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Special Issue “Analyzing activity, what constants and what renewals?”

ACTIVITY AND EMOTIONS

**ANALYSIS OF ACTIVITY AND EMOTIONS: A CASE STUDY
BASED INVESTIGATION OF AN EVOLVING METHOD**

by C. RIBERT-VAN DE WEERDT[•] AND R. BARATTA[•]

RÉSUMÉ : L’analyse de l’activité, qui constitue l’un des fondements de l’ergonomie, poursuit son évolution vers la recherche continue d’une meilleure adaptation des méthodes aux situations de travail, présentes et futures. En effet, les conditions de travail évoluant à grand pas, les méthodes d’analyse de l’activité sont souvent revues et ajustées pour pouvoir répondre au mieux à cette réalité évolutive, prenant des formes variées. C’est ainsi que parallèlement à l’activité, les émotions au travail font de plus en plus souvent l’objet d’analyses. A l’heure où les risques psychosociaux sont préoccupants, la prise en compte de cette dimension émotionnelle est d’autant plus d’actualité. Cet article expose une recherche-intervention menée dans une entreprise du secteur du soin à domicile. Basée sur une approche psycho-ergonomique, la démarche a fait appel à une méthode d’analyse de l’activité et des émotions, avec l’utilisation d’auto-confrontation collective. A travers cette étude de cas, nous détaillons la méthode utilisée et les résultats qu’elle a produits, ainsi qu’une réflexion méthodologique autour de la question de l’adaptation des méthodes d’analyse et d’intervention. Nous montrons que dans une perspective d’amélioration des situations de travail, et plus précisément, de prévention des risques psychosociaux, les méthodes d’analyse de l’activité et des émotions, avec l’application d’auto-confrontations collectives, ont une place à part entière. Nous montrons en quoi la méthode a cherché à saisir les évolutions du monde du travail en s’adaptant, tout en respectant les fondements

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même des méthodes d'analyse de l'activité. Un regard particulier est porté sur cette progression méthodologique vis-à-vis de la prévention des risques psychosociaux.

MOTS-CLÉS : activité, auto-confrontation collective, émotions, ergonomie, psychologie, soin à domicile.

I INTRODUCTION

Activity analysis is one of the foundations of ergonomics. It is continuously evolving in the search to improve the correspondence between methods and present and future occupational situations. Indeed, as working conditions change rapidly, the methods used to analyse activity need to be reviewed and adjusted regularly to better respond to this changing reality. In order to supply relevant responses, when designing or enhancing working situations, activity can be analysed in various ways, taking into account the changing occupational world. Thus, in parallel to the activity itself, emotions at work are increasingly the subject of analyses (Grosjean, Raufaste, & Giboin, 2003; Cahour, 2006; Cahour & Lancry, 2011; Karsenty, 2011; Février, Gauducheau, Jamet, Rouxel, & Salembier, 2011; Bourgeon & Cahour, 2013; Prost, Cahour, & Detienne, 2014; Nguyen & Cahour, 2014). The emotional component of work is analysed in the context of various occupationally-specific domains such as interaction (cooperation, written or oral interpersonal relationships, man-machine interfaces), design (participative and organisational) and the use of new instruments, but also in relation to health. Indeed, at a time when concerns about psychosocial risks have come to the fore, questions relating to occupational health necessarily lead to questions about the emotional component of activity (Zapf, 2002; Marc, Grosjean, & Marcella, 2011; Valléry & Leduc, 2014). In an attempt to determine psychosocial risks and implement actions to reduce them, emotions and activity are increasingly analysed together in research and in empirical studies. Greater preventive efforts are being made to include these risks, and it is therefore essential that all aspects of activity be analysed in order to understand the full complexity of any given situation.

This article describes a research and intervention project undertaken in a company and involving activity analysis in situ. We sought to determine the actual working constraints, and to examine how emotions contributed to them. Through this study, we provide a methodological reflection on the question of how analysis and intervention methods can be adapted to help improve working situations, and more precisely, how they can contribute to the prevention of psychosocial risks by taking emotional parameters into account.

In the context of this research and intervention project, methods of activity analysis based on the theoretical foundations of psycho-ergonomic methods were adapted to take into account the affective component of work, the strategies applied dynamically by workers, and their relevance in specific situations. A methodological approach was specifically applied with the aim of preventing occupational risks, in particular psychosocial risks. This research and intervention project was carried out in the home-healthcare sector. This sector presents the specificity of involving work which is by its very nature emotionally charged, and which is carried out in workplaces that are becoming increasingly common in modern society. The work is characterised by its isolated nature, in that it is highly constrained in organisational terms, because of the way in which visits are planned, and because it is performed in an environment which necessarily presents risks for personnel.

II THEORETICAL FRAMEWORK

Home healthcare is expanding rapidly in modern society, where it represents one of the sectors of activity that have seen the fastest growth in recent decades. Indeed, the Bureau of Labor Statistics (2008) predicted that employment of home-healthcare workers would increase by 55% between 2008 and 2016 in the United States. There could be several reasons for this sort of progression. Ageing populations have created growing demands for this alternative form of healthcare, which allows vital medical assistance to be provided to older, disabled or convalescing people in their own homes, rather than requiring them to use hospital services. As the cost of hospitalisation is high, home healthcare contributes to minimising this public or private expenditure. In addition, a large number of people prefer to stay in their own daily environment, or

to live with members of their family, rather than stay in a hospital setting. Indeed, as a rule, people wish to maintain as much independence as possible with regard to their living conditions. In addition, home healthcare is particularly well-adapted to those at risk of falling down and being unable to get up by themselves, those at risk of forgetting to take their medication, or those with certain diseases, such as Alzheimer's, for whom removal from their habitual day-to-day context could be a source of stress. Home healthcare allows patients to return rapidly to their familiar environment after hospitalisation, while still regularly receiving any necessary care or health monitoring. In addition, it offers patients the possibility of receiving high-quality medical care in the comfort of their habitual living environment.

It has long been known that home-healthcare workers face risks for their own health (El-Askari & DeBaun, 1999). Recently, the Niosh (The National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, 2010) published a report presenting a list of occupational risks to which these workers are exposed. The risks listed include chemical and biological hazards, the risk of developing musculoskeletal disorders, as well as psychosocial risks. In the latter category, the report listed the following reasons for the high level of risk associated with these professions: overinvestment, occupational exhaustion, verbal and physical aggression, isolation and occupational stress. Burnout, which is undoubtedly related to these factors, is very common in these professions (Estryn-Béhar & al., 2007). The European NEXT study on the quality of life for healthcare personnel, for which the initial survey was carried out between 2002 and 2003 and continued until 2005, also described the difficulties that these workers encounter in the practice of their professions, and explained why early exit is so common (Meissner & al., 2007). Early exit is a widespread worry ; it was encountered in all ten countries participating in the study. Similarly, the emotional aspect of work can be significant in these professions (Hochschild, 1983; Soares, 2002; Totterdell & Holman, 2003; Van De Weerd, 2011). Healthcare workers must often manage difficult situations related to the affective part of their work. These situations expose them to strong emotional constraints when performing their jobs. For example, healthcare workers may be required to hide negative emotions about the progression of a patient's disease if they have doubts about how a treatment is working. These emotions are masked to avoid negatively

influencing the patient's reaction. In other cases, emotional contagion must be avoided. This can be defined as "an automatic, unintentional and often unconscious tendency to imitate and synchronise facial expressions, body movements and vocalisations during meetings with other individuals" (Hatfield, Cacioppo & Rapson, 1994, p.5). Several researchers have shown that strategies for avoiding emotional contagion are often used by healthcare personnel in their work (Hatfield & al., 1994; Barsade, 2002 ; Van Hoorebeke, 2006 ; Ribert-Van De Weerd, 2011). However, sharing emotions with other people is often an "insatiable need", as shown by Rimé (2005), particularly when major emotional events must be endured (Rimé, 2005; Prost, Cahour, & Detienne, 2014).

The strategies to which we refer relate, on the one hand, to what can be termed as "coping" and, on the other, to the concept of how the emotions can be regulated. The concept of coping was developed by Lazarus and Folkman (1984), and is defined as a group of cognitive, emotional or mental efforts that a person uses to control or tolerate internal or external tensions that threaten or exceed his resources. Faced with a stressful situation, the person assesses the situation and the means at his disposal, and attempts to reduce or eliminate the stress by applying several strategies. These strategies are applied as part of a dynamic process that also attempts to change the situation (Luminet, 2002; Mann, 2004). With task-related coping, the person confronted with a stressful situation attempts to analyse the problem, to seek additional information and to find a solution. With emotional coping strategies, the aim is to find a means to moderate the intensity of negative emotions.

As for regulating emotions, Krauth-Gruber (2009) found several types of strategy in the literature he reviewed. For example, Hochschild (1983) described the strategies to regulate specific emotions that are used by people faced with a heavy emotional load. These strategies can be classified into two categories, corresponding to different levels of emotional effort, one superficial, the other deeper. With "surface acting", we mimic emotions which we do not really feel, whereas in "deep acting" we seek to really feel the emotion expressed (Hochschild, 1983; Pugh, 2001; Grandey, 2003). While surface acting is an attempt to exert voluntary control over behaviour, deep acting relies on a cognitive action aiming to really feel the appropriate emotion. Thus, surface acting focuses on behaviour (at the external level), while deep acting is centred

on feelings (at the internal level). In the first case, the person attempts to act as if they feel a particular emotion while knowing that it is not what they actually feel; in the second case, they try to elicit an emotion that they would like to feel. Several studies have shown that this emotional work, which plunges people into emotional dissonance, is expensive in terms of workload, causing an overall increase in the load (Soares, 2002; Zapf, 2002; Scherer, 2006; Mann, 2004). Gross (1998) distinguishes between emotional control which is centred on emotional precedents and that which is centred on responses. While, with emotional precedents, regulation can be applied early in the emotional process in an attempt to control the emotional impact of a situation, response-centred control emerges later and seeks to influence responses at the level of feelings (either by focusing the attention on the thoughts accompanying the emotion, or by suppressing these thoughts).

Based on these theoretical notions, we have developed and applied a specific methodology that aims, on the one hand, to concomitantly analyse actions and emotions in an occupational situation, and on the other, to improve working conditions. In terms of results, we will see how this methodology allowed us to define the characteristics of healthcare worker activity, describe formally the emotional aspects of their work, identify the strategies used by personnel to preserve their health, and initiate debates within the company as part of a dynamic and long-term strategy to prevent psychosocial risks. These results have led us to direct our attentions to a methodological reflection on the question of how analysis and intervention methods can be adapted to consider the different aspects of certain occupations.

III METHODS

Our psycho-ergonomic research and intervention project had three objectives: to provide knowledge, to implement a specific methodology, and to transform work.

The study was carried out in a home healthcare service employing 42 people, and its aim was to study the working conditions of the workers - i.e., “carers” (nurses and nurses’ aides) and “coordinators” - and to determine how these conditions affect their work in terms of activity, satisfaction, well-being, emotions at work and relationships with others (patients, colleagues, coordinators, doctors, managers, etc.). From this

point of view, the research and intervention project analysed not only the activity, but also the emotional load, the working constraints, and the strategies used to deal with all these aspects of the work.

Another aim of this research and intervention project was to improve our knowledge of the health and safety risks for home healthcare workers, and to contribute to reducing occupational risks through a participative approach. As part of this facet of the study, recommendations were made and implemented, with the help of input from the workers, in an attempt to improve working conditions and develop an appropriate risk prevention strategy.

The healthcare service we investigated was created 20 years ago and has expanded very rapidly in both human and financial terms. Thus, within the last 10 years, the number of workers has doubled and the turnover has increased three-fold. The director of the service currently employs 19 nurses (one of whom is on call at the care centre and 18 of whom provide care in patients' homes), 17 nurse's aides, 3 coordinators (2 nurse coordinators and a nurse's aide coordinator), as well as 3 secretaries (two medical secretaries and an administrative secretary). The coordinators also act as middle managers, proximity managers, and team leaders (nurse or nurse's aide teams).

The research and intervention project was conducted over a total of 13 months. It was run by two researchers, R. Baratta and C. Van De Weerd. Their roles in the study were similar and they acted together from steps 1 to 4 (Table 1), except for the individual interviews (step 2) and the observations (step 3), which were divided up and conducted in parallel with different individuals. All video-recorded observations were dealt with exclusively by R. Baratta, who was responsible for assembling the video sequences. The sequences selected for assembly were chosen in tandem by the two researchers.

Interviews and/or observations were conducted over a one-week period, monitoring the activities of 11 nurses, 7 nurse's aides, 3 coordinators and 3 secretaries. Video recordings were made whenever possible, with the consent of the interviewees.

The methodology developed for this research and intervention project relied on the use of video as a vector for the analysis of working situations through collective self-confrontation with the healthcare and administrative personnel (Van De Weerd, 2011; Baratta & Berthet, 2000; Baratta & Desmares, 2004; Baratta, 2006, 2010, 2012). This

methodology was specifically developed to allow data to be gathered on the activity including emotions at work and coping strategies. Among the various existing forms of self-confrontation at our disposal (Salembier, Cahour, & Zouinar, 2013), collective self-confrontation appeared to us to be particularly relevant when trying to determine the dynamics of a particular activity, create conditions where the representations of work would be shared, find solutions to problems encountered as a group, re-establish a favourable social climate, and help the structure to self-regulate any difficulties in the long-term. The approach involved four stages (Table 1).

The first step consisted in a “pre-investigation”. This pre-investigation involved observation of the service, analysis of documents, exploratory individual interviews with the director, the coordinators and personnel representatives, pre-observations of the healthcare workers’ activity in the care centre (during preparation of their rounds), and during practical preparation for the intervention in the patient’s home. The data from exploratory interviews and pre-observations were gathered by means of note-taking. This step made it possible to take into account the company organisation and culture, as well as the way its structure operates.

The purpose of the second step was to study the general context of the structure, but also - and in particular - to get workers to assess their working constraints and their health status. To do this, semi-directed individual and team interviews were conducted. This step aimed to determine how workers within the service viewed their working conditions and their own state of health. We focused our analysis on the subjective and perceptive dimensions of working conditions and health. Indeed, we consider that these aspects, which are both representational and evaluative, are essential when studying emotions at work and psychosocial risks. The importance of these aspects is supported by theories relating to stress which underline the importance of the workers’ own perceptions in estimating levels of chronic stress (Karasek, 1979; Lazarus & Folkman, 1984). As part of this step, we sat in on several team meetings and conducted individual interviews with personnel. Video or audio recordings of interviews were made with the interviewees’ consent and when technically possible (i.e., when it was possible to conduct the interview in a quiet, private room). Notes were taken when recording was not possible.

	DETAILS OF THE METHOD
STEP 1: Pre-observation	<ul style="list-style-type: none"> - observation of services - analysis of documents - 9 individual exploratory interviews with the director, coordinators, personnel representatives, - preparation of the intervention - pre-observation of workers' activity in the care centre
STEP 2: Analysis of the overall context, the working constraints and assessment of health status	<ul style="list-style-type: none"> - observation of two team meetings - observation of a monthly meeting with the participation of home-based nurse's aides - 12 semi-directed individual interviews with: <ul style="list-style-type: none"> ✓ 3 home-based nurses ✓ 3 home-based nurse's aides ✓ 2 coordinating nurses ✓ 1 coordinating nurse's aide ✓ 1 nurse on-call at the centre ✓ 1 medical secretary ✓ 1 administrative secretary
STEP 3: Analysis of activity and emotions while performing an action	<ul style="list-style-type: none"> - 31 observations of real activity over 5 days, monitoring the activity of a single person continuously over a daily period lasting at least 2 hours and at most 7 hours - 17 video recordings of activity - 5 collective self-confrontations to gather comments from personnel on the activity, the working conditions and emotions experienced at work - 3 video recording of collective self-confrontations - selection by the two researchers of the video sequences to be conserved - video assembly - 3 meetings to validate videos before viewing by a wider audience
STEP 4: Group reflection on the	<ul style="list-style-type: none"> - 1 oral presentation of the results with presentation of the supports (video and slides) to the Administrative Council, directors, coordinators, personnel representatives and volunteer workers

potential actions to be undertaken	<ul style="list-style-type: none"> - 1 written report - 1 prevention plan designed in conjunction with the director, coordinators, personnel representatives, volunteer workers
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Table 1. *The four methodological stages of the psycho-ergonomic study.*
 Les quatre étapes de la méthodologie issue de l'approche psycho-ergonomique.

The third step was to analyse the activities involved and the emotions triggered by performing an activity. The aim of this step was to analyse the real activity, by means of direct observations or video recordings of situations whenever possible and with the agreement of those concerned. Collective self-confrontations were staged to gather comments from the participants on the activity performed and the emotions felt during work; these were based on video sequences or notes. The activities of the healthcare workers were observed by the two researchers in parallel over a 5-day period. Following this period, the video recordings were reviewed, and the most relevant sequences were retained for presentation to all personnel.

To prepare the collective self-confrontations, we proceeded to the intermediate stages of our method, which consisted in

- (i) exploiting the raw data gathered during interviews by carrying out themed content analysis;
- (ii) selecting themes derived from the themed content analysis which would be relevant for initiating debates during the collective self-confrontations;
- (iii) exploiting the data gleaned from observations by making activity logs;
- (iv) selecting film sequences which would be relevant for use in initiating debates during collective self-confrontations, and ensuring that the video-recorded situations corresponded to all the themes we wished to address and which we had identified during the themed content analysis ;
- (v) identifying themes covered in interviews for which no video sequence was available, but which needed, nevertheless, to be addressed during collective self-confrontation;

- (vi) identifying the themes from the content analysis and the video recordings which raised questions for the external researchers and which would benefit from additional comments to assist in their interpretation;
- (vii) elaborating questions on real elements of the work in order to trigger debate and, if possible, obtain firm opinions that would make it possible to provide practical solutions to the problems encountered.

We designed a table (an extract is presented here as Table 2) to combine the results of all these selective analyses (of themes and video sequences). This table contains the themes retained from the content analysis, and provides links to the video footage of real activity relating to these themes. Among the themes and sequences retained we purposely distinguished between situations which were judged favourable for workers (i.e., related to positive working conditions) and those judged unfavourable (related to negative working conditions). The table is subdivided into two parts to highlight this distinction. In addition, two supplementary columns were added indicating the themes that needed to be dealt with, but for which no video sequence was available, and questions relating to real aspects of the work which were worthy of debate in order to find answers that could lead to the development of practical solutions or ideas as to how working conditions could be improved.

During collective self-confrontations, this video footage was presented to participants, whose activity was monitored and their comments recorded. These collective self-confrontation sessions were also video-recorded. Video extracts from the real activity and extracts from the collective self-confrontations were then assembled. For the collective self-confrontation sessions, participants gave their consent for participation and for the sessions to be video-recorded. When participants did not consent to video recording, notes were taken during self-confrontations, as participants viewed video footage of real-life activity and slides presenting the data that had been selected from the study as being most relevant for presentation and discussion in collective self-confrontations.

Main themes from the themed content analysis				Themes to address to clarify grey areas	Questions to provoke debate
Positive aspects of the working conditions		Negative aspects of the working conditions			
Content analysis	Video extracts or corresponding notes	Content analysis	Video extracts or corresponding notes		
Real-time adaptation of the programme of visits by employees to ensure quality of care.	Corresponding video extract: the nurse takes the time to explain the reason for the injection to the patient. Note: the nurse calls a colleague to ask for help lifting a heavy patient.	Difference between the expectations of the nurse in terms of the time required to do the work and the time imposed by the tight schedule.	Corresponding video extract: the nurse supports the patient with a few calming words to help allay worries. Note: the nurse's aide gives some summary advice on hygiene and says afterwards that she has only half-completed her work.	Are the tasks of the home-carers clearly defined in the service? Do workers think that it is important to debate the limits of their role to clearly define them?	Discuss in the group the sense of each person's limits. Create a debate on the criteria of quality of work.
The worker incites the patient to perform a task by himself to encourage him to maintain his self-reliance.	Corresponding video extract: the nurse allows the patient to wash himself. Note: the nurse's aide encourages the patient to shave alone.	Difference between the patient's expectations and what the nurse can provide.	Corresponding video extract: a patient insists on taking a shower even though it is not planned. Note: the patient is not at home at the time of the scheduled visit.	Are these situations common?	Is there a contract defining the carers' tasks? Is there a form describing the workers' missions to be given to patients?

Table 2. *Extract from the table used to prepare the collective self-confrontations.*

Extrait du tableau de préparation des auto-confrontations collectives.

The video-recorded collective self-confrontations first assembled people of the same profession (4 nurses , then 3 nurse's aides), and then it assembled people of different professions (3 coordinators and 1 secretary). Confrontations which were not video-recorded assembled people of the same profession (3 nurses, then 3 nurse's aides). In all cases, the confrontations sparked debate about the working conditions and how they could be improved.

The debates we wished to launch during collective self-confrontations mostly dealt with organisational aspects of work (e.g. ambiguity relating to roles, conflicts between roles, or implicit instructions).

To determine whether the situations encountered and recorded could be considered typical, we were careful, during the collective self-confrontations, to verify whether these situations had already been encountered by other participants, and if this was the case, whether they had occurred frequently or not. We thus took into account the occurrence and frequency of situations (quantitative data), in addition to their relevance for workers (qualitative data).

Once the self-confrontations had been carried out, video sequences were assembled to create three distinct videos (2 for the like- professions groups and 1 for the differing-professions group). Each video consisted of sequences of real activity and sequences from the collective self-confrontation, lasting around 1 hour. These videos were presented to participants for validation before being distributed. As a result of this validation step, some scenes were altered (1 cut and 2 masked) to comply with the participant's wishes. A summary video, lasting 52 minutes, was also assembled from the main sequences. This video was viewed during the final delivery of the results, step 4 of the research and intervention project.

This fourth and last step consisted of a group reflection on the actions to be undertaken. The aim of this step was to present the final results to the management, the Administrative Council, the coordinators, the personnel representatives and the volunteer workers, using slides and the short summary video as visual supports. At the end of the presentation, these two documents, and the full videos (lasting 3 hours in all) were sent to the management as the final documents. The purpose of this stage of presentation of the results was to propose recommendations which could be used to develop an action-plan for prevention. These recommendations were adapted in accordance with the result of the

exchanges and debates with those present, and the axes of prevention to be set up were validated by decision-makers. The presence of decision-makers at this presentation (the Administrative Council, the director and coordinators) made it possible to directly validate the majority of the solutions suggested. All those present therefore obtained immediate confirmation that the management took the proposals seriously, were directly implicated in the approach, and were ready to make real, concrete decisions to help improve working conditions. A third final document was later sent to the management listing the recommendations retained and validated during this presentation of the results.

As we wanted the approach to be both participative and collaborative, ample time was allowed for internal debate. The collective self-confrontations were opportunities to see these debates emerge from the group, and the final presentation of the results was an occasion for debate among all those working in the care centre.

IV RESULTS

The results are organised into four sections. The first section describes the healthcare workers' daily activity and highlights the existing time constraints. The second part shows the importance of the emotional dimension of the work performed. Several cases of emotional dissonance were identified, indicating situations in which the workers found themselves required to display or "act out" emotions that they did not feel, and to repress some emotions that they did feel. The third part retraces the strategies used by healthcare workers to attempt to meet the requirements of their activity. The fourth, and last, part focuses on the preventive actions which were undertaken to improve working conditions and act to prevent risks, including psychosocial risks.

IV.1 ACTIVITY OF HEALTHCARE WORKERS UNDER PRESSURE

Nurses and nurse's aides must administer healthcare to patients while also fulfilling certain expectations in the realm of relational interactions. Their activity is, thus, both technical and relational. These two aspects are judged by the healthcare workers to be equally important. However, the time constraints of their jobs do not always make it possible to favour relational aspects. For example, the mean duration of nurses' visits to

patients was 8 minutes in the morning (based on 13 observed situations) and 6 minutes in the evening (based on 14 observed situations) (Table 3). The shortest duration of a nurse's visits was 4 minutes in the morning and 2 minutes in the evening. For nurse's aides, visits lasted slightly longer than for nurses (particularly in the morning, as this is usually when they help the patient to wash and dress, and this takes some time). Healthcare workers would like to have more time to spend with patients, given that this is the cornerstone of their profession (Soares, 2002; Estryn-Béhar et al., 2007). The journeys, although necessary, were perceived by the majority of workers to be an irritation which is both time-consuming and potentially dangerous (particularly under poor road conditions). Indeed, time spent travelling can represent up to 43% of the total round time. This large proportion of time devoted to travelling was considered by healthcare workers to be a source of stress (Lazarus & Flokman, 1984; Meissner et al., 2007). In a limited number of cases, the journey was viewed as a moment of transition allowing the worker to make a clear separation between the situation in one patient's home and that in the next. In some very specific cases, the healthcare workers took advantage of this time to "take a breather", "clear their minds", "gather their wits", or to call a colleague and share thoughts on an emotional event experienced during the previous home visit (Luminet, 2002; Mann, 2004).

The proportion of time devoted to the technical and relational dimensions of their work was variable, depending on the situation and the context, as well as on the patient and their characteristics. When everything went as planned, without problems which could delay visits, as much time was devoted to the technical aspects of healthcare as to the relational aspects. But when the health care worker was running late, technical aspects were favoured. In most cases, the quality of the carer-patient relationship was considered essential to performing the healthcare procedure correctly. For example, in situations where the patient complained of pain, resisted care by adopting an inconvenient posture for the healthcare worker, used aggressive language, demanded repeated explanations of the reason for the procedure, or even expressed the need to hear soothing words, it was necessary to favour the relational aspects of the care, because a good carer-patient relationship was what made it possible to perform the healthcare procedure.

Healthcare workers manage their visits as a function of these technical and relational aspects (to avoid accumulating delays that are incompatible with their printed schedule). As the schedule of visits is planned in advance by coordinators, any adjustments made by the healthcare workers will have consequences on the coordinators' work. The latter should, theoretically, leave room for these in-the-field adjustments and adapt the schedule of forthcoming visits to the best of their ability. However, this would often require a very large number of adaptations in the schedules, and coordinators therefore cannot take everything into account. Thus, in practice, this type of synchronisation between healthcare workers and coordinators remains difficult to manage.

	MORNING			EVENING		
	Mean duration of visits (min)	Mean duration of journeys/round (min/h of work)	Mean journey time between visits (min)	Mean duration of visits (min)	Mean duration of journeys/round (min/h of work)	Mean journey time between visits (min)
Nurse's aides activities	32 (Min: 5 Max: 61)	11.2	8	15 (Min: 2 Max: 23)	26	10
Nurse's activities	8 (Min: 4 Max: 19)	17.83	8	6 (Min: 2 Max: 11)	25	6

Table 3. *Mean duration of visits and journey times for home-carers.*
Moyenne des durées consacrées aux visites et aux trajets des soignants à domicile.

Observations of healthcare workers' activity during a round showed that considerable time is devoted to travelling. The need to travel between patients' houses, sometimes in difficult conditions (e.g. heavy traffic, snow, or roads blocked by large vehicles) further reduces the time healthcare workers have to spend with patients in their homes. This situation reinforces the healthcare workers' impression that the time they

have to devote to the emotional and relational part of their work is less than it should be.

Based on these observations, it appears essential, if healthcare workers are to be able to perform their activity in favourable conditions, to recognise the relational and emotional aspects of their work.. This recognition relies largely on good coordination between workers within the service: the coordinators scheduling the visits and those performing procedures in the patient's home. Similarly, the structure can only function well if all parties take each other's' constraints into consideration. These two elements are the key to success.

IV.2 THE EMOTIONAL ASPECTS OF HEALTHCARE WORKERS' JOBS

We have observed that taking into account the emotional aspect of work in the healthcare structure is essential to helping healthcare workers produce high-quality work. It can also help reduce the emotional dissonance experienced by personnel. However, the interviews and collective self-confrontations carried out with healthcare workers in this research and intervention project showed that the affective aspect of their work is perceived to be inadequately recognised by their hierarchy. The stress noted by healthcare workers stems, for a large part, from this lack of recognition. These workers are faced with contradictory requirements (speed and relational management), which could negatively impact the quality of their work. Healthcare workers must attempt to comply with the requirements for speed in performing their work (to better adhere to the schedule of planned visits), but they must also try to preserve the patients' health, and their own, as well as their interpersonal relationships. Compromises are often necessary in order to perform tasks rapidly, or on the other hand, to favour the relational aspect of their job.

In addition, we observed that some emotions are expressed, while others are repressed, depending on the context and the people involved. In terms of emotional work, healthcare workers try to hide negative emotions when dealing with patients, in order to avoid transference (Hochschild, 1983). However, they can discuss these emotions with colleagues after the visit (Rimé, 2005). This emotional sharing generally takes place outside working hours, due to lack of time, often in the evening and, more rarely, between two visits (Table 3). The more intense

and frequent the emotional components of their work, the more healthcare workers feel the need to talk to their closest colleagues.

It also emerged from the interviews and the collective self-confrontations that positive emotions experienced by the healthcare workers in their work are more often linked to the following factors: regression of the patient's disease, the quality of relationships with patients, the sense of usefulness, the success of technical procedures that cause the patient to experience less pain, the patient's acceptance of his state of health and of the care administered and, finally, material aspects such as good journey conditions or even material being available in adequate supply.

Negative emotions are linked to difficult relationships with patients, performing healthcare activities in difficult conditions (lack of space, no medical bed, lack of hygiene, etc.), time pressure which restricts the relational activity, and lack of recognition of constraints by the carers' superiors.

IV.3. STRATEGIES USED BY HEALTHCARE WORKERS TO CONTROL THEIR EMOTIONS

Despite time pressures, healthcare personnel attempt to find strategies that can help to develop a good relationship with the patients. They believe that high-quality healthcare can only be delivered when this emotional aspect is taken into account, and they do everything possible to fulfill this need in the most appropriate manner.

Another strategy involves setting an emotional distance between patients and healthcare workers in general. Indeed, healthcare workers are warned that attachment to patients can lead to strain if patients' health declines, or if they die. Confronting death and disease are an emotional aspect of the work to which healthcare workers are often exposed. As these situations arise, healthcare workers attempt to protect themselves against strain as much as possible by adopting an "emotional stance" that places them half-way between strong attachment and weak attachment. This strategy consists in finding the best distance to maintain with patients on the emotional plane (this ideal distance is generally located somewhere between two extreme minimum and maximum positions). This positioning is very personal and depends on the healthcare workers' personalities and also on their experience. In addition, the fact that their

work is conducted in the patients' homes tends to reinforce interpersonal links. The healthcare workers enter the patients' intimate and private realm, where they may encounter family members, or they may have known patients for a long time (as neighbours, or friends of the family, etc.). The emotional distance the healthcare workers maintain - neither too great nor too small, based on their own criteria - allows them to preserve human relationships while better coping with the death of a patient if it should occur.

The interviews and collective self-confrontations revealed two categories of emotions and strategies implemented by workers: those touching on the nature of their work and those resulting from problems linked to instructions or to management issues. In the first case, the emotions were related to situations commonly encountered in their work. These are recurrent and "expected" as they are considered "*to be part of the job*" (excerpt from an interview with a nurse). As mentioned by Robert (2007), these situations are related to how these professionals view their job. They correspond to the "*more or less conscious archetypal representation that the subject has of situations characterising their profession and the emotions associated with these situations*" (Robert, 2007, p.15). In the second case, the emotions are triggered by situations which are either rare, or not covered by instructions, or not the subject of support from management. The emotions and strategies used by workers faced with difficulties therefore depend on the source of the emotion experienced and its classification (Table 4).

	EMOTIONS AT WORK	ASSOCIATED COPING STRATEGIES
Emotions relating to the nature of the work and associated	Sadness when a patient dies	Go to the funeral to grieve
	Sadness when a patient mentions fear of death	Centring on the relational aspect of work by talking and spending more than the scheduled time with the patient
	Joy on seeing that the patient is getting better	Spend more time on promoting the patient's self-reliance

coping strategies	Irritation faced with a patient who complains more than perceived necessary	Take the time to provide support to the patient through soothing words, or using humour to defuse a situation
	Fear that the patient will fall or faint	Go to the patient's home outside working hours to check up on him
	Fear of going to a new, as yet unknown house	Ask questions on the context to prepare the visit
Emotions relating to instructions or management issues and associated coping strategies	Anger when faced with violence or mistreatment inflicted on a patient by their own family	Alert the coordinator to this situation
	Fear when faced with an aggressive client	Alert the coordinator to this situation
	Sadness faced with a suicide attempt by a patient	Search for a social solution with colleagues or with other people in the service
	Anger when faced with a lack of appropriate syringes for the injection	Request additional specific syringes or use them sparingly
	Anger at not being able to help the patient more because of instructions	Obtain help from colleagues, without the need for an additional journey, by making telephone calls to get social support
	Disgust when faced with insanitary living conditions	Attempt to change this situation by signalling it

Table 4. *List of emotions observed at work and associated coping strategies.*

Liste d'émotions au travail observées et stratégies de régulation associées.

When the nature of their work resulted in an increased emotional load, workers generally considered that they had to take it upon

themselves to deal with it. On the other hand, when the emotional load was related to problems linked to instructions or to management issues, the workers intimated that it was more difficult to accept. The coping strategies used in this case tended to involve seeking a solution. Analysis of positive and negative emotions at work thus showed that workers accepted difficulties better when they were directly linked to the nature of their work.

VI.4. ACTIONS UNDERTAKEN TO IMPROVE WORKING CONDITIONS AND TO PREVENT RISKS

The implementation of the research and intervention project was based on a methodology enabling individual and group data to be produced on the activities of healthcare workers and coordinators, their perception of working constraints and health issues, sources of positive and negative emotions, and working constraints and the strategies used to cope with them. Analysis of the results provided information on the working conditions and their impact in terms of activity, emotions at work, job satisfaction, difficulties in handling constraints and relationships with others (e.g. patients, colleagues, and managers). However, this research and intervention project also made it possible to implement a psycho-ergonomic interventionist approach with a view to improving working conditions. Thus, among the results presented, a number of solutions were developed collectively, in a participative and collaborative perspective.

The action-plan that was developed and applied consisted, firstly, in setting up discussion groups so that workers could discuss their work-related emotions and find solutions to the difficulties encountered, with a view to changing their working conditions. For these people, the opportunity to discuss emotions with colleagues has now been accorded a place within the organisation. Previously, this sharing took place outside working hours. The formal implementation of a discussion group within the structure was beneficial in reducing the emotional load and gaining recognition for this aspect of the work. This discussion group allows workers to express their emotions, which can be highly charged. It makes talking freer and contributes to reducing internal tensions, which previously had to be managed individually. It also allows mutual sharing. Discussion in this group is guided by a facilitator (in this case, by the

external expert, in future by the director of the care centre, who will take over the job). Participants express the emotions they feel at work, and then together identify solutions, with a view to improving situations. This process ensures that the exchanges are aimed at actual goals, so that they move forward and do not remain at the stage of simply expressing emotions. To initiate the process, first one of the researchers involved in the research and intervention project acted as facilitator. Later on, the director himself would take over this role. We interpreted this desire to conduct the discussions himself as additional proof of the director's implication in the process. In addition, this initiative indicated that this action had a chance of becoming permanent. Participation on the part of the director was well appreciated by the personnel, who perceived his desire not only to change the working conditions, but also to recognise that the emotional aspect of their work was essential for their well-being.

Another action was then implemented: this consisted in making specific materials available to facilitate technical aspects of the healthcare workers' work. For example, butterfly syringes were purchased to help perform particularly difficult injections.

In addition, organisational measures were implemented to make it easier for workers to help each other out. By proposing that the recommendations on helping colleagues be clarified, a network of social support and physical assistance could be provided, thus reducing the risks of lumbar problems (when heavy patients had to be moved) and psychosocial problems (by avoiding isolation).

Thus, actions were undertaken and presented through several examples. These actions were the fruit of collaboration with all the staff in the health care service. The objective of this research and intervention project was to improve the working conditions and also to improve prevention of psychosocial risks. In the description of this project, we show that working conditions can be improved by analysing the activity, the existing working constraints and the emotions experienced at work. Technical or organisational measures can be developed and applied from this starting point.

This leads us to the question of how methods for analysing activity and emotions at work can be adapted to improve working situations, and more precisely, to help prevent psychosocial risks. We show that the methods used to analyse activity and the emotional aspects of work, as

well as the intervention approaches, relying in part on collective self-confrontations, are useful in this perspective.

V DISCUSSION – CONCLUSION

The research and intervention project, carried out in a home-healthcare centre, tested a methodology which takes into account the activity and emotions experienced in real working conditions. This paper details the individual results of these two objectives, by considering real-life situations which have been experienced and how they are dealt with, based on the various aspects of the job, including emotional aspects. With this approach, we have sought to throw light on the activity and to encourage workers to share their perceptions of what their jobs entail, to seek solutions and improvements together, to re-establish dialogue where professional relationships have become strained and to ensure a long-lived dynamic organisation favouring day-to-day adjustments. To implement this approach, we adapted the “traditional” methods used to analyse activity, in order to progress both on a theoretical and methodological level. This progress is due to the recognition and implementation of the following:

- theories specific to embodied situated emotions that have, up to now rarely been used in research and intervention projects,
- theories relating to the strategies used in a dynamic process,
- a relatively innovative method that focuses on the emotional aspects of work, in addition to the activities performed,
- a novel collective self-confrontation method,
- an approach aiming to help prevent psychosocial risks, both in the short-term and in the long-term.

At the methodological level, collective self-confrontation has a certain number of advantages and limits. The advantages include the fact that this method can be used to analyse the activity, check that the situations encountered occur frequently, help to develop a shared point of view on the working conditions that should be improved (based on examples of real-life situations), identify sources of stress, and finally, allow discussion of the strategies implemented. The disadvantages include the fact that it can be difficult to implement technical responses and that the process can be time-consuming. Using video as a support for the analysis of the work and the self-confrontations produced rich data,

but also required a certain number of conditions to be combined (such as obtaining prior written consent from participants [workers and patients], the availability of participants on the scheduled dates [for follow-up of the activity], careful selection of the sequences and the extracts to be used, which takes time, the presence of all participating workers at several meetings, etc.). These requirements mean that it is necessary to allow enough time and thus run the risk of making the overall timeline for the intervention very long, if any unexpected events occur.

In terms of the intervention, we were able to analyse how effective facilitation was in the formal discussion groups set up to allow workers to share emotions. The manner in which this group was steered made it possible, for those who wished to do so, to express themselves and to discuss their emotions (e.g. in one of the sessions, emotions were evoked by the healthcare workers in response to an emotionally challenging situation linked to a patient who was mistreated by his family). Afterwards, it was possible to set up specific actions, in collaboration with the social services, to alert to the risks run by this patient. Sharing these emotions not only had the effect of freeing speech about a case which was difficult for healthcare workers to deal with, but also gave rise to a feeling that the emotional and relational aspects of their work were really recognised by the management. This discussion group should be maintained as part of the psychological assistance provided by the company to its workers, and should help promote the co-development of solutions aimed at improving working conditions.

This participative interventional approach helped to reinforce internal collaboration and facilitate steps to finding solutions. In addition, it contributed to a heightened sense of mutual confidence and re-created a favourable social climate for dialogue. The approach also had a positive effect in terms of motivation at work, according to the personnel. The use of video, in the methodology developed here, allowed us to fully explore the ways in which workers fulfil their tasks. This is particularly useful in professions where workers work alone, as with home-healthcare activities.

Although the research and intervention project was developed according to the basic principles of psycho-ergonomics, it was also partially adapted so as to be compatible with the analysis of the emotional aspects of work which are a concern to so many people in current working practices. The affective aspect of work is today being

investigated in its own right. It is not only analysed with a view to understanding it, but also to taking steps towards researching means to improve well-being for workers. As the world of work is continuously changing, it seems justified to adapt the classical psycho-ergonomic methods by tailoring them to take into account new aspects of work, which up to now have received less attention. These aspects include, in particular, emotional aspects, which take on even more meaning as psychosocial risks continue to increase in occupational settings. From this point of view, we feel that our method is a methodological progression which adapts to new forms of work and fulfills a need for the prevention of ever more present psychosocial risks.

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SUMMARY: *Activity analysis is one of the foundations of ergonomics. It is continuously evolving in a steady search for better ways of adapting the methods available to present and future occupational situations. Indeed, as working conditions change rapidly, the methods for analysing activity must be reviewed and adjusted to better meet these changes of reality, in their various forms. For this reason, in parallel to actual work-related activity, emotions at work are increasingly a subject of analysis. At a time*

when psychosocial risks are of concern to many, taking this emotional dimension into account is even more relevant. This article describes a research and intervention project carried out in a company in the home healthcare sector. With a basis in psycho-ergonomics, the approach relies on a method of analysing activity and emotions through the use of collective self-confrontation. In this case study, we detail the method used and the results it produced, and we present a methodological reflection on the question of how analysis and intervention methods can be adapted to these aims. We show that the methods used to analyse activity and emotions based on collective self-confrontations have their full place in improving working situations, and more precisely, preventing psychosocial risks. We show how this method has sought to adapt to the changes that have occurred in the world of work, while at the same time respecting the actual foundations of the methods used to analyse activity. This methodological adaptation is discussed in the context of the prevention of psychosocial risks.

KEYWORDS: Activity, collective self-confrontation, emotions, ergonomics, psychology, home-care.