Paraprofessionals and caring practice: negotiating the use of self

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ABSTRACT

Responding to increasing concerns with the quality of care in both Sweden and England, this paper explores the way in which caring practice emerges out of the interplay between personal and social agency. Working from a socio-cultural perspective, results from an English and a Swedish study conducted independently of each other were used to explore the construction of caring practice. The English study drew on practice observations and four interviews conducted at monthly intervals collecting data on life history and critical incidents. The Swedish study drew on group interviews and two interviews with each participant – one at the beginning of an in-service recognition of prior learning process and one at the end. Interview data was transcribed and thematic analysis identified common themes. The findings from both studies suggest that caring practice involves the intentional use of self to build relationships, understand users and provide personalised interventions. Although practice presented as personal and individualistic, it took place within an organisational context requiring co-configured activity. The practitioners' negotiations with work teams were often conflictual or contested. It is argued that workplaces may enhance caring practice by enabling affordances for the use of self through the design of in-house training programmes, supervision and the organisation of teams. Reflexive practice may also be an important part of the effective use of self.

Keywords: Caring practice, care, paraprofessionals, use of self, socio-cultural learning theory.

INTRODUCTION

Both in England and Sweden, paraprofessional workers such as health care assistants or care workers work under the direction of registered staff to provide much of the frontline and one-to-one care. These workers are one of the enduring features of the workforce but are often overlooked in research. Recently a concern with the development of their practice has emerged as one of the planks of government policy both in England (1-3) and Sweden (4, 5) This demand for skilled and caring practice raises significant questions concerning how care work is constructed within organisations and how 'entry level' paraprofessionals can be developed to provide it. This paper draws from socio-cultural theories to propose that the construction of caring practice involves a negotiation between personal and social agency. It explores this interaction drawing on data from a Swedish and an English study.

Policy in the English sector in general (1) and the Swedish older persons' sector (6) is increasingly emphasising care work as a skilled practice. Care work requires skilled, knowledgeable and reflective practitioners (7), but presents challenges around how to ensure the delivery of such practice among an entry level workforce. Goodrich and Cornwell (8) present a model describing the way in which the construction of good practice is not only shaped by the actions of the individual staff member, but also by the functioning of the team, unit or department, the hospital and wider health system. Writing about hospital care in terms that could easily apply to other sectors, they argue that the setting's culture, its routines and training shape the quality of care.

Goodrich and Cornwell's view suggests that the socio-cultural nature of the workplace will not only influence practice, but also what and how individuals learn. The requirements for performance at work will be projected by workplace practices, norms and discourses as well as material contributions in the form of socially-derived physical artefacts and tools (9). Such projections determine what practitioners understand and how they practice. Research into the role of context (10), communities of practice (11) or activity systems (12) all suggest that performance will be shaped by the dynamics of social structure.

However, Holloway (13) warns against sociological reductionism and suggests that while structures, cultures, practices and discourses play a part in care giving, one must also attend to the part played by individual dispositions, capacities and psychological processes. If the practitioner is presented as subsumed in the social and their development solely a product of socio-cultural conditions, any sense of the individual with their particular values, histories and practices is erased (14).

An account that erases the individual's unique qualities is particularly problematic in discussions of health and social care practice. Wosket (15), for example, writing about counselling stresses the practitioners' 'use of the self' as a central part of the process. The way in which practitioners apply themselves, make their personhood present and extend aspects of their personality into the therapeutic encounter in order to influence the user are crucial to the effectiveness of the intervention. Similarly, Edwards and Bess (16) argue that effective therapy requires the formation of relationships which serve as a context for change. In such relationships, the practitioner does not simply offer skills and knowledge but themselves as a person – their values, their empathy and their genuineness. Practitioners mine their personal qualities in the service of caring practice.

These are not analyses privileging the individual over the social. The therapist, the social worker or the health care assistant will be reproducing the normative practices that are recognisably those of therapy, social work or nursing. However, these reproductions will be uniquely subjective interpretations and enactments of these practices and not carbon copies (9). In addition, practitioners improvise as events unfold, responding to the unique needs of the person needing care. This improvisation will be shaped by the personal style, personality, capacities and unique histories of the practitioner. Thus, the worker's own agency plays a part in the remaking of practice as they interpret or reconstruct practice within the demands of the world of health and social care.

The relationship between structure and agency can be thought of as an interpenetrated or transactional one. To take examples from this journal, Hov et al. (17) and Clarke (18) describe the tensions for practitioners operating within the interface of duty to the patient and duty to the organization. Such organisational duty involves working

within a hierarchically tiered agenda and attempting to minimize disruption to the organisation (18). For example, Hov et al. describes a process in which practitioners build up a deep knowledge of each patient through continuous, close and long lasting contact. This individual understanding however, is interpenetrated with collective understanding – individuals clarify their understanding in discussion with colleagues and decisions are made collectively. This collective process can build individual certainty, but can also involve disputes, silencing, and exclusion from decision making. In other words, the performance of caring practice always involves a transactional relationship between personal and social agency.

So, while practice is socially constituted, the nature of individual agency and disposition plays an important role. Also, the way in which the negotiation between personal and social agency proceeds and is resolved can have significant implications for personal practice and development. In exploring this tension between personal and social agency, this paper sets out to describe the way in which paraprofessionals in both Sweden and England negotiate caring practice in health and social care.

METHOD

Although the Swedish and English studies drawn on in this paper were carried out independently in 2008, these projects shared a number of commonalities. Both were fundamentally concerned with the learning experiences of paraprofessionals and drew data from workers with similar roles. The Swedish practitioners were not only involved in an in-service course but all were still in practice. Similarly, all of the English practitioners were all in practice and some were involved in formal education. To the two authors, these two datasets presented a good opportunity to do some cross-national work on an issue of mutual concern. Table 1 presents participant characteristics from both studies.

Table 1. Summary of participant characteristics

	Gender		Age				
	Female	***Male***	***20-29***	***30-39***	***40-49***	***50-59***	***60-65***
English	12	2	3	0	8	2	0
Swedish	14	0	0	2	7	5	0

The English strand of this paper drew from a subset of data from a PhD project focused on understanding paraprofessional learning. 14 participants in paraprofessional roles working in learning disability, mental health services and health visiting were involved in the study. 6 workers were observed engaged in practice activities such as working with users, talking with colleagues or administration. The sensitive nature of the field of practice meant that those in the mental health and health visiting services participated in interviews only. With two exceptions, each participant was interviewed four times:

1. A biographical interview and an exploration of their role and setting;
2 & 3. Interviews carried out at monthly intervals exploring critical incidents and follow up questions drawn from the previous interviews;
4. Discussion of a participant profile prepared out of the data and a further critical incident interview. This profile interview was not simply respondent validation. It was a final stage in data collection and the first step in analysis in which the participant discussed some of the themes emerging in their data and contributed to interpretation.

The Swedish study was primarily focused on understanding the process of recognition of prior learning (RPL), which was part of an in-service program supporting health care assistants with considerable experience of practice to become licensed practical nurses. The majority of participants worked in elderly care or with people with learning disabilities. 25 interviews were conducted with the 14 participants (9 before, 2 group interviews during and 14 after the RPL-process). The intention of the first interview was to get to know the participants and discuss their thoughts and feelings about the up-coming RPL-process, including questions about their work in practice. Only 9 (out of 14) of the health care assistants were able to participate in the first interview session. During the RPL-process two group interviews (one with 7 and one

with 6 participants) were also conducted to take 'snapshots' of the participants' experience of RPL and practice.The last interview was the most in-depth and involved all 14 participants. Even though focus in this last interview was primarily concerned with the student's view of the RPL process, questions concerning the participant's general view of caring practice were included and discussed to a great extent. Table 2 summarises the research methods used in both projects.

Table 2. Summary of research methods used in the English and the Swedish projects

	No. participants	**Interviews**	**Observations**	**Group interviews**
English study	14	53 at monthly intervals - 4 with 12 participants, - 3 with 1 participant, - 2 with 1 participant.	6 participants in practice, 4 – 11 hours each	None
Swedish study	14	23 - 9 participants before the RPL process - 14 participants after the RPL process	None	2 during the RPL process with 7 and 6 participants respectively.

Ethical issues

The English study was approved by the NHS Research Ethics Committee and the Open University Human Participants and Materials Ethics Committee. Participants signed a statement indicating they understood the study's description in the information sheet which included its' methods and purpose, the use of data, the right to withdraw, avenues for complaint and confidentiality. Service users present during the observations of practitioners also gave permission for the researcher's presence. Data was stored on a password protected computer and any identifying features were

carefully removed or changed. Upon completion of the project, the data will be destroyed.

In the Swedish study, a written contract was signed with a representative in charge of the education of the participating health care assistants. This contract reflected the Swedish Research Council's ethical principles for research within humanities and social sciences and included information about the participants' confidentiality. The participant's were also informed about their confidentiality orally during an introductory meeting at the beginning of the research project. The data (recordings and transcriptions) were safely stored on a computer with code-lock, only available to the researcher. The data will be destroyed when the project ends.

During the analysis and reporting, confidentiality was maintained by not revealing the participants' birth names or locations. In group interviews, not only does the researcher need to promise confidentiality but participants should also agree to these terms. To this end, the course's teachers asked the participants' to sign a contract agreeing to respect each other's confidentiality throughout their involvement in the in-service program. This promise of confidentiality also applied to the group discussions.

Analysis

Thematic analysis (19) was applied to the data. Both authors analysed their data independently, reading through the material from their projects and identifying a list of themes that recurred across the participants. These themes were developed into codes which were applied to each piece of data. Comparing themes between the two projects and using theory as sensitising concepts, the authors identified two broad areas of commonality to explore further in their datasets. The authors returned to their data to identify commonalities, uniqueness and ascribed meaning in the participants' experience in relation to these themes (20).

FINDINGS

Data in both the English and Swedish study suggested similarities in the care workers' use of self in caring practice. The nature of this use of self as well as the negotiations between social and personal agency were explored.

Distinctive relationships and personal understandings

In the English study[1], caring practice was concerned with ensuring user choice, facilitating personal development and supporting participation in the activities of daily life. Relationship work was an essential part of this process, necessary for the negotiations, support and understanding that facilitated user development. Practitioners emphasised striving for a *personal* relationship with users, valuing rapport and being seen as more than just another worker who is, for example, missed when absent or asked for over other workers. As such practitioners stressed their distinctive understanding of, and relationships with users – one in which they could respond in a uniquely tailored way to each person. These sorts of relationships were seen as a context for change and support somehow distinct from what other practitioners would have with the service user. For example, a team dealing with an unresponsive user tapped into the practitioner's unique rapport:

> *"He was sectioned and they rang up and said 'is there anybody in the team that's got a good rapport with him that can come and persuade him to get in the ambulance before we call the police', so I was asked to go then …"* (PB).

Regular contact with users was emphasised as the basis of insight into their unique circumstances and needs. Practitioners strived to remain open to how each user presented to them personally rather than working from preconceptions or generalisations based on diagnostic labels, user notes or behaviour with other workers. User notes and staff meetings did inform practice too but practitioners favoured improvisation in the moment - *"floating things into the equation"* (PU), trying things out and observing reactions to understand 'what works'. As such, practitioners emphasised their understanding as personal and distinctive, a kind of 'frontline authority' with a different value to the more detached knowledge of the academically trained practitioner.

Handing the conductors baton to users

[1] In the English study the quotes are marked with letters only (e.g. PB as participant B) and in the Swedish study they are marked with letter and number (R1), Respondent 1 and (GI 1) group interview 1.

Participants in the Swedish study also focused on building relationships with users in order to better support their development and choice. Care workers described themselves as handing the "conductors baton" to the user to ensure choice:

> *"You can't put yourself above them* [patient], *and command and decide for them, does not work anyway . . .* [you need to] *ask them what they want for breakfast. You cannot count on the fact that they want to eat the same breakfast 31 days of the month for ten years. You should not do anything as a production line."* (R5).

With this approach comes a strong agenda to build a unique and person-centred understanding of users by observing and listening to them. One of the participants, working in the older persons care sector, explained that she could not rely solely on co-workers' information about a patient:

> *"Even if someone else tells you before hand, you have to ask. You have to make your own judgment, because it can be really wrong."* (GI 1).

Even though practitioners would gather information from co-workers, they felt a strong need to build a personal understanding of each user. Daily relationship building and maintenance involved on-going conversation and questioning of users. One participant explains this further:

> *"At our workplace we have four* [co-workers] *who say different things about a user. He wants bread; no he does not eat bread. He wants sausage on his sandwich; no he does not eat sausage on his sandwich. Then you have to make the decision by yourself. You have to ask the user."* (GI 1).

'Being me'

In the English study, practitioners gave detailed descriptions of practice. They described themselves operating within well defined organisational routines (for example, when responding to seizures, feeding or providing medication). However, they also emphasised the way in which they worked out of a personal style - 'being me', doing what comes naturally or working out of instinct, exploiting their personal characteristics such as personal enthusiasms or a sense humour. Being able to bring something personal was seen as a qualification for the job as important as formal training:

> *"… when I came to this job I stated in my interview the only thing I can bring is me. I don't have any qualifications in any kind of social care."* (PU).

'Going through the motions' (acting in a depersonalised fashion) was criticised by workers 'Truly caring' for others, suppressing some aspects of their personality and emphasising others was part of practice. Practice was not detached from the practitioners' sense of who they were but intertwined with it. In its ideal state, workers tried to connect care work to their personal interests and history (for example, the exercise enthusiast worked the gym sessions) creating authentically human encounters based on shared enthusiasms. Similarly, past and present experience influenced the practitioners' approach and sense of competence – the ex-teacher worked from educational principles, ex social work assistant focused on social care needs or the Mother supported independence in a nurturing fashion.

Understanding users' needs in terms of personal experiences

The Swedish practitioners also emphasised their personal history and style as a key part of their work with users. For instance, one participant felt that her interest in travelling abroad had given her a deeper understanding of working with users from other cultures. More everyday experiences were also discussed. For instance, one participant discussed users' daily routines in terms connected to her own preferences:

> *"If someone would wake me up at seven o'clock I would kick them out. You should not do that and why should breakfast be served at eight o'clock? Maybe you want to sleep until ten o'clock and why do they* [users] *have to go to bed at seven o'clock?"*(GI 2).

Participants drew on their own lives and experiences to make sense of and provide direction in their everyday work. Questions such as "How would I want to be treated?" seem to be part of everyday practice where the practitioners filter users' needs and interests through their own experiences. This suggests that care work and the participants' sense of self is closely intertwined, as in the English study. Prior and present experiences in life also influenced how the Swedish care workers approached their work. Being a

mother, a traveller or using experiences from leisure activities are all examples that arose in the interviews:

> *"You are a mother, you have it in yourself I think. So it is motherhood; that is caring. Take care of. Take care of your children, take care of others, take care of husbands* [laughter]. *But that's how it is. I think it is that way."* (R4).

Negotiation between personal agency and social agency

These two studies suggest that caring practice involves the intentional use of self to build relationships, understand users and provide personalised interventions. However, as personal and individual as practice was, it had to be performed within an organisational context that typically involved co-configured practice. That is, teams attempted to build a common understanding, agreement on shared goals and in part, consistent approaches to each user. Formal and informal discussions, problem solving, care plans, supervision and service goals were often concerned with the consistency and continuity of established practice. Yet, effective caring practice is personal, involving the 'use of self' within collective practices and as such, involves a negotiation between personal agency and social agency. This negotiation will be explored.

Dealing with conflict and maintaining team relationships

While building shared understanding was a typical team process in the English study, practitioners also deviated in their understanding, values and interests. Thus, co-configuring practice involved working with provisional understandings rather than a fixed and agreed consensus. Discussions between workers often involved differences of opinion and conflict. The construction of practice therefore becomes a contested practice given voice not only in group discussions about particular service users, but while in practice itself:

> *" ...he* [service user with learning disability] *asked me to come and open the sachet - so I said to him 'you're more than capable of opening a sachet' – and I could see the other staff member getting up from here – I knew they were going to go across to take over - and I said 'leave it for a second' – now what I thought was strange - I'm*

> *trying to control, if that's the right word, another support worker from interfering …"* (PU).

Practitioners present their negotiations as a balancing act between direct conflict and trying not to 'step on toes' so as to avoid damage to positive team relationships. Power plays a part in resolving disagreements:

> *"Sometimes I forget myself that I'm, there is a hierarchy and that I am a support worker … that I forget that I actually am not in a position where I can actually engage so openly in a clinical discussion."* (PM).

Participants were not powerless though. Managers were lobbied. Positional authority was used to pull rank. More subtle power sources may also be used. Assertion of extensive and daily personal experience with the user (a kind of 'frontline authority') and the capital of long term experience may be asserted, but did not bring the same certainty that the registered practitioner's veto power holds. Teams sometimes broke into factions divided along 'old school' or 'new school' approaches, social care or medically-based orientations, friendships and cliques or registered and non-registered workers. Factions provided a locus for discussion to get an angle on practice, moral support or 'back-up' in disputes. They may also operate through subversion by, for example, dealing with an overly negative colleague by asserting to users and colleagues behind the worker's back that *"We don't listen to* [colleague]*, you know."* (PI).

Finding a place in the team

In the English study, practitioners and managers also negotiated places for individual capacities within the constraints of the role or the team's skill mix. Negotiations may be focused on finding tasks that better match practitioner skills, interests and ambitions. Others sought to carve out a particular niche:

> *"How am I - me and my personality – not just as another body - how am I going to fit in here – and am I going to be able to offer something different?"* (PG).

Workers may also seek the sense of competence and confidence arising out of continuity with past skills, knowledge and interests by finding familiar roles within

the team. Others have ambitions to develop themselves further. Losing these continuities or growth opportunities can be demoralizing:

> *"I'm beginning to feel that most of the skills that I have is not being utilised, and I'm beginning to lose those skills and because I have that fear of losing those skills I'm always going on. I think I find myself going on about wanting to do this and this, because I have those expertise, and sometimes I just think - am I in the right place?"* (PC)

Workers also lobby managers to visibilise their capabilities to create, or move to, a better fitting role. Recognising the value of use of self to caring relationships, managers may fold the service around the practitioner's personal characteristics by, for example, giving the gardening groups to the gardener or matching them with users they have a rapport with. Such discussions are also an important part of supervision:

> *"... every time we had a supervision I'd just sort of say the ones* [sessions] *that I liked doing. I suppose that's how I've come to do the ones that I like really, cos they've tried to keep me with the ones that obviously I'll be ... if I'm enjoying them I'll be putting more in and therefore so service-users are getting more out."* (PG).

However, such affordances for the use of self may have an ambivalent place in the organisation. Accommodating user-practitioner rapport may be balanced against ambivalence about creating 'dependant' relationships that were seen as inappropriate in a professional service relying on an interchangeable workforce. Practitioners new to a workplace seeking continuities with a past role or personal style, may encounter resistance from colleagues:

> *"... other staff will say you know, like I'm an arselicker because I'm doing more than I should be doing ..."* (PJ).

Old-timers as newcomers

In contrast to the permanent work roles in the English study, the Swedish workplace data relates to their experience of working in a 6 week placement for the RPL programme. As such, these experienced workers present as newcomers to their placements but do not strive for full, permanent membership. As in the English study the participants emphasised the importance of being open to the individual and their

personal needs and as such, felt a strong drive to avoid becoming a part of a 'production line' associated with institutionalised care. Effective care work was considered as more than routinised working habits, but also involved tapping into the user's potential for development. For instance, one participant raised concerns that users were not supported to improve their mobility:

> *"There were people or users sitting in their wheel-chairs a lot. And I was a bit against that, since they could walk . . . she* [user] *can actually go to the bathroom and then she will get to the train walking several times a day. I guess I was brought up working with my hands on my back."* (R1).

Participants also reacted against institutionalised care bringing them into conflict with colleagues. Some participants openly debated such issues with ordinary staff at the placements. The conflicts seemed to hinge on the idea that the participants, as 'old-timers', suddenly became 'new-comers' in the placements. For example, a participant came into conflict with an ordinary staff member, based on this kind of assumption:

> *"She* [a co-worker]*; that person probably thought I was a student. She was a little bit like that, pushing people around … and I thought that I don't care what she says. I do my own thing."* (R1).

Knowing that the placement was limited in time, the participants seemed to act differently to the participants in the English study. They were not aiming to become full participants in their placement settings. However, conflicts appeared to be a 'battle' to prove themselves as worthy of a RPL-claim, as well as making clear that they were experienced care workers:

> *"… I did what I thought was right. And I stood up for that … on some occasions there were conflicts, not with the ordinary staff but with some supplement workers … But I thought, I will not give up, she will walk to the bathroom. That was the argument … ".* (R1).

Being a 'newcomer' as 'old-timer' did create a tension that had to be negotiated. Personal norms set against workplace norms could create conflicts that needed resolution. Some conflict was easily and amiably resolved while others were more enduring. Despite the focus on care work as a personal activity, involving the use of

self to facilitate individual relationships, understanding and user development, it is also clear that participants valued good team work. One participant emphasises the importance of a professional attitude towards other co-workers and highlights the need for consensus:

> *"You must talk to each other. Not throwing pastries at each other, we are here for the user, and then we must arrange for how we do it."* (GI 1).

DISCUSSION

Caring for others is one of the behaviours of our species (21). Parents care for children and friends help each other out. People strive to develop relationships that are special in their intimacy and understanding. They draw on their unique skills, knowledge and personal qualities to provide care. Such activities have meaning for people and relate to their identity and values. When the people in these studies entered the workplace and went 'professional', they did not leave these aspects of self behind. They drew on pre-existing skills and knowledge (of gardening, cooking, teaching, travelling, parenting or nursing, for example) and extended their personality and values into the practice. Such qualities are exploited to advance the aims of the caring relationship - not simply in terms of relationship building or intervening in a personal and authentic fashion but also to build insight into the user and their needs. This process of using oneself in practice has been referred to elsewhere as 'presencing' (22).

This process of presencing and the use of self raises the question concerning the way in which organisations and individuals manage what has been referred to here as the negotiation between personal and social agency. Certainly in the English study, workplaces attended to ensuring that workers had a place in the organisation that responded to personhood. The Swedish studies suggest that workers feel driven to assert a personalised approach. Indeed, there seemed to be an acknowledgement that to do otherwise would be to jeopardize the caring quality of practice and in particular, the authentic human encounters and mutual rewards that constitute positive relationships in health and social care.

The tensions and conflicts associated with practitioners attempting to negotiate a way of working that is personally congruent, suggest that to find a place for the personal is not necessarily straightforward. As the Swedish and English studies suggest, engaging in the practices of a workplace is a negotiated and contested process, not simply a matter of being shaped by social agency or asserting a personal approach. The factional relationships among the English participants and the assertion of shared interests and values that coexist with disagreement in both studies, underline the need practitioners have to belong and affiliate. After all, collegial relations are a necessary part of care work. This dynamic only further highlights the negotiated relationship between the self and the collective.

However, it is important to attend to power differentials and workplace inequalities in the development of practice (14) (23). Certainly, paraprofessionals are low-paid, predominantly female and at the bottom of the work hierarchy. For some workers, their authority appears fixed by their position in the hierarchy. However as suggested by the authoritative roles served by the workers in the English study and the challenges and small wins of the new coming old timers in the Swedish project, power is something negotiated and not set.

The negotiation of the use of self also relates to reflection. Both the Swedish and English study described the way that the practitioners' insights into their users was filtered through understandings derived from their history and particular values. The English study suggested that the use of personal style was helpful in relationship formation and past orientations shaped present activities. Kwaitek et. al. (22) problematises these ideas arguing that underlying values and assumptions may lead practitioners to intervene in an unhelpful or inappropriate fashion. For example, the Swedish and English studies beg the question – if the experience of Mothering prepares one for care work, could this also bring with it inappropriately paternalistic attitudes? Kwaitek et al., (22) advocate the need to focus on the 'therapeutic self' – a process of evaluating the way that the practitioner's personal characteristics and values impact on the user. They describe a course which includes extensive self awareness and reflection coupled with an understanding of person-centred practice and the appropriate use of 'presencing'. They focus on enabling practitioners to know

themselves within the context of the work environment and how internal factors and external factors shape behaviour.

Kwaitek's et al'.s notion of reflection revolving around the relationship between self and context hints at a process that is more than a meta-cognitive activity like a study skill. Reflection may also be about identity work within a particular context. This links to Wenger's (24) work on learning as a process of identity formation. Issues of *who am I, what do I want to be, how do I want to be in this place, what do I feel comfortable doing and ready to develop further* are all questions for *reflexive* work or self authoring. Returning to the interpenetration of personal and social agency, it may also be fruitful for reflection and professional supervision to consider such matters not only in relation to the individual, but also in terms of organisational affordances to accommodate the use of self. Reflexive organisations foster reflexive practitioners.

Affordances for the use of self are no small matter. Sennett (25) writing about the nature of character argues that practitioners do not strive to be just another pair of labouring hands but desire to develop careers, professional identities and work with a meaningful vocation. The evidence from this study suggests that such issues are important to the quality of care.

CONCLUSION

This paper explored the negotiation between personal and social agency in caring work. The findings suggest that practitioners strive to create personal and individual encounters with, and understandings of users. They also work to find a place in the team that is congruent with their personal qualities and understandings. This process involves a negotiation with their work teams, a process which may be conflictual or contested. It is argued that workplaces may enhance caring practice by enabling affordances for the use of self through the design of in-house training programmes, supervision and the organisation of teams. Reflexive practice may also be an important part of the effective use of self.

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