# Boundary Setting between ‘Private’ and ‘Professional’ in Care Work

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# Boundary Setting between 'Private' and 'Professional' in Care Work

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## 1 Boundary Setting in Care Work

The ethical principles of social work (IFSW 2018) guide standards and rules to protect the well-being of both clients and care workers. However, care workers' everyday professional experiences of physical and emotional engagement, including living with clients, require choices and solutions which do not necessarily fit general recommendations (Trimberger 2012: 71-74). 'Boundary' issues involve such circumstances where 'workers encounter actual or potential conflicts between their professional duties and their social, sexual, religious, or business relationships, thus engaging in so-called dual or multiple relationships, which are potentially harmful to care workers and their clients (Reamer 2003: 121).

Moreover, the excessive working hours, emotional overload and sometimes even psychological and physical risks faced by care workers threaten their well-being and, eventually, the well-being of the care receivers (Özcan et al. 2017; Kay 2013). Unclear professional boundaries and the issue of maintaining the well-being of care workers and clients alike are particularly relevant for care regimes with a low professional autonomy of care workers (Iarskaia-Smirnova, Romanov 2002). Our research participants are well aware of these risks, a widely present topic in the interviews about social and care workers' routines during the transfer of care to non-state actors (the research stage 1 conducted by author 1) and the covid-19 pandemic (the research stage 2 conducted by author 2). The research has been finalized in 2021.

However, what practitioners do to set boundaries and maintain their own well-being with the well-being of clients, remains largely an under-researched topic (see some discussions on the topic in Maschi et al 2013; Shier and Graham 2011). It is despite the fact that the formation of such boundaries is not only a theoretical, but also a common practical puzzle for social service workers to solve in their work routine. Hence, the research question driving this study can be formulated as follows: how do care workers create and manage boundaries in their everyday mundane activities to minimise risks to their well-being whilst keeping a balance between their well-being and the well-being of the service users? To answer the research question, we first discuss definitions of the key concepts in a theoretical chapter on setting boundaries in care work. Then, we present results of the qualitative sociological research of the state-based and non-governmental elderly care provision in five Russian cities. Specifically, we provide evidence on how care workers create and maintain or challenge boundaries in their everyday communication with senior-aged users of their services. Finally, a set or 'toolkit' of boundary setting tactics of the Russian care workers is summarised in the discussion section.

The Russian case is relevant for studying boundary setting in care work because of care work routine uncertainties associated with care regime transformation. Until recently, in Russia, in-home care as an activity was mainly informal and provided in households by family members, neighbours, and former coworkers (Grigorieva, Sidorenko 2019) with some caring functions performed by the social workers from municipal services. In 2015, Federal Law 442 "On social service provision" (further – FL 442), allowed non-governmental actors to engage as contractors in state care work provision if they succeeded in ensuring state standards (Tarasenko 2018). As a result, Russia's voluntary and private sectors have started to play an increasing role in social care provision. At the same time, despite the new standardisation efforts embodied in the FL 442, social and care worker professions are still poorly institutionalised in Russia (Zdravomyslova and Savchenko 2020: 120; Iarskaia-Smirnova, Lyons 2018). Thus, non-state care workers, especially those working part-time for an additional income source, have little or sometimes no professional training and occupational solidarity (Romanov, Iarskaia-Smirnova 2016). As a result of the low professional institutionalisation, contradictory policy reforms, and multiple challenges care workers face in their everyday lives, care work in Russia can be characterised as intrinsically uncertain. It makes the Russian case particularly relevant for studying setting of boundaries between 'private' and 'professional' in care work, which we understand not just as a practical implementation of certain practices (tactics) against risks and threats care workers face, but also as an epistemological work of constructing the very notions of "private" and "professional" (in care work) as such. To sum up, in this article, we discuss vulnerabilities, resilience, and creativity of care workers under structural pressures as the covid-19 pandemic and the subsequent care regime transformation. As a result, we come up with a "toolkit of boundary setting tactics by care workers aimed at constructing notions of "private" and "professional" and, ultimately, making everyday service provision activities manageable, bearable, and balanced regarding the well-being of both senior age service users and care workers.

## 2 Care Workers' Well-Being and Boundary Setting

In the framework of this study, "care worker" is an umbrella term for paid and unpaid home care health visitors (*patronazhnye rabotniki*), social workers performing basic home help and care functions, and home-based nurses. Each listed profession varies in a scope of duties and responsibilities, as well as the level of institutionalisation. However, all research participants in one way or another assist seniors in what the latter cannot do themselves, in particular with non-medical aspects of health care, sanitation, cooking, cleaning, and bodily and daily life routine maintenance. Crucially, these care practices are home-based and involve lasting relations between care workers and care receivers.

All jobs involving care work are low-paid (Iarskaia-Smirnova, Romanov 2002) and often performed by vulnerable group representatives (Raijman et al., 2003). Working conditions for care workers are demanding as societal expectations of good care standards are high (Ayalon, 2009: 678; Pols and Moser 2009). Crucially involvement "in the 'backstage' world of (…) service users' blurs the boundaries between work and non-work practices" (Eustis 1991: 447). As a result, care workers often find themselves performing various care practices, which are not part of their job duties due to intimate interpersonal relations built with their service users. As boundaries between work and non-work become blurred, workers face multiple emotional, psychological, and financial challenges. Undetermined and fluid working arrangements (Baldassar et al 2017; Wåhlin et al 2020) linked to the perceived low professional status of care work occupations (Kay 2013; Ostraszkiewicz et al., 2016) exacerbate professional issues

of care workers. It comes to no surprise that burnout (Lightman 2017) and reduced life satisfaction (Harris, Leather 2011) are common among care workers.

To address the multiplicity of work-related challenges and issues and improve own well-being, care workers must secure a life-work balance and define limits of their working obligations. The work of defining such limits and facilitating life-work balance is exactly what we call 'boundary setting'. However, a common professional consensus is that such boundary setting might be harmful to service users, who are assumed not getting enough qualitative care if interpersonal relations are regulated by self-care considerations of care workers (Reamer 2003: 121). Such assumption builds on ethical imperative of a priority of service users' interests and safety over the needs of care workers. One crucial consequence of such professional focus on service users is that widespread care workers' experiences of violence, aggression, and harassment remain somewhat sidelined in the professional debates and reflections (Hanson et al, 2015). This is despite a violent behaviour of services users is well documented (e.g. Soniat, Michlos 2010; Nelson 2014: 1373; Eller 2014). Risks of various forms of violence and a deaf ear of a professional debate about the topic reflect structural societal negligence towards violence against women and other vulnerable groups (Funk et al., 2020: 107).

Notably, setting boundaries does not mean "restoring" some sort of "objectively existing" private and professional lives. Rather tactics of boundary settings is an epistemological work of constructing concepts of "private" and "professional" in specific settings of the Russian state and non-state care provision to senior service users. Before boundaries are "set" by specific care workers, the "blurness" between private and professional lives merely indicates that "professional" and "private" do not yet exist as separate ontological entities, both theoretically and empirically. The epistemological emptiness we speak about manifests in unavailability of tools, like guidelines, and specific policy recommendations, for managing risks and vulnerabilities associated with disbalance in work and 'private' life (Balkaran et al, 2023: 9). No distinction between professional and private is a common ontological situation for for care regimes with a weak institutionalisation of occupations involving care work,, like that of Russia, where ethical codes of conduct, shared values among caregivers, and self-care strategies are not part of the care work-related formal education curriculum (Holavins 2020; Iarskaia-Smirnova, Lyons 2018; Iarskaia-Smirnova, Rasell 2014). In absence of resources and knowledge necessary for managing violent interactions with service users, care workers engage in epistemological work of defining certain interactions as 'violent' and distinguishing between 'professional' and 'private' practices. Gradually situated and spontaneous 'tactics' of addressing work-related challenges are being created and informally shared among care workers (Trimberger 2012: 68; Paul et al 2000). What are these emergent tactics of a Russian care workers and how do they allow making ethically appropriate decisions in the framework of setting boundaries between 'professional' and 'private', frame issues, and is exactly the topic of this article.

## 3 Studying Russian Care Workers

The key data production methods applied in the research were semi-structured interviews with care workers and participatory observation of care work, mostly in a home environment, with few exceptions for institutional care. All interviews were conducted in the Russian cities of Saint Petersburg (before the covid-19 pandemic), Kazan, Saratov, and Tomsk (during the covid-19 pandemic, in 2021). The main research topic of the fieldwork in Saint Petersburg was organisational constraints for senior age people to engage in participatory care provision. The main research topic of the fieldwork in the three other cities was the effect of the covid-

19 pandemic on work routines and the well-being of care workers. In both cases, the topic of power imbalance and boundary settingwork was brought up by the research participants.

A snowball sampling method (Biernacki and Waldorf, 1981) was used to recruit research participants. In Saint Petersburg, the first research participant was a project manager at a charity foundation. With his help, author one was introduced to several non-state organisations providing care to senior-aged users. As a result, interviews have been arranged and conducted with non-state care managers, home-based care workers hired by several third sector organisations for state-outsourced assistance to seniors with a need for assisted living, and Vkontakte-based social network group volunteers regularly visiting nursing homes and seniors living alone in their apartments. In Kazan, Tomsk, and Saratov, local level state and non-governmental social workers were interviewed. Diversity of research participants allowed to speak of cross-contextuality of the psychological and physical risks and tactics used against such risks: care workers involved in different forms (state and non-state) of care, having different occupations (social workers, nurses, home-based carers), and living in economically and socially different regions, were all facing similar issues in their relations with users and used similar tactics to address them.

In total, 37 interviews were used for the purpose of this research. The average length of each interview was 80 minutes. All of them were recorded and transcribed verbatim. The language of the interviews was Russian, with any quotes used below for illustrative purposes being translated by the authors. All research participants were duly informed about the study and gave written or verbal consent. Anonymity was preserved for all research participants by changing any recognisable characteristics, such as name, exact age, and affiliated organization.

Stratifying sampling covered both paid and unpaid caregivers, care managers, and representatives of both non-governmental organisations and municipal social service-providing entities. As a result, research participants represented five state local social service agencies, eleven non-governmental care-providing organisations, three self-help veterans' organisations, and three volunteer groups. The age of the participants ranged from 19 to 88. Thirty identified themselves as women and seven as men. Twenty-three were care workers of different kinds and fourteen were care managers responsible for organising care provision. See table 1 in the appendix for more information on the research participants and interviews.

In addition to interviews, practices of boundary setting work and boundary toolkit application implementing these measures were observed during lasting engagement with the work of non-governmental organisations, including managerial work in the offices and "shadowing" (following) care workers in their daily work. Overall, observations covered four organisations in a time span of a year. Some sessions were short, no more than a couple of hours, with participation in the managerial meetings being an example of such short activities. Visits to home and institutional care facilities lasted for a whole day, covering a full working day of care workers. The data was written either in a fieldnote diary 'on-site', or immediately after each of the observation instances. The focus of observations was the interaction between service users and care workers. At the latest stages, tactics used before or after caregiving aimed at minimising risks associated with boundary crossing were closely followed. In some cases, the authors observed the process as outsiders. In other instances, they participated actively in care work.

Data collection continued over subsequent years with the updated guide that reflected the key indicators of boundary setting. The interview transcripts were coded according to a code sheet based on the dimensions and indicators of boundary setting issues, using open and axial coding (Strauss & Corbin 1994).

## 4 Results

### 4.1 Symbolic and Social Boundaries

Both experienced and inexperienced care workers are expected to know the limits of their responsibility and relationships. However, diversity of practices, informal contexts, needs, and scope of opportunities contribute to the high level of uncertainty, thus limiting the applicability of any formal regulations and recommendations, if the latter two are available to care workers at all. Therefore, many tactics, though persistent and used across regions, are still context-bound, situational, practice-based and ad hoc performed. The rules are then defined at the first acquaintance with the service user and can be strict or flexible:

> 'When I come to meet a new person, I immediately stipulate that this is my job, and there are rules here. If these rules are violated, then we say 'goodbye'. There is a contract for this, and if I break it, I will be scolded.... Sometimes they ask you to come at night. ... There is a contract, she can count on the fact that if she suddenly feels bad, of course, I will come running. I have had such cases when the clients called and said that they were ill. That's why you run to them' (Saratov, social worker at the state social service agency).

According to the care worker quoted above, night calls are handled differently in different situations. Some calls get rejected, while others will still be treated as an emergency and responded despite set rules. Unavoidably, it creates tension. The director of the self-help veteran organisation in Saint Petersburg recalled a service user threatening to complain about care quality, despite a specific care case being a voluntary service by non-state organisations unregulated by the state: '[Client said]: 'Alexander, should I die out of hunger because of you?' („„) 'I will write a complaint to...', then she named a [federal] vice-minister, whom she happened to know.' (Alexander, director at the self-help veteran organisation). This, and many other examples like calling after midnight for non-urgent matters or asking to spend care worker's personal money, show how clients refuse to provide compliance. In their attempt to reverse the power relationships, they try to show themselves as 'being in charge' by appealing to their good connections 'at the top', or to their past merits, senior age and other elements of social or cultural capital. Thus, they attempt to cross the boundaries, reframing their statuses in order to stop their downward social mobility in their roles of care users.

A complete refusal to care for a particular client is a tactic resorted to the utmost radical cases of violent behaviour on the side of the clients:

> 'She says, 'you are moron, jerk, ill-mannered, have no taste etc' (...) I withstood it for two months, could not bear it anymore and ran away (...) It was so stressful; I was ready to take anti-depressants. (...) So aggressive! She [even] had hit me many times!' (Ekaterina, a nurse and a care worker at a non-state social service provider in Saint Petersburg)

Describing the situation, Ekaterina underlined that any compromise did not work with this specific senior. The refusal was the only possible tactic for the caregivers who suffered in

these malfunctioned communications. Considering that most of the care work happens in non-institutional environments, the risks of physical violence against care workers are particularly high (Campbell et al, 2014). In some organizations, employees are trained, have the opportunity to discuss and reach agreements on their rights and restrictions with their superiors, while in other cases, such regulations remain a responsibility of a particular employee, like keeping silent and ignoring verbal and physical abuse. Withdrawing from relations with abusive care receiver is particularly crucial, as continuing such relations would be harmful for a mental health of Ekaterina. Moreover, it might have negatively impacted her professional empathy towards patients (Nam et al., 2021). Another dimension of preserving boundaries is physical distance, which appeared particularly relevant during the covid-19 pandemic. The risks, the firm rules and exceptions were redefined and boundaries were redrawn: 'You need to survive. That's why I can't come into your kitchen yet. Or go to the gym, as before (…) Of course, when the restrictions were relaxed, everything became better. 'Granny' could move from room to room, and I was already standing in the hallway, that is, we kept our distance, but at the same time we could communicate normally' (social worker at state local social service agency in Saratov).

Intimacy, including physical proximity, in some cases, grew in response to the needs of people who acutely felt loneliness during the period of isolation. A simple hug has now been assigned vital importance: 'when I came, she touched [me] and said that now at least she wants to live' (Saratov, social worker at state local social service agency). The physical and emotional boundaries in the pandemic 'vibrate', expanding and then narrowing. Old arrangements did not work, whereas new ones were set on the ground, led to numerous conflicts, and reshaped boundaries.

During transformations and crises of the care regimes like that of the covid-19 pandemic, the ethical challenges for social and care work increased. Among them was the balance of the rights, needs and risks of the service user, on the one hand, and the personal risks of care workers and others. Professional and personal boundaries have blurred. As 'good care' ideals require that care workers subdue their interests, care workers often lean to complying with the excessive demands of the service users and tolerate their whims, with the complete refusal from maintaining relations with service users remaining as a last resort.

At the same time, remaining boundaries are important not only because they thought to divide and exclude but because they 'also connect and make coordination possible' (Lamont, Molnár 2002: 187). Boundaries help see both differences and similarities, reframe and negotiate, create frames, meanings, bridges, and niches. Several predominantly informal tactics, circulating and shared among care workers, play a crucial role in this process, being a vital element of the care workers' well-being maintenance.

### 4.2 Boundary setting tactics of the care workers

Having no professional training - or realising that such professional training does not provide necessary solutions to their specific situations - care workers develop their own lay knowledge and practices to mitigate risks, overburden or, sometimes, plain abuse when they feel humiliation and disappointment. Discussing respective measures – pointing at the vulnerability of care workers in relationships with their service users – had become either central or one of the key narratives in all analysed interviews.

Identified boundary setting tactics include a complete refusal to care described in the previous section, emotional distancing, refocusing on self-care, sharing responsibilities, creativity and

humour. Some of these tactics result in generating differentiation and widening divides, while others make coordination and negotiation possible. Similar tactics are part of the earlier documented practices of care workers (Leite, et al., 2017). However, almost all research participants did not have professional education, relevant training, or otherwise obtained this knowledge via formal education. It is not theoretical but very much practical knowledge. All research participants use listed tactics, adjusted to the specific situations in which they are facing overburden and other risks to well-being. If successful, they also share these tactics with newcomers.

*Boundaries Generating Differentiation - Emotional Distancing*

Emotional labour (Hochschild, 1983) is a part of the daily routine for care workers. However, overuse of emotions and overly emotional attachment to service users might also make them feel deprived of having leisure time or spending quality time together with their families. In particular, inexperienced care workers invest more into emotional labour work comparing to their experienced colleagues. Such disillusioning experience of the newcomers was described by Peter Blau (1960) in his study of a public welfare agency where new case workers were typically full of sympathy for clients' problems but soon began to experience a "reality shock", which made change their orientation with a support of their more experienced co-workers. In our fieldwork, an experienced care worker Anna, the leader of the volunteer movement providing home care and assistance to institutional care workers- in Saint Petersburg, newcomers are often "too enthusiastic" and need to understand that "they cannot save the world". Social service-providing organisations, state and non-governmental alike, side with experienced care workers on that, and frame "family-like relations" as danger:

> 'You must not let it happen. First, it is dangerous for the mental health (…) If you do not keep your distance, the stress might be enormous! (…) It is just your job. We had a lecture on that in my organisation. They said, 'You have to take your time and do not think about your job' (Irina, care worker at non-governmental social service providing organisation in Saint Petersburg).

As seen from the quote, emotional distancing is framed as a key and necessary condition for well-being of care workers. Such distancing helps to live through their work and minimise the stress. Hence, care workers put quite a lot of effort to ensure the balance between work and free time. Moreover, both paid and unpaid experienced care workers not just create boundaries for themselves through emotional distancing, a rather usual and recognisable precaution for professional social workers. They also actively share the tactic with newcomer colleagues through informal networks, substituting absent or insufficient formal training. It allowed emotional distancing competence to become widely, though not universally, accepted as critical to care work by a significant part of the care workers' communities in Russia despite the weak institutionalisation of the social work profession.

*Boundaries Generating Differentiation - Refocusing on Self-Care*

The next identified tactic is refocusing on self-care. In short, it means an additional conscious effort by care workers to rebalance work and leisure time (Holland et al. 2019; Fan and Smith 2018; Ungerson and Yeangle 2005). It is crucial activity to do for maintain well-being, as working schedule of care workers varies from several hours a week to twenty-four-hour permanent stay at care receivers' homes.

Switching to home chores and relaxing with her child as well as keeping a diary is one possible way to rebalance work and life:

> 'I'm rebooting. I promised myself to come home not to think about these situations... I read, I walk a lot with my child, and then I wake up at night and write a diary' (social worker at state local social service agency in Tomsk).

Another informant uses the term 'shut yourself in your shell,' but she manages to do it with difficulty. Maneuvering between the functions of caring in the public and private spaces of her life, she tries to hide from everyone for at least one day:

> 'I do routine household chores. (...) I have so many phone calls from my wards in a week that I can not pick up the phone on weekends. Then I go to my mom, I'll listen to what [TV programme] said there. I have to listen, but sometimes I want to hide. And then Monday – you go back to work somehow ...' (social worker at state local social service agency in Saratov).

The tactic of refocusing on self-care is taught to social workers and nurses in the classrooms. In their turn, care workers without professional training learn it from practice. One such example is an informal code of conduct developed by the volunteer movement in Saint Petersburg. It explicitly advises new volunteers not to share personal details with service users and prioritise self-care over care for senior service users as "ruined and miserable volunteers cannot help anyone". Overall, rebalanced work-life relations shape boundaries towards emotional distancing and morally easier refusal, if necessary. In times of covid-19 pandemic, respective self-care has become also a pivotal component of the care for senior service users, making it somewhat easier for care workers to justify and implement rebalancing.

*Boundaries that Make Coordination Possible - Sharing Responsibility*

In the process of informal negotiations, to defend established boundaries, care workers position themselves as "one of many" people responsible for the care and emphasise that their skills, knowledge, and capabilities are rather limited. Furthermore, interviewed research participants explained that they aim to recover contacts of the senior service users with their relatives to share as many duties as possible with the latter as well as medical professionals, legal advisors, and other actors. We call this tactic sharing responsibility, i.e. any conscious decision to transfer duties to the other care-providing actors:

> 'Under no circumstances should you take responsibility for [the complex health issues]. You provide first aid in an emergency, but then you call and explain the situation to relatives. Then they arrive and decide what to do (…) What happens next is none of your business' (care worker at the non-state social service provider in Saint Petersburg).

At first sight, described sequence of actions seems like a self-evident and technical thing dictated by medical protocols and legal requirements. However, the goal of sharing responsibility is not just about the quality of care or obligations but also about protecting care workers from uncertainties of being too engaged in the lives of their service users. As some research participants have said in the interviews, sharing responsibilities is something they do without legal or medical consideration, simply to keep themselves safe if something goes wrong. Being a primary decision-maker in care provision, care workers in Russia tend to delegate even minor things to other actors: doing a walk together, buying a new chair, ensuring a senior age person follows a physiotherapist's instructions.

Care workers justify such delegations exactly by preserving their well-being and maintaining boundaries. Having fewer duties and responsibilities narrows opportunities for service users to make unwanted demands crossing care work boundaries. At the same time, good care standards and social work ethical considerations make such boundaries rather flexible and dependent on situational decisions:

> 'Earlier, when she [a client] did not want me to leave home, could fall on the floor like a small child and kick her feet on the floor, throw a tantrum so that I would stay with her as long as possible, that was it. ... When I called her relatives, they would tell me to close her in the apartment and leave calmly. Well, I cannot leave calmly, of course, I go out, close the door, wait for her to calm down, and only after that leave because I'm worried...' (social worker at state local social service agency in Saratov).

When it is impossible to stay but risky to leave, a care worker decides 'leave, but wait at the door' to make sure that everything is in order. In the meanwhile, she calls for reinforcements or a shift in the person of relatives. Sharing responsibilities then is a common and important tactic but is not an easy-to-go solution, which requires a lot of mental work and adjustments to a specific situation. Boundaries are being created and defended but also moved if felt necessary by care workers.

*Boundaries that Make Coordination Possible - Creativity and Humour*

Our research participants talked about individual approach, humour, and creativity that help to maintain a balance between the well-being of the service user, on the one hand, and their own well-being, on the other: 'You need to know with everyone whether it is possible to joke. It is an individual approach. But, the joke should be [relevant] in the context. There are even differences in clothing. I can come to someone in a dress and to someone only in a formal suit plus a working robe. I have shoe covers, a hat, gloves, a mask' [social worker at a local social service agency in Saratov]. A competence of changing her image, and dressing up differently is a symbolic resource that allows the care worker to build and strengthen relationships, and achieve mutual understanding with various senior-age individuals. The porousness of symbolic boundaries in these cases turns to the permeability of social boundaries (Lamont and Molnár 2002).

Moreover, humour and mutual understanding with clients help her cope with her tasks:

> 'I constantly tell them one saying: 'The main thing is to live to be a hundred years old, it will be easier there' [laughs]. On the one hand, they understand that this is a job, and on the other, I try to be humane. And one man asked me to find him a bride. By the way, he is 90 years old. I told him that we are not a marriage agency and that we will not be able to do this… He then began to joke that I would then move to live with him. (…) These were all jokes, of course. We laughed, and that's it' (social worker at local social service agency in Saratov).

In various work situations, a creative approach is vital for care workers. It makes boundaries porous, resilient and negotiable. It also might allow engaging service users in boundary setting. By seeking to make boundary setting mutual, care workers seem to aim at legitimising such boundaries. If differences between care workers and users of their services are being established together, it might bring similarity in a vision of good care. As a result, a balance of personal well-being and ethical standards of good care might be achieved easier.

## 5 Boundary Setting Tactics against Uncertainty of Care Work

The article illustrates a wide range of vulnerabilities in care for senior-age service users during and before the covid-19 pandemic, as perceived by care workers in Russia. The context for discussed vulnerabilities and tactics to create boundaries between professional and private is uncertainties of the post-socialist hybrid care regime, with the authoritarian state undergoing neoliberal reforms aimed at diminishing the role of the state and expanding the role of the non-state actors, including non- profits (Cook et al., 2021). Despite Russian local particularities, there are cross-border commonalities of the case in terms of principles of neo-managerialism, the standards of rational administering, and the lack of quality standards and understanding of clients' needs (Bolshakov et al 2021). All of these characteristics aggravate uncertainty in care work, contributing to vulnerabilities of user services and care workers alike.

We analysed boundary setting and mitigation tactics against respective vulnerabilities and risks to the well-being of care workers. As a result, we identified a "boundary toolkit". It consists of five distinctive boundary setting tactics developed and used by care workers to protect themselves from the risks in personal communication with their service users: a complete refusal to care described in the previous section, emotional distancing, refocusing on self-care, sharing responsibilities, creativity and humour. All tactics are interconnected and, in Frank Cooper guide framework, aim at setting limits between clients and care workers, keeping relationship professional, preventing burnout, establishing boundaries, and managing client's behavior (2012: 30-37).

Boundaries in question may ruin care relations. In practice, however, creating and establishing boundaries assumes reciprocal participation. Moreover, the feminist ethics of caring and critical and poststructuralist scholars point out that care work boundaries are porous, flexible, and intersubjective (O'Leary et al., 2012). When a care worker tries to set up the limits, to draw the symbolic boundaries related to the cultural beliefs and assumed differences in structural positions, their service user is doing simultaneously the same from his/her side. The service users are testing the borders, trying to cross and redraw the boundaries, to break or challenge the power (im)balance. Hence, boundary setting is mutual and distributed. By doing boundary setting, care workers and their service users shape their understanding of their responsibilities towards each other as members of social groups through constructing themselves as similar and different (Lamont, Molnár 2002).

Notably, care work boundaries in the narratives of research participants involve spatial metaphors: distance, restrictions, barriers, frames, and the main emphasis has often been on the rigidity of borders. Nonetheless, the flexibility of as-if firm boundaries is being preserved and re-established by the personal influences of individual care workers, especially those without professional training. Nonetheless, in the end, the boundaries are performative of the resulting care regime structure in Russia. Such basic categories as worthy and unworthy, modest and arrogant reinforce the relative social distance between the groups and their relative status in society (Fernández-Ballesteros et al. 2018: 1613).

To sum up, gaining an understanding of how care workers develop and interpret boundaries in their everyday work situations, in particular in times of crises such as the covid-19 pandemic and uncertainties of social interactions in general, 'enhance educational efforts and (…) policy, prompting a minimi[s]ation of harm' (Trimberger 2012: 68) both to service users and care workers themselves. In this regard, boundaries, with all their simultaneous fluidity and rigidity, and tactics to establish and preserve them, are crucial, if not central for ethical debate

and good care standards, worthy of further research and analysis. Crucially, identified tactics are usually developed and shared informally, are mutually reinforcing, and are situational. Whether it is the Russian case particularity or a feature of any epistemological work of constructing notion of private and professional, and boundaries between the two, is a matter for further research.

## Appendix

Table 1. Care Workers – 37 Interviews

| | Stage 1 (2016-2018) | Stage 2 (2020-2021) | | |
|---|---|---|---|---|
| | Saint Petersburg | Kazan | Saratov | Tomsk |
| State local social service agencies | | | | |
| Care workers | 0 | 3 | 3 | 3 |
| Care managers | 1 | 2 | 1 | 1 |
| Non-governmental care providing organisations | | | | |
| Care workers | 8 | 2 | 2 | 2 |
| Care managers | 5 | 2 | 1 | 1 |
| Sum | 14 | 9 | 7 | 7 |

## 11 Interviews Quoted in the Article

Interview 1 Kazan, unpaid care worker at a non-governmental service providing organisation, man.

Interview 2. Saratov, social worker at a state local social service agency, woman.

Interview 3. Kazan, social worker at a state local social service agency, woman.

Interview 4. Saratov, social worker at a state local social service agency, woman.

Interview 5. Saratov, director at a non-governmental care providing organisation, woman.

Interview 6. Tomsk, social worker at a state local social service agency, woman.

Interview 7. Saratov, social worker at a state local social service agency, woman.

Interview 8. Saint Petersburg, director at the self-help veteran organisation, man.

Interview 9. Saint Petersburg, home care worker at a non-governmental social service provider, woman.

Interview 10. Saint Petersburg, home care worker at a non-governmental social service provider, woman.

Interview 11. Saint Petersburg, home care worker at a non-governmental social service provider, woman.

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