants' who engaged in 'perverse' practices (Joffé, 1997). However, as medical knowledge improved and AIDS was identified in the heterosexual community – and as gay men reacted against stigmatisation – representations changed. In the western world, 'the gay plague' was transformed into representations that conceptualised AIDS as a disease that could affect anybody if they practised certain high-risk activities. Now, AIDS tends to be represented as a 'third world tragedy', given how the drugs used to slow the impact of the disease in the west are proving too costly for developing countries.

You might also consider the difficulties that people with AIDS encounter in 'telling' others, family or professionals. You could read the accounts in (Extract 23) 'Telling other people' by Ann Richardson and Dietmar Bolle in the Anthology. The experiences in these accounts illustrate how perceived or anticipated labels and the way an issue is socially constructed can lead to a fear of moral judgements (Imrat's account) or lead to actual judgement from others (Angela's account). The difficulty (anticipated or actual) of each encounter can depend on the social construction placed on AIDS or HIV status by a particular group in society and can influence both communication and relationship profoundly.

Key points

1 Practitioners routinely judge and evaluate service users at a personal level and as part of their remit.

2 It becomes problematic when these judgements involve disempowering and stigmatising labels and representations.

3 Different theoretical approaches account differently for the process of labelling and ascribing social evaluations.

4 Social constructionists draw on social representations theory and discourse analysis. They argue that evaluations arise out of and are produced within social contexts.

1.3 Social worth

My research on occupational therapists' views showed that moral evaluations and social representations were often implicit and only revealed in terms of oppositional contrasts. Specifically, negative evaluations of service users only became apparent when contrasted with people who are explicitly positively evaluated. For instance, therapists readily admitted to having 'favourites' but, at the same time, they were more reluctant to admit to not liking certain patients or clients. Euphemisms were common in this context: for instance, one therapist talked about a patient as being 'one of my least favourite'. Another denied not liking patients; however, negative evaluations emerged when she contrasted a 'good' family with another she was currently experiencing difficulties with: 'They're such a lovely, warm, welcoming family, very friendly ... not grumbly, groany ... ' (Finlay, 1997, p. 443).

Activity 11.8 **Favourites**

5 minutes

Referring back to Activity 11.6, are the course testers' responses relevant to your own experience of having 'favourites'? Try to think of three favourite people (clients, students, teachers, carers, children, whichever group is relevant to your situation). Do you explicitly talk about having 'favourites' in some way? If so, do these favourites tend to have certain characteristics in common?

Comment *Recognising that evaluations are often implicit and arise within specific relationships, my research indicated the existence of:*

> *a strong consensus that 'good' patients made [the therapists] feel valued and effective. They were experienced as rewarding to treat as they changed. This was all the more so when they were 'difficult', complicated, clinically interesting cases which challenged and tested the therapists' skills/knowledge. It was perhaps unsurprising that popular patients had bright, warm, responsive personalities with a good sense of humour. The other side of the coin also made sense in that 'bad' patients made the occupational therapist feel incompetent. Such patients [tended to be those] who were unappreciative and resisted change or were boring, routine cases. Equally it was not surprising that cold, unresponsive, manipulative or threatening patients were unpopular.*
>
> *Finlay, 1997, p. 444*

1.4 Ambiguous criteria

My research suggests that, while there seems to be broad agreement about what constitutes 'good' or 'bad' service users, we need to be cautious about generalising too far. The process of making social evaluations defies simplistic formulae and involves *multiple meanings* which emerge in different social contexts.

Firstly, the patterns are not predictable – they *vary* from individual to individual. The pattern suggested by research in general is that professionals do not 'like' service users who are abusive and threatening. However, in my study one therapist disagreed with this view, arguing that some of her potentially violent and aggressive patients were 'good fun' and even likeable on a 'superficial basis'. Johnson and Webb similarly note individual variations, such as those nurses who reported a covert liking for patients no one else seemed to like.

Secondly, social evaluations involve *multiple*, even contradictory, meanings. The same service user can be perceived simultaneously as both 'good' and 'bad' both by different professionals and by the same professional. My research revealed how the same patients perceived as 'boring' or 'routine' were also viewed positively as they offered opportunities for straightforward, successful problem solving. Another therapist, somewhat unusually, felt drawn to particularly 'difficult, manipulative' clients who had been sexually abused, as they engaged her clinical interest.

The fact that an individual may draw on multiple meanings and representations for the same label or evaluation adds to the *ambiguity*: for example, the meanings of words such as 'difficult' or 'demanding'. Johnson and Webb (1995) point out that 'demanding' can mean being unpleasant, being challenging (as in a difficult game), or simply asking for that which is due in an aggressive manner. One of the therapists in my study exposed the ambiguity within the idea of someone being 'difficult and demanding' when she said:

> I have a client who is particularly difficult ... a very demanding client. The thing is I don't mind if they are demanding if they get somewhere. She was very demanding and very abusive, and not willing to put any commitment to a change in. That's when you feel frustrated and as if you are just not getting anywhere.
>
> *Finlay, 1997, p. 444*

1.5 The social construction of labels

Johnson and Webb (1995) identify a complex web of social influences, including power, status and the management of uncertainty involved in the construction of labels. Somehow, the social context creates the conditions where the social judgement of other people is necessary, even if we experience reluctance or guilt in doing so. We need to ask '*Who* is doing the labelling, and why'? In their discussion of power, Johnson and Webb suggest that professionals have been socialised into using certain tactics (for instance, labelling service users) to keep users vulnerable and compliant, enabling professionals to better achieve their goals.

It is important to recognise that there is a *dynamic relationship* between people's personal lives, their professional persona and the social evaluations made. Any social evaluation is a product of the individuals concerned, their relationship and the wider social context.

The individual professional or helper comes into the helping encounter loaded with personal assumptions, preferences, needs, biases and prejudices. Professionals, too, can be difficult: they are people after all and respond to service users as 'people', not just as 'patients or clients'. This personal dimension was illustrated in my research when one therapist admitted to favouring older male patients from a particular area of town as they reminded her of her grandfather.

The relationship between the professional and service user has a bearing. The service user is not a passive recipient of labels: indeed, they might actively invite them. In other words, 'labels' and representations are negotiated, if not actively chosen. Further, the point that these labels can change over time suggests they are relational and a product of mutual interactions within an evolving relationship.

The social context, including the wider health care practices and ideologies, can be highly influential. Professionals are influenced by their professional socialisation; their personal values; the values of the treatment team in the context of hierarchical power relationships; and the representations and ideologies existing in society at large. At the level of practice, work load pressures undoubtedly influence professionals' views of service users. In my research, therapists expressed a desire to get deeply involved in more 'complicated cases' but were unable to do so because of time pressures and the number of routine referrals. In this context it is not surprising that some evaluations of patients relate to how easy or difficult they make work and how effective they make a therapist feel.

Key points

1. According to social constructionists, labels and representations are created through social interactions and in certain social contexts.
2. It is important to consider *who* is doing the labelling and their relationship with the individuals being labelled.
3. It is necessary to recognise the influence of the broader work/social/cultural context.

1.6 Revisiting the idea of the 'difficult patient' or 'difficult professional'

The discussion so far highlights the importance of being cautious about representing an individual as 'difficult'. Multiple, ambiguous meanings and values are involved – possibly both positive and negative. *Difficulty is in the eye of the beholder and emerges within particular relationships set in particular contexts.* The difficulty may lie with the individual service user or with the professional or it may relate to the context of their relationship. Specifically, the representation of 'difficult' may be associated with the particular context of how work is made more difficult (that is when it becomes unduly challenging or too time consuming or when it results in unsuccessful outcomes). An individual may be described as 'difficult' when the difficulty relates to processes beyond them.

Social evaluations cannot be avoided and they are not necessarily bad. What is problematic is when there is a negative impact on the person or on their treatment. In making evaluations, it is worth reflecting on the following critical questions.

1 Would we mind the other person knowing that we perceive them as 'difficult'? If we do mind, what does that indicate?

2 What intentions lie behind evaluating someone as 'difficult'? Are we trying to express our own uncertainty or are we alerting others to the complexities of the problems involved? Are we being derogatory?

3 What is implied by the label 'difficult'? That is, how is the person being positioned? Are we representing them as being 'uncooperative', or as 'having so many problems', or as being an 'interesting, challenging case', or as 'taking up more time than I can commit'?

4 Do any damaging consequences result from representing someone as 'difficult'? For instance, are they likely to be discharged or denied treatment? Might they behave in a more difficult way in response to such evaluations? Or might this offer an opportunity to help them become more aware of their behaviour and ultimately become more reasonable?

5 Can anything be learned from becoming aware that we are representing someone as 'difficult'? What does it tell us about ourselves and our relationship with the 'difficult' person?

6 What emotions are being experienced and what 'emotion work' is involved when we make negative social evaluations?

Key points

1 Evaluations may relate to notions of social worth.

2 Labels and social evaluations are not just passively accepted by recipients. They may be actively invited and they can be resisted.

3 Social evaluations such as saying a person is 'difficult' are complex and caution is needed when using these terms. They involve multiple meanings which are constructed within a broader social context.

2 Handling difficult encounters

2.1 Why some individuals are still perceived as 'difficult'

In Section 1 the discussion focused on problematising the notion of the 'difficult' individual or encounter. It took a broadly social constructionist (and academic) look at labelling and social representations. It stressed the need to take care when socially evaluating other people. You saw how complex emotional and social dynamics are implicated when people make social evaluations such as saying someone is 'difficult'. However, while accepting that we should be cautious about how we categorise and evaluate, most practitioners would say that, in their day-to-day practice, there are encounters which cannot be described as anything other than difficult!

This raises an important debate. Some social constructionists would deny that difficult individuals even exist. Instead, they would argue that difficulty is constructed through language, in particular social contexts, and that the notion of difficulty varies between different cultures: that is, difficulty is 'relative'. Others would argue that there is a 'reality': some people's behaviour is actually difficult. Further, it is precisely because their behaviour is difficult in the first place that they get labelled.

Activity 11.9 **Debates within social constructionism**

5 minutes

Which side of the debate are you on? Or do you prefer a middle position? Take 5 minutes to write a short paragraph stating, however tentatively, your view on this debate at the moment. You could also discuss this issue further with other students, friends or colleagues.

Comment

In this unit I have taken the middle position. I argue the need to recognise how social evaluations are subjective labels produced in a social context – 'difficulty' does not simply reside in the individual. At the same time, I am suggesting practitioners also experience encounters as difficult. Focusing on 'experience' (rather than reality as such) and on 'encounters' (rather than just the individuals) allows me to side-step the claim that difficult people really are difficult.

This discussion should alert you to the fact that academic (and indeed any) writing is never neutral or completely value-free.

'Telling' other people may also be constructed as difficult. Often it is, as shown in the next activity.

In order to explore the different meanings of social evaluations, this section changes tack and engages in a different sort of discourse. Now you will consider how practitioners and helpers cope with the challenges that arise in their day-to-day practice as they face a myriad of difficult, traumatising, abusive and violent situations. You will explore the kinds of understandings, skills and resources they need to handle those 'difficult encounters'.

In this section four case studies of difficult helping encounters are used. You might regard them as 'windows' looking out on to a range of different sorts of problems. Each window is a personal narrative of a 'difficult encounter' seen from the point of view of the helper or service provider involved. The four situations all involve complex dynamics where individual and social aspects

interrelate. There is no way of providing a definitive explanation of 'why' people behave in a certain way, but some tentative formulations can be offered of what may be occurring and why. Also, rather than analytically describing an incident, the stories reveal something of the individuals' personal and emotional worlds. As you read their accounts, you may find yourself similarly responding at both (or either) an analytical and an emotional level.

Each case study is followed by a discussion of the following questions.

- What is 'difficult' in this encounter and what issues are raised?
- Why might the situation be occurring?
- How might the encounter be handled positively?

With questions such as these, you will examine and explore the issues each situation raises, while I will also give my responses. If your ideas seem to differ from mine, do not feel that yours are wrong and mine are right. We may both have ideas that could usefully be applied. No one practice, theory or policy has 'the answer': there are no simple solutions. Instead, difficult encounters – by definition – pose difficult questions and require us to think carefully and reflexively about the situation and what can, or should, be done.

As you read through the case studies, try to identify some constructive actions that could be taken at personal, professional and/or institutional levels. Often in a difficult encounter there is a *pivotal* moment where the people involved can be seen to make a 'choice' about how to behave: a choice that might prevent conflict, for example. Beyond questions of what is in the individual's control, there may also be institutional 'structures' that can be used to pre-empt these sorts of difficulty in the future. Lessons can thus be learned, both in terms of handling the immediate situation and in terms of minimising such difficulties in the long term.

2.2 Feeling 'stalked'

Case study 1: Karen

One of my patients is extremely 'creepy'. He will come up to me and want to touch me all the time. He's a bit predatory in that he will follow me down the corridors of the unit. He stalks me. One time he preyed across the gym and crept up behind me. He then whispered, 'They [my colleagues] can't watch your back and protect you all of the time. I'll get you one day.' Even when he can't get to you physically, he'll find a way to threaten you. He'll stand there leering at you while rubbing his groin and drooling.

I'm frankly terrified by him and it's partly because I know his horrendous sexual history. Sometimes it's even hard to go to work if I think I'm going to have much to do with him. It's like I think of the unit now in terms of the places in it that I can be safe versus those open public spaces where he can 'get' me. I don't know exactly what it is that I fear. He is just so loathsome: so menacing and sinister. I feel there is nothing I can do about the situation; nothing I can do to stop him focusing on me and touching me. There is nothing I can do to stop him. One day he will get me.

(Source: Karen, a mental health therapist working in a secure unit, personal communication)

Most people have probably never experienced such a directly menacing situation in their work practice. However, you may have faced a much weaker variant – a diluted version of stalking – for instance, a sense of disquiet or feeling unaccountably threatened by a person you work with. Understanding our own experience can help us to understand the experiences of other people.

Activity 11.10 Menacing situations

30 minutes

1 Can you think of one interaction you have had in your work context where you experienced something similar to Karen?

2 Now reflect on why you might have reacted in the way you did. Was it something about the individual concerned, such as their manner or personal history? Was it something about your vulnerability related to your own history and experience? Was it a product of the situation itself in terms of your interaction or as a result of the particular context of the interaction? Perhaps it was a combination of these factors.

3 Returning to Karen, try to answer the questions raised earlier:

- What is 'difficult' in this encounter and what issues are raised?
- Why might the situation be occurring?
- How might the encounter be handled positively?

Comment

Karen is probably experiencing 'difficulty' because it feels out of her control. She feels unable to prevent this patient touching her and eventually, one day, doing something even worse. It is also difficult for her because this patient has managed to 'attack' her in a more personal, sexual, intimate way. He has effectively broken through Karen's professional defences leaving her more vulnerable than she might otherwise be. As Kottler powerfully asks, 'How do our clients get to us, unravel our previous control, and haunt us with their fears?' (1993, p. 78).

This situation raises two particular issues for me. Firstly, Karen is being threatened: physically, emotionally and sexually. She is terrified this 'creepy' patient will one day 'get' her. Although he has not yet hurt her physically, in her anxious, frightened state, she has been rendered vulnerable. Secondly, the point that Karen is being threatened at a sexual level (even if only by innuendo) alerts us to the gender issue and how a power role is being acted out here. Karen feels threatened as a woman and this power imbalance cross-cuts the power she holds as a professional. Being sexually threatening is one way the male patient can assert his power and control.

The fact that this situation occurred in the context of a secure unit is part of both the problem and the solution. Karen will, at some level, be used to dealing with potentially abusive patients who have a range of difficult, long-standing violent and/or sexual histories. There are probably several patients in the unit with whom she has to keep up her guard. Moreover, the unit, including the staff and their procedures, will be geared up to monitoring for, and preventing, violent attacks. Karen should be aware that she has the backing of the team who will, to some degree, be able to protect her (and they also will have experienced similar anxieties). Once the team are aware of the potential danger and Karen's vulnerability, a team strategy should be formulated. It should be possible to institute certain procedures (without over-reacting): for instance, Karen is never left alone or this patient is restricted to certain areas and is constantly observed. Karen should also be given extra supervision and support

to help her work through some of her anxieties and to suggest new coping strategies. The team also needs to give extra attention to working with the patient. If Karen was not around he would probably stalk another woman.

Activity 11.11 **Supervision issues for Karen**

10 minutes

1 If you were Karen's supervisor and/or colleague, could you suggest three positive strategies that she could adopt when dealing with this 'creepy' patient?

2 Now assume Karen's unit is orientated towards a particular theoretical approach (e.g. behavioural, psychodynamic, humanistic or social). Choose one of these orientations and suggest how the unit might respond to help with the problem. When you have thought this through, read the comment, which is followed by some ideas about each approach.

Comment

One positive strategy I would make revolves around the need for Karen to re-establish some boundaries. She has a right to ask not to be touched and to put her sexual/personal self out of bounds. I might suggest she tries to face her stalker (when she has another member of staff with her). First, she would need to attend to her non-verbal communication. Ideally, she should try to show she is not frightened and look squarely at the patient (with all that involves in terms of, for example, straight posture and direct eye contact). Then, Karen might attempt to ask the patient what he means, what he wants, and what he is trying to do. The aim here would be to highlight the inappropriateness of his behaviour and to consider more acceptable alternatives. Confronting the patient like this may help to turn the tables somewhat, allowing Karen to reassert, and re-engage with, her professional role – a role that offers her some more protection and distance.

The following text suggests how each of the four theoretical approaches might deal with this encounter.

Cognitive–behavioural

A cognitive–behavioural perspective would focus on the behaviour of both Karen and the patient. Treatment would seek to identify any negative thinking patterns and the triggers which provoke the patient's inappropriate threatening behaviour. Attention would be paid to what makes the threatening interactions sufficiently rewarding that he repeats it. For instance, does he enjoy Karen's anxious reaction to his sexual threats? A programme might be implemented involving other forms of reward when he behaves more appropriately.

Psychodynamic

A psychodynamic approach would focus on the unconscious emotions, drives and needs underlying the patient's behaviour (and Karen's response). The patient's fixation on Karen would be explored in his psychotherapy. Does she represent someone or something from the patient's past? Is she an object of 'transference' perhaps? Questions would be asked about the patient's problematic sexual history and how this may relate to abusive relationships he had in his early childhood.

Humanistic

A humanistic approach would involve trying to acknowledge, with empathy, the emotions, needs and fears consciously being expressed by both Karen and the patient. Treatment approaches would involve Karen in finding ways of relating

to the patient that involved more positive interactions. For instance, an 'appreciative inquiry' approach might be adopted (see Unit 9), or they could work together on a creative project aimed at enabling the patient to feel a sense of control, self-esteem and positive achievement.

Social

Sociologists, social constructionists and feminists would focus on the power dynamics between Karen and the patient and how the *personal* becomes *political*. In particular, the gender dimension is relevant: recognising this may help to reduce Karen's sense of personal vulnerability. She is not alone in her experience and she can draw on the strength and support from other women.

Key points

1 This difficult encounter raises issues at personal, professional and institutional levels. All three levels need to be taken into account to understand the problem and its possible solutions.

2 Ideas and strategies for dealing with difficult encounters depend on both the context and which theoretical approach is brought to bear.

2.3 Being physically assaulted

Case study 2: Graham

I was working in a group home that was run as a therapeutic community. Two afternoons a week we held a group cookery session. Normally these groups worked really well: everyone was friendly and co-operative and there was a great atmosphere while we created something tasty together. On this one day Pat was obviously tense. She wasn't responding to the usual jokes and social chit-chat. We all decided to leave her to it so we tended to ignore her. In retrospect, maybe that was the wrong thing to have done. At some point, I made a slightly critical comment by asking if she had enough flour in her cake mixture. She suddenly blew up. She threw this big mixing bowl at me (I had a bruise on my arm for ages) and she smashed a couple of other bits of crockery. She was screaming and shouting. She called me a 'f***ing bastard' and said she hated me and she hated the group. She said she wanted nothing more to do with the whole lot of us.

I was pretty unnerved. I didn't know what to do. I was scared that Pat would get even more out of control and hit out at the other group members. She was a big woman and she could have done a lot of damage. I was aware that everyone else was scared too. I knew I had to take control and responsibility. Luckily, a couple of the residents managed to hold on to Pat, without me asking. They stopped her lashing out.

That gave me the chance to shout: 'Okay, everyone stop now! Pat is trying to tell us something. We can't hear you when you're being so violent Pat. We know you're upset and angry. Are you ready to sit down more calmly and talk us through what you're wanting to say and what is

bothering you?' I had to say this several times but, amazingly, it seemed to work. It was like I was taking control and Pat was relieved I could sort of contain her 'out-of-controlness'.

We all went to the side room. It was lovely. The two residents who had restrained Pat stayed by her side holding her hands. People were being really supportive (despite being a bit shocked and shaken themselves). Pat then shared with us how she had received a phone call from her father the previous evening. He upset her – which was kind of normal ...

The group then turned into a bit of a therapy and support group, which was good in a way. I knew though that, according to unit policy, I had to get Pat to take some responsibility for the damage she had caused. She would have to pay for the broken crockery and I needed to get her to tidy up her mess. At the end of the group I faced Pat with this and I was relieved when she acquiesced quite sheepishly.

(Source: Graham, a care worker in a group home, personal communication)

Activity 11.12 Effective strategies

30 minutes

1 What is 'difficult' in this encounter and what issues are raised?
2 Why might the situation be occurring?
3 How might the encounter be handled positively?

Try to identify at least two factors about the context that helped Graham's strategy to be effective.

Comment

(a) Graham's approach – *the helper in this situation, Graham (despite feeling scared), seemed to have struck exactly the right note in this encounter in the way he repeatedly acknowledged Pat's anger and stayed calm. (Some key ways to defuse violent situations are described below.) Seeing Pat's behaviour as a 'cry for help', he could look beyond it rather than react defensively or aggressively himself. His first response – to contain the violence by shouting 'everyone stop' – was effective. He could have been more controlling, critical and authoritarian in his approach and homed in on the unacceptability of Pat's behaviour (perhaps something Pat's father would have done). Rather, he tried the more sympathetic/empathetic line, while also trying to present himself as being 'in control' and able to keep everyone safe. It is important that the group members could also contribute positively and help to contain Pat's destructiveness.*

(b) Pat's needs – *I sense that Pat also wanted to be contained. It sounds as though she capitulated quite quickly and was aware of her actions and responsibilities. Having the 'therapy group session' allowed her to 'save face' in some way: that is, she had an 'excuse' to behave in the way she did. With safe boundaries re-established and the warm support of others, she was enabled to take responsibility for clearing up her mess.*

(c) The context – *the fact that this incident occurred in a group home run on therapeutic lines is also important. They had the time, space and a caring group – conditions that allowed the group to work through the problem constructively. The group members (including Graham) have what sounds like a positive, supportive and ongoing relationship built on some trust. Part of the nature of the therapeutic milieu of the home involves residents in assuming some responsibility for providing both mutual support and control. Homes based around such ideologies tend to favour democratic, rather than authoritarian, forms of control. This home also*

adopts a broadly psychodynamic approach in its focus on understanding the underlying causes of behaviour. All these factors combined to aid the success of Graham's strategy. In another context he may well have had to respond differently: for instance, following such procedures as pressing a panic button to call for help to restrain Pat; ensuring that all the other group members were physically out of harm's way by getting them out of the room.

The rest of this section suggests how different theoretical perspectives would approach defusing violent situations.

Defusing violent situations

Practitioners from different theoretical orientations would emphasise different strategies to defuse violent situations. You learned about behaviourist and humanistic perspectives in Unit 4. The following account by Weiner (1999) suggests, first, a combination of behavioural and humanistic strategies. These strategies rely partly on social learning theory, in which a practitioner might 'model' behaviour, such as 'staying calm and talking in a normal voice'. Weiner then focuses on an account from a humanistic practitioner.

Behavioural strategy

- The 3 As: *Acknowledge* anger; *Agree*, where possible, that the situation is anger provoking; *Apologise*, if appropriate.
- Stay calm and talk in a normal voice.
- Be non-judgemental (e.g. do not blame, patronise or put the other person down).
- Use diversionary tactics (e.g. make a cup of tea).
- Use active listening skills.
- Keep repeating what you want the other person to do.

Humanistic strategy

> Humanistic practitioners would emphasise the importance of 'core conditions' where violence might be pre-empted and deflected by empathy and through genuinely valuing and accepting the other.
>
> *Personal communication to the author*

Do you remember the story at the beginning of Unit 9 where Jim's caring and charming response to Janice defused conflict? While violent encounters tend to occur most often in units for people with severe mental health problems, it also routinely occurs in other places: for instance, in accident and emergency departments, children's homes and secure units. All of us in our different environments can suddenly be faced with violent, aggressive, unpredictable behaviour. Many units or organisations issue guidelines for the 'management of violence'. Employers have a legal responsibility to take steps to manage risk and to establish relevant procedures and training. If you work, are you aware of the policies, procedures and training opportunities in place? If you are unsure of them, it might be a good opportunity to find out.

If you are in contact with other students, for instance in your tutorial group, it might be interesting to compare notes and share the practices of your different organisations.

The guidelines in Box 11.1 identify the sorts of areas you should be alert to when considering policies to manage violence.

Box 11.1 Guidelines on the management of violence policies

1 Effective *risk assessment* guidelines to analyse:
   - safety of physical space and layout (such as having safe areas with locks, good lighting, no dangerous objects around, windows on doors so that others can see what is happening, alarm systems, etc.)
   - risk factors (related to individuals' motivations, access to victims, opportunities for violence and the triggers or conditions that may provoke violence)
   - probability of violence and likely harm.

2 Good *communication* and *planning* to include:
   - effective case reviews and handovers (within and between agencies) to have warning and opportunity to plan for possible violence
   - clear guidelines on boundaries and responsibilities.

3 Clear *procedures* to call for help (such as alarm routines and ensuring that staff never work alone).

4 *Training* opportunities (to include attention to antecedents of behaviour and tactics for de-escalation, break away and physical restraint).

5 Post-incident *support* and *reporting* procedures

Key points

1 Violence can be defused by acknowledging the other person's position and by ensuring a safe, containing environment.

2 Employers have a legal responsibility to manage risk and to establish procedures and training, for instance, on the management of violence.

2.4 Feeling manipulated

Case study 3: Geeta

I have one elderly lady I care for, who I really find difficult. She sucks me dry. I see her for three mornings a week. I have to take a deep breath before I go in. She winds me up really. It's a combination of things. 'She's just very confused, lonely and frail', I tell myself. I need to try to be more patient.

The main caring I do is to help Marjorie dress in the morning and I clean her commode and any messes from 'accidents' in the night. She can manage to dress herself really, it's just that she's sometimes not safe and she falls. But she sits and waits for me to dress her. (I think she thinks I'm her servant because I'm Asian – well, third generation! She was brought up in India and she often talks about all her servants and the ayah she used to have.) She'll whine, 'I can't do it. It's too difficult for me. I'm too old now. I need you to help me. I can't do anything any more.' And then

she'll cry. I try to cajole and encourage her. But I don't have the time to do this every day – I mean I've only got twenty minutes to do just the basics! In the end I often end up just dressing her. I tell her that I have other clients and that many of them are much worse off than she is. Then she cries and says, 'Why won't you help me? I need help. You don't care. No one cares.' She holds on to me and won't let me leave. She usually has other little jobs she wants me to do. It's all so pathetic and I feel so guilty. I always leave feeling bad.

(Source: Geeta, a carer attached to a private care agency, personal communication)

Activity 11.13 Geeta

30 minutes

Reflect on Geeta's situation and answer the following questions.

1 What does she seem to find difficult, and why? Try to identify at least three specific things she personally finds difficult.

2 Can you identify one institutional factor that may be relevant to creating this difficult helping encounter?

3 If you were Geeta's supervisor, could you suggest a positive strategy for dealing with Marjorie's demand to have things done for her?

4 Can Geeta's organisation help her in any way?

Comment

Geeta does not seem to know why she feels bad but, somehow, her 'buttons are pushed' – she feels 'wound up' and 'guilty'. Her sense of being 'sucked dry' is related, at least partly, to the way she has to 'battle with' both Marjorie and her own complicated emotional responses. Several factors are probably intertwined here. At an interpersonal level:

- *Marjorie is 'difficult' because she makes Geeta's work difficult. Having to cajole and deal with Marjorie's crying or whining makes it hard for Geeta to finish her required tasks in just 20 minutes. She is made to feel that she is not doing her job properly.*
- *Geeta also seems to find Marjorie's 'pathetic' behaviour – her crying, passivity and dependence – difficult in itself. Marjorie tries to manipulate and 'hang on' to Geeta, which turns their encounters into battles. While Marjorie is being 'pathetic', she is also exerting some control and showing considerable tenacity, which Geeta has to resist. All this adds to Geeta's sense of guilt that she cannot – or does not – 'care' enough.*
- *Geeta believes she is perceived as a 'servant', which adds a further layer of mixed emotions (for all that she has not explicitly expressed her responses to this). We might surmise that she feels somewhat insulted and angry in the face of what might be seen as Marjorie's racism. Geeta's anger and guilt are likely to be bound up together as she may perceive Marjorie is too frail to deserve her anger.*
- *Geeta probably has previous negative experiences of racism that may make her more aware of, and sensitive to, Marjorie's attitudes.*

At an institutional level, some other issues seem relevant, for instance:

1 *Geeta's work role is difficult. She has a job that involves caring for others, often in difficult circumstances (for instance, having to clean up after a person has been incontinent). The fact that she is not well paid may add to her sense of stress and feeling undervalued by her employers and by society at large.*

2 *Geeta's care agency appears to emphasise an ideology that 'independence is good'. This creates some tensions for Geeta as she believes she should encourage Marjorie to care for herself. At the same time, for a variety of reasons, she is being drawn into dressing Marjorie – almost colluding with Marjorie's desire to be cared for. One positive strategy that Geeta could adopt here is to negotiate a behavioural contract whereby Marjorie agrees to do certain tasks by herself and, in return, Geeta agrees to do some things for her.*

3 *The 'racial' dimension adds a further layer of complexity. The discourses arising from Marjorie's colonial past could be said to impact on Geeta's own sense of herself as a 'British Asian'. Geeta may have a sense of being exploited, which is likely to resonate given the powerful parallels with her family and community history. Referring to his own identity as a British African–Caribbean man, Stuart Hall emphasises the importance of the social and historical context in shaping identity: 'Identities are the names we give to the different ways we are positioned by, and position ourselves within, the narratives of the past' (Hall, 1990, p. 225).*

4 *Geeta's care agency may well have some organisational frameworks in place for addressing racism and supporting staff. For instance, they may suggest another care worker visits Marjorie with Geeta, to give Geeta extra support and validation.*

Key points

1 Reactions in the face of difficult encounters can be ambivalent (mixed) and complex, involving both personal and social dimensions.

2 Racism, however subtly experienced and expressed, needs to be tackled at an institutional (i.e. not just at a personal or an interpersonal) level.

2.5 Witnessing self-injury

Case study 4: Valerie

Steven is a boy with organic brain damage which has led to cerebral palsy and an IQ in the severe range (40). He is referred to Valerie Sinason, a psychoanalytical psychotherapist who has specialised in working with children who are profoundly disabled. When he was first referred Steven was just 10 years old. Valerie saw him for a treatment session once a week for six years. Her story (told in the Reader chapter you will read in Activity 11.14) gives a glimpse into Steven's extraordinary world and into Valerie's own extraordinary work.

Activity 11.14 **Steven**

1 hour

1 Read and reflect on Chapter 29, 'Steven', by Valerie Sinason in the Reader. You should be prepared for the fact that it describes some powerful scenes and grapples with profound issues about the nature of disability that may be distressing. At the same time, you may find the therapist's expertise, sensitivity and wisdom an inspiration.

2 Focus on what you think is difficult about this encounter and the emotions and issues it raises for you. Take up to 15 minutes to write notes on your personal reactions or to discuss them with another person.

3 You will probably be struck by the highly specialised nature of psychoanalytical psychotherapy as you read the chapter. Some of the ideas in it (for instance, Valerie's interpretations of Steven's behaviour) may be alien to your everyday understandings. Try, if you can, to identify three assumptions underlying Valerie's theoretical orientation. Also, try to identify how Valerie manages to cope emotionally with witnessing Steven's self-abuse and deep distress. Spend up to 10 minutes writing notes on this.

Comment

I was struck by several assumptions of psychoanalytical psychotherapy, as follows.

(a) Having a prolonged and intense treatment period lasting many years is accepted as a good and necessary process.

(b) The therapist is focused on trying to understand what emotions and drives underlie Steven's overt behaviour.

(c) The therapy process is based on interpretations of unconscious needs. (In Steven's case he was often unable to express himself verbally, so Valerie interpreted his non-verbal behaviour.)

(d) Valerie uses her own bodily and emotional responses, particularly her fears, as communications in themselves (she listens to these unconscious 'signals').

Valerie seems to have coped with the violence, self-injury and the sheer intensity of emotions experienced with Steven, using insights derived from psychoanalytical theory. It strikes me that she believed in, and gained solace from, this knowledge. In addition, she regularly drew on the support from other staff and colleagues and engaged in her own personal psychoanalysis in an effort to understand better what Steven was trying to express. The intensity and depth of her commitment is, in my view, extraordinary.

Key points

1 Some encounters are deeply personal, emotional and profoundly touching.

2 Difficult encounters raise moral dilemmas.

3 Understanding a situation at a theoretical level can help people to cope in the face of difficult encounters.

3 Themes and questions

Section 2 has shown how:

- Professionals and helpers face a myriad of difficult, traumatising, abusive and violent situations in their day-to-day practice.
- The impact of these encounters is experienced at personal, professional and/or institutional levels.
- Strategies for handling difficult encounters need to encompass both personal aspects and institutional structures.

Several themes can be identified across the four case studies, in particular: responsibility, choice, boundaries, control, ethics and ideology. It is worth dwelling on them further, in relation to both the case examples and how we handle difficult encounters in general. Some of the questions arising from each of the issues are discussed below – questions that can be used to guide reflection.

Responsibility

Who has, or should take, responsibility? Here we need to think broadly in terms of individual or role-related responsibilities alongside institutional or societal responsibilities.

Choice

In every encounter 'choices' are made (at some level) about how to behave and how to respond. To what extent do we have a choice? Can we respect the choices of other people – particularly if we see they are damaging in some way? Remember the discussion in Units 2 and 3 on autonomy and paternalism?

Boundaries

What is and what is not acceptable? Beyond thinking about our personal boundaries (for example regarding emotional limits and physical space), there are organisational and legislative boundaries. Protection is a particular issue here in terms of the need for staff to keep safe as well as keeping safe those in their care.

Control

Who has, or should be in, control? Here we can distinguish between being in control, taking control and allowing others to have control over their own actions and lives. It is also possible to see different types of control: for instance, the control we have over our own emotions versus the control institutions have over us.

Ethics

Value systems are not absolute – they are negotiated through particular relationships and set within particular communities and cultures. It is important that individuals act from different ethical stances. Difficult ethical dilemmas haunt health and social care practice: questions are raised about people's freedoms and civil liberties; about whether they have a right to be treated and how; about the welfare of a few when weighed against the welfare of the many.

Ideology

We take for granted many sets of ideas that prevail in our social world: for instance, about how health and social care should be organised. These ideas are steeped in values and assumptions about the desirability (or otherwise) of social arrangements, and they often arise to support and reproduce existing power structures. These ideologies are important because they shape us, our practices, our institutions and society at large. An example of ideology in practice is the emergence of our semi-privatised social care system from political and economic ideas favouring a 'mixed market'. Another example is how practitioners draw on particular theoretical frameworks, for instance psychoanalytical ideas, to explain and treat psychological problems.

Activity 11.15 Relating themes to case studies

20 minutes

So far, the discussion in this section has been abstract. This activity aims to relate some of the themes and ideas discussed to the specific case studies. There is not space or time to apply each issue to each case study. However, it might help you grapple with these ideas if you focus on each case study by choosing a particularly pertinent issue for each one (that is, you can explore the same issue or a different one for each case study).

Use the themes in the grid below to get you thinking. You may find it useful to draw up a grid like this, noting any points that occur to you in the different boxes. Do not think there are any 'right' answers here, nor that every box needs an entry. The point is to use this exercise to reflect more deeply on the issues involved in difficult helping encounters. When you think you have considered the issues sufficiently, you might like to read my own thoughts in the comment.

Case study	Responsibility	Choice	Boundaries	Control	Ethics	Ideology
Karen						
Graham						
Geeta						
Valerie						

Comment

1 *Levels of responsibility strike me particularly in Karen's and Graham's situations. For Karen, a central issue is the extent to which her forensic unit has a responsibility to ensure her safety; to protect and train her to manage any violence. Graham's situation, in contrast, raises issues about lines of personal responsibility. His home emphasises the personal responsibility of each resident. Pat, for instance, is seen as being accountable for her behaviour and she is expected to clean up, make amends and pay for any damage.*

2 *Issues of choice seem particularly pertinent in Geeta's and Valerie's relationships. In Geeta's case, is Marjorie free to 'choose' to be dependent, to not dress herself? Is Geeta free to not work with Marjorie if she feels she is being racially abused? The issue of choice comes over in Valerie's relationship with Steven in the way she continually tries to offer him choices. She gives him the space to choose whether or not to come for the therapy, as well as allowing him to choose what to do and how to behave once there. She even offers him a degree of choice in terms of*

'allowing' him to be violent or to engage in self-abuse. Critically, Valerie herself makes the point that her choice to tolerate the self-attacks was not one his residential staff were free to make.

3 *Boundaries are the critical issue for Karen: specifically the boundaries between her personal/sexual self versus her professional self. This case raises questions about the boundaries between patients and staff and to what extent these are fixed. Is it acceptable, for instance, to touch and to be touched in different professional relationships and contexts? (This was discussed in Unit 8.) A different, more subtle, concept of boundaries is involved in Valerie's story. Here, there is a sense that some of the boundaries between Valerie and Steven are rather diffuse. Joined in their relationship, their responses are intertwined and often mutual. This came out particularly strongly in the way Valerie tried to empathise and to use her own emotions (for instance, her fear and her feelings of distraction) to understand Steven's.*

4 *Issues around control come over particularly in Karen's and Graham's accounts. Karen explicitly says she feels there is nothing she can do, i.e. the situation seems out of her control. She feels that she will not be able to stop the patient touching her and, ultimately, 'getting' her. Homing in on Karen's vulnerability, the patient controls their encounters. Graham, on the other hand, seems able to take control (even if he does not feel fully in control of the situation). Taking control – without being unduly controlling – allows the other group members to feel 'safe'.*

5 *Ethical dilemmas underpin each case study in subtle ways. For me, Valerie's story in particular raises questions: for instance, about the profound nature of Steven's disability and the methods used in his therapy. Valerie herself picks up this point when she comments (in a passage not included in the Reader chapter):*

> *I needed the support of my own personal psychoanalysis ... to manage emotionally and deal with the ethical issue that Shirley Hoxter (1986, p. 87) has put so succinctly with regard to physically ill and disabled children: 'we find that our methods of psychotherapy are requiring the child to confront and assimilate something which, thankfully, is far beyond that which most of us have had to experience ... Sometimes we will ask ourselves whether it is not better to let well alone, to let these children remain in their states of non-integration, utilising the merciful defences of repression, denial or splitting, or even being excessively withdrawn, half-alive rather than painfully alive. The pains of integration may be worthwhile when they lead to 'ordinary human unhappiness' but we feel guilty and cruel if integration seems only to offer the sufferance of suffering.*
>
> *Sinason, 1992, p. 123*

6 *Finally, different ideologies can be seen to underpin all the encounters. At a practical level, a role for ideology is apparent in the choices of particular psychological and theoretical orientations as revealed, for example, in the democratic and psychodynamic values of Graham's institution. At a societal level, we can see the impact of political and social ideologies at work in each of the health and social care contexts. Geeta, for instance, works for a privately run care agency (a service which would have previously been provided by social services). Karen works in one of the many forensic units which have been created in the last 30 years to deal with the 'problem' of offenders who are seen as mentally ill.*

Activity 11.16 **Taking responsibility**

45 minutes

Go to the Course Resources area of the K309 course website. Look in the list of websites for Block 3 and find the Department of Health website called 'National Task Force on violence against social care staff'. Make notes on what this tells you about the incidence of abuse.

Comment

At the time of writing the rates of violence were surprisingly high. What is particularly interesting is that there is an estimated unreported incidence of violence. You might speculate that staff assume this is part of the job. How far would you agree with this and the extent to which health and social care staff should go down the 'zero-tolerance' route?

You might have looked at other aspects that are noted there and the extent to which staff claimed to be unsupported by their organisation. You might want to consider this again in Unit 13, which explores organisational culture more closely.

Key points

1 Issues around responsibility, choice, boundaries, control, ethics and ideology permeate difficult helping encounters.

2 Being aware of these issues may allow better recognition of where responsibility for handling difficult helping encounters lies and the minimisation of their more problematic aspects.

4 Conclusion

This unit has examined the topic of difficult helping encounters in two ways: first, we saw how the very concept of 'difficult' is problematic and involves multiple meanings. We explored the need to be cautious and critical about representing individuals as 'difficult', given the crucial consequences that can result in terms of service provision and in the way they can disempower and stigmatise.

Section 2 explored a range of issues arising in particular encounters that people have experienced as difficult. We recognised how 'problems' and 'solutions' can be understood at the level of both the individual and the institution or organisation. Particular themes around responsibility, choice, boundaries, care, ethics and ideology were discussed.

One lesson that emerged is the importance of thinking reflexively and critically about the possibilities, pitfalls and potentials – within both the specific encounter and the different organisations in which an encounter takes place. This understanding allows us to recognise, and thereby minimise, some of the more problematic dimensions of helping encounters.

Our analysis emphasised that difficult encounters are invariably complicated and are not easily resolved. The helpers or professionals who manage to find ways of handling their difficult encounters demonstrate wisdom, sensitivity and empathy. They are prepared to listen, to reflect critically, and to seek to understand. As Arthur Bochner puts it, 'In the quiet of our eye contact, I've learned that without silence, words would be meaningless; without listening, speaking loses its capacity to heal; without empathy, fear becomes consuming' (2002, p. 168).

We need to listen to the messages, to learn the lessons that are present in every 'difficult' helping encounter.

Unit summary

Social evaluations such as saying a person is 'difficult' involve multiple meanings which are constructed within a broader social context. Professionals and carers face a myriad of traumatising, abusive and violent situations, which can be experienced as difficult. 'Problems' and 'solutions' around difficult helping encounters can be understood at both the level of individuals and the level of institutions. Being reflexively self-aware, and critically reflecting on institutional resources and constraints, enables us to recognise better and minimise the more problematic aspects of these encounters.

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