OpenLearn

The Open University

The boundaries of care

The Open University

The boundaries of care

OpenLearn | Free learning from The Open University

About this free course

This free course provides a sample of Level 1 study in Health and Social Care: http://www.open.ac.uk/courses/find/health-and-social-care.

This version of the content may include video, images and interactive content that may not be optimised for your device.

You can experience this free course as it was originally designed on OpenLearn, the home of free learning from The Open University - www.open.edu/openlearn/health-sports-psychology/social-care/the-boundaries-care/content-section-0.

There you'll also be able to track your progress via your activity record, which you can use to demonstrate your learning.

The Open University, Walton Hall, Milton Keynes, MK7 6AA

Intellectual property

Edited and designed by The Open University.
Printed in the United Kingdom by the Alden Press

Contents

Introduction

In this course, we are going to look at a number of situations which put a strain on the idea that caring is just 'being ordinary', including times when people are giving intimate care. In these special circumstances, since the normal rules do not apply, we have to develop a set of special rules to guide practice.

This OpenLearn course provides a sample of Level 1 study in Health and Social Care.

Learning Outcomes

After studying this course, you should be able to:

- demonstrate an understanding of the difficult decisions that need to be taken to improve the quality of interpersonal relationships in health and social care contexts
- appreciate key moral dilemmas in the provision, delivery and management of health and social care services
- identify ways in which boundaries can be respected in situations where intimate care is being given.

1 Crossing boundaries: a case study

A number of situations put a strain on the idea that caring is just an extension of 'being ordinary'. These include times when people are giving intimate care. Since the normal rules do not apply in these circumstances, we have to develop a set of special rules to guide practice, thinking very carefully about the core question: 'How can boundaries be respected in situations where intimate care is being given?''

This question will be explored through a fictional case study set in a residential unit for young people with learning (and some associated physical and sensory) difficulties. The story is fictional in the sense that I have made the characters up and put all the separate strands together, but the setting is based on a real establishment and each incident or situation is based on a real event or on the experience of someone known to me through my work or personal life. The fact that it is presented as a story does not make it any less real, it merely provides anonymity for the people and services involved.

In this case study you will meet Marie, a new care assistant.

Marie

Marie is a young white woman who has recently started work at a residential unit for young people with physical and learning disabilities run by a local charity. She trained as an NNEB nurse at her local college after leaving school but did one of her placements at a day nursery which included children with learning difficulties and really enjoyed it. She was very thrilled to get this job: it is local and she can easily get there on the bus even for the early morning shift. It doesn't pay very well but it is better than being a private nanny or babysitter and she really looked forward to getting her first proper pay packet. Marie lives at home: she has been going out with her boyfriend Barry for two years and is saving up to get engaged.

Figure 1

Before the interview Marie was sent a prospectus about the unit, which described how it had been set up to help young people who had left special schools to make the transition to adult living. There was also a special needs unit for people with more severe learning difficulties. The brochure said:

> We have a commitment to treating the residents here like any other young people. We provide opportunities for them to reach adulthood by making their own choices and by treating them as normal young adults would expect to be treated.

Marie was at a bit of a disadvantage in the interview because her previous experience had been with younger children. The interviewers asked her about her training and said that it would be important to treat the young people as adults and not as children. They said they were looking for someone who could act ‘more like a friend than a parent’. Marie latched on to what they were saying and said she thought she could do that because she always prided herself on treating children with respect and not in a babyish way.

The head of care also asked Marie about care plans and she was able to talk about the system used at the nursery for recording what each child liked and needed during the day, such as if they had a special diet or needed a nap at a certain time, and so on. She talked about her work with Tom, a boy with Down's syndrome in whom she had taken a special interest, and how they had been working on helping him to learn new words by noticing toys he liked to play with and getting him to ask for them.

The head of care was impressed with Marie's maturity and enthusiasm and as she had a good reference from her college and from the nursery, they offered her the job. She started on the Monday after she finished college but was invited to come up for a couple of hours on Friday evening to see round the unit and to meet her ‘shift’, especially Joan, who was the

senior care officer who would be showing her the ropes. Joan introduced her to Richard and Rachel as she was to be keyworker for them both and would be getting to know them better than the other residents.

For the first week she was to be on day duty, which involved getting people up and ready for breakfast and then helping them into the dining-room. Understandably, she was nervous on her first day but she got there on time and worked with another member of staff to help Rachel get dressed. Rachel needed a lot of help and Marie realised as they were having breakfast that she did not know how to feed someone who needed this amount of support. She looked round for help but there was no one near who wasn't busy so she ‘owned up’ to Rachel, who grinned. When Marie put the food in too quickly Rachel spat it out, but gradually Marie found the right speed and relaxed and they began to get on well.

The second day began in the same way except that Marie was to get Richard up first as Rachel was having a lie in. Richard had his own room and Marie knocked and went in. Joan had said Richard was a ‘total care but Marie wasn't quite sure what that meant. She had met him briefly the day before and knew he liked to play on his computer using a probe he wore around his forehead, but she felt a bit shy of barging into his room and didn't really know where to start. She had been told that he could move from the bed to his wheelchair but would otherwise need help with dressing and toileting.

When Marie went to help Richard get up it was obvious that he had an erection. She didn't know what to do: she didn't want to embarrass him but she couldn't help blushing. She wondered if she should go out of the room or go to find Joan, but if she did find her Joan would be busy and also Marie didn't know what she would say, so she decided to stay and just turn away for a bit. Eventually she took Richard to the bathroom. By this stage she was confused as well as embarrassed. She realised that Richard was going to need help to go to the loo and saw the urinal bottles on the shelf. Since he could not use his hands she had to put his penis into the bottle and keep it there while he peed. Then she took him back to his room and helped him to wash his face and get dressed.

Marie had never seen a man's penis before: although she was going steady with Barry, they had decided to wait until they were married before they had sex, which was in keeping with

their religious beliefs. She felt upset that she had not realised this would be involved in the job and when she got home she thought it best not to say anything in case Barry or her parents misunderstood. She thought Barry might tell her she should leave the job so she kept it to herself. All the other women at the centre just seemed to get on with it and she didn't want to make a fuss. When her friends asked her about her new job she talked about her trouble feeding Rachel and about her time in the art room.

If Marie had got a job in a bank or a shop she would not have been expected to take a young man of her own age to the toilet, or to see him naked. Everyone acted as if it was the most ‘normal’ thing in the world, but it wasn't normal in Marie's world. Over the next few months Marie came to see it as normal too: when her friend Pebbie came to work at the unit after Christmas, Marie forgot to tell her what she was letting herself in for.

2 The strains of intimate care

Intimate care involves stepping over people's usual boundaries. It takes us out of familiar territory in terms of how we relate to each other. It necessitates *breaking* the usual rules about how to behave in order to attend to bodily functions which we normally take a lot of trouble to keep private, and this 'secrecy' extends to the work itself. A key issue in Marie's story is the assumption that this area of the work does not need to be mentioned.

Activity 1 A better induction for Marie?

0 hour(s) 15 minutes(s)

Consider the information you have about how Marie was introduced to the work. Then make your own notes on the following questions.

1. What could have been done differently in the interview or during Marie's first few days?
2. How could the subject have been brought up in a way which would have made Marie's introduction to the work easier and would have acknowledged that it was a difficult position to be in?
3. How do you imagine Marie's inexperience and the way in which she had been introduced to care work affected Richard's experience of being cared for?

I have written a short statement which the head of care could have made at the end of the interview to prepare Marie for this aspect of the work. First I asked myself: What needs to be said? How can the subject be broached in a way which leaves it open for Marie to come back if she has any problems?

> *You will find that the work requires you to undertake some very **intimate tasks**, like taking a young man to the toilet, washing parts of the body – his penis, his testicles – which most people keep **private**. It may worry you at first. If we appoint you, I'll make sure I'm on hand when you start work, and at the end of your shift for the first week, so that you can raise any questions you might have, and ask for advice. **Managing feelings** about intimate care is an important part of the job. You need to feel **comfortable** with it, and so do the residents, who may also feel quite **sensitive** about it. These young people may have **disabilities**, but they are also men and women, and their **feelings about their bodies** need to be respected*.

Revisit Marie's story

Now look back over Marie's story and over what you have scripted for the head of care to say to her.

Did you imagine that the head of care was a woman or a man?

Think about how this affected the way he or she spoke to Marie and what it was appropriate for him or her to say. Would it have made a difference if Marie had been an older woman do you think?

Answer

Personally, I found it easier to imagine a female head of care making the statement I scripted than a male.

It might also have been different if Marie had been a young man. It is possible that if *she* was a *he*, he would not have been expected to dress or toilet a woman. Women are expected to know how to do care work because of their previous experience in the private sphere of the family, whereas there tends to be a different set of beliefs about men doing caring work. Sometimes this includes fears that they might be less sensitive, or even abusive. In establishments like this one, men tend to do less of the actual caring work and more administration or management. These concerns help to justify this division of labour. The ‘taboo’ around male carers also means that service users themselves might choose not to be cared for in intimate ways by a man.

So we can see a number of factors at work in Marie's story:

- First, there is the issue that an important part of the work she is being expected to do has been left unspoken. It is ‘taken for granted’, silent and invisible. In turn this has the effect that Marie oes not feel able to ask for help and actively colludes in keeping the ilence around it by not telling her boyfriend or family, and by not assing on her experience to her friend who later joins her in the ork. Marie learns that what is expected of her is to do the work ithout commenting on it.
- Second, Marie doesn't know *how* to do this aspect of the work in a sensitive way, without embarrassing Richard or making him feel wkward. She has to manage this part of the work so that she can lso relate to Richard as his key worker – and she hardly knows him!
- Third, we can see that this aspect of the work has something to do ith gender because the rules are different according to whether the people concerned are male or female. Because Marie is a woman it is s if she is expected to know how to do these tasks without being told: because it is ‘women's work’.
- Lastly, we can see that the issue of intimate care cuts across the formal culture of the workplace. Marie is given information about what her job entails in a formal interview. This may have been conducted according to agreed rules designed, for example, to ensure equal opportunities. There is a job description which sets out the main requirements of the job (but which doesn't include taking people to the toilet) and a person specification (which doesn't say anything about it either). The personnel officer has not deliberately missed out these aspects of the work, but consigned them to a different space. They are part of a private sphere even within the workplace, not part of the publicly acknowledged aspects of the job. Marie does not get induction, instruction or supervision in how to do them, and they are not part of the management relationship. Especially if her manager is a man, Marie will not expect him to go into detail about how this part of her work should be performed, whereas for other parts of her job, such as how to fill in a care plan or draw up a teaching programme, he may show her what to do or assess her competence and give her feedback on how well she is doing.

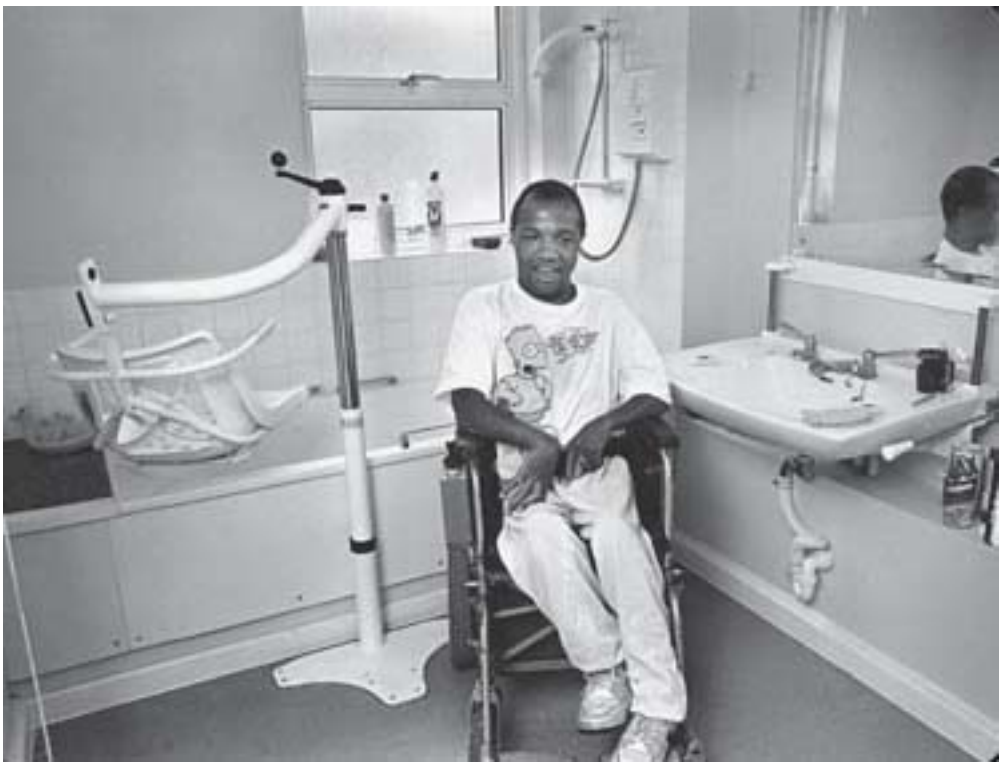

Figure 2

It is almost as if Marie has taken on two jobs, one which is publicly acknowledged and accounted for (her professional role) and the other which takes place behind the scenes, which she has to manage privately. This sometimes causes problems as it did, for example, in Marie's third week in the job when she was told off by her manager because she was late for a meeting with Richard's social worker and speech therapist. The reason for her delay was that she was helping to clean someone up after an ‘accident’ in the toilet. Marie's workload is often discussed as if these private elements of it do not take up any space or time. Actually they have to take priority over the written and administrative functions but that is not openly acknowledged. J. Lawler in his book *Behind the Screens: Nursing Somology and the Problem of the Body* comments that:

> Nursing involves not only doing things which are traditionally assigned to females, and learning to do them by experience and practice, but also crossing social boundaries, breaking taboos and doing things for people which they would normally do for themselves in private if they were able.
>
> (Lawler, 1991, p. 30)

Key points

- Intimate care is not ‘ordinary’. It presents a very unusual set of dilemmas for both the carer and the person cared for.
- Despite how ‘extra-ordinary’ such tasks are, care workers are often expected to be able to do this side of the work ‘naturally’.
- Expectations about intimate care and caring are different for men and women staff and service users.

- Although care establishments are largely organised around the need to provide intimate care, this may not be acknowledged in the public face of the service, or reflected in its training, guidance or supervision.

3 Silences and concealment

Anthropologists and psychoanalysts use the term ‘taboo’ to describe forbidden activities, feelings or relationships. All societies seem to have particular rules and rituals to deal with bodily functions, sexuality and death, sometimes expressed in terms of hygiene or religion, and these keep them separated off from everyday life. When social rules function well they are invisible. We only notice them when we have committed a *faux pas* and caused embarrassment.

Marie very quickly and correctly learnt the rules in this establishment: from the lack of acknowledgement of this aspect of the job she picked up that it was not an oversight that no one had spoken about it. It was *not to be* spoken about. In another care home down the road a friend of Marie's complained to the proprietor that one of the (male) residents tried to grab her in a sexual way. He told her quite sharply that ‘if she couldn't stand the heat she should get out of the kitchen’. In other words, she was being told not to complain and that her only option, if she didn't like it, was to leave. She found she was working in an occupational subculture where only certain things are permitted to be discussed.

This kind of silence tends to be produced when there are hierarchies in which tasks are delegated to some people rather than others. Dealing with intimate care tends to be a low-status task. It is often referred to as ‘basic’ care as opposed to the more technical tasks within nursing and the planning, educational or therapeutic tasks within residential services. The sociologist Goffman referred to it as 'backstage work'. Hughes, another sociologist, writing in 1971 coined the term ‘dirty work’, which is the work within any society or profession which is delegated downwards and/or concealed (Hughes, 1971). Caring for people's bodies could be regarded as the ‘dirty work’ of care, as well as ‘backstage’ work.

While nurses are taught procedures for carrying out personal care tasks, they are rarely explicitly ‘taught’ how to deal with the emotions these tasks occasion. Learning ‘on the job’ produces a kind of knowledge based on practice rather than theory which is literally difficult to put into words. This helps to keep the work and the skills it involves invisible.

4 ‘Women's work’

Gender and power play a role in keeping issues pertaining to intimate care out of the public arena. One reason for carers' (who are much more likely to be women) comparative silence in our culture is that much of what many women do is defined as ‘private’ or ‘personal’. Unfortunately, things women talk about are often downgraded – being deemed unimportant or ‘boring’. When large and difficult areas of experience are left out of public discussion we need to ask why. Ignoring the experience of certain groups of people is a way of exercising power over them. It allows their points of view and their needs to ‘slip off the agenda’. Women and members of minority ethnic groups have protested against being treated in this way. But it is an experience shared by carers and users of services (Pascall, 1986, p. 30; Brown and Smith, 1989, p. 108).

Beyond the fact that many women have tasks to do which are defined as ‘not worth discussing’, is that women do seem to be given roles in dealing with and containing feelings. This is true in care settings and also in other work such as shop work where ‘the customer is always right’, or in reception where the receptionist is expected to be always welcoming and on display. Women workers have to manage the way they present themselves and control their emotional reactions in ways men are not usually expected to. This is particularly so in care work, when they are dealing with intimate or intrusive procedures. In 1983, Hochschild introduced the idea of 'emotional labour'. It is hard work, partly because it is not made explicit or rewarded. In fact, you only see it is part of the expectations of the job if you stop doing it. Hochschild's work was with air hostesses, who have to put on a brave (and usually very well made up) face and be ‘nice’ to passengers no matter how obnoxious they are to them. Similarly, carers have to be open to all the people in their care whether or not they ‘like’ them or find them easy to look after. If ‘the customer is always right’, it makes it very difficult to know when you *can* draw the line, for example in relation to sexual or racial harassment from users. If the customer is always right, it is often at the expense of the care worker, who is very likely to be a woman.

5 Distance and closeness

A lot of emotional labour is concerned with getting the right balance between being close, friendly and warm, and maintaining a proper distance. Lawler writes about learning emotional control by sticking to a set procedure and cultivating an ‘air of detachment’ (1991, p. 126). In terms of care work it is never quite clear which side to err on – being too cold would be seen as unprofessional, but so is being too familiar.

Click to read Jocelyn Lawler on 'Body Care and Learning to do for Others'.

Activity 2 Learning to manage embarrassing situations

0 hour(s) 45 minutes(s)

Now read the extract from the course reader (click on "view document" above) Lawler has written about the way nurses learn to manage their embarrassment and the discomfort of their patients. Jot down some notes about your own experiences.

Here are some pointers to help you.

- In his study, Lawler describes the background of the nurses he interviewed. If you do caring work, either in a paid or unpaid capacity, how do you think your own background has equipped you? Has it helped or made it more difficult for you to be comfortable around other people's bodies and bodily functions? If you need help with intimate care yourself, has this been made more or less embarrassing for you as a result of the way you were brought up?
- The nurses interviewed by Lawler all have particular stories to tell about their *first* bed-baths, dead bodies and so on. Do you have any particularly vivid experiences relating to your own initial experiences of caring or being cared for?
- Have you ever been in hospital or had any intimate procedure carried out? Did it help you if you had a sense of the nurse following a set procedure, or would you rather they had asked you how you wanted something done, or how you would have done it yourself? If you are a carer, do you have a routine? Does it help you? Do you think it makes things less embarrassing for other people?
- If you are, or have been, a carer, have you learnt to switch off your emotions or do you sometimes find things harrowing, disgusting or unpleasant? What do you do then? Do you pretend, or do you avoid the person who needs your help? If you are on the receiving end of care, do you like your carer to keep their distance or do you prefer more of the human touch?
- Language is mentioned in Lawler's study because that is a particular stumbling block when it comes to discussing bodily functions or sexuality. What kind of vocabulary do you feel most comfortable using at home – or at work? For example, children have their own vocabulary of ‘wees’ and ‘poohs’ while other people may use medical terminology.

You probably came up with some very personal anecdotes in response to this activity. Keep these in mind as we explore why these areas are so difficult.

Lawler describes the context in which nurses work as a ‘social vacuum’. Care workers like Marie often have even less structure. Their role is not one other people recognise. They

may be called something quite vague like a ‘support worker’ or a ‘house companion’. When they are not providing physical care they are supposed to act as a friend or equal to the person they are caring for, which means they have to switch in and out of roles and vary the distance between them as they perform different aspects of their work. They also have to maintain this very responsive personal touch even when they are responsible for looking after a group of people whose needs have to be juggled and balanced.

When people make decisions in this kind of environment there are no clear markers and after a while there is a tendency to forget what the normal rules are. One study on this subject explored how women care staff manage distance around the sexuality of men with learning difficulties. It describes:

> … how acutely aware some women staff are of the contradictions within their role … when it comes to performing their caring responsibilities without compounding the risk of sexual harassment from their male clients.
>
> (Thompson et al., 1997, p. 574)

Walking the tightrope between being too distant and too familiar, several women acknowledged the double messages they give out to the men they care for. For example, one woman said she wouldn't be this nice to any other man unless she was going to have a sexual relationship with him. Here we see that the expectations of her role as a carer cut across the way a woman of her age would normally expect to behave with men, leaving her, and her clients, confused. To continue Marie's story, later in the year Richard developed quite a crush on her, which she handled by telling him emphatically about her boyfriend Barry. In Thompson *et al*.'s study this was described as a common strategy and one way of re-establishing distance.

The paper by Thompson *et al*. also considers the organisational context within which much care work takes place: a predominantly female workforce with men occupying management roles. They describe the lack of support from managers and the unspoken expectation that women will *cope with* this aspect of the work, on their own. If a man service user misunderstands, the woman carer is invited to think it is her fault and something she should get right herself, not a function of the situation she has been put in. Even when the sexual behaviour of service users is seriously outside what any other women would expect to deal with at work, it is played down and not taken seriously. The authors comment on:

Figure 3

> … the differential power which men and women staff hold within their organisations to frame behaviour such as this as a ‘problem’ rather than to see it subsumed as a routine part of the work.
>
> (Thompson et al., 1997, p. 580)

Steps have been taken to try and address some of these issues. The Training Organisation for the Personal Social Services (TOPSS) has issued guidance for residential social care managers on the induction of new care staff in a publication entitled *The First Six Months* (TOPSS, 2002). This will enable managers to show that they are meeting the new standards that have been set for residential care by the National Care Standards Commission.

We have so far considered the issue of boundaries from the point of view of paid carers. Doing intimate things for someone you *do* know and have an ongoing relationship with can be just as difficult to manage. Oliver (1983) writes about the experiences of wives caring for disabled husbands. She tells how wives are expected to take on the role of carer with little help. Their presence and assumed willingness to care often lead to their husbands being discharged earlier from hospital and sent home with fewer aids or support services than a single person would have, or than a woman being cared for by her male partner. Rather than being treated as a person in her own right, ‘the wife’ is not able to negotiate what she will and will not do. Oliver writes of one woman who despite being:

> … extremely distressed by the very intimate tasks she now had to do for her husband, like wiping his bottom, was told by the examining doctor [when she applied for attendance allowance] that what she was doing was ‘no more than any wife should’. She broke down completely when the doctor left, and when her husband's application was turned down, forbade him to appeal, in order that she should not be put through such a humiliating ordeal again.
>
> (Oliver, 1983, p. 77)

In this case embarrassment had a real financial as well as an emotional cost. Crossing boundaries is also an issue for men who take on the role of ‘carer’; for example, a father might find himself coming into contact with his disabled daughter's menstruation in a way other fathers would not. Family members and care workers find themselves being asked

to stretch to meet an ideal no matter how pressed they are or how unrealistic the expectations on them.

Key points

- Intimate care is seen as both ‘low status’ and ‘women's work’ (not a coincidence).
- ‘Emotional labour’ is more than just managing emotions. It refers to the work of maintaining at least the fiction of a close, supportive role in a relationship which is not reciprocal.
- Care workers are constantly crossing and rebuilding boundaries: hence the tension between closeness and distance in their relationships with service users.
- The lack of clear boundaries presents problems in relation to sexual behaviour as well as to intimate care.

6 Developing agreed ways of working

Although it may be undesirable to cut across the informality of care relationships by making unnecessary rules or regulations, intimate care is clearly one site where things can go wrong. There is a narrow margin of error. The usual social rules and inhibitions have already been broken and it is not always easy to arrive at new ones which are appropriate to the particular context within which you are caring or being cared for. Moreover, receiving or giving care arouses strong feelings which people rarely put into words.

Activity 3 Help with going to the toilet

0 hour(s) 10 minutes(s)

Imagine that you need help to go to the toilet. Perhaps you do receive this kind of assistance, or have done in the past. If so, you will have first-hand knowledge to draw on. Write down three things which your helper could do to ease any embarrassment or discomfort you might feel, and three things which would make the whole situation even worse. Think about who would be helping you in this situation, their gender, their relationship to you, their manner, what they say, their facial expression, and so on.

You might have included things like:

- what tone you would like them to take with you
- whether you would want them to talk while they were helping you
- whether you would like them to pretend they haven't really noticed what is going on.

Lawler's research identified the following ‘scene-defining’ strategies employed by doctors and nurses when undertaking intimate care:

- They set up the caring task by making clear that the context is'medical’ rather than social or sexual.
- They use their uniform as ‘a barrier’.
- They put on a deliberately matter-of-fact manner.
- They protect the person's privacy by sending other people away or drawing curtains.
- They say things which minimise the awkwardness like ‘Oh, it isn't much’, ‘It isn't that bad’, or ‘It could have happened to anyone’.
- They change the style, volume and tone of their conversation tocreate a private atmosphere.

Figure 4

But still nurses have to deal with their own natural reactions especially around smell, which can be particularly difficult to ‘stomach’. Here they will develop ways of concentrating on the mechanics of the task, or they may take breaks by going out of the room. One of the nurses Lawler interviewed said she ‘hides the horribleness from the patient’ (p. 176). It is as if the worker becomes more formal to compensate for the very personal and potentially intrusive nature of the help they are giving. But this might not be appropriate if this help is being given at home or in a homelike setting.

So what can be done to help carers or people being cared for in these situations? One approach is to bring the subject of intimate care ‘out of the bathroom’, so to speak, and on to the job description. This has benefits for workers and management: it allows this part of the work, its difficulty and delicacy, to be acknowledged, but it also makes managers take back responsibility for how it should be done. Some services have begun to explore just what good practice would mean in these areas as an alternative to waiting until things go wrong and then saying something. For example Eric, who is a colleague of Marie's, always leaves the door open a bit when he takes service users to the toilet: anyone passing by can see that he is in there with someone. The staff are now having a discussion about whether it should be shut and, if so, locked or not. Eric says he is ‘covering his back’ but some people were saying that Eric is not doing his job properly. He can reasonably say that he does not know what ‘properly’ means until the staff group make up their minds.

Activity 4 Guidelines for intimate care

0 hour(s) 10 minutes(s)

Imagine you are the head of care at Marie's unit and you are asked to draw up some rules on how to give intimate care which would act as a safeguard for the residents and also for the staff. See if you can sketch out the section on bathing residents.

Did you think about the following issues in drawing up your 'practice guidance'?

- Who should give baths, what gender, and should there be oneperson only or two?
- Should doors be shut and locked?
- What exactly does 'bathing' involve? What needs to be washed andhow?
- How will help be given? Should staff do the bathing or try to help theresidents do it for themselves?
- What *don't* you expect to happen?

Key points

- Workers providing intimate care emphasise the formality of their roles to compensate for the crossing of boundaries.
- It is difficult to hold workers to account for intimate care tasks when no one has spelt out how they want these to be done.
- Agreed procedures provide one 'benchmark' for good practice which can protect service users, staff and workers.

7 Unofficial work cultures

The whole issue of bodily care and bodily functions tends to be driven underground and then emerges in jokes or crudeness. Picture this scene, a few months after Marie has started, when she has become more settled within the care team.

It was quite late on a Saturday night and a group of the younger staff were sitting in the staff room waiting for Jenny's boyfriend. He was going to give some of them a lift to the pub and the plan was for them to meet up with friends for a few drinks and then go for a curry. Marie was a bit late because she had been getting Richard ready for bed and he had had an 'accident' so she had to wash him and change his pyjamas. She rushed in after the others had already finished their handover meeting with the night staff. When she came in and mumbled about having to change Richard's pyjamas, Jenny started giggling and said it must have taken ages because he was so 'well hung'. Everybody laughed. If you had played back a video of the scene you would have seen that Marie froze for almost half a minute before she started laughing as well.

Activity 5 Joking apart…

0 hour(s) 10 minutes(s)

What do you think was going through Marie's mind in that 30 seconds? Draw some thought balloons to script what she might have been saying to herself.

I think Marie might have had quite a struggle because my guess is that she disapproves of this kind of language. She may also have felt disloyal to Richard as a person she respects, and have felt uncomfortable about what could be racist undertones because Richard is black. But perhaps she also found it quite a relief to get

some of her feelings out of her system before she went home. Perhaps it helped her to put work, with its peculiar rules and relationships, out of her mind so she could go back to an ordinary Saturday night out with her mates.

My first reaction to Marie and her friends was very disapproving but then I thought that maybe laughing was therapeutic. You have probably heard of ‘a Freudian slip’. Although we try constantly to censor what we say, forbidden thoughts and secrets tend to leak out in the form of jokes, mistakes or slips.

Another reaction I had was to think how difficult it would have been for Marie *not* to laugh. Getting on well at work depends on going along with what other people do and fitting into the ‘culture’ of the place. Different workplaces develop their own jokes and jargon. Perhaps laughing about people's bodies and sexuality is one way Marie and her colleagues ‘let off steam’ about being exposed to the intimacy of people's bodies.

Isabel Menzies carried Freud's thinking a bit further in a classic piece of work on nursing practice called *The Functioning of Social Systems as a Defence Against Anxiety* (Menzies, 1970). She said that it was not only individuals who have an ‘unconscious’, but organisations and whole professions. The informal culture (the jokes, the language and also the way jobs are set up) is partly a consequence of the need to be defended from some of the things they are dealing with. For example, if you were an undertaker you couldn't get upset about every individual whose funeral you arranged. For your own sanity you'd have to distance yourself. Probably there are all kinds of ‘corpse jokes’ which take the sting out of the work.

A nurse I know who works on an oncology ward told me the joke about cancer being safe from ‘cut-backs’ in her hospital because it was a ‘growth area’. Lawler relates an interview with a nurse who, with her fellow trainee, became ‘hysterical with laughter’ when she encountered her first death, but who then became ‘sad because we hadn't witnessed anything like this before’.

Perhaps once you start making jokes you can't draw a neat line which stops you from passing on some of the cruelty to those receiving care.

Key points

- Jokes may be used as a way of ‘letting off steam’ about the strains of care work.
- Aspects of the work which are not publicly acknowledged tend to get dealt with in the informal culture of the establishment or work group: open supervision or discussion may avoid this.

8 Establishing boundaries

Activity 6 Managing the hidden culture

0 hour(s) 15 minutes(s)

Imagine now that you are Marie's manager and you decide to call in at the unit on your way back from a day out. You often drop in unannounced to make sure everything is OK and because it is the only chance you get to talk to some of the night staff. You walk in on the joke-telling incident and hear from the corridor what has been said. What do you do?

1. Go in and join in the laughter.
2. Go in and confront the staff – if so what exactly would you say?
3. Turn around and pretend you didn't hear.
4. Decide not to challenge the staff now but to put on some staff training at a later date.

Now write a paragraph saying why you decided to tackle it this way. What went through your mind? If you decided not to intervene, think about how much worse it would have to get before you did go in and say something.

Well, managers clearly have a role to play in containing these aspects of the work: acknowledging difficult issues, setting agreed limits on how tasks should be approached, and helping individual staff to walk the tightrope of not being too cut off or too close to those they are working with. If Marie's manager joined in, or even initiated the joking, there would be no containment and nothing to stop things getting worse. It is up to the manager, or occasionally inspectors, to set out what is expected and then monitor whether staff keep within agreed boundaries.

Intimate care is an area in which boundaries are almost inevitably crossed but it is by no means the only area in which a spontaneous response can have unforeseen implications.

Now we look at a real-life attempt at establishing the boundaries of care relationships. Enfield Social Services (1996) has drawn up guidelines on professional boundaries for a wide range of staff including field social workers and those working in residential care. The guidelines attempt to set markers on a range of issues in professional relationships with children and adults. In particular they cover issues about:

- not taking advantage of clients (e.g. in sexual or financial transactions)
- disclosure of personal information within professional relationships
- expressing affection in worker-client relationships.

Click on the player below to hear Vicky Golding of Enfield Social Services discuss their guidelines on professional boundaries

Audio content is not available in this format.
Guidelines on professional boundaries

Activity 7 Guidance on professional boundaries

0 hour(s) 30 minutes(s)

Listen to this audio clip now. You will hear Vicky Golding, an Area Manager for Enfield Social Services, describing why her department decided to develop these guidelines and talking about some of the controversial areas in the guidelines and what it means to be ‘professional’.

As you listen to the audio clip jot down anything you react strongly to.

Then look through at Enfield Social Services' guidelines on professional boundaries between staff and service users (click on the link below to access the file) and note which items you agree with and which you would not want to be bound by in your own situation. If you are on the receiving end of care, think about whether you would want this kind of ‘professional’ relationship with your carer or if you expect them to be more open and personal with you.

Click to view
Enfield Social Services' guidelines on professional boundaries between staff and service users.

Enfield Social Services' guidelines grew out of two situations in which workers had ‘overstepped boundaries’ by taking individual children home, but they cover the more general issue of where to set limits in professional relationships in terms of how much personal disclosure and expression of affection is ever appropriate in a professional relationship. The model of professionalism represented here is one which errs on the side of maintaining a certain distance. Did you agree with this, or would you have drawn the line at a different point?

One of the controversial areas is just how much we expect workers to reveal of themselves. The Enfield Social Services guidelines suggest that workers should not reveal much about their personal lives to their clients but this can also create difficulties. For example, Marie told Richard about her boyfriend Barry as one way of re-establishing some distance when he was interpreting their relationship on a more personal level. Another exception might be that a gay worker at Marie's unit might be able to provide a very positive role model to gay or lesbian young people if they were allowed to be open about their sexuality. Vicky Golding drew a distinction between the kind of reciprocal sharing which goes on in a self-help group where one's personal experience would be seen as an asset in the work, and the more anonymous role of a care worker or social worker. Do you agree with this distinction?

Another difficult area addressed in the guidelines is the expression of affection and touch, which would be considered quite normal for children if they were being cared for within their families; kissing and hugging, saying ‘I love you’ and so on were also singled out as issues in services for older people and people with learning difficulties. It might be different for service users who get affection from other relationships in their lives than for people who are isolated and otherwise deprived of any such contact. What do you think? The guidelines also address the issue of favouritism; for example, if one resident is given gifts or taken out more than others in a group care setting.

Actions are ‘graded’ in the guidelines so that some are forbidden altogether, such as having sex with a client, others are subject to a manager's discretion and others are up to workers to decide for themselves. Did you find this helpful? Craft and Brown (1994) highlight the importance of guidance which works to ‘define the greatest possible leeway

within which individual workers and teams can reach their own decisions' (p. 18) and which balance these two functions:

> … to draw some acceptable boundary around the personal and the professional and to define the boundaries within which individual workers can respond as they think best.
>
> (Craft and Brown, 1994, p. 18)

The open consultation which has taken place in Enfield Social Services goes to the heart of what social and care services are about. Are social workers or care staff there to replicate ordinary relationships, to compensate for a lack of them, or to provide practical help while staying in the background so that people can 'live their own lives'? Some clients may rely on professional carers to provide them with affection and social contact which they do not get elsewhere. The answer is bound to vary for different people and different settings, but the process of consulting with a wide range of people and attempting to provide some clarity is an important one for clients, staff and managers.

Vicky Golding emphasised that 'professional boundaries' are important for service users who:

> are often very vulnerable – they can be needy and boundary-less themselves and open to exploitation by a worker in a powerful position …

But she also points out their usefulness as a framework for managers because they:

> clarify what is acceptable and so where a boundary has been breached, we can actually point to it and use [the guidelines] as a management tool …

and for workers:

> but they are also for protecting the worker, which is really important because workers are vulnerable and don't always realise how they're leaving themselves open.

This reflects the triangular nature of accountability.

Key points

- Managers need to 'contain' difficult areas of care work.
- Boundaries are not only crossed in intimate care but in 'social' settings as well.
- Professional relationships are different from ordinary reciprocal friendships.
- Formal guidance provides a reference point which can protect service users, staff and managers.

Conclusion

This free course provided an introduction to studying Health and Social Care. It took you through a series of exercises designed to develop your approach to study and learning at a distance and helped to improve your confidence as an independent learner.

Keep on learning

Study another free course

There are more than **800 courses on OpenLearn** for you to choose from on a range of subjects.

Find out more about all our free courses.

Take your studies further

Find out more about studying with The Open University by visiting our online prospectus.

If you are new to university study, you may be interested in our Access Courses or Certificates.

What's new from OpenLearn?

Sign up to our newsletter or view a sample.

For reference, full URLs to pages listed above:

OpenLearn – www.open.edu/openlearn/free-courses

Visiting our online prospectus – www.open.ac.uk/courses

Access Courses – www.open.ac.uk/courses/do-it/access

Certificates – www.open.ac.uk/courses/certificates-he

Newsletter – www.open.edu/openlearn/about-openlearn/subscribe-the-openlearn-newsletter

References

Brown, H. and Smith, H. (1989) 'Whose "ordinary life" is it anyway?', *Disability, Handicap and Society*, Vol. 4, No. 2, pp.105–19.

Craft, A. and Brown, H. (1994) ‘Personal relationships and sexuality: the staff role’, in Craft, A. (ed.) *Practical Issues in Sexuality and Learning Disabilities*, Routledge, London, pp. 10–22.

Enfield Social Services (1996) *Guidelines on Professional Boundaries* London Borough of Enfield, London.

Hochschild, A. (1983) *The Managed Heart*, University of California Press, Berkeley.

Hughes, E. (1971) ‘Good people and dirty work’, in *The Sociological Eye: Selected Papers*, Aldine Atherton, Chicago.

Lawler, J. (1991) *Behind the Screens: Nursing Somology and the Problem of the Body*, Churchill Livingstone, Melbourne.

Menzies, I. (1970) *The Functioning of Social Systems as a Defence Against Anxiety*, Tavistock, London.

Oliver, J. (1983) ‘The caring wife’ in Finch, J. and Groves, D. (eds) *A Labour of Love: Women, Work and Caring*, Routledge & Kegan Paul, London, pp.72–89.

Pascall, G. (1986) *Social Policy: A Feminist Analysis*, Tavistock, London.

Sobsey, D. (1994)*Violence and Abuse in the Lives of People with Disabilities*, Brookes, Baltimore.

Thompson, D., Clare, I. and Brown, H. (1997) ‘Not such an “ordinary” relationship: the role of women support staff in relation to men with learning disabilities who have difficult sexual behaviour’, *Disability and Society*, Vol. 12, No. 4, pp. 573–92.

Acknowledgements

Grateful acknowledgement is made to the following sources for permission to use material:

Course image: Presidencia de la República Mexicana in Flickr made available under Creative Commons Attribution 2.0 Licence.

Illustrations: pp 10,14, 19, 21: Brenda Prince/Format; p19 (top): Sally and Richard Greenhill.

squishband

Don't miss out:

If reading this text has inspired you to learn more, you may be interested in joining the millions of people who discover our free learning resources and qualifications by visiting The Open University - www.open.edu/openlearn/free-courses