

Empathetic Attuning: ‘How Would I Feel If I Had to Expose Myself All the Time?’—Strategies for Managing Personal and Intimate Care in Swedish Formal Home Care

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Abstract

Sweden, as a welfare state, has a long tradition of providing formal home care and support to their citizens in their own homes, either through home care services or personal assistance. A large percentage of frail elderly and persons with disability who receive formal home care require personal and intimate care, such as help with eating, showering, getting dressed and personal hygiene. Managing intimacy and safeguarding the care recipient’s integrity pose particular challenges for staff. The aim of this qualitative interview study is to describe and analyse care workers’ (CWs) and personal assistants’ (PAs) strategies for managing situations and challenges related to provision of personal and intimate care in the context of formal home care. Semi-structured interviews with eleven CWs and nine PAs were conducted. Our analysis reveals a complex repertoire of relational and communicative strategies, within an overall approach—which we labelled ‘empathetic attuning’—of relating to the current situation and task at hand whilst safeguarding integrity. These strategies were intertwined with dimensions of time. The possibility to accomplish satisfactory personal and intimate care rests on structural and organisational conditions that promote sustainable working conditions, where relations characterised by continuity, integrity and respect can be realised.

Keywords: care workers and personal assistants, empathetic attuning, formal home care, personal and intimate care, relational and communicative strategies

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Introduction

In Sweden, a large percentage of the frail elderly and persons with disabilities who receive formal home care need support with personal and intimate care, which is defined as help with eating, showering, getting dressed and personal hygiene (Statistics Sweden, 2021). This article sheds light on care workers (CWs) and personal assistants (PAs) experiences of providing personal and intimate care tasks within formal home care—two vocational groups with different legislation basis and background, for example, working and employment conditions—but all deeply involved with personal and intimate care work, which is one of the most common work tasks in formal home care.

The private and intimate nature of such care entails particular challenges that may emerge in relation to how the care is to be performed and facilitated, how integrity is to be safeguarded, how feelings of, for example, anxiety and embarrassment are to be managed and how what are often complex and pervasive care needs are to be adequately met (cf. Twigg, 2000; Carnaby and Cambridge, 2006; Clark, 2009). Many of those in need of help with personal care have difficulties expressing their individual needs and preferences due to, for example, embarrassment, communicative or cognitive difficulties, which heightens the challenge and the need for ethical awareness (cf. Mol, 2008). These challenges are often left to the staff to resolve, by devising their own methods and coping strategies or resorting to informal exchanges of information (cf. Clark, 2006, p. 15, 128; Inoue et al., 2006, p. 566).

Research on social care is extensive and has largely focused on conceptualisation of care and care relations (cf. Waerness, 1984; Christensen, 1998; Kittay, 1999; Mol, 2008), welfare changes and consequences of rationalisations within formal home care, as well as on working conditions for staff (cf. Meagher and Szebehely, 2013; Szebehely et al., 2017; Strandell, 2020). Research on personal and intimate care, ‘bodily’ care work (cf. Isaksen, 1994; Twigg, 2000), has been less portrayed in social care research, despite the increase of frail elderly and people with disabilities living at home, dependent on personal and intimate care.

The aim of the present interview study is to describe and analyse the ‘doing’ of personal and intimate care work, based on CWs’ and PAs’ own experiences and perceptions of working with personal and intimate care. What are their strategies for managing and resolving challenges related to the provision of personal and intimate care in the context of Swedish formal home care?

Theoretical framework

It is generally acknowledged that intimate care is experienced as a precarious situation and a challenge by both parties (Twigg, 2000; Clark, 2009). Early, and influential, studies on intimate work in medical and nursing practice (cf. Emerson, 1970; Heath, 1986) have shown how professionals and their clients, through routines and social interaction, create 'frames for interaction' that provide a distance that regulates and characterises the interaction between participants. Other identified strategies of framing, as means to create professional distance, is 'objectification', which refers to the way a person's body might be seen as a set of typical features rather than as unique to the individual (cf. Heath, 1986).

In general, participants' understanding of a situation and of what is about to happen is displayed in ritualised social conventions, for example, in how people talk, gesture and orient their bodies (Goffman, 1981, Introduction and Chapter 3). Goffman (1981) identified strategies that help frame the social interaction, three of which are 'embedding', 'ritualisation' and 'footing'. Embedding refers to the fact that, even as we speak, the words are often not our own, because our utterances may have other subjects, implied or explicit, such as when our speech represents a role, for example, a person with authority (p. 3). Ritualisation indicates the ways in which individuals, when they gather for, for example, professional or service meetings, often initiate and terminate their mutual transactions with periods of small talk. Footing concerns how alignment, orientation of gaze and posture frame the interaction.

Through professional framing in social care, the intimate sphere may be altered, and legitimate access to a person's private sphere as well as control of participants' concomitant feelings may be accomplished (cf. Goffman, 1971). Inoue *et al.* (2006, p. 563) describe how focusing on the task at hand might serve the dual purpose of controlling one's feelings and protecting the other person from embarrassment, which highlights the emotional work at play in strategies of framing. When tasks of intimate care are performed, a 'reality' of care is created and framed in embodied 'routines and reaffirmed in social interaction' (Emerson, 1970, p. 75). Our analysis has been guided by an awareness of these frames for interaction but with focus on professional framing through the interviewees' own expressions of managing personal and intimate care.

Earlier research on intimate and personal care in formal home care

Personal and intimate care has mainly been researched within institutional settings in nursing practice, such as in residential care/nursing

homes and hospitals (Clark, 2006, 2009; Inoue *et al.*, 2006; Wilson *et al.*, 2009). How personal and intimate care work is provided by staff in formal home care has been less in focus for social care research. This ‘body work’, also labelled ‘dirty work’ as it is connected to manage bodily fluids, etc., has been ascribed low status—an invisible work that includes somewhat taken for granted tasks within home care (cf. Isaksen, 1994; Twigg, 2000; Stacey, 2005; England and Dyck, 2011).

Observational studies of formal home care in Sweden have described how CWs and care recipients often resort to silence whilst performing the more intimate parts of care, and how they, in these situations, use interactional strategies such as objectification, distancing and routinisation (Kalman and Andersson, 2014; Andersson and Kalman, 2017). An earlier interview study from New Zealand described similar strategies amongst care recipients and how they expected the care-giver to be competent, work quickly and efficiently, and ‘anticipate their needs’ (Conder and Mirfin-Veitch, 2008, *our italics*). These results depict intimate care as sensitive and challenging; they also show that this is a topic most CWs and care recipients find difficult to talk about (*ibid.*).

Perceptions and experiences of intimate and personal care amongst care-givers and formal home care recipients were explored in a recent interview study (Ahnlund *et al.*, 2022). Descriptions of what personal and intimate care means to them covered a broad range of aspects, from concrete actions concerning ‘personal hygiene’, such as caring for and washing intimate parts of bodies, to intrusion into care recipients’ ‘personal spheres’, as well as how the need for preservation of integrity varies depending on ‘situational’, ‘relational’ and ‘temporal aspects’. Many described intimate care as something that cannot be separated from the person’s general need for services (cf. England and Dyck, 2011).

Swedish context of formal home care

Sweden, as a welfare state, has a long tradition of providing formal home care and support to their citizens in their own homes, either through home care services (HCS) or personal assistance (PA). Formal home care is regulated by national legislation and local guidelines. The Swedish welfare system can still be regarded as generous in comparison with other countries, although formal home care system has gone through several transformations within the last decades, and these changes have been influenced by neoliberal politics emphasizing economic efficiency and cost reduction through competition (cf. Meagher and Szebehely, 2013; Norberg, 2019). This neoliberal turn is common in most western countries, although it has had different consequences due to differing contexts of welfare systems (Christensen and Chou, 2018; Lloyd and Sullivan, 2018). These rationalisations have implied, for

example, an increased time pressure on CW staff in HCS including heavier work load with more clients to visit and less support from supervisors and colleagues (Strandell, 2020) and a general decrease in the level of support for care recipients of both HCS and PA.

Organisation and legislation

The personal and intimate care examined in the present article is provided through HCS and PA. There are similarities between these two services; they are publicly funded and recipients must be considered eligible for services, that is, their needs must meet the criteria that have been set up for each service.

Formal home care is regulated by SoL, the Social Services Act (SFS, 2001:453), which entitles anyone (regardless of age) who cannot meet their own needs to support in their home. Further, there is the Swedish LSS Act (SFS, 1993:387), the Act concerning Support and Service for Persons with Certain Functional Impairments, which gives extended rights to services for persons with extensive disabilities. One of these services is PA and the eligibility criteria for PA are having a long-lasting and extensive impairment that requires support with basic daily needs for a minimum of 20 h a week. Central to both acts are that the services are to be designed to strengthen the individual's opportunities to live an independent life.

The vocational groups

The vocational groups working in formal home care, that is, HCS and PA, respectively, have varying levels of formal education and training. In HCS, the CWs are auxiliary nurses, with a high school education or equivalent, or nurse's assistants, the majority of whom lack formal training. In PA, the staff often lack formal care training, in line with the independent living movement's efforts to move away from a medical view of disabilities (cf. Guldvik *et al.*, 2014).

PAs often work with only one person, often younger. This is because PA recipients have extensive impairment and (are therefore in need of far-reaching support) requiring a significant number of hours a week. In HCS, the CWs have many recipients to attend to and the work is often characterised by short and targeted interventions performed within tight time frames (cf. Blomberg and Petersson, 2010; Kalman and Andersson, 2014). Despite the differences between the two groups regarding training, working conditions and the recipient group, they commonly provide and manage personal and intimate care to a large extent of their working hours.

Materials and methods

As part of a larger project focusing on intimate and personal care, this study sheds light on CWs' and PAs' strategies for managing challenges related to intimate and personal care. Semi-structured interviews were performed with staff working in formal home care in three larger Swedish towns. The interviews were conducted in 2019 and 2020, most of them during personal meetings and later by Zoom or phone, due to the Covid-19 pandemic. Following contact with care unit managers in the three municipalities, to whom we introduced the project and whom we asked for permission to come in person to inform the care-givers, interviewees were recruited.

Three of the authors, all experienced researchers with previous experience of working in social/health care, performed a total of twenty-five interviews with twenty persons (eleven CWs and nine PAs; seventeen women, three men; age interval 30–65 years). The length of the individual interviews ranged from 25 to 66 min. Their work experience ranged from 1.5 to 42 years. They were all permanent employees, working from 67 per cent up to full-time. Amongst the CWs, eight were auxiliary nurses, one was a trained CW and two had no care education. Amongst the PAs, there were five auxiliary nurses, one had no care education and two had education in social work.

Analysis

The interviews were transcribed and analysed qualitatively (cf. [Creswell, 2014](#)). The interviews were read through by all four researchers separately to get a general sense of the material. In a second round of reading, notes and keywords were added in the margins, and then compared and discussed. Categories and themes were worked out jointly and analysed in light of earlier theorizing and research. The categories and themes form subheadings in the report on results and are exemplified by representative citations from the interviews. To capture the authentic meaning of the verbatim quotes, the translation of the quotes was thoroughly discussed.

Ethical considerations

Participants received oral and written information about the study and informed consent was obtained. This study was approved by the Regional Ethical Review Board in Umeå (Reg. No. 2018/363–31).

Results

The overall approach described by the CWs and PAs was to find or create a common basis for communication and interaction, the current situation and the tasks at hand, whilst being attentive to the importance of safeguarding care recipients' integrity. We choose to label this overarching framing 'empathetic attuning', as it authentically describes the framing, a concept not previously described in the literature. Within this overarching framing, frames for interactions were mainly created through 'communicative' and 'relational strategies' that enabled 'the doing' of personal and intimate care. Although our interviews were focused on how they managed personal and intimate care, the answers also reflected difficulties in the performance of care in relation to manning, schedules and workload (cf. Strandell, 2020). Regarding where they had learned how to perform personal and intimate care, many of them referred to having 'learnt on the job' or using themselves or their family as a reference point.

The overall approach—empathetic attuning

Attuning to the care recipient basically started when one entered someone's home. The CWs and PAs then tried to identify the care recipient's current mental and physical health status and to adjust empathetically to the care recipient in the situation:

You have to, as always, check out the person you have in front of you. Your work is based on that—you have to establish contact. (CW4)

Many of them have poor hearing and may not hear the doorbell ... You just come into their home, maybe they're sitting on the sofa in the living room and then, all of a sudden, you're standing there. You have to try to take it on their terms. (CW6)

Attuning to the care recipients often emerged as a form of general empathetic thinking: '[e]verything that happens to her/him could happen to me' (PA6), by raising questions such as: 'always ask yourself: how would I feel if I had to expose myself all the time?' (CW4), or by putting oneself or a dear family member, such as a parent or a child, in the situation at hand. These kinds of questions also served as a reminder for them of the need to respect self-determination and everyone's right to integrity.

Another example of empathetic thinking was given by a CW in relation to presenting a neutral expression in the presence of bad odours:

Well, you have to endure sometimes. You have to, of course. But there is never anything I would say or show with my face. [...] You have to

be professional and keep your expression neutral. I probably wouldn't have thought it was fun if someone wrinkled their nose. (CW5)

These quotes illustrate the close relation between empathetic attuning and using oneself as a reference point. Attuning by taking a neutral posture can be described, using [Goffman's \(1981\)](#) terminology, as 'footing'—in this case, keeping up a professional appearance so as to avoid feelings of embarrassment on the part of the care recipient.

The term empathetic attuning refers broadly to the CWs' and PAs' conscious effort to relate and adjust to care recipients' present needs. As can be seen in the quotes above, interviewees indirectly suggested a shared human vulnerability by referring to themselves or close family members. However, leaving people to rely on their personal experience as a basis for knowledge in care work might also be problematic.

I myself have gotten a bit older now, and we help a lot of women. When you get a little older, you get a completely different insight into what dry mucous membranes mean, it causes great discomfort. And maybe think a little more about the fact that you have to lubricate a little and things like that. I didn't think about that when I was younger. (PA1)

On the one hand, this example illustrates how relevant knowledge, based on personal experience, helped the PA pay attention to an important aspect of intimate care. On the other hand, we learn about the lack of training and education in intimate care. Using oneself and/or family as a reference point, however, might mean adopting a taken-for-granted approach, where everyone is thought to be like oneself in individual needs and preferences, or be based on standard representations.

Other attuning strategies had a more concrete and individualised focus on the person and life situation, trying to strike a balance between care for the person and respect for self-determination:

I was a contact person for a man, he had a hard time. He was to some extent independent where he ordered taxis and went to the [alcohol] monopoly and stuff. With his medicine, it didn't really work properly with alcohol. It was so hard for the other staff to talk to him ... I usually asked him if he had been to the monopoly and if he was going to a party, then he usually went quiet because he knew it didn't fit with his medication. Then I asked, 'is it okay if I put it away?' [...] I tried to tell my colleagues that the person needs help in this area. [...] at least you can explain how dangerous it can be and what you think about that. It's not easy. (PA5)

The above example, which represents a classical dilemma of care work, reveals the complexity of attuning, as different staff acknowledge a precarious care situation differently. This PA had to put in a great deal of emotional effort by framing and sustaining the definition of precariousness in the care recipient's situation (cf. [Emerson, 1970](#)).

Other ways of communicating empathetically with the care receiver were described as ‘normalizing’ the need for help, sometimes by using humour:

It’s more about downplaying: ‘Oh, but this is what happens when there’s something wrong with one’s stomach’ [...] ‘Then we take the trousers and put them in the laundry’. (PA4)

Even if it’s really tough, you have to take it in your stride, ‘nanana’ [cheerful humming]. ‘We do this and then that, and then you get to bed’, that’s sort of what one says [...] I think that if I was to throw up and needed help to get clean, I wouldn’t want somebody to start sighing [...] That is to say, it’s no big deal even though the care recipient undoubtedly finds it embarrassing. One has sort of done this before. (PA3)

The attuning strategies exemplified above show that, when identifying care recipients’ needs, the CWs’ and PAs’ overall frame is basically empathetic and relational.

Relational strategies

Relational strategies, within the overall empathetic attuning, were mainly used to ‘establish an individual relationship’ with the care recipient (cf. [Waerness, 1984](#)), but also to balance and keep a ‘relational distance’ so as to remain professional in how one treated the various care recipients.

Establishing and balancing an individual relationship

Knowing the person’s needs and wishes was a cornerstone for providing personal and intimate care, and several informants described the need to listen to the care recipients in their attempts to build a working relationship.

The most important thing is to listen to the person, even if they’re suffering from dementia or the like [...] You have to listen to how they want us to perform the work, that’s the priority. (CW3)

[I want to] find out how frail this person is. I would like to meet the person and see what their concerns are, and [by myself] figure out how to best treat that person. (PA5)

The CWs and PAs often stressed the importance of being affirmative and knowing the care recipient’s normal conduct and preferences. In relation to persons with dementia, providing the care recipient with positive experiences of care procedures was described as crucial to actually establishing a care relation.

It’s like the shower, it’s not just that she has to do it. It is the procedure that’s important. [...] Sometimes she just wants her body to be

showered, not wash her hair. You have to get to know her, otherwise it won't work. [...] I always test on their feet, is it too hot or cold? [...] If it's not nice, they'll never shower. It must be almost perfect the first time. (CW7)

The quality of the care relation was key to managing intimate care situations. One PA related a situation with a male care recipient who, due to severe impairments, needed a great deal of personal and intimate help. Humour was mentioned as an example of showing respect for the care recipient's personality, in addition to managing a critical situation:

We joked a lot. One example was at a party and he had a urine sheath and it was not completely emptied. He was very angry when we got to the toilet. [...] I joked about it and then he just started laughing. Then it was okay! (PA2)

Although the importance of building a good relationship was stressed, getting too close to one another is not always experienced as positive.

Relational distance

One PA reflected on how a long-lasting care relation might take the form of friendship, which might make it more difficult for the disabled person to ask for help, not wanting to be too much of a burden. Excessively close relationships may result in emotional challenges for the care recipient as well as for the PA. Keeping a certain professional distance is therefore also an important relational strategy (cf. [Guldvik et al., 2014](#); [Ahnlund et al., 2022](#)).

Working with care recipients who might become aggressive was a challenge described by several CWs. In such cases, another kind of relational distance was needed. They described different approaches to, as well as outcomes of, these situations:

They say they showered yesterday. Dementia is very difficult. Then we have to persuade, slowly step by step. You can't take a person with Alzheimer's directly to a shower, there could be war. [...] You have to be careful. [...] We can't ignore them. We have to respect their home. [...] Sometimes we succeed and sometimes we don't. (CW8)

As the quote reveals, the CW emphasised the dementia diagnosis by explaining how tricky it might be to relate to a common behaviour, which adds to the complexity of managing the intimate care work. By referring to the dementia diagnosis, a professional distance is created that can be referred to as objectification (cf. [Heath, 1986](#)). This does not necessarily imply an emotional distance towards the care recipients.

We have to be professional, do the best we can. [...] But if she gets aggressive and you don't want to get anywhere near her, you walk away. Talk to the boss, and the boss chooses someone else to go there and try.

You can't leave someone without assistance. [...] Sometimes it works well, sometimes it's chaos. [...] We always have to think that we are working with people who have feelings. They're not machines. (CW7)

As we can see, the use of relational strategies was sometimes referred to as being and acting like a professional, such as being responsive in the care relation, but also maintaining a relational distance. Although calming, guiding, making things easier for and persuading the recipients, especially the cognitively impaired, could involve 'hard work', the CWs often seemed to feel content with and proud of their work.

So sometimes when they get angry and have outbursts or something then we have to work like professionals. We're trying. Good treatment. Patience! Security! It feels good. (CW8)

Even though the informants described the work with aggressive or obstinate care recipients as difficult and sometimes even futile, they also emphasised that no one is left without support. Different approaches were tested in their efforts to find a solution, for example, changing to a new CW or getting support from the managers. Relating to and being responsive in the care relation rested on a set of ongoing communicative strategies.

Communicative strategies

The CWs and PAs used a wide array of different communicative strategies. Many of these strategies were verbal, such as when embedding (Goffman, 1981) the care relation and informing about what would happen next. There were also visual strategies accomplished through bodily alignment and use of prompts, which might be communicated via senses such as touch and smell. Depending on the person in need of personal and intimate care, different communicative strategies were used—basically 'informative' ones, but at times 'distracting conversations' were also employed.

Informative communication

The PAs and CWs described how they initially informed the recipients about what was going to happen to make them feel safe, stressing how an ongoing conversation could facilitate the entire care situation and improve the recipient's ability to participate.

It's good if you explain from the beginning how you intend to do it, so they know. Are they with you or are they suffering from dementia? [...] if they have dementia perhaps one should tell in more detail, otherwise they may feel they aren't with you. [...] They should be able to feel safe, so we should tell them. (CW9)

At times, care work was said to involve a certain amount of trying to ‘persuade’ the care recipients, especially when older people with cognitive disorders were involved. One strategy described was being very specific and instructive by focusing on the ‘how’ and ‘why’, for example, if someone refused intimate care:

Then you get to talk about what could happen to the genitals. [...] you have to think about what it will look like tomorrow. Because then the faeces have worn down the skin, then there might be open wounds. (PA1)

As part of informative communication, alignment along with symbolic actions and objects might serve as prompts and be used to visually communicate the next step, for example, to take a shower:

I never say ‘now we’re going to’. Those words don’t work [...] Instead you go and prepare, pick a little, take out the towel, things needed in the bathroom. Then you can ask ‘what do you think?’. Then that person can decide. (PA8)

One CW explained how she tried to arrange situations step by step, in an attempt to appeal to the recipient in different ways. As an example, she mentioned a person who most often does not want to get out of bed, but who can be tempted to do so by the smell of newly brewed coffee and a heated bun. The next step might be to suggest a visit to the bathroom, just in case there is a need. Using this stepwise approach usually worked for this care recipient, whereas a straightforward and decisive suggestion that it’s time to take a shower would be met with instant objections: ‘But if you tell them, “Do you want to take a shower?” Then you get called names and they get angry’. (CW7)

By creating a step-by-step morning routine, a form of ritualisation and arranging prompts in the form of visual signals or scents, the CW creates and sustains realities care recipients can follow because they understand the situation as a procedure they can manage (cf. Goffman, 1981).

Distracting conversation

Distracting conversation was a strategy commonly used to divert the care recipient’s attention away from what might lead to negative reactions and/or associations. One common problem mentioned was embarrassment on the part of the care recipient. One PA related a tradition created together with a care recipient who needed help with ‘number two’. On entering the bathroom, the PA lights a match for the recipient to blow out. After this, the recipient gets into a position that enables wiping properly. In similar and potentially embarrassing situations, one strategy described was to downplay, divert and distract:

Well, we ... We talk about it calmly, it's all right, start talking about something else, to change the subject so they don't think about it. What have you done today? Where have you been? (CW 4)

A combination of distracting, relational and persuasive strategies was described by a CW who talked about her work with a care recipient who had thus far refused help with personal hygiene—and who had not taken a shower for three months. Knowing that she had a knack for making things easier for care recipients, she volunteered to take him on. On her arrival, he asked who she was, and she told him that she was the one who would help him take a shower. When asked where she came from, she told him: 'Spain' (even though she did not). He lit up and said: 'Oh, Mallorca, Spain! I've been there!', and she let this become the first building block in their relation: being someone from Mallorca. He still denied any need for a shower. But then she told him: 'I have to work to earn money, you have to let me shower you, otherwise I can't go to Mallorca' (CW11). The man was distracted by the talk and was persuaded to get into the shower, not only on that day. They always talked about Mallorca, a place that was obviously a dear memory for him.

To facilitate the performance of care work, the staff used communicative strategies—mostly informative, but also distracting conversations. This was a way of relating to the care recipient whilst, at the same time, playing down the level of intimacy of the body work. The communicative strategies used for framing—such as embedding, alignment, footing and ritualisation, which regulated the participants' interaction—can be seen as examples of how professional framing changes personal and intimate care, thus legitimating access to the private sphere (cf. Goffman, 1971; Ahnlund *et al.*, 2022).

The presence of time in performing intimate and personal care

Whilst describing situations in which different strategies came to be of use, the temporal aspects of these strategies were often mentioned by both vocational groups. In fact, time frames and dimensions of time were also intertwined with their strategies. In the case of CWs this was to be expected, considering the ever-present time schedule that the staff needed to relate to, especially in times of rationalisation and limited time frames (cf. Strandell, 2020).

Awareness of time for the CWs often meant that they referred to common procedures and personal qualities such as having the flexibility, patience and 'posture' (cf. Goffman, 1981) to succeed with intimate care work. These qualities were needed to calmly meet the person's needs in the present and to provide a sense of security. One CW who works at night explained: 'That you say a few words, it doesn't need to take long. It might even shorten the time because it makes things easier.' (CW 5)

Another example of flexibility was to reorganise the time schedule all together:

If you're not successful when trying to help with the morning routine, then you turn to making a good breakfast instead. Then when she has started eating, you leave for your next client. [...] Time and patience. If you always succeed in the afternoon—then you reschedule the shower to the afternoon. [...] You have to be flexible. (CW7)

In this example, the CW's flexibility meant rearranging the time schedule to adjust the intimate care work to unforeseen situations as well as to individual needs and preferences.

Having an established relationship with the recipient was described as facilitating and time saving, as the recipient's needs and care procedures were already known: 'It often goes better when you've been to someone a couple of times. (CW6)

Furthermore, there were common routines, which both allowed the staff group to coordinate their efforts by keeping the same routines and allowed the recipients to know what to expect: 'Yes, we say we should do the same thing, work the same way.' (CW8)

Routines were often described as a common procedure for avoiding stress and anxiety among the recipients. In some cases, these routines were created jointly by the individual CW and the care recipient: 'you have to come up with your own tricks for how to relate to the person'. (CW2)

The importance of being calm and not (due to lack of time) signalling stress through their posture was emphasised by PAs as well, as stress might have a negative effect and even be counterproductive.

If somebody I work with asks: 'but why don't you rush?', then I just tell them to take it easy. Stress makes the work worse. Instead of thinking that it will be done faster, something will go wrong. Better to take your time, even when there is too much. You will find time for more than you think. [...] Higher pace *and* calmness. Don't show that you're in a hurry. It's contagious because they get stressed as well. (PA5)

The examples illustrate how aspects of time were always present in intimate and personal care work and how these were handled by being flexible and patient as well as by adjusting to common routines. Simultaneously, time pressure was not supposed to be present in the CWs' and PAs' posture or through any sense of stress. This duality of time functioned as a way of giving dignified care and of protecting care recipients from staff members' work pressure.

Discussion

The repertoire of strategies for managing and resolving challenges related to personal and intimate care provision was framed by empathetic

attuning. This created a base for communication and interactions in which efforts were made to get to know and understand the individual and her/his current needs. Even if the attuning was explicitly described as beginning when one walked through the door, it had signs of a particular kind of 'preparedness' that existed beforehand. In this preparation, regardless of whether one was going to visit a new or a familiar care recipient, the CWs and PAs in formal home care relied on previous experience and the experience related by others. The empathetic attuning established an overall frame for interaction which was clearly situational in the sense that it was described as being dependent on the individual care recipient's state of mind in a particular situation and on the tasks that were to be done. The CWs' and PAs' own alignment (footing) and calm organisation of things further informed and embedded the care situation as such. (cf. Emerson, 1970; Goffman, 1971, 1981).

To relate to all the different care recipients, relational strategies were used, both to establish a relationship and to maintain some professional distance and not get too emotionally involved (cf. Guldvik *et al.*, 2014). Relational strategies varied, but were always balanced between adjusting to the individual recipient and maintaining professional distance, with a view to getting the intimate and personal care work accomplished. One way of keeping distance was through objectification, which involved focusing on the person's diagnosis whilst relating to the individual recipient as well, especially when someone was suffering from cognitive disorders (cf. Heath, 1986). Finding a 'proper' way of approaching intimate care, using the strategies described above, constitutes a way of gaining access to the private sphere that becomes legitimate for both parties (cf. Goffman, 1971; Kalman and Andersson, 2014, n.d.).

The communicative strategies revealed in this study were informative and entailed an ongoing conversation along with verbal and visual clues, symbolic actions and prompts. These were at times mixed with distracting conversations. Informative strategies sometimes included step-by-step arrangements to inform the care recipient about what was going on and to prepare for the next step, the goal being to create cooperation. Likewise, downplaying and distracting conversations served the purpose of creating cooperation, where the goal was not to embarrass or frighten the care recipient. Attuning to a communicative style that suited the individual care receiver created a basis for interactions that enabled 'the doing' of personal and intimate care as well as downplaying potentially embarrassing situations (cf. Inoue *et al.*, 2006). Such empathetic attuning also created trust and cooperation.

When the CWs and PAs in this study referred to personal experience or having learnt on the job, a general lack of organisational awareness and training in personal and intimate care provision was revealed. Despite this lack, most of our interviewees were well experienced and had developed a complex repertoire of strategies. Still, this does not lessen the need for

educating and training staff in personal and intimate care, instead of leaving them to devise their own methods (cf. Wilson *et al.*, 2009).

The pressure on CWs has increased over the past decades (cf. Strandell, 2020), and our interviewees described situations where limitation of time schedules and shortage of time added an extra challenge in their work situation. For the PAs, on the other hand, the pressure for flexibility in scheduling work creates mismatches in personal life rather than in the care situation (cf. Guldvik *et al.*, 2014). However, our analysis also shows how the strategies used to accomplish personal and intimate care *well* for both vocational groups rest on being able to create a calm situation without stress in a context where the pressure of time is non-existent for a whilst. This is not possible without structural and organisational conditions that promote sustainable working conditions, both within the collegial group and within the individual care unit, where relations characterised by continuity, integrity and respect can be realised. Whereas our analysis has highlighted a complex repertoire of professional strategies, our study also pinpoints the importance of sufficient time, manning and education for a satisfactory *quality* in the provision of personal and intimate care in Swedish formal home care.

Limitations

This study includes a small sample of interviews with CWs and PAs where analytical focus has been on strategies for managing personal and intimate care, meaning that other aspects of formal home care have evolved less. We are aware that we, as researchers with different backgrounds and experiences, may have influenced the interviews differently. In the analysis we therefore have worked jointly with interpretations and different understandings of the material to reveal possible bias. Also, the shift of face-to-face interviews to Zoom meetings may have affected the interviews with the staff. This study is located in a Swedish home care setting, which needs to be taken into account in comparison with international research in other welfare contexts.

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References

- Ahnlund, P., Lövgren, V., Andersson, K. and Kalman, H. (2022) 'Perceptions of intimacy and integrity in formal home care', *European Journal of Social Work*, 1. <https://doi.org/10.1080/13691457.2022.2113862>
- Andersson, K. and Kalman, H. (2017) 'Strategies to handle the challenges of intimacy in nighttime home care services', *European Journal of Social Work*, **20**(2), pp. 219–30. <https://doi.org/10.1080/13691457.2016.1188779>
- Blomberg, S. and Petersson, J. (2010) 'The increasing importance of administrative practices in the shaping of the welfare state', *Social Work & Society*, **8**(1), pp. 70–81.
- Carnaby, S. and Cambridge, P. (2006) *Intimate and Personal Care with People with Learning Disabilities*, JK Publishers.
- Christensen, K. (1998) 'Andre-orientering og omsorgsarbejde' [Other-orientation and care work], *Tidsskrift for Velferdsforskning*, **2**, 82–97.
- Christensen, K. and Chou, Y.-C. (2018) 'Variations and innovations in care and care work: Critical perspectives (Editorial)', *International Journal of Care and Caring*, **2**(2), pp. 157–63.
- Clark, J. (2006) 'Providing intimate care: The views and values of carers', *Learning Disability Practice*, **9**(3), pp. 10–5.
- Clark, J. (2009) 'Providing intimate continence care for people with learning disabilities', *Nursing Times*, **105**(6), pp. 26–8.
- Creswell, J. W. (2014) *Research Design. Qualitative, Quantitative, and Mixed Methods Approaches*, 4th edn. London, Sage.
- Conder, J. and Mirfin-Veitch, B. (2008) 'Giving and receiving personal care—what does it mean for clients and carers?', *Nursing New Zealand (Wellington, N.Z. : 1995)*, **14**(10), pp. 20–2.
- Emerson, J. P. (1970) 'Behavior in private places: Sustaining definitions of reality in gynecological examinations', *Recent Sociology*, **2**, 74–97.
- England, K. and Dyck, I. (2011) 'Managing the body work of home care', *Sociology of Health & Illness*, **33**(2), pp. 206–19.
- Goffman, E. (1971) *Relations in Public: Microstudies of the Public Order*, New York, NY, Basic Books.
- Goffman, E. (1981) *Forms of Talk*, Oxford, Blackwell.
- Guldvik, I., Christensen, K. and Larsson, M. (2014) 'Towards solidarity: Working relations in personal assistance', *Scandinavian Journal of Disability Research*, **16**(Suppl.), pp. 48–61.
- Heath, C. (1986) *Body Movement and Speech in Medical Interaction*, Cambridge, Cambridge University Press.
- Inoue, M., Chapman, R. and Wynaden, D. (2006) 'Male nurses' experiences of providing intimate care for women clients', *Journal of Advanced Nursing*, **55**(5), pp. 559–67.
- Isaksen, L. W. (1994) *Den Tabubelagte Kroppen, Kropp, Kjønn og Tabuer i Dagens Omsorgsarbeid. [The Taboo Body. Body, Gender and Taboos in Today's Care Work] (Diss.)*, Sociologisk Institutt, Bergen University.
- Kalman, H. and Andersson, K. (2014) 'Framing of intimate care in home care services', *European Journal of Social Work*, **17**(3), pp. 402–14. doi:10.1080/13691457.2014.885882

- Kittay, E. F. (1999) *Love's Labor: Essays on Women, Equality and Dependency*, New York, Routledge.
- Lloyd, L. and Sullivan, M.-P. (2018) 'Ageing, ethics and social welfare: Contemporary social work and social care practices with older people. (Editorial)', *Ethics and Social Welfare*, **12**(3), pp. 201–3.
- Meagher, G. and Szebehely, M. (eds) (2013) *Marketisation in Nordic Eldercare: A Research Report on Legislation, Oversight, Extent and Consequences*, Stockholm, Stockholm University.
- Mol, A. (2008) *The Logic of Care: Health and the Problem of Patient Choice*, Abingdon, Oxon, Routledge.
- Norberg, I. M. J. (2019) *Life in the Hands of Welfare Bureaucracy: The Impact of Austerity on Disabled People in Sweden*, Doctoral dissertation, University of Glasgow.
- SFS. (2001:453) *The Social Services Act*. Socialtjänstlagen.
- SFS. (1993:387) *The Act Concerning Support and Service* [Lag om stöd och service till vissa funktionshindrade].
- Stacey, C. L. (2005) 'Finding dignity in dirty work: The constraints and rewards of low-wage home care labour', *Sociology of Health & Illness*, **27**(6), pp. 831–54.
- Statistics Sweden. (2021) *Statistics on care and services for the elderly 2021, tables 2022-4-7870, definitions*. <https://www.socialstyrelsen.se/statistik-och-data/statistik/alla-statistikamnen/socialtjanstinsatser-till-aldre/>.
- Strandell, R. (2020) 'Care workers under pressure—a comparison of the work situation in Swedish home care 2005 and 2015', *Health & Social Care in the Community*, **28**(1), pp. 137–47.
- Szebehely, M., Strantz, A. and Strandell, R. (2017) *Vem Ska Arbeta i Framtidens Äldreomsorg? [Who Will Work within Future Eldercare?]* Arbetsrapport, Stockholm University.
- Twigg, J. (2000) 'Carework as a form of bodywork', *Ageing and Society*, **20**(4), pp. 389–411.
- Waerness, K. (1984) 'The rationality of caring', *Economic and Industrial Democracy*, **5**(2), pp. 185–211.
- Wilson, N. J., Cumella, S., Parmenter, T. R., Stancliffe, R. J. and Shuttleworth, R. P. (2009) 'Penile hygiene: puberty, paraphimosis and personal care for men and boys with an intellectual disability', *Journal of Intellectual Disability Research*, **53**(2), pp. 106–14.