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The Body/Work Nexus: The Work of Nursing Assistants in Nursing Homes



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The Body/Work Nexus:
The Work of Nursing Assistants in Nursing Homes

by

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DISSERTATION

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ʻA ʻohe hana nui ke alu ʻia.
No effort is too big when done together by all.

Hawaiian proverb

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Abstract of Dissertation

The Body/Work Nexus:
The Work of Nursing Assistants in Nursing Homes
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This dissertation considers how certified nursing assistants (CNAs) construct the bodies of nursing home residents and how they assign meaning to work that is commonly viewed in one way or another as "dirty", tainted, or undesirable. CNAs invoked dignifying discourses to reinterpret meanings of their stigmatized work to mitigate the degrading implications of their labors. Together, body constructions and dignifying discourses shape the hands-on, intimate care aides provide to nursing home residents.

Observations and interviews were conducted with 27 aides in three different types of nursing homes in California. Other data included a content review of texts such as job descriptions and observations of aide training classes. All participants were people of color and, except for three aides, were first generation immigrants. Most were women and reflected U.S. demographics of CNAs working in metropolitan areas.

Nursing assistants constructed three distinct views of residents: resident as fictive kin, resident as commodity, and resident as autonomous person. Related dignifying discourses supported each construct and helped produce enactments of care giving. Caring practices were influenced by institutional forces such as commodifying the physical body while cultural understandings entered the rhetorics of duty and caring. The dominant discourses did not arise from training or other official sources but were generated by aides themselves in the course of their work. These findings extend the

concept of “dirty work” to nursing assistants and contest some conventional views that aides accept stigmatized labels of their work.

Implications for practice confirm other studies that recommend changes in the length and content of aide training. These findings also offer possible directions for nursing home policies to enhance worker retention and satisfaction. Areas for future research include taking up the central inquires across several contexts, such as in rural nursing homes and among licensed nurses and residents and their families. Additionally, the increasing globalization of healthcare workers would benefit from a closer look at the way immigrant workers experience and practice carework.

In our society the elderly are regarded as biodegradable and superfluous, instead of what they really represent: a biological elite who, with weathered wisdom, have much to offer the world.

Ashley Montague (1971)
*Touching: The human significance of the skin*

TABLE OF CONTENTS

# CHAPTER ONE: INTRODUCTION AND STUDY PROBLEM

## The Body/Work Nexus: The Work of Nursing Assistants

Nursing assistants, also known as aides and certified nursing assistants (CNAs), provide the bulk of daily hands-on personal care to elderly and disabled persons living in nursing homes. These workers are predominately women and paid less than the median wage for work that has one of the highest on-the-job injury rates (SEIU, 1997). Located at the bottom of the nursing hierarchy, their job is delegated care for the elderly and disabled, those needing more care than they are able to give to themselves.

The work of personal care is usually an intimate and private affair that takes place behind closed doors. Typically, this work is considered "activities of daily living", tasks most of us take for granted: eating, bathing, toileting, dressing, and physically moving from place to place. When individuals are no longer able to perform these tasks themselves they have to allow others to take over these intimate activities. In assuming this work, aides engage in direct touch with human bodies, often naked human bodies. The subject of bodywork, this regularity of our daily lives, is a missing dimension in research generally, and specifically vis-à-vis nursing assistants' performance of this work for others. Perhaps regarded as incidental, too personal and ordinary, there is little scholarly attention to nursing assistants and their day-to-day bodywork.

Yet the implications of ignoring this critical dimension of care are significant because it is from within this domain that much of what is considered quality of care in nursing homes emerges. To address this gap in our understanding, this study examined the work of those attending to the daily maintenance of bodies, seeking to uncover how

CNAs understand and find meaning in their work, and how this is played out in approaches to care.

The focus of this research is the body/work nexus of nursing assistants at the site of labor where both intimate contact and sustained relationships occur. Specifically, the purpose of this project is to elucidate how CNAs construct the nursing home resident as a focus of work and how these constructions shape day-to-day practice. Blumer (1969/1986) and other leaders of the "Chicago School" of sociology built on Mead's (1934) analysis of viewing people as living and working in worlds of objects and forming their activities around these objects. These objects are conceptualized as social constructs rather than self-existing entities with intrinsic natures. Their nature is dependent on the view and action of the people around them. Casper later built on Mead's definition of social objects to define a *work object* (Casper, 1998). She was concerned with social objects in work settings: "A work object is any material or symbolic entity around which people make meaning and organize their practice" (p. 381).

Taking this definition of the work object into the nursing home, the object for the nursing assistant is the body of the resident. The work object here is clear: it is the body of a resident which must be bathed and fed and toileted. The body may also be at times, a materialization of personhood. The definitions the aides bring to this work object, then, have consequences for how aides interpret their jobs, how they organize their work, and how they negotiate the variety of responses they receive from the residents in the course of their work. Moreover, the symbolic meanings of this work, which occur in an institutionalized health care system, are real in their consequences for the resident and the nursing assistant (at the very least).

Many people consider aide work to be stigmatized work (Cancian & Oliker, 2000; Diamond, 1992; Gass, 2004; Redfoot & Houser, 2005; Schirm, Albanese, Garland, Gipson, & Blackmon, 2000). The concept of stigma, credited to Goffman (1963), has provided the theoretical foundation for innumerable studies over the years. He described stigma as "an attribute that is deeply discrediting within a particular social interaction" (Goffman, p. 3).

Aide work, above all, is characterized by its intrusive, transgressive nature. This work is also poorly compensated, physically and emotionally taxing, and demands daily contact with noxious sights and smells. It is a job positioned at the lower rung of the nursing home organization in pay, training, and authority and located within institutions characterized as bureaucratic, heavily regulated, and profit-driven (Diamond, 1992; McLean, 2007; Foner, 1994b). The poorly educated, immigrants, and women of color are over-represented in this occupation in urban areas (Berdes, 2003; Mercer, 1993; Yamada, 2002). In part because of its very low status, CNA work is also often "invisible work." Strauss and colleagues (see, e.g., Star & Strauss, 1998; Strauss, 1988; Strauss, 1993) sought to make such work more visible (Star, 1991).

Early in the research process, the notion of "dirty work" became a prominent concept in examining practice. Specifically, aides acknowledged the stigmatized nature of their work but reinterpreted this perspective in ways to justify, explain, and understand their stigmatized work. Everett Hughes (1971) is credited for conceptualizing and creating a framework for the study of "dirty work". Numerous studies attest to the salience of a moral division of work, shifting shameful or degrading tasks to those with

less standing. Thus, with nursing assistants lowest in the nursing home hierarchy, another question to pursue was how nursing assistants find dignity in their "dirty work" job.

Framed by definitions of the body, the nursing hierarchy, dirty work, and the structure of the workplace, my research focuses on these specific aims:

1. to explore how nursing assistants construct the bodies of nursing home residents and the kinds and modes of care they provide the bodies of residents;
2. to see whether (and if so how) gender, race and ethnicity, and immigration status affect care work;
3. to investigate how CNAs make meaning vis-a-vis a stigmatized "dirty work" job; and
4. to identify how these constructions influence the practice of everyday work

My approach is to elicit and represent the perspectives of aides and their work in nursing homes, rather than the viewpoint of the researcher, nursing home management, or other perspectives. For this project, the preponderance of data came from interviews and field work including direct observations of personal care performed by nursing assistants.

I build on ethnographic and other research on nursing homes (Diamond, 1992; Foner, 1994b; McLean, 2007, Hartig, 1998). My project is informed by "sensitizing concepts" such as dirty work and dignifying rationalizations. Contrasting "sensitizing concepts" with definitive concepts, Blumer (1954) explained that a definitive concept refers to clear attributes or bench marks, while a sensitizing concept provides guidance and suggestions for research in specific settings. This study also began with an understanding of CNAs' poor working conditions including low wages and poor benefits for a predominately female workforce (see, e.g., www.directcareclearinghouse.org, 2006).

My task is three-fold: to challenge both the historical absence of and (when present) universalizing renderings of nursing assistants in the literature; to attend to the sensitizing concepts of stigma and dirty work; and to make visible the work of hands-on care. As several scholars argue, the body and physical care may be neglected in scholarship because the topic itself is implicit, diffuse and fragmented in nursing literature (Jervis, 2001; Lawler, 1991; Twigg, 2000b). This project seeks to uncover the everyday of bodywork, the invisible work, situated in the competing priorities surrounding the elderly and disabled, for-profit corporate nursing homes, and the labor of nursing assistants.

The ageing of the "baby boom" generation underscores the need for quality long-term care workers. Given that the number of persons needing assisted or long-term care will increase from 15 million in 2000 to 27 million in 2050 (U.S. Department of Health and Human Services [HHS], 2003), it is imperative to examine the day-to-day work lives of those who care for the elderly and disabled. Rich on-the-ground investigations have addressed performance by hospital nurses at the bedside (Lawler, 1991), homecare workers performing intimate care (Solari, 2006; Stacey, 2005; Twigg, 2000a), and nursing assistants caring for people with dementia (McLean, 2007). This study builds on this tradition and takes it into the nursing home (Diamond, 1992).

This research fills a gap in knowledge about nursing assistants, vulnerable low-wage workers at the nexus of employment, long-term care, and stigmatized work. While the discourses of residents, families, and aides themselves might include the "emotion" of carework (see, e.g., Berdes, 2003; Bone, 2002; James, 1992), residents largely require hands-on personal care of their bodies. It is the work enumerated in job descriptions,

emphasized in text books, and taught in nursing aide training. It is work the CNAs are paid to do and upon which their evaluations are based. Understanding how perceptions of this work emerge and influence care can lay the foundation for the evolution of practices that enhance the care of older adults in nursing homes.

## Dissertation overview

The dissertation is organized into five chapters. Chapter Two, reviews and discusses the literature relevant to these research questions, including a fuller treatment of the key concepts of dirty work, boundary work and recent literature on nursing assistants and caregiving. Chapter Three discusses the research methodology and the processes used in data collection and analysis.

Chapter Four presents the substantive finds of this study. The sample and settings are described, and three types of constructions of bodies by CNAs are presented, compared, and contrasted. The description of each construction is followed by the particular meanings that aides crafted as response to their work. Together, each construction and their meanings shaped how care was enacted, providing the foundations for practice.

The final chapter, Chapter Five, summarizes the findings, discusses the limitations of the study and presents implications for nursing practice, education, and research.

# CHAPTER TWO: REVIEW OF THE LITERATURE

## Social Constructions of the Body, Dirty Work, and Dignifying Discourses

Despite a substantial history of nursing home ethnographies and studies of nursing aides concerning quality of care and labor force issues, the direct touch necessary to perform work on naked, human bodies has been, with few exceptions, given scant attention in public discourse (Frank, 1991; Lawler, 1991; Twigg, 2000a, 2000b). Related literature has examined the nexus of bodies and work in home care workers (Solari, 2006; Stacey, 2005; Twigg, 2000a) and nurses (Lawler, 1991) but the experience of direct touch of nursing assistants has been minimally described. This gap in our knowledge stimulates the examination bodywork from the vantage point of those who perform it. In short, how do nursing assistants constitute the object of their work and give meaning to their job, and how do these perceptions shape their everyday hands-on labor?

The purpose of this chapter is to briefly review the research relevant to these questions. Thus, this chapter first explores selected studies of nursing assistants that contextualize their work. The second section reviews the currently available literature on constructions of residents from the standpoint of nursing assistants. The third section examines “dirty work”, a concept derived from studies of jobs acknowledged as involving stigmatized work. Finally, the review includes the two prominent ethnographies of bodies and work. A summary of this work supports the need to examine more closely how CNAs view nursing home residents, how they find meaning to a stigmatized job, and how these views and meanings influence care practices.

## Overview of Nursing Assistants

Before proceeding with this literature review, it is useful to provide some background on nursing assistants. The Institute of Medicine's report on long-term care is useful for this purpose (Wunderlich & Kohler, 2001).

*Nursing Homes and CNA Training Requirements*

Nursing assistants make up the largest proportion of caregiving personnel in nursing homes. Nearly 70% of U.S. nursing homes are privately owned ("proprietary"), and most are affiliated with for-profit multi-site corporations (Wunderlich & Kohler, 2001). Other types of ownerships are voluntary non-profit and government entities. Typically, a home may have 50-99 residents, with one or two licensed nurses (registered nurses or licensed vocational nurses) to administer medications, chart in the medical record, and supervise aides (www.directcareclearinghouse.org, 2004). The federal government requires training only for nursing assistants (NAs) who work in Medicare- and Medicaid-certified nursing homes. The National Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA) requires NAs to have a minimum of 75 hours of training and 12 hours of in-service training per year, and they must pass a competency test within four months of employment (OBRA, 1987). (In California the 40-item written and skills test is established by the state but administered by the Red Cross or other non-governmental entities.) California exceeds the training standard and requires 150 hours of initial classroom and clinical work plus 24 hours of in-service training each year (www.dhs.ca.gov/lnc/cert).

In California, the Department of Health Services (DHS) certifies nurse assistants, maintains a registry of these care workers, and enumerates their job functions. The requirements for certification are to be at least 16 years of age and to meet two pre-

screening requirements. The first is a physical exam that states the applicant has no health condition that would create a hazard to her/him, fellow employees, residents or visitors. The second requirement is a criminal conviction screen that automatically denies certification for felonious crimes such as murder, extortion, and kidnapping (www.dhs.ca.gov/lnc/cert).

Certification allows CNAs to provide personal care and comfort measures, including bathing, oral hygiene, and incontinence care to residents in skilled nursing homes. The Department of Health Services also permits nursing assistants to perform procedures such as feeding patients, dressing them, providing perineal care, and making beds. The CNA role, according to the certifying body, is to "ensure the safety, comfort, personal hygiene, and protection of patients/residents" under the supervision of a licensed nurse (www.dhs.ca.gov/lnc/cert).

This brief synopsis supports the importance of nursing assistance to the functioning of nursing homes yet also documents the relatively minimal pre-screening regulations and training for the work they provide. The next section briefly reviews studies which expressly center the work of nursing aides; these include the disciplines of nursing, sociology, and anthropology**.**

*The Context of CNA Work*

In one of the earlier ethnographies of nursing homes, Gubrium (1975) examined the social organization of care in a large, nonprofit home in the Midwest. Published 30 years ago, the study explored the ways in which ordinary work is accomplished by people who participate in the everyday life of the home. In the chapter titled "bed-and-body work", Gubrium detailed the day-by-day routine, with deviations seen as intrusions and

their impact minimized by nursing staff. Staff was annoyed at patients who interfered with their routine. Patients who “dillydally”, were uncooperative, or complain to administration were sedated and restrained, and staff broke administrative rules to resolve care dilemmas.

Twenty years later, in writing about new ethnographies, Gubrium (1995) critiqued the standpoint he used in Murray Manor. He assessed his perspective and consequent story as being too present oriented and not taking in a wider world. For example, he was little concerned with how the nursing aide’s personal history, especially her family, class, or ethnic background, related to bed-and-body work, nor how the life experiences of patients link to their present lives in the nursing home. He concluded that his neglect of the social and historical experiences of the women and men he saw as patients and aides resulted in a partial view.

In another ethnography, Kayser-Jones (1981) compared two homes, one in the U.S. and one in Scotland. It presented a portrayal of policies and practices which depersonalize and dehumanize the human soul in the American home, in contrast to very person-oriented practices in Scotland. In the American home, for example, staff infantilizes residents, including “such behavior as scolding incontinent patients” and addressing the elderly “by their Christian names or in familiar terms such as ‘Nana,’ ‘Mother’ or ‘Honey’” (pg. 39). Her analysis included a historical and structural explanation of these differences in care, contrasting the British health care system which provides comprehensive care for the elderly with the American system that emphasizes acute, short-term, hospital-based care.

Additional ethnographies were published in the 1980's and 1990's when initial OBRA nursing home standards were formulated by the U.S. Congress. Diamond's (1992) often-cited monograph began with his training and work as a nursing assistant at three homes in the Chicago area. He linked this situated experience to the social organization of nursing homes, then to caretaking as a business, and more broadly to social and economic forces in the U.S. Using the theoretical perspectives of political economy and feminist theory and methods, he noted three sectors in American society which converge to create and sustain nursing homes as industrial enterprises. These are corporate America (caretaking as business), medical America (a person is a body with illnesses), and federal and state government which gives money to, certifies nursing homes, and regulates how corporate America's caretaking practices interface with medical America. In essence, he explored the process whereby the business model converts caregiving into a commodity that is managed as a capitalist industry.

Foner (1994a, 1994b) analyzed the nursing home as a place of work. She pursued questions about the bureaucratic demands on nursing assistants as they cared for residents and the nature and effect of their informal work culture. Nursing aides, she concluded, are subject to numerous pressures from residents and families, supervising nurses, rule-bound administrators, and protective co-workers. She viewed aides as neither "saints nor monsters" but somewhere along this continuum. What remains unanswered is given that aides are subjected to similar bureaucratic and other demands, why are some aides closer to "saints" and others to "monsters"? However, a caregiving dilemma resulting with intersections of personal care values and those of the institution invariably affects

residents and rewards efficiency and prioritization of physical tasks. This dilemma also diminishes psychosocial care of residents and NAs.

Most recently McLean (2007) contrasted two approaches to caring for elders with behavioral disturbances due to dementia. On one nursing home unit the approach is person-centered, while on another unit in the same home the care is based on instrumental tasks. She also shows how NAs differ in their personal capacity to empathize with patients and to "work around" regulations to dignify older people. In this monograph, McLean employed critical social theory to analyze care as a moral enterprise and reviews historical legacies and cultural barriers to quality dementia care. The final chapters, which include ideas, modalities, and designs for a "culture change" in dementia care, are both hopeful and cautious. McLean demonstrated how elders thrived under intensive caregiving relationships but warns us that "cost-saving" instrumental practices are reflective of moral standards of our society.

## Conceptualizations of Residents

Research has provided a range of perspectives on how CNAs conceptualize nursing home residents. Nursing aides have been described as constructing home residents as fictive kin (Berdes, 2003; Bowers, Esmond, & Jacobson, 2000; Diamond, 1992; Foner, 1994a, 1994b; Jervis, 2006), as categories and objects (Kayser-Jones, 1981; Lee-Treweek, 1997), and as autonomous persons (Black & Rubinstein, 2005; Hartig, 1998; McLean, 2007). In both nursing and social science literature, aides define good care as a supportive, caring relationship using the intimate terms of parent and grandparent. Aides in two ethnographies (Diamond, 1992; Foner, 1994b) used family images to describe relationships with residents and often came to feel like surrogate

family members. As several researchers noted, however, complexities in definition as fictive kin quickly emerged. While aides' work provided personal meaning and reinforced images of themselves as caring people, aides preferred residents who were among the more mentally alert and who reciprocally expressed an interest in and cared about the aide as a person (Berdes, 2003; Foner, 1994a).

Jervis (2006) explored staff perspectives and reactions to family noninvolvement in two diverse nursing homes. She found that although staff conceptualized their relationships with residents in metaphorical kinship terms, it was understood that while residents were like kin, they were not actual kin. The most serious impediments to a "real" family-like relationship were lack of time due to required instrumental tasks, purposeful distancing to ease the emotional toll of resident deaths, and staff turnover.

The literature is replete with examples of assembly line approaches to care. One thoughtful analysis is offered by Lee-Treweek (1997), who approached the study of carework as "labor" and the patient as the well-groomed, hygienic product. Drawing on field work with British auxiliaries (aides) in a nursing home, she argued that, for some women, paid care work is undertaken for an economic reward rather than as a vocational choice. From this perspective, Lee-Treweek asserted that the production of the body is similar to the production of objects. The product in this case is the "lounge standard" patient, sufficiently presentable to be placed in a public area. In other words, the patient is a product, worked on in private to achieve a standard of appearance fit for public display in the lounge of a nursing home.

Lee-Treweek (1997) regarded auxiliaries as similar to male assembly workers and women's non-care labor, using resistance as an everyday strategy to get through the day

and exercise some control over their work. Resistances came in the form of non-compliance or selective compliance to patients' needs, contrary to their job descriptions and to lay expectations of nurturing care. Like their counterparts in assembly workers, the auxiliaries exacted their resistance through the materials they worked with and therefore could control. In this case, material was the patients' body and the processes involved working on them. These "rituals of resistance" took several forms such as the spatial management of truth and lies (truth-telling in private areas and lying in pubic) and seeing themselves as better than the nurses in coping with violent patients.

The construction of the resident as an autonomous person is well presented in case studies such as those in McLean's (2007) ethnography. Through profiles of residents with behavioral disturbances of dementia, McLean portrays how two aides enacted their beliefs that caregiving was not simply a matter of completing tasks, it was a moral rendering and a way of being in the world. Staff was able to look beyond the disease to take the resident seriously as a human being and pay attention to his or her wishes, feelings, and behaviors. McLean also attributed this outcome to the flexibility, willingness, and leadership of the head nurse to communicate values and priorities of care with staff and families.

Black & Rubinstein (2005) also viewed residents as autonomous persons using narrative analysis to study direct care workers' responses to care, dying and death. Their case study of "Jayson", an activities director in a nursing home, illustrated how staff gave physical and emotional care to elders in the last stage of life and now mourn residents who have died. Characteristic of other bereaved direct care workers, Jayson spoke of meeting the needs of elderly persons "one-on-one" to affirm the worth of human life.

Analyzing interviews with eight NAs, this study described the care activities of expert nursing assistants (Hartig, 1998). One major category of care was psychosocial activities, consisting of seven values and activities. Two of these were supporting resident control of care and treating residents as individuals, affirming the construction of the resident as an autonomous person.

## "Dirty Work"

This section briefly explicates the concept of "dirty work" and selected research which extends this notion of stigmatized work and meaning-making to different occupations. Chicago School sociologist Hughes (1971) initially conceived the term "dirty work" to describe work that is viewed in one way or another as tainted, unpleasant, or undesirable. It is work considered less honorable and respectable, though sometimes offering greater economic rewards than comparable levels of prestige. Hughes notes that all occupations, including nursing, involve some dirty work. However, he proposed that those tasks considered menial are likely to "drop" to another kind of worker, one with less distinction. Lawyers and nurses, for example, might retain or delegate certain duties, depending or whether the tasks are considered "dirty" or "clean". He called this a moral division of labor. But since work of any sort is one of the more important parts of one's social identity and since the language about work is loaded with prestige judgments, many people attempt to revise their own conception of themselves and of their work. Hughes formulated the concepts of "collective pretensions" and "dignifying rationalizations" to explain how people, particularly in less respected occupations, seek to give their work, and consequently themselves, value in the eyes of each other and of outsiders in order to mitigate the degrading implications of their work (p. 340).

Over the years, the concept of dirty work has been used to examine psychiatric workers (Emerson & Pollner, 1975); home care workers (Stacey, 2005); nurses involved in pregnancy terminations due to diagnoses of genetic malformations (Chiappetta-Swanson, 2005); police officers (Dick, 2005); general practitioners (Shaw, 2004), and nursing aides (Jervis, 2001). Emerson and Pollner's frequently cited study extended Hughes' work. Arguing that dirty work is a function of perspective, Emerson and Pollner proposed the concept "dirty work designations" in which dirtiness may not only inhere in the task itself but "something of the judger is involved in the judgment". Furthermore, such designations are also the "means through which the perspective is enacted and perpetuated" (p. 244). By defining a particular task as dirty work, the worker declares a kind of moral distance from that dirtiness, informing others that he is aware of and committed to the moral order just violated. In their investigation of psychiatric emergency teams, the category "shit work" is used to characterize not only times when professional carers are unable to do something for a patient but also when they then feel compelled to do something to them in a coercive sense.

Ashforth & Kreiner (1999) note that the concept of "dirty work" raises a provocative issue: specifically, how do "dirty workers" maintain a positive sense of self? Using social identity theory in this non-empirical work, they proposed that workers use three modalities to make sense of their work in esteem-enhancing ways: (a) reframing, where the meaning attached to a specific occupation is transformed; (b) recalibrating, where the tasks that constitute the role are re-categorized to emphasize more acceptable ones; and (c) refocusing, which is an attempt to shift attention to non-stigmatized aspects of the role.

In a more recent study, Dick (2005) explored how British police officers use dirty work designations to deal with moral dilemmas in their use of coercive authority. Using Goffman's (1959) concept, she argued that "dirty workers" construct their jobs differently in "front regions" and "back regions", revealing the arenas and boundaries of different moral and social orders. In "back regions" such as work with colleagues or at home with supportive friends and family, the individual can relax; "the audience is absent, and the boundaries of professional ideology are relatively secured" (p. 1373). Dick used critical discourse analysis to study the "front region". Here, the audience, such as a researcher, is present and the individual may feel compelled to give an appearance of adhering to particular or higher moral standards in their work. This "front region" is public and workers are exposed to potential criticism of their actions. It is the site of contested meanings of the job and, by extension, the identity of the person doing the work.

The focus of the next study is the designation of dealing with revolving-door psychiatric patients as dirty work and how this, coupled with moral judgments by general practitioners, can lead to a process of exclusion (Shaw, 2004). Physicians who regard such patients as "difficult", not suitable for psychiatric care, pass them on to others "in the vain hope that someone else has a solution" (p. 1040). Shaw concludes that the revolving door process includes a degree of moralizing or victim blaming by physicians and others who point to poor motivation or moral character of the patient.

Chiappetta-Swanson (2005), Jervis (2001), and Stacey (2005) each investigated how health care workers themselves assigned dignity in dirty work. In her study of home care workers, Stacey reported that these workers had a conflicted, often contradictory,

relationship to their labor. They identified constraints in doing good work but reported several rewards from caring for dependent adults. Constraints included overwork and added responsibilities, increased risk on the job, and the physical and emotional strain of providing care. One reward was deriving dignity even when doing dirty work. These aides found meaning in stigmatized work through their willingness and ability to perform dirty and mundane tasks that others avoid, knowing that their efforts improved lives of clients.

Chiapetta-Swanson (2005) studied Canadian nurses who managed genetic termination (GT) procedures for women who wanted to end their pregnancy due to fetal anomaly. The nurses readily discussed problematic aspects of managing GTs but also described their work as professionally rewarding and personally gratifying. In their eyes, the quality of care they were able to provide transformed their job from dirty work to work with dignity and satisfaction. The researcher extended previous studies in dirty work by illustrating the importance of social support for those isolated by the stigmatized nature of their work and by discussing how lower status workers (nurses vis-à-vis physicians) transformed their dirty work position to one with rewards. Nurses accomplished this by shifting their focus from the problems of their practice to the value of their work and by developing routines that allowed them to successfully manage GT's without the presence of a physician. Of interest is the wording "genetic termination", an example of Hughes' (1971) "collective pretension" and "dignifying rationalization". Elsewhere, "GTs" are known as abortions.

Jervis (2001) explored how CNAs' continual contact with pollution (i.e., incontinence) affects their workplace status, their relationships with others, and their

beliefs about their work and themselves as workers. She brought anthropological conceptualizations of pollution and elimination to frame this study. The researcher stated that, following Douglas (1966), ethnographers generally conceptualize pollution in both actual and symbolic terms, as “disorder” or “matter out of place.” Jervis proposed that incontinence causes residents to feel shame and to loose self-esteem, that observers experience revulsion, and that this results in the stigmatization of aide work.

Given the continuous contact with symbolic pollutants, Jervis (2001) found that CNAs employ four strategies to cope with the occupational stigma of caregiving. These are (a) deploying protective barriers, such as carefully handling stool; (b) cultivating bravado, that is, adopting a “macho” attitude toward excreta; (c) using humor to relieve stress; and (d) reinterpreting the meaning of the job. This final approach, in which aides tended to emphasize the more culturally valued role of helper when discussing their work with outsiders, supports the work of several others, including Ashforth & Kreiner (1999), Dick (2005), and Stacey (2005).

## Bodies and Intimate Work

Twigg (2000a, 2002) has written specifically about carework as a form of bodywork. Her ethnography of home care providers in England is based on a study of bathing and washing older people living at home. Twigg’s central argument is that bodywork is a pivotal dimension of carework and a legitimate focus for academic study. She provides a dissection of why bodywork has been neglected and a reasoned, in-depth commentary of how carework is defined. The failure to emphasize the body, she concludes, is due to several factors: the study of paid carework relying on concepts from informal carers; the word “care” itself is surrounded by a warm and loving quality; and

retaining the concepts situated in informal care emphasizes its relational rather than physical aspects. The workers themselves also de-emphasize the body and stress the emotional and interpersonal aspects of their work. They also may be reticent to expose the realities of their work to the wider world.

Finally, Lawler (1991) argues that nursing work includes the presence of the body but that there is a relative absence of discourse surrounding this subject.The problem of the body and some of its functions, she continues, is that it is constructed as a private matter and not recognized as an arena for legitimate scholarship. This Australian nurse-sociologist used nurses' experiences to better understand how the body is constructed in social life and to explore the private and invisible parts of nurses' work. Lawler's theory of somology posits that nurses deal with the bodies of other people by integrating lived experience with the object body; that is, nurses interacted with the patient in a manner that merges the patient's lived experience with their material body. Somology is derived from a knowledge base that is fundamentally person-related and context bound. It is a view, Lawler asserts, which nurses developed in practice by intimately knowing the patient.

## The Body/work Nexus and the Work of Nursing Assistants

In sum, research on how nursing assistants construct residents' bodies, how they give meaning to their work, and how these processes might shape hands-on care is at a seminal stage. Although the studies here point to dirty work realities of intimate, personal work, minimal research exists on the day-to-day experience of nursing assistants in nursing homes. Little is known about this material experience of interacting with bodies that constitute the site of labor nor about how these care workers find meaning in

their job. This question stimulated this investigation of bodywork from the vantage point of nursing assistants. Since our everyday life is dominated by the specificities of corporeal existence, we begin our study with bodies, the immediate site of labor.

# CHAPTER THREE

## The Processes and Production of Research

This qualitative study used grounded theory methods to theorize the personal care component of everyday work, the body/work nexus, of nursing assistants (Charmaz, 2000, 2006; Glaser & Strauss, 1967). Grounded theory is abductive, tacking back and forth between data and concepts that analytically capture the action—key social processes---in the data. Abductive methods such as this allow us to formulate ways that people make sense of their lives and to see them through definitions they create to interpret, and then act, in a social world.

## Research Design and Methods

Design and methods are derived from the research question being asked. Since the primary purpose of traditional grounded theory is to explore the dominant social processes present within interactions, the "theory/method packages" of grounded theory/symbolic interactionism (Clarke, 2005, p. xxxiii) is an appropriate theoretical underpinning for my focus of study. My questions about nursing assistants may also be understood by this particular approach in order to gain a fresh perspective on a familiar situation. Although nursing assistants are ubiquitous staff members in nursing homes, much of the research on bedside care lies outside bodywork and is studied primarily as emotional labor. The hands-on, body work of CNAs, reinforced by training, certification, and job descriptions would lead us to investigate this understudied bodywork aspect of their job.

A recent supplement to grounded theory expands the usual data sources of interviews and field work to include both the human and non-human, and offers expanded approaches to analysis (Clarke, 2003, 2005). The human interactions in this case are those which occur in the social worlds of nursing assistants, residents, and others during the provision of personal care. Non-human "things" are also possibilities to include in grounded theory analysis. These may include wages, discourses on the parameters of aide responsibilities, and objects that present in the everyday of aide work, such as mechanical lifts and supplies, like diapers. The theoretical framework of symbolic interactionism, with methods and analytic strategies of grounded theory, are thus a suitable approach to describe the processes of nursing assistants in their work. The specific procedure for selection of the settings, sampling, data collection, and analysis follows.

Before commencing data collection, the Institutional Review Board (IRB) at the University of California San Francisco (UCSF CHR) reviewed and approved this project (approval number H6362-28971-01A). The approved consent clearly noted that I would be observing the CNA while she or he provided care, but if the aide or resident requests privacy, I would remove myself from the caregiving area. In addition to UCSF CHR approval, one nursing home required approval from its own IRB before data collection could begin there. In addition to obtaining CNA consents, this IRB also required consents from residents before direct observations could occur.

*Selection of Settings*

The criteria for study settings were certification for Medicare and Medicaid funds, located in the northern California Bay Area, and a site from each of the three major payer

types of U.S. nursing homes (Wunderlich & Kohler, 2001). These types are proprietary, the most common; non-profit entities, which may be incorporated or affiliated with a religious organization; and government-sponsored. In addition, sites ranged in size from small to large and in a range of locations (urban and suburban and in three counties). I contacted one site "cold" but nursing colleagues referred me to administrative contacts in the other two. I declined to pursue one site because of objectionable requirements from the home's administrators.

*Sampling Procedure*

I proposed observing and interviewing 5-8 nursing assistants from each of three sites, with an eventual total of approximately 15-24 participants. The approved recruitment procedure involved contacting the Director of Nursing (DON) at each site to request a meeting with aides to explain my study. The actual process and degree of involvement by the DON varied at each nursing home. For example, although I emphasized the voluntary nature of participation in my initial meetings with the DONs, at one nursing home, the Director recruited the first two CNAs. At the second home, the nursing director made a general announcement at breakfast in the residents' dining room. At the largest home, the Director scheduled a meeting with three nurse managers who suggested names for me to contact. Although I gained entrée through meetings with the DONs, recruitment was primarily by aides inquiring about this study after seeing me at their work setting or by snow-balling referral from one CNA to another co-worker. Later, aides at each home informed me that DONs scheduled meetings with them infrequently (about every quarter) or only called meetings for critical announcements (e.g., health department inspections).

In each home, I interviewed aides on both the day (approximately 7 a.m. – 3:30 p.m.) and evening shifts (generally 3 p.m. – 11:30 p.m.). Most meals and personal care (e.g., showers, hygiene and grooming) occurs on the day shift. I also included a mix of men and women to examine possible gender differences in care. Finally, my sampling plan included aides with a range of lengths of experience and aides from several ethnic and racial backgrounds. There were three aides who declined to consent, including the only Caucasian aide. He said being interviewed would for him be akin to making an anxiety-provoking public speech, while the others indicated that work and family obligations precluded interviews before or after work.

*Sample Inclusion and Exclusion Criteria*

Inclusion criteria for the nursing assistants was state approved certification and the ability to speak and understand English. Exclusion criteria were aides who worked less than one year and part-time employees. CNA educators were included in the sample if they taught aides in the past or were currently teaching.

*Sample Selection*

The primary sources of data were interviews with nursing home aides and field notes from extended time in the nursing home environment generally and observations of face-to-face interactions between aides and residents. The approved consent clearly noted that I would be observing the CNA while she or he provided care, but if the aide or resident requests privacy, I would remove myself from the caregiving area. This occurred fewer than five times in each setting.

However, interpretive frameworks look at a broader situation of the phenomenon and do not restrict data to the thoughts or actions of individuals. Therefore, my data

sample also included written material (CNA job descriptions and performance evaluations, nursing home informational material and mission statements, and nursing aide text books), observations of CNA classes, and interviews with key informants who educated aides in the past as well as current instructors. These data sources were selected because they could provide greater fullness and breadth to my study questions (Becker, 1996). My intention in looking at these discourses of nursing home life was to analyze the foregrounding (or not) of physical care and how and where these were presented.

*Data collection*

Notes from field and participant observations and informal and formal interviews with nursing assistants were the primary sources of data. I obtained the CNA job descriptions and nursing home mission statements from the DON or nursing home administrator and a CNA instructor gave me nursing assistant text books. I attended two classroom training sessions at the local community college and interviewed three instructors. The data collection period extended from June – December, 2006.

After signing consent to be a research subject, each aide was observed for at least one work shift, followed by an interview. Four aides were interviewed twice for clarification of their responses or to follow-up further questions. Each was given a $20 gift certificate from Safeway after the first interview in acknowledgement of their time.

Because of the sequence in which nursing homes gave approvals, I started data collection at the for-profit home, proceeded to the non-profit, church-affiliated home, and concluded at the county-owned facility. However, I continued to collect data simultaneously at all three sites. Interviews and field observations continued until data saturation occurred and no new information was forthcoming.

*Participant observation.* Observations were conducted on the day and evening shifts when most personal care occurs, and during the week and on weekends. This decision resulted from my work as a clinical nurse and nursing supervisor in acute and long-term care settings: there were differences between the shifts and between week days and weekends. The numbers and types of visitors, the pace and content of work, and the interactions among staff resulted in different "feels" that I wanted to observe from these vantage points. Hand-written, preliminary notes were made of all observations and informal interviews and expanded into typed summaries. These were supplemented by transcriptions of final interviews.

In addition to field work with aides enrolled in the study, I observed about 10 other aides in their duties and spent time in public areas such as dining and family rooms, staff lounges, and activity areas. I joined aides during lunch breaks and attended a birthday party for the 12-year old son of an aide. The party was held in the aide's home and attended by about 25 current and former aides and their families. In all three work settings, aides made a point of introducing me to their family members.

Finally, my field work extended to CNA training, which took place towards the start of my data collection period. I attended two days of aide classes at a local community college. The supervising instructor suggested these particular days towards the end of their course work, when the curriculum emphasized hands-on care. My purposes included observing what particular knowledges and skills were given emphasis in teaching (what mattered), how the skills were taught and evaluated, and who the students were and how they responded to their education. I also intended this to inform my observations and interviews with the nursing home aides.

Although not initially planned, in every nursing home and on numerous occasions, residents and their families approached me and began conversations. One family asked me to join them at lunch and many residents invited me into their rooms to visit. Some wanted to express concerns about their care, while others offered opinions about the quality of the aides and made suggestions about their training. Most just wanted someone to listen to them. Since residents and their families were not part of my study questions or design, I took few detailed records and did not consider these in my formal data analysis. They did serve, however as background texture to each nursing home.

*Interviews.* Semi-structured, open-ended interviews were conducted after the observations occurred. Two aides declined to be recorded. I took detailed notes during their interviews and transcribed them soon after. Aides selected the interview times and locations; interviews took between 45-minutes to three hours, with most between one and one and a half hours in length. Most CNAs elected to find a place in or around the work setting; thus interviews took place wherever space was available, such as DON and social work offices, vacant resident rooms and activity rooms, or outside the grounds of the nursing home. One interview took place in an aide's home and another at a bookstore's coffee shop. At the end of the interview, demographic information was obtained using a brief questionnaire.

The interviews opened with the questions: "How did you decide to become a nursing aide?" and "How do you describe your work to others?" The interview then followed the aide's lead. I guided the interview to probe areas they felt were important or if they did not address aspects of the study questions. These areas included relationships with residents and their families, interactions with other aides and licensed staff, and

what good care meant to them. The guide developed prior to data collection was modified over the course of the interviews to reflect explorations of emerging themes and patterns and to saturate core categories as the data analysis proceeded. One of these themes was how they continued to work in a job they described as “dirty” and how this changed over time.

I observed two days of classroom instruction followed by interviews with three aide training instructors. During the observations, I focused on the content of didactic instruction, how and what skills were taught, and the interactions among the instructors and the students. Since the second day of observation occurred just prior to the students’ start of clinical training in nursing homes, I noted in particular how the instructors prepared the students for this experience. This subject was especially salient since many aides had spoken at length about their troubling transition from classroom to the work world. Interviews with the aide instructors focused on clarifying my classroom observations, the process and content of curriculum changes and certification exams, and eliciting their opinions about student preparation and practice.

*Data management*

After the audio taped interviews were transcribed verbatim either by me or a professional transcriber, I reviewed the transcripts for accuracy against the digital recordings. This process requires a fuller explanation. Except for three women who were born in the U.S., the participants in my study spoke English as a second language. The aides came from eight countries and spoke many more languages and dialects (e.g., Hindi-speakers from Fiji and several Filipino dialects). I listened to each taped interview

several times and again while reading the written translations until I felt I grasped the intention of each participant.

The analysis was conducted from the verbatim transcriptions; however, I made slight changes to the quotations extracted for presentation of the data in these dissertation chapters, maintaining the spirit and intent of the speakers while making their quotes readable to a reader of standard English. The process of editing was aided by peers who reviewed the progression of changes over several weeks. I also was guided by the process of reflexivity, self-scrutiny in particular about representation of the participants in written word. I wanted to avoid a pull to romanticize, villainize, condescend or otherwise essentialize the participants.

To preserve confidentiality, pseudonyms are used in place of each nursing assistant, other staff members, and residents. Residents are referred by first names or family names, depending on how they were addressed by the CNA. Hardcopies of interview transcriptions, memos, and field notes were stored in a locked area available only to me. All data were backed up on a USB data storage device kept locked in a different location from the paper-version copies of the transcripts, memos, and field notes. Atlas/ti, a computer-based software program was used to help with storaging, coding, retrieving, and organizing data and text. The two computers that hold these data are also password protected and secured in a locked location with limited access.

*Data analysis*

The theory/method package of grounded theory and symbolic interactionism were used to analyze the data. The characteristics of grounded theory include coding and categorizing, theoretical sampling, the constant comparative method, memo writing, and

theory generation, all of which occur *simultaneously* throughout the whole project (Charmaz, 2000, 2003; Glaser & Strauss, 1967). This study takes a constructivist epistemological approach to grounded theory (Charmaz, 2001, 2006) and employed principles of situational analysis, a recent innovation to supplement grounded theory (Clarke, 2003, 2005). Rather than a focus on individual "voices", situational analyses expands the theoretical view to include the full situation of inquiry.

In this analysis, initial coding categories were developed from line-by-line coding (including "in vivo" codes) that emerged out of early interviews and observations at each site. For example, early in the interview process several coding categories emerged: fitting in, dividing my time, requirements to be an aide, and dirty work. These categories helped modify later interviews and stimulated returning to sites and interviewing selected aides a second time.

I requested second interviews when new themes surfaced either in subsequent interviews or in preliminary data analysis. In one example, after a second aide spoke of becoming a CNA because she wasn't able to care for her parents, I was mystified by this notion and re-interviewed the first one for clarification. Subsequently, I sought consultation from a cultural expert of the aide's ethnicity. Later a focused code became the category "means to repay a debt". In another example, when two male participants designated qualities necessary to work as a CNA, I used theoretical sampling to include males from all three sites for conceptual development about the meanings of being male in a female-dominated occupation and qualities they considered to be requirements to provide good care.

I also returned to the settings and adjusted my sampling plan to compare and contrast categories that emerged over time. When the issue of supplies (which led to the core category "boundary making") surfaced in interviews in the second home, I returned to the first home for further observations and informal interviews. Analytic memos along with situational mappings of this non-human element led me to extend this phenomenon to the variations of boundary making and to the literature on boundary work and boundary making.

Perhaps most importantly, the first interviews high-lighted the importance of dirty work. Although this was a sensitizing concept prior to data collection, the acknowledgement of dirty work, the frequency that aides spontaneously spoke of this, and the intensity and contestations within this discourse pushed me in early, partial memos on dirty work. I considered how research participants thought and felt about a dirty work job, how this changed for them and how these changes came about, and how aides framed this work. Returning to the literature on dirty work helped my understanding how the standpoint of nursing assistants, the particular physical work they do and the larger social worlds they inhabit have indeed connections with other dirty work occupations.

Dirty work as a sensitizing concept was sufficiently broad to allow comparisons and interconnections among aides individually, among aides working at a particular home, and among aides who viewed residents similarly or differently (constructions of the resident's body). This last analysis disrupted my typology. As I tried to place aides individually or by groups in one of three categories, I shortly realized the essential futility of this effort. Although I constructed empirical theoretical categories, people defied

definitive placement in categories, even between or among categories. These attempts ultimately lead me to understand and analyze both dirty work and constructions of residents' bodies as *discourses*. This introduced another grasp of qualitative research and the multiple and overlapping realities of nursing assistants and their work.

# CHAPTER FOUR

## Foundations for Practice: Constructions of Bodies, Constructions of Meaning

This chapter considers how aides construct the bodies of residents, the meanings they assign to their work, and how these two processes shape their hands-on care.
In the pages that follow, I introduce three primary constructions derived from my analysis of the data: “Resident as fictive kin”, “Resident as commodity”, and “Resident as an autonomous person”. Each formulation is linked to discourses, meanings that aides give to bring dignity to their work and mitigate the stigmatizing nature of their job. Finally, I present the particular repertoires of care performances, the enactments of these social constructions that I observed in interviews and field work.

I take up Hughes’ (1971) suggestion to “penetrate more deeply into the personal and social drama of work” and feminist theorists’ regard for the situatedness of women and men. Both support an interpretivist view of the stories and visible work of CNAs.

As these analyses unfolded it became clear that they could be understood within and built on Hughes’ (1971) concepts of dirty work and dignifying rationalizations and Emerson and Pollner’s (1975) theoretical development of dirty work designations. In particular, the latter authors’ presentation of the levels of significance of dirty work, including breaches of moral order, are useful in considering how CNAs view their work and how these perspectives influence their caring practices.

Another concept useful to this analysis is what Lamont (2000) calls “boundary work”. In her study of working class men, she examines how they construct similarities and differences between themselves and other groups to construct a sense of self worth.

Lamont writes that morality is generally at the center of these workers' worlds. Workers, she says, use moral standards to define who they are and why what they do matters, and just as important, who they are not. Similarly, aides perform boundary work to assign meaning and dignity to their lives. I extend Lamont's theory of boundary work with men and class for use with nursing assistants and stigmatized work.

## Sample and Settings

The data for this analysis is derived primarily from in-depth interviews and field observations. In total, I conducted interviews with 30 participants involved in providing care to nursing home residents. Twenty seven interviews and observations were conducted with nursing assistants employed in three nursing homes. In addition, I interviewed three instructors of nursing assistants and informally interviewed two DONs and observed and interviewed another ten CNAs.

All CNAs live and work in northern California and range in age from 24 to 62 years, with a mean age of 41 years. The mean length of employment as an aide is eight years, with a range of 1.5 to 25 years. The racial composition and immigrant status of the group differed from national characteristics. In my sample, all participants were people of color and except for three aides, were first generation immigrants. Nationally, 88.9% of nurse aids working in nursing homes are native born and 56.6% are White, non-Hispanic (Scanlon, 2001). However, my sample more closely reflected the composition of aides in California. More than any other state, California has the highest percentage of foreign-born NAs (Redfoot & Houser, 2005). Between 1980 and 2000, for example, the proportion of aides who were foreign born more than doubled to 45% and almost 90% worked in metropolitan areas (Redfoot & Houser, 2005). Five aides in the study were

male, a somewhat higher percentage than the statewide figure. The aide instructors were White women.

The study was conducted in three locations in northern California. The first nursing home is in a major city. It is a medium-sized facility (148 beds) and part of a national, for-profit chain. The home is a non-descript modern building on a heavily trafficked, four-lane boulevard which bisects the city. The first of three floors was recently refurbished, including improved wheel chair access to an open-air patio. Each floor has a dining room, seating about one-third of the residents. The remaining residents eat in their rooms or lining the halls. Residents are assigned three to a room which leaves little space to maneuver wheelchairs. A high percentage (93%) of residents is supported by Medicaid funds; 81% are ethnic-minorities and most of this group is first-generation immigrants (www.alirts.oshpd.ca.gov). There were twice as many female as male residents, not usual for nursing homes in general.

The second site is the nursing home component (67 beds) of a residential care community. It sits on a quiet, tree-lined street of a small suburban town and blends in with neo Colonial-style homes in the neighborhood. Grounds are well-kept and spacious, dining tables are covered with table cloths and fresh flowers, and residents have private or semi-private rooms. Except for two Asian- American women, the residents at the facility during my study were White and about 30% were men. U.S. Department of Health and Human Services (2006) certifies the home to receive Medicaid and Medicare funds, but 84% of the residents paid from a combination of Medicare and personal funds (www.alirts.oshpd.ca.gov). The home has non-profit status and is affiliated with a Christian denomination.

The third site is located in a medium-sized suburb, just south of a large city. It is certified for 281 beds and is part of a county-government health network (www.medicare.gov/NHcompare). Because this home is licensed by the state as part of an acute care hospital, details such as funding sources, gender mix, and ethnicity are combined with figures of the affiliated acute care hospital. From the street, the home appears as a no-frills cement block, across from a train station and strip shopping malls. Wheelchair access is via an elevator from the basement parking lot. The home is divided into four nursing units, two on each floor. Similar to the for-profit home, the dining rooms are too small for all residents to eat together. Sparsely furnished, two- and three-person rooms line wide hallways. The home has a look and feel of a mini- hospital, with nursing stations, racks of medical charts, and overhead announcements.

A brief discussion of linen and diapers, the basic tools of aide work, gives a closer look at each setting. Several aides in each home spoke about these supplies and how it contributes to day-to-day conditions each shift.

Items were in short supply each day I went to the for-profit home. I watched aides hoarding wash cloths in backroom closets, reusing pillow cases and blankets, and substituting sheets for towels and bed covers for blankets. Sheets and bed covers were often patched and threadbare. I also witnessed a brief quarrel between two aides vying for blankets.

The religious-affiliated setting provided a small cart for each aide. The blankets and spreads were color coordinated. A worker from laundry services stocked and arranged the linen closets several times a day. He also delivered requests for extra

bedding to resident rooms. Cloth diaper covers, not found in the other two settings, came in three sizes.

County aides also had their own cart and supply rooms were stocked regularly. However, when certain items (pillow cases, wash cloths) were unavailable, the day and evening shift aides "borrowed" from the closet set aside for the night shift. One aide said shortage was a recent problem and thought it might be due to a change in the laundry service contract.

In all, the three sites provided a range of variation of nursing aides and residents, nursing home ownership, and working conditions and physical environments.

## Resident as Fictive Kin

### *Constructions of the Resident's Body*

The first formulation, expressed by both female and male CNAs, is the resident as fictive kin (Stack, 1975). The term fictive kin is one form of kin relationship and has been defined as the adoption of non-relatives into kin-like relationships and as an affective relationship over an extended period of time (Ibsen & Klobus, 1972; Muraco, 2006). Both definitions hold for these findings, but vary depending on the aide, the particular resident, and the particular situation.

For this construction, the designated kin term for the resident is usually a parent or grandparent of either gender or a neutral "baby". This latter referent was the most contested of the terms. Some aides were devoted and protective towards a "baby", others were amused and condescending, and a few interacted with "baby" in a disrespectful manner. Kayser-Jones (1981) wrote that staff infantilized residents by "addressing the elderly in casual or familiar terms…such as 'Baby'" (p. 39). In this study the aides

considered “baby” in a nuanced, de-sexualized, and situationally defined discourse. For example, I watched Nita feeding a resident pureed food. My notes say the resident looked patrician and unresponsive, lying immobile with her eyes closed. Nita said “I told them [other aides] Catherine is my baby, the one I feed… I move from that assignment already [but] I come over there and feed her.” Nita was quietly encouraging and eventually the resident ate the entire meal. In this interaction, Nita’s calling the resident her “baby” was also a term of endearment and affection and apparently effective.

A few aides took pleasure in referring to themselves as sons or daughters and linked specific characteristics of residents with their own family members (“I have a cousin like that.”). Others used cultural references of respect, such as “Apo” (aunt in Cantonese) when addressing elderly Chinese residents. While these residents were often not adopted into kin-like relationships, the term nevertheless signified inclusion in a social network. Conceptualizations of residents as fictive kin helped position aides to make sense of who the resident is and how the relationship is enacted.

This construction is also an idealized view, both in renderings of those being cared for and in the affective relationship between the aide and the resident. Barbara said “Oh, they love me. I love them too. They just like family…One family wrote a letter saying how good I was, taking care of their mom… It’s stuff like that. And when I hear that, it makes me feel really good.”

Beyond the family member label, however, aides made distinctions between their “real” parent and the resident “as if he/she were” my parent, and between one’s home and the nursing home, but the aide-resident relationship as surrogate family is woven into their vocabulary. Myra captured a characteristic sentiment of this group by saying “I

don't treat them like a patient. I treat them like they're a member of my family." The ignoble role, the one as a patient, is refuted as temporary and tenuous. She continued "I make them feel at home" and "touch" them like a family member would. In their portrayals, the discourse as fictive kin includes their personal relationship with the resident (and often the person's family) as familiar, comfortable, and enduring.

A familial representation also legitimizes the basis for conceptualizing and rendering care. If the resident is like their parent, performing care is legitimate, justifiable, and based on practical experience. CNAs who frame residents as family members had cared for a parent or grandparent as a child or adult. Some are still caring for a parent, either alone or with help from siblings and extended family.

The family metaphor serves at least four purposes: (a) as a framing device to indicate caring and intimacy, (b) as a means to repay a debt, (c) as a screen to protect oneself against unpleasant tasks and (d) as a foundation for practice.

*Framing Device*

Like some CNAs in Diamond's (1992) ethnography, the words used for family roles help construct the resident. While Helen, who is 45 years old, thinks of some residents as infants ("Like a baby, the situation, almost the same."), Eduardo, who is 30, thinks of his grandparents: "I do. I think of them as my grandparents. That's why I gotta be gentle. They're so fragile. Yeah, I think like that." Hazel is 52, and speaks of residents as parents and grandparents: "We treat them, my friend and I treat them, like they're our parents, our grandparents…with the hugs and kisses and all the love we can lavish on them. We put them to bed with the goodnight kiss."

Another recurrent theme is how aides would want their parent or grandparent cared for. Many used an interpretation of the "golden rule" to mean treating residents as you would like your family member to be treated:

> Barbara: You would want to treat every patient as if they're your parents. That's my philosophy. I treat every patient I have as if they're my mother or father. I know how I want my mother to be treated and I know how I want my father to be treated. And I know I can give them [the resident] the best of care because I really love doing this kind of work.

Most often the aide refers to a resident as the family member. However, the idea of family was occasionally also extended to the resident's family as well as the family of the aide. Hazel brought her sons to the nursing home to "help out" by writing letters for the residents, visiting with them, and bringing their pets. Janet agrees that the reach and responsibility of the aide can extend to the residents family:

> You don't only have to be the CNA to that patient, sometimes you also have to be the CNA to the family too. When you make the family feel comfortable, then they know their parents are getting the best of care. You can't be just, "Oh, that's just the family of the patient." You have to deal with both sides…Once they know you can make them comfortable, they trust you. They know you're doing a good job. They can sleep at night.

Nita illustrates the interconnectedness of her family with the nursing home:

> My mom always says "Just do. Be good to them and you know, they are old" and all those things. Always said that every morning that I go out the door. If not, when we say our prayers. She always says "You bless my kids so they will take

care the old people very good and do the right thing."…We have 3 sisters [working] over here [nursing home].

Hazel, Janet, and Nita speak to other meanings as well. Invoking the public support of residents' families as well as their own helps de-stigmatize the nature of their work and offers dignity to their job.

*Means to Repay a Debt*

A second variant on the fictive kin construction is the resident as a stand-in for a parent for whom they could not provide care. This culturally-derived explanation by a few care workers from the Philippines may stem from the cultural value of a "deep debt of gratitude", *utang na loob* in the Philippine national language. This is a debt towards parents which cannot be repaid (G. Padilla, personal communication, February 2, 2007). Jenny informed me that "I'm very close to my grandparents and then they passed away... I can't give my care to my grandparents. I was just kid that time so I decided…to give my care to the old people that they cannot do by themselves."

Amy, also from the Philippines, told me she wasn't able to care for her parents because she immigrated to the U.S.: "I didn't have a chance to care for my parents so the residents are like my parents. I was here less than one year and my mom passed away. And my dad is paralyzed because a tree fell on him." Later in the interview she revealed how her father abused her mother "physically and psychologically, that's why I hate him. But I understand him because his father didn't treat him well." Her father's behavior, however distasteful, did not diminish the strength of this cultural value to repay her debt towards him.

Despite the depth of Amy's feelings, she preferred rotating among residents rather than a newly implemented permanent assignment of residents. This recent change at her nursing home created a messy debate among the aides. One aide declined to offer an opinion about this but most held strong—and contradicting—thoughts and feelings. Amy, who told me that residents' deaths were "like my mom or dad passed away", evaluated the pros and cons of the two systems and decided that permanent assignments were "not good because residents get attached to you."

*Screen to Protect the Self*

On a daily basis, aides encounter numerous affronts to the self. They work at the "end point" of health care delivery to the institutionalized elderly. Construction of the resident as a member of one's family helps alleviate the moral and social taints which accompany this work. Aides who care for the intimate needs of residents over months and years may realize a sense of self-worth by the active transformation of the resident as fictive kin.

Tran and Helen, like some aides in Diamond's ethnography (1992) and Stacey's (2005) home health workers, use the family metaphor to transform unpleasant aspects of the work to protect the self. Tran says "So I have to help, I have to help them. I don't think I feel dirty. That's why I say, you work and then you think that's your relative, like your mom, like your grandma, you don't feel like…"

> Helen: You need patience. All the time she wants to go to the bathroom. But you get used to it, not all the time like that. You have to understand. Sometimes you get irritated but you have to help them. They're like your family, like my mom.

That's what I think when I feed Betty. At first, they give you a hard time but after they see you everyday...

### *Dignifying Discourses for Fictive Kin*

The constructions of residents as fictive kin draw upon moral grounds to give meaning to a job they acknowledge as stigmatized work. Some aides used the term "dirty work" itself to characterize their work; others allude to it by describing their repugnance and reactions to specific smells, sights, and sounds encountered in their daily work. Nursing assistants in this group take up four repertoires to address the physical, social, and morally tainted nature of the job. These are (a) "calling" to aide work; (b) the motivation of altruism rather than personal or financial gain; (c) the use of boundaries to define their work identities; and (d) directly addressing dirty work as family work.

A sub-group of aides spoke of their work using references to religious beliefs and work is spoken of in quasi-religious terms. Endorsed by several aides, both men and women, being "called" arises from explicit Christian sources or more embedded humanistic traditions. It infers that the individual is doing the work they were intended to do in this life.

Nursing home work, when derived from altruism, is manifested in highly personal ways. While some draw on the principle of the "golden rule" as explanation of their values, others are rewarded by external recognition from others. The reference to altruism supports a view that receiving pay for care tarnishes the meaning of care.

Drawing boundaries, doing boundary work with other staff and other nursing homes, also evokes moral imagery (Lamont, 2000). Like Lamont's working class men, nursing assistants employ boundary work to symbolically locate themselves in a social

hierarchy and articulate self worth. Defining one's position as moral workers—particularly those discounted and unacknowledged--affirms dignity apart from one's low social status.

The last dignifying repertoire directly confronts the notion of dirty work. While acknowledging that aide work is dirty work, this "reality" was reframed by aides to give significance to work (Ashforth & Kreiner, 1999; Hodson, 2001). CNAs claim that dirty work isn't dirty if one is caring for a member of the family. In this way, rejection of the aides' job as dirty was not to reinstate status but to normalize what is perceived as tainted work on others' bodies.

*Like a Calling*

Several aides spoke of their work as a "calling" and others added a religious conviction to care. Caregiving was not simply a matter of completing tasks, it was a moral rendering and a way of being in the world. For these CNAs, to be "called" is deeply felt and embodied "in my heart." It is perhaps not surprising that religious rhetoric enters this discourse on care. One might assume that religious beliefs, such as vows of poverty or silence and doing selfless work, lend themselves to a more giving outlook and help alleviate the low pay and working conditions of a "religious" worker.

Raul is 36 years old and his family lives in Mexico. Being a Jehovah's Witness, he said several times, "saved" him in critical situations, including in his work as a CNA.

> I like work with older people. Before in my country I care for my grandfather. Now I still care for my mother and I think it's not only job for money, you know. Its God bless you when you work like that. I happy with this work. Sometimes it's

hard, but 10 minutes after that and I know I have a lot, ah care. God care me a lot of things. When I driving, I think about [what] I do.

Eduardo came to the U.S. from the Philippines when he was 12 years old. He is now 30 and completed LVN training but has not taken the licensing exam.

It's like my calling or something. I keep thinking about that and why am I here and how come I'm not taking my [LVN] test seriously. If I'm an LVN I'll just be passing meds and I won't be hands on, helping them out….I even got hit a couple times and I just, it doesn't really bother me…'cause I learned, when Jesus got, when Jesus said slap, when you get slapped by the cheek, give them the other cheek. That's the way I am.

*Altruism: "Helping other people"*

The tension between labor and caring, being paid to care, may be difficult to reconcile. For some aides, this is accomplished through helping others while simultaneously recognizing but minimizing the importance of wages. Affection, salaries, and fictive ties are reconciled by the explicit use of altruistic motivations.

Barbara: You know it's not about the money. It's, I like helping other people, that's all. That's my thing, I just like helping other people… When I was about 11 or 12 years old I liked helping other people. That was my dream, in a way.

Lisa also called on selflessness and altruism to provide justifications for work:

What's good about this work? I feel like I'm helping. One way of helping people. So, it's not the…I'm not caring about the salary alone. And sometimes I love to meet some different people too. Different characters. So you are learning.

Stacey (2004) found that the home health workers in her study also used "calling" similar to the findings in this study to confirm a moral authority of care while diminishing monetary compensation. The non-family care providers in her study emphasized their work as altruistic or a response to a larger calling. She proposes that fictive kin ties emerge in response to the stigma that comes from receiving pay for work still normatively expected to be carried out privately, by families.

*Doing Boundary Work*

I broaden Lamont's (2000) theory of boundary work to understand comparisons aides made between themselves and other aides and between themselves and outsiders to the nursing home world. This discourse constructed boundaries based on a set of moral standards, offering a way to maintain dignity in their lives.

*Requirements to be an aide.* CNAs have specific and principled ideas about requirements to be an aide and requisite qualities for caring work. The standards create borders for those inside as well as out. One aide contends that "if you have the heart for this field" the job is not difficult. But, she continues, "the heart or not depends on you."

Of interest are the qualities submitted by male aides. Although a discussion of morality, gender and carework is beyond the scope of this study, male aides considered themselves legitimately positioned to voice proper qualities for careworkers.

> Raul: Not all mens can work CNA. I have a lot of friends working hard, hard and tired, but they can't work CNA. The personality is different. The mens need to have … "limpia mental", no think nervous. Clean thinking about the old ladies …Gentle to the older people, especially to the woman. I know sometimes they like work hard, but I see when his girlfriend or his wife, like machismo, you

know? These people can't work CNA. When you work CNA you need to calm down so everything is gentle.

Eduardo: Only a few can I think do this type of job. People [need to] have patience…None of my [male] friends are in the nursing business. I mean nursing environment. They're all in business or accounting and I don't think they can do this type of thing. Cleaning up and stuff. I don't think they can do that. They get disgusted by it. But for me, it doesn't bother me.

*Shielding my reputation.* Some CNAs actively engage in boundary work to protect themselves from important others knowing about their work. Raul describes his phone conversations with his family: "My wife and my children they still live in Mexico. I don't explain to them because in Mexico it's different. They think I work in a hospital and the older people I take care. That's it."

Field note: While observing Juliet, she says she told her former "colleagues" in the Philippines that she works as a nurse's assistant and takes vital signs. "I don't tell them I do this kind of work" as she changed a resident's diaper. She says she taught chemistry and math in a provincial high school.

*Dirty work is Family Work*

In creating the resident as family, the CNAs without exception spoke of how little intimate care bothered them, even as they acknowledge the "dirty" aspect of their work. The odious part of their job is refuted because the resident is like family. "Some people" according to LiFong, "they think it's a job, too dirty, but for you and for me I know the nurse, what job they do in a hospital." She continues by describing good

nursing care as treating a patient like a family, like taking care of a family member at home.

> Tran echoes connections among dirty work, family and home: Some of my friends, they say “How can you do that? I cannot do that.” I say “I don’t know, I don’t know how can I do that”, right? Because I think, oh ‘that’s my mom, my grandma’ I don’t feel anything. That’s why sometimes I told you its very hard job, with the CNA is a very hard job. But that’s why the CNA works by the heart.

### *Foundations for Practice: Experience, Loyalty, and Fictive Family*

#### *Using the Family Experience*

The family metaphor provides the underpinning for how aides interpret and carry out their work. One practical use is experience with their family of origin to guide their everyday work. Ellie related that she told residents who “talk, talk talk” that she’d leave the room because this tactic worked successfully with her mother: “She’s like that. I learned that from her.”

Broader than the practical and idiosyncratic is the assumption of familiarity. Referring to another person as mother or aunt may presume a quality and intensity of the relationship which the resident may not share. With good intentions, the aide who relies on the “golden rule” principle but is from another culture or generation may not fully be a “member” of the resident’s family. The presumption of a familial relationship may also be supported by the everyday nature of intimate, physical interactions, which over time become routine. I watched residents and aides during diapering and bathing, anticipating the actions of the other. It appeared, at times, that transgressive aspects of cleaning naked

bodies disappeared as attention focused instead to sharing news of the aide's day off or a family member's visit.

*Expressions of Protection*

The construction as fictive kin also evokes a sense of protection and devotion towards residents. Several aides, both male and female, spoke of thinking about their residents while away from the job. This was most prevalent among the aides who had permanent assignments of residents but also for those who rotated assignments every month. These off-duty concerns usually referred to a specific worry about a resident but also included purchasing beauty and hygiene products from their personal funds or bringing clothing for those who needed these items. If a resident had a sudden decline in health, had fallen, or was near death, aides might call co-workers on the job or go early to work to learn about the resident's condition.

> Helen: M. when he's still alive. He don't eat nothing everyday. Only [drink milk] shake, shake, shake. And if I'm home, I said tomorrow is my day off. And then the following day is my day off again. I don't know what's going to happen to him. He don't eat. I was thinking that maybe, close. And then when I came back [to work], I was thinking positive. [RN], she told me that Mr. M was gone. That's too early in the morning. I said "Well, he needs to go because he really suffered a lot of pain". Yeah, we also worry about them. Especially your permanent group, we see them every day.

*Caring as Fictive Family*

CNAs in nursing homes may care for a resident for months or even years. These intimate and prolonged interactions create opportunities for emotionally significant

relationships, and a nursing home is a natural setting to create a family-like world—or perhaps an ideal, imaginary one. The word "home" brings up an image of warmth, comfort, and autonomy, while simultaneously aides and residents live and work in an impersonal institution. Nevertheless, dyads and small groups manage to produce and sustain enduring relationships. Because of this view as fictive kin, aides sometimes grieved for residents like they would a family member.

> Mila: We have this patient. She died like 5 years ago. She's a Filipina lady. I love that patient and I get in touch with her every afternoon. Even if I'm at home she calls me. And every time I come to work she always have something for me. Like if there's a hard boiled egg from the kitchen she save it for me. That's why when she died, it's really… I didn't even come to work for how many days because I feel bad, even if passing her room… And every time I go there until now it remembers me. I still miss her. We have the same birthday…She's been here I think 4 years. Yeah, 4 years.

Two institutional rules were broken in this telling: the resident broke a well-known rule by keeping perishable food in her room and the aide broke another by accepting food provided by the nursing home and intended for residents. However, the meaning the egg represented was love and intimacy and Mila retained this memory for five years.

Some aides establish a special tie with residents who have no biological family or close ties with someone in the community. Neal spoke about a woman he was especially drawn to, saying "Her life is hard. She tries because she's a polio victim. She can't stand. She's got no one."

> Gloria, and several other CNAs, spoke about Martha: Sometimes ah, you've been close to your residents…You treat them as your family. You don't want them to, something happen to them. I'm close to Martha because you know, Martha doesn't have family and she's blind. Before she has a conservator [who] comes here, but now no more. She doesn't have anybody… Well, we're going to take care of Martha.

Finally, CNAs make use of family framing to put tasks "into a social relation to carry them off" (Diamond, 1999, p. 164). These could be distasteful duties, such as cleaning bodily discharges, or attempts to engender cooperation from a resident. Embedding an act into some kind of personal context makes some tasks easier, more palatable and understandable for the CNA: "I think they're just my mom. When my mom sick I try to feed like that. At least you eat!"

## Resident as Commodity

### *Constructions of the Resident's Body*

A second construction of the resident's body is as a commodity, a work object, and care is defined as a job (Casper, 1998). Unlike the first view of the resident as fictive kin, this one minimizes care as an intimate relationship and foregrounds caregiving as employment. The resident as commodity is constructed by (a) categorizing bodies; (b) dividing minutes; and (c) emphasizing appearance of the resident.

In this view, the resident-as-commodity is the object of work, time is bounded, and the appearance of the resident matters at the end of the day. CNAs are constrained by delegated duties. They are hemmed in by time. The subject of wages enters this discourse

of work. The rendering of this construction includes categorizing work objects, time is defined as “dividing minutes”, while the appearance of the resident is a salient concern.

In 1961 Erving Goffman described “The staff world” of total institutions:

> Within this context, perhaps the first thing to say about the staff is that their work, and hence their world, have uniquely to do with people. This *people-work* [emphasis in original] is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people.
>
> As material upon which to work, people can take on somewhat the same characteristics as inanimate objects (Goffman, 1961, p. 74).

Nursing homes and mental institutions may both be seen as total institutions and the people within them as objects. Mila reported “I prefer to have bed ridden [residents]. Even if you give me 20 patient bed ridden, not alert patient, I’ll get that 20 patient. Compared to 10 alert, 20 bed ridden, I’ll get the 20…. At least this one [bed ridden residents] if you do their care, that’s it.”

Mila preferred incapacitated residents because “alert patients” are “demanding”, “complain” and can’t be satisfied or kept neat. In other words, they disrupt a normal work routine, much like the “floor staff” at Murray Manor, who become “fed up” when anything interfered with a normal work routine (Gubrium, 1975, pg. 124). “Alert” residents, those deemed mentally aware by aides, may be a code word for entitled or obnoxious and therefore more likely to hamper the smooth production of work.

> Gloria: Well, you have to divide your time. You have to do the first, first I have to, I have my routine already. I know where to start, who to get up first. If Martha is combative I have to leave her… [let her] stay in bed and do some other residents.

The "routine" revolves around institutional parameters such as resident mealtimes, staff break times and "shower days". Each resident has a shower scheduled twice a week, designated by bed location. This routine is the aide's as well as that of the resident. However, unlike the routines of the "family" construction, the resident fits into the aide's schedule rather than the aide responding to the individual's needs or wishes. A well-organized shift is created when the aide moves from bed to bed and room to room, smoothly and without interruptions. For the aide, the consequences of this approach are control, structure, and predictability. The resident becomes just a component of the overall task, rather than the reason for doing it.

McLean (2006) speculates that residents who receive such care may be seen as "getting in the way" of the task. Gloria: "Like 12A. I cannot do my work if it started like that. If she [resident]…get up from the merry walker and go around, walking by herself, then it's hard for me." Gloria tells me that when this resident doesn't sleep well at night, she's awake during the day, becoming disoriented and agitated, "and you have 8 residents to do." Situated in a world of institutional requirements, in a job rather than a calling, and lacking clinical or educational support, Gloria recognizes the causes of the resident's behavior but is unable to address it effectively and, instead, views it as an impediment to task completion.

*Categorizing bodies*

Each resident fits into a customary "routine" and aides "know" each resident. The process of "knowing" involves seeing a resident's behavior, associating it with another resident's, and responding as if it was identical. This shortcut makes work more efficient. "Knowing" a new resident may occur after one or two shifts. The common descriptor, "She's like that" indicates to the observer that the resident's behavior is understood and unchanging: residents may be nameless bed numbers:

> Jenny: It takes me just one day [to know a resident]. Like 3B?, yeah, like 3B, she's like every time, every 5 minutes she has to use the bathroom, so I think oh, she's like this. So I think, oh, she's just like that.

Each resident/work object is a "good patient" or a "difficult patient" and within each category, the resident becomes a "like that." "Like that" is short hand, sometimes with a dismissive quality, for a particular way of being. A resident frequently wants to be taken to the bathroom: "She's like that". A resident frequently complains of pain: "She's like that."

Field note: I accompany Dipna as she takes a tray to Ruth, who calls me over and wants to talk: she says has no appetite and would like corn flakes and the aides don't answer her call light. She asks me to open her blinds. Dipna has left. Ruth's roommate wants to know her surgeon's name, says she's in pain and wants her cold feet covered. I later ask Dipna to whom she reports complaints of pain: "Just ignore her. She's just confused--if you listen you'll never get your work done. She just like that."

This short hand manner of speaking, phrases "like that" and use of bed numbers to refer to residents has been called "strategically stylized" speech (Burke, as cited in Oe, 1996, p. 134). In cases where a background of mutual understanding exists, this sort of

abbreviated conversation is useful to save time and effort. The difference and the problem in these circumstances is the dismissive nature of its use. It also wards off possibilities of other understandings and actions.

*Dividing Minutes*

Experienced aides advise novices to organize themselves and efficiently "divide minutes" to finish their work. Even aides with long work histories recall their first months of work feeling "rushed", "tense" and "slow". They remember "not even having time for breaks", losing weight, and imagining call bells in their sleep. But most were able, as one said, "…as time goes by, the days goes by, you just know how to manage your time." Managing time for some includes teamwork to make work more efficient. Some aides were clear about who were long-standing members of their team, co-workers who willingly offered and shared work.

> Jenny: [You must] figure out who's the first one [to care for], who's the second one, yeah and then I have to divide my time until 11 o'clock because at 11 o'clock we're going to have our lunch, so before 11 I have to finish those 8 patients. So I have to divide my minutes, yeah.

Aides are not only responsible for the hands-on care for residents but also "other assigned tasks", often the final item in job descriptions. These "related duties" further erode available time. One such duty is wheeling residents to an authorized smoking area, waiting while they finish a cigarette, and wheeling them back to the unit. With time a constant backdrop, aides devise a methodical, exacting schedule that cares for residents room by room and bed by bed. Each resident is accounted for and efficiency is insured. Short cuts may be necessary to keep a schedule intact, completing physical tasks but

leaving little room for emotional care. Supply shortages as well as “working short” (sick calls or other absences not filled by administrators) add to this view of residents and work.

Field notes: Juliet tells me she doesn’t use soap because patients get a shower on Mondays and Thursdays. Not rinsing saves time, she says. She pours water between Mrs. Tong’s legs to clean her perineal area.

Roadblocks, uncooperative residents in particular, may derail a carefully orchestrated shift. Slow-moving, agitated or intrusive residents “waste time” in a schedule that includes set meal times, activity times, and medication times. Residents who are impatient are characterized as “demanding” and who get in the way of timely completion are “frustrating” to some aides. Managing residents with recalcitrant bodies, with physical disabilities or who are cognitively unable to adhere to an established schedule, is deeply troublesome. On the other hand, one could take pride in the efficiency of one’s work:

Field notes: The shift starts at 6: 38 a.m. I arrive at 7:45 a.m. and Dipna tells me she’s finished care to 4 of her 7 residents. Of the remaining three, she says, one bed is empty, 1 is tube fed (Doris), and 1 refused to get up (Ken). Dipna says she’s “fast” and repeats that several times to me during the shift. Because she’s fast, she says she answers other aides’ call lights. After breakfast, she showers Doris who has advanced Parkinson’s and is aphasic. Doris will stay in the lounge chair the remainder of her shift (and probably until the next morning, according to Dipna). Dipna turns on the TV but doesn’t give Doris her glasses. There is no verbal communication between Dipna and Doris the entire shift.

*Appearance matters*

Perhaps because the resident is viewed as a commodity, the aides in this group value appearance, which becomes a quality control standard. Most could describe their criteria although they were not always able to achieve this. In my observations, all aides took some time to attend to residents' outward dress. Dipna, who otherwise took pride in efficiency, took time to blow dry a resident's hair; Jean, who told me she "really didn't like" her job was able to engage with a man who disliked changing his clothes. Another described her earlier, inexperienced days wanting residents to look attractive and so skipped breaks to dress her residents "properly."

Appearance may be how a resident looks (combed hair, jewelry, matching outfit) or it may be the appearance of attentive care. Mouth care, which is not readily visible, can be more easily ignored than having a resident dressed and out of bed. The audience for appearance differed from aide to aide and resident to resident. Some CNAs were particularly mindful of families they viewed as having exacting standards. One aide mused aloud about putting a sweater on a resident (daughter's wishes) on a very warm day (not "making sense" to her). The resident herself was non-committal.

Mila describes her standard of good care:

> I can tell if they [aide on previous shift] do their job. As far as I smell… they didn't do a good job…Did you see the patient earlier, when you start [at] 3 o 'clock? Did you see the blanket and everything? Now you do your rounds on that side. Because for me, I want the, if you see me tuck [the blanket and sheets] I want it nice and straight to my patient. That's what I do. I want them, if possible, they don't move in that blanket. Nice and neat.

*Dignifying Discourses for Commodity Group*

The discourses presented by "commodity" aides help reframe their location as stigmatized workers to give meaning to their work. Dirty work for these CNAs is redefined in four distinct ways to give legitimacy and dignity to their work:

1. dirty work is part of the job contract

2. jobs are plentiful ("in- demand") so I am doing work that is needed

3. I am doing this work for my children, not myself

4. boundaries are created to circumvent stigmatizing aspects of the job

These repertoires make room for assistants to justify higher wages. Two aides are union shop stewards and others have interest in labor union activities. One steward says she is "lucky" to earn the higher county government wages. The other says higher pay is the only part of her job (at $11.60 per hour) that needs changing. She says CNAs should be paid what those in acute care hospitals earn, which she says is $16-$17. Identical training, certification testing, and annual re-certification are required for employment in nursing homes and acute care hospitals. Several study participants have work experience in acute care settings and argue that work in nursing homes is more difficult and justifies equal compensation. All agree hospital work is easier since it usually entails responsibility for one patient, but say it is "boring" compared to nursing homes. Natty described her feelings about doing "sitter" work in a hospital:

LF: So being a sitter means?

Natty: One on one. Confused patients. You have to stay with them like that. Especially if there's too many tubes, they usually give sitter because if they just came from the operating, they're confused.

LF: What's that like for you?

Natty: It's boring though. It's boring. It's better to work in the nursing home.

*Dirty Work is Part of the Job*

Aides acknowledge the presence of unsavory, repugnant aspects of their work but accept these as part of the job. The daily routine is organized around repetitive and predictable tasks. Diaper "check and changes" is a prominent marker in the segmented work day. However unpleasant, it is the aides' responsibility to keep leaking bodies clean and dry and note the regularity of residents' bowels. As one aide put it: "Although you don't like it, it's already there. You will gonna do it. It's your job." In Twigg's (2000a) study of the elderly living in the community, most of the homecare workers also accepted that dealing with human waste is part of the job. They used a variety of coping techniques, including internalizing their feelings and avoiding direct language, such as distraction and humor.

Dirty work of course is more than the physical aspects of bed and body work. In a hierarchy of disgust, workers reported that verbal and physical abuse by residents was more disturbing than hands-on care. Spitting, swearing, and hitting were mentioned, as were overt and coded sexual comments. Although one young aide excused overtures made by male residents with cognitive deficits, another was repulsed and angry that she and other aides were subjected for years to sexual requests from "alert" male residents: "Specially when he will have a shower, he plays. And then he's gonna say, he's telling [female CNAs] 'Stroke me, stroke me.' I don't know, it's not good for us too."

Similar to aides in Foner's (1994a) ethnography, the significance lay in a differentiation between confused and alert residents. But because patients' rights were interpreted by many to be inviolable, aides felt they were placed in a position of silence

and acquiescence. “They [management] know about this” and Mila felt helpless to react: “I’m stressed with him [but] we cannot do anything. We have to handle him.”

A prominent training textbook for aides gives little guidance for managing unwanted sexual behaviors of residents and instead focuses on the physiology of the reproductive system (Sorrentino, 1996). Of interest is that while Mila has taken up one suggestion in this textbook by bringing the issue of sexual behavior to a supervisor’s attention, she asserts that management ignored this, reinforcing the status quo. From Mila’s standpoint, it appears that both management and written texts find ways to disregard the concerns of aides while escaping further responsibility, and distress remains with the everyday care of this resident.

*Being “In Demand”*

Many CNAs in this group use the term “in demand” to explain their attraction to aide work: “It’s easy to get money because this kind of job is very in demand. The other jobs, they’re going to lay you off. There’s a lot of people who’s getting older, so it’s easy to find a job.” Jenny’s quote above captures important features about elder care, economic insecurity by job outsourcing, and the expanding aging population in the U.S. She experienced these forces, coming to CNA work after being laid off from her factory job and a position in residential care that did not provide medical benefits. Many the immigrants in this study send money to extended families in their country of origin. Some also retain homes and land “back home” which are further incentives and burdens to multiple jobs.

Lamont (2000) writes that “…work is the only means workers have to achieve upward mobility measured by material acquisitions” (p. 26). Family responsibilities,

education, and current skills hold little promise for getting another job with higher salaries. Most, therefore, rely on using "free" time to work toward a better life. Except for three study participants (two of whom care for parents), all have second or third jobs or regularly work overtime shifts. One also takes in boarders, another uses her cosmetology license, and two cook and sell food of their home country. May, a single mother, works for a private client during the day and works an evening shift as a CNA. Benefits for this type of private work include "pay you under the table…don't have to pay taxes, and most of the time the private patients paying more than here. $15 or $16 per hour. But here they only pay $12 or $13. So it's big money."

Although the preponderance of study participants has other jobs, the aides who view the resident as a commodity spoke about this in more detail. Without probing, I heard how they weighed the amount of earnings with work schedules, family life, and the nature of the second or third jobs. Usually, the second job was less physically demanding or involved other, more enjoyable skills such as cooking or hair dressing. Other considerations were jobs with flexible hours or and located close enough to the first job to be able to get to work at the second one on time.

*Working for the Children*

A third theme voiced by a sub-group of aides was an emphasis that CNA work was done exclusively for their children: "That's what I said. It's for my children's sake. I'm always telling my children you have to be good because if it's for our sake only, we're satisfied with the Philippines. I would not do this kind of job." Gloria, who has three jobs and her husband has two, told me that her daughter plans to attend LVN training after high school ("I told her that first, before RN").

Jean also said she does aide work because of her daughter and grandson. She dislikes her work but believes she has limited options. She has a nursing degree from her country of origin but has no interest in pursuing a nursing license here.

> I have a daughter but she said "No, this is my home. I grew up in America. If you like to go home, you go home." That's what she told me and that's why I stay here. Because she's only 19, but maybe when, when at the age of 23, 25 if I see she will be stable, maybe I'll go home someday. I will go home.

*Doing Boundary work*

Nursing assistants who construct residents-as-commodity employ a variety of tactics and reinterpretations of their job to articulate self worth. Aides in this group use humor and protective barriers to gain distance and relieve stress from unpleasant details and numbing routines of work.

*Humor and barriers.* Aides use humor to manage visceral aspects of their job. Gloria said "the smell of the poo" was most revolting for her. "And if it's loose, my god. I can make icing. Icing for the cake--chocolate cake!" Natty answered my question about how she describes her job to others:

> CNA? Well, a Certified Nursing Assistant. PAW. My work is PAW…Professional ass washer. Yeah. Giving a bath, cutting their nails. Everything. Do everything.

Practical barriers are used to manage encounters with substances that most of us attempt to avoid but are delegated to the realm of aide work. Although mandates for infection control have made gloves and masks a pervasive presence in nursing homes, neither controls tell-tale smells permeating the air. Consequently nurses and aides alike

use barriers to help ward off the sensory unpleasantness of dirty work. Jenny said when residents with dementia throw "BM" (bowel movement) at each other, she takes particular care to "look over before we step our feet. Then we have to wear a gown, a disposable gown to protect ourselves".

Occasionally, humor combines with practical barriers to relieve objectionable smells. Tran told me:

> We have one resident she have a BM 2 or 3 times a day. The smell is so strong. It's like in the hallway. Even though we use the spray, it couldn't go. So we use the popcorn, you know. You go there and open the bag and then it's gone. The smell is gone right away… I told them after that I cannot eat popcorn!

*Boundaries above.* The resident-as-commodity group constructs boundaries that extend up the nursing hierarchy. By defining themselves as committed and hardworking, CNAs reverse the usual ranking system to claim only they are qualified to do dirty work. Ellie contends that although it's "hard to explain" the job of a CNA, when residents need help "to go to the bathroom, to assist the residents, the nurse they can't do that."

Mila agrees that aides, not nurses, provide essential care in the nursing home. Confirmatory evidence comes not only from her belief but from those who are authorized to know, the family: "Some people say without CNA, nurses cannot do this job. Nurses cannot clean poo poo… That's why they say 'Without you guys, my mom cannot be like this.' That's the comment they're giving me sometimes, the family. Yes, they appreciate us."

*Foundations for practice: Routinizing work, Techniques, Prioritizing tasks*

*Routinizing work*

Depending on the nursing home and work hours, aides are assigned 7-18 residents. Each CNA must complete a list of duties within an 8-hour shift, including bathing, continence care, meal times, and transferring residents from beds and wheelchairs. These duties are listed in job descriptions in all three nursing homes as "essential" to the job.

The commodity body is given care that elevates the physical body over emotional relationships with residents. Everyday work leaves little room for spontaneity. Work is described as a series of instrumental tasks: "Our job is to take diaper out [of the room], not housekeeper. [Our] job is to put clothing in the basket. When shower day, change beddings, give bed baths three times a week, change diaper 3, 4 times a shift: change in morning, check at 10 [o'clock] or 11, change after lunch, then put [the resident] to bed, check diaper after that." Commonly known as the "check and change", May has a well-ordered schedule: "I do rounds. I make sure everyone is still alive. Then I put them back to bed, then change their diaper. Then I'm done and wait for the [dinner] trays."

Tony is a 37-year old Filipino who became interested in CNA training while a janitor in this nursing home. The following is a field note from the evening shift. At 3:30 p.m., Tony went methodically from room to room and bed to bed, folding back blankets and sheets and replacing draw sheets. He transferred Mrs. Chan to the bed and changed her gown before he changed her diaper. We went to the next room. Mr. Earl tells Tony he's wet and wants to be changed but Tony finished making up the first 2 beds in the room before changing him.

This assembly line approach brought another, more disquieting, incident to the surface. In her plan to move from room to room and bed to bed, Jean created a confrontation that might have been avoided: Field notes: Jean tells Mr. Sheldon its time

for his shower. He says “I just had breakfast” and she again says he needs one. “My supervisor is here” and motions me to join her. “I don’t care who you call, I just had breakfast!” The RN enters, stands by the door and says “Come on Mr. Sheldon…” RN says to Jean: “Give him a time.” Jean says to Mr. Sheldon: “How long? Ten minutes?” Mr. Sheldon doesn’t answer. RN says “I’ll call [the DON]. Mr. Sheldon: “I don’t give a damn who you call.”

This goes back and forth several times while Jean returns breakfast trays to the cart. The RN says to me “They’re just like kids.” Jean takes a banana from Mr. Sheldon’s neighbor and gives it to Mr. Sheldon. “Ready, Mr. Sheldon?” He doesn’t answer. Jean moves to Mr. Sheldon’s neighbor and gives him a bed bath.

*Managing Residents: Techniques and Good Body Mechanics*

In the discourse of commodity, CNAs manage residents through “techniques” and good body mechanics. “Techniques” describes both physical and psychological interventions and assumed to be commonly understood. Several CNAs engaged in social conversation with residents (“being nice”) as a vehicle to gain the resident’s cooperation. Tony tells me “If you’re not nice to the patients, they are angry with you. So if you talk nicely, they nice to you because, you know, they are already like baby now. They are like a baby, right?” Tony consciously re-ordered some elderly residents as a baby, making them innocent but able to be controlled. By doing so, Tony’s meaning was not the resident as fictive kin but rather had a patronizing tone.

Techniques also included physical actions. Some were universal expectations, such as the agility to operate mechanical lifts. Other techniques referred to specific residents, developed over time, such as how best to dress and shave a man with an

idiosyncratic movement disorder. A third type, “precautions”, applies to behavior considered dangerous to staff. Jenny, with a little over six weeks of training, was sanctioned by her peers and supervisors to call on stock interventions for immediate use. Employing standardized precautions helps make work simpler and more predictable.

> Jenny: The lady… every time I pass her, she go like that [makes scratching motions]. She kick me and scratch me and spit. Every time I put her to her bed I need somebody to help me. I can’t do it by myself...
>
> LF: What do you do when that happens?
>
> Jenny: Oh, I just gonna call somebody “Can you help me?” Because she’s spitting me and you know what? We just have to put some towel in here [puts hand over mouth] so she won’t spit. And if she spit, it’s just in the towel.
>
> LF: What about scratching? What can you do about that?
>
> Jenny: Oh we have precautions. We have to alert [other staff] every time we put them to bed, yeah. We have precautions, to protect [us].

Good body mechanics, on the other hand, has a narrower definition, and Jenny did not minimize its priority: “Body mechanics, the right way first, myself first, because I’m still young and then they’re old”. CNAs use their own bodies daily, to lift, push, and pull. Mechanical lifts, when available, were often difficult to maneuver in the crowded rooms in two field sites. Some female aides, older or less fit, called male CNAs for help with lifting and pulling residents. Although the musculoskeletal injury rate for nursing assistants is one of the highest of any occupational group in the U.S. (SEIU, 1997), none of the aides commented about reviewing their practice in CNA training or the on-going in-services.

*Prioritizing tasks*

More experienced CNAs prioritize tasks in the day-to-day. In their interviews, aides reached back to their early, inexperienced days. Organizing and prioritizing work, they said, is critical in a job with limited time and set reqirements. Some elements were assumed priorities, such as having residents dressed and ready for medical appointments.

> Natty: As long as you have a good routine or you are organized. See, you have to be organized. You have to know your priorities. For example, if [the resident has] an appointment you have to do this, the first one. You have to have your priorities like that. Routine.

However, performing human care while doing shift work can impose a toll on aides. As Carol discloses, prioritizing tasks can elicit feelings from relief and exasperation to frustration and apprehension:

> Carol: There are residents that just ..can't…wait. They not only use the call light, they will call your name. Like 17A. If I don't answer her, she'll just call my name over and over and over until I answer her. I tell them "Just wait, just give me a few minutes" but they say "I want this now, I want this now." And you have another resident "I want this now too!" So, what can I do? I just have to finish what I started. But if somebody like 1A, I really have to go to 1A or else she's gonna fall and if she falls it's gonna be my fault. Especially with that alarm. Once that alarm starts beep, beep, beep I have to check and make sure she's OK.

## Resident as Autonomous Person

*Constructions of the Body*

The third, and last construction created by nursing assistants is the resident as an autonomous person. The aides in this group construct the resident as more than a body. This resident (a) embodies personhood; (b) participates in a relationship of reciprocity and mutuality with the CNA; and (c) has dignity and individuality. Tran's affirmation of personhood is disclosed:

> I have one resident, he only drink a milk shake. He didn't eat anything… so I come by and put a small spoon in his mouth and then I touch him. He never say anything since I started to work. He come and drink the milk and go back to his room...I just massage, massage and touching and he drink everyday. He keep drinking but he just stay in bed, total care, and then one day, I don't know. When I'm touching him, he hold my hand, he hold back, and then oh, maybe he understand. Maybe he want to say something to me but he cannot. Then the next day when I come to work, I know he passed away last night, the night before.

Although the resident is regarded as an autonomous person, with intentionality and purpose, autonomy as understood by these CNAs was usually "unidimensional, overly simplified, and taken-for-granted", using broadly-drawn words such as privacy or independence to describe how they viewed and interacted with residents (Barker, Mitteness, & Wolfsen, 1994). However, there were occasions when CNAs spoke of and enacted autonomy in more nuanced ways.

Collopy (1988 as cited in Barker, 1994) untangles the complicated concept of autonomy specifically for long-term care. Barker notes that autonomy is not fixed but flexible and multivalent and difficult to parse. It also may be taken-for-granted as the opposite of dependence, rather than a form of coercion. In looking more carefully at this concept, Collopy identifies six aspects or "polarities" of autonomy, some of which are potentially at odds with one another. These polarities are tensions between decisional versus executional autonomy, direct versus delegated, competent versus incapacitated, authentic versus inauthentic, immediate versus long-range, and positive versus negative autonomy.

Of the six aspects, CNAs spoke of and demonstrated decisional versus executional autonomy. Decisional autonomy is defined as being able to decide what to do or not do while executional autonomy is the ability to perform or carry out those decisions. Aides affirmed the decisional aspect of the polarity by giving, even encouraging, residents to make decisions, albeit relatively modest ones ("What do you want to wear today?"). Executional autonomy was less certain; for example, the desire to smoke a cigarette (decisional autonomy) may be delayed or negated if the resident is dependent on a CNA to wheel him out to a smoking area (executional autonomy).

A second aspect of autonomy is the polarity of direct and delegated autonomy, that is, making decisions for oneself (direct) versus one giving to another the right to make or execute decisions. For most aides, extending delegated autonomy was a limited one. Although aides often offered choices to residents, they were limited decisions rather than global ones. Delegated decisions were partial ones and arose around specific issues, such as when to get out of or return to bed, or when to shower. However, direct autonomy

occurred, for example, when a CNA gave a wash cloth to a resident to wash herself or set up shaving equipment for a man to shave himself.

Despite evidence that autonomy, as problematized by Collopy, was not uniformly nor universally supported, in general residents had a unique history, identity, and ways in the world. Aides told me of a resident who was a "Harvey girl" or lead a "bohemian" life, and one related how she located a resident's family members who were absent for decades. They affirmed residents' emotions as legitimate and confirmed this intellect as well as the corporeal body. The construction was also expressed in relational terms: "Sometimes they just want to talk…all they want you to do is listen to them." Barbara recognized the moral duty in cultivating this confidence: "I'm not just asking people about their business and then having them talk to me about it and walk out of the room and just don't care."

In this construction, residents were accorded dignity as an individual rather than as a person vis-à-vis a relationship, such as a family member. As such, this discourse of bodies provides meaning for carework and instructs person-centered actions. Eduardo said his job was to "just make the residents happy, 'cause that's what we're here for, them." Personhood, dignity, and reciprocity and mutuality figure in this construction of the resident as an autonomous person.

*Having Personhood*

For these aides, the resident is regarded from a humanistic approach, retaining a personhood despite a loss of cognition and reason. A person has a unique identity and is capable of and engaged in a relationship that endures over time. Amy has cared for some residents for six years: "The patients even know my voice. Joann is blind. She's so

confused now but Joann recognize my voice. That's my Joanne." Another CNA spoke of a resident: "I still remember one patient, she have the contracture. When I feeding her it's hard for her to swallow but I give her small, small [spoonfuls]. She didn't talk but the way she see me, the way she look at me, I think she understand."

In her quote below, Sylvia reflects Collopy's idea of authentic autonomy when she constructs the resident as having social recognition and intrinsic worth. Moreover, she alludes to arguments about personhood of the elderly and articulates a more enduring concept rather than one that relies on traits, such as cognition, which may be transitory (McLean, 2007).

> You know, some people say "I want to be a nurse", but no take care of old people. I say it's exactly the same… I know persons who deliver the baby and they make poo poo and you have to clean. When they take the baby out they have a lot of blood, so I say I don't see any difference. Some people say, oh, how you work with older people, you don't feel? I say its people like me. And I don't do them whatever I don't like somebody do to me or to my family.

McLean's (2007) ethnography of two approaches to dementia care emphasizes the relational aspect of personhood as well as agency and will. Care, she says, is "intersubjective; it is a mutual relationship and ongoing negotiation that involves both caregiver and receiver" (p. 198).

> Carol: I think even though [a] resident doesn't talk… in a certain way you communicate with her through touch. She knows you even though she doesn't tell you that…They don't talk but you feel attached to them. I feel that working with

them everyday it's like she's, they're being a part of you. If you really like your job, it will show. It will show the way you interact with your residents.

*Creating Reciprocity and Mutuality*

With a construction as personhood, there is possibility of reciprocity and mutuality in the aide-resident relationship. The resident has potential and promise to participate in the social world. There can be benefit in each other's company. One aide emphasized that she declined a potentially more lucrative job to have time with "the elders—they're so cute" and also to improve her English. She added that later, "When I work with them, I think they lonely or something. When you try to talk to them they try, you know, and we help each other." Another adds learning to reciprocity: "They (resident) teach you a lot and you teach them a lot. Just don't give up. They teach you to hang in there as long as you can."

If the resident is cognitively intact, there is a give-and-take that involves both parties in negotiation. One aide based her effort on the resident's acceptance that the aide has other residents to care for. Ellie explains:

> My Alice? She really likes me because every time she's depressed, I talk to her and she says "Oh, you are so good. You relieve my problems."…I say "That's a part of my job." You know, before she goes to surgery for her foot, she wants me to go with her to the hospital. I said "No, I cannot do that because I have seven [residents]. You are not the only one I am taking care of."

Ellie concluded her portrayal by saying that while Alice was in surgery she fixed Alice's bedroom the "way she likes it" but also to anticipate the impairments foot surgery would bring. Since reciprocity and mutuality invites the duality of intimacy and distance,

a titration of closeness and detachment, it is possible that Ellie and Alice have established a balance that suits them both.

*Dignity and Individuality*

> Neil: But everybody, I treat them differently, every patient. I treat them in their individual way. I don't think that if somebody has dementia, they are the same [as others with dementia]. People are like that, right? Everybody is different.

According to this construction, individuals do not lose personhood because they are in a nursing home, in a wheelchair, or cannot speak. They maintain their fundamental worth and individuality. "Every one of mine is different, so with this one…" The aide discerns who the person is and what each one wants or needs. Interaction, through shaping and re-shaping cues, is possible whether someone has Alzheimer's or is unconscious:

> Raul: Sometimes people have Alzheimer no remember their son, no remember their wife or no remember their husband. But if you give good, good care, they remember you all the time. Maybe no remember your name but you talk to them and they see your face, you know they remember you. That feels good.
>
> Tran: Some of them they unconscious. They don't know anything, like total care, but when you work with them everyday, everyday you feel like they're talking, right? Sometime I talk to her. I say "hello" even though she don't say anything every day… I say "Are you OK?, OK!" … At least they know your face, that's something.

It is possible that this manner of engaging arises from a reflection of one's own mortal being, a "humble admission of [one's] own vulnerability in the universe"

(McLean, 2007, p. 203). Manny spoke of this: “When I start working waiter [in assisted living], I’m thinking about my grandma. The old people’s like that and I’m going to be tomorrow like that. You’re thinking lot of things in your mind…”

### *Dignifying Discourses*

As with other constructions, CNAs in this group use a variety of explanations to provide meaning to their work. These aides, who regard nursing home residents as individuals, reformulate dirty work as (a) offering altruistic intentions for work, (b) opportunities for learning and career advancement (“stepping stone”), and (c) “better than” valuations.

Like the family construction group, the rhetoric of nursing assistants reference moral grounds to attach legitimacy to work. “I like to help” and “I’m not doing it for the money” appear as altruistic explanations for their work.

#### *Altruism: “I feel like I’m helping”*

As in the fictive kin construction, aides in this group acknowledged the stigmatized nature of their job and invoked altruism to transform their work. Pay for work is deemphasized and helping others, feeling needed and other intrinsic rewards of their work are brought to the fore. Jenny challenged and rejected the denigrating label of CNA as externally defined:

> Some others they’re putting you down because you’re just slaving, and the boss just commanding you. That’s the other people. I meet people like that. “She’s just only slaving”, I say “I don’t care if I’m just slaving as long as my job”…I’m happy because I’m helping other people. Yeah, there are some people like that, talking with them. Mostly. Mostly people think that.

According to many aides, appreciation and recognition for their work is a powerful mediator for a stigmatized occupation. They point to thank you notes and cards from families prominently displayed at nursing stations and recall the food from families "not only for me but for all the staff". CNAs make recognition public and invited me for Chinese snacks that a son brings for them each week. Visible acknowledgement, when coupled with an unexpected expression of validation, is particularly touching:

> Carol: Just like this morning. Ruth? She doesn't want to get up. I try to cheer her up, and then on the way to the dining room she hugged me real tight, "Oh, oh you're so nice!" (Carol's eyes well up) I'm crying! And then Maria [another aide] saw us. Oh yeah, she hugged me! It feels good, they appreciate it. Certain things, little pieces of touch, hug you, say thank you, yeah little things.

Foner (1994a) notes that aides in her study "valued, above all, …patients who expressed an interest in and cared about them as people" (p. 50). Few aides in this study commented on this, perhaps because so many residents were cognitively impaired and unable to engage in this level of interaction. However, they found this appreciation from family members, through written notes, occasional verbal acknowledgement, and sharing food and other gifts.

*Stepping Stone*

A subset of aides spoke of their position as a stepping stone up the nursing hierarchy. They volunteered their "dream" and "hope" for continuing education. Some asked for information on training programs and financing. Myra, who is 30 years old, said "I know that I have a future in the nursing field. I think this is a stepping stone to become an LVN, and after that, an R.N. That's why I decided to become a CNA." Of

note is only one of the seven interested in further education spoke of directly entering a registered nursing program. The remaining have plans similar to Myra and Manny: "…go to the higher state. LVN, from LVN to RN, from RN to, you know? I like to learn. That's my target".

It is perhaps not surprising that with hurdles of other jobs and responsibilities of family care that none of the CNAs knew of others who directly entered RN education. But they did know of co-workers who had completed nursing school in their country of birth but failed licensing exams in the U.S. One of the reasons is English proficiency, part of the licensing process. In the 2000 census, 12% of nurse aides reported that they could not speak English or that they could not speak it well (Redfoot & Houser, 2005).

The rhetoric of dreaming and hoping allows aides to share their ambivalence of the possibility of changing identities. One aide said she wanted to be a nurse in order to wear a "white uniform", but others concurred with Myra who deflected her personal ambition ("I believe I have a future, not for myself, for my family, too."). Many included hesitation and uncertainty ("I'm planning to go back to school. I don't know if I can make it but I try my best to go to school."). Sylvia minimized the difference a nursing license would have for her work:

> The only difference [between an aide and LVN]. I don't know. I want to work with children. And labor. That's one of the thing that I really want. When the mom delivers the baby. That's what I want to do… I have plans already. Maybe I cannot make them, but I hope I will make next year. I planning to stay here like two years to get more practice with the medicine. You know my English is not good.

*Doing Dirty Work is Being Human*

This group's construction arises from their perspective that everyone has a body and everyone's body needs care and attention. Bodily needs are normal, natural ways of being and occasionally "accidents" occur. Washing bodies, lifting bodies, turning bodies—these practices are the everyday of work. Hazel: "I don't think about it anymore. It's just something I do. It's like breathing now. You do it, you do it, you do it, you keep doing it... I don't think I really, from the very first time, I never really thought about it. It was just something I did. And it just seemed natural."

Field notes: The resident going to dialysis has a BM just prior to being transported. He is embarrassed and apologies. Amy responds: "No one can tell when accidents strike" and asks the ambulance drivers to wait while she changes his diaper.

*Doing Boundary Work*

This group erects borders between their selves as individuals and others, and between their nursing home and other homes. Positioned in a job that possesses little social recognition, boundary work can help elevate their status as an aide on a personal level. Several said that they were asked to orient newly hired workers, while others cited awards from their institution for good care. Occasionally, CNAs were assigned to residents because of a family's request or because the resident had difficulty with another aide. This last type of recognition was not emphasized in interviews, since special assignments reside outside the norm and imply criticism of another aide. Some boundaries were public and enduring while others, such as being asked by a director of

nursing to evaluate a head nurse, were more uncertain and hidden and fraught with potential perils.

Additionally, aides construct "their" home as better than others by marking dissimilarities between their place of employment and other settings. Depending on where the aide worked, the evaluation included cleanliness and sanitation ("bird feces in the other place"), problem residents ("homeless persons", morbidly obese) and sufficient supplies and equipment. Other workplaces, outside the home turf, are dismissed as "a dump", smelly and unclean, inhabited by disfigured persons and uncaring staff.

Helen: The other [nursing home]. My job, oh my goodness. I think everybody…

LF: Everybody?

Helen: Yeah, heel, big sore. That's why I told you. The bone is...the bone is showing…jeez, the smell.

Helen prefaced her story by saying that now, at "her" home, the aides check residents' skin everyday. "If there's a redness [on the skin], we report right away. The nurse will come put something, so the following day, gone, no more. We don't wait until it get worse. It's very good here because the treatment nurse is very good."

Boundary work with other employees is delineated by the quality of work and commitment to a strict work ethic. Eduardo said

I'm… not thinking about them [residents] 24/7 but sometimes I do. I sleep early just to wake up early to plan ahead what I'm going to do tomorrow…Everyday is a different day cause we have different showers so I'm thinking ahead who should I do first…They [other aides] say it's not too stressful but I think it's stressful. They say the RNs have more stress than we do but I think it's the same.

Eduardo's stance on work ethics extends "up" the organizational hierarchy as well as across to other CNAs: "I call in sick once in a while but I feel bad when some people keep calling in sick and nothing happens...I don't know if they're really sick or have emergencies. Sometimes they have other jobs. I think they [management] should be little tougher…"

The work quality of other aides was a common demarcation. Throughout interviews and observations, aides focused my attention to lapses in care by others. Sylvia showed me an inch-wide open area on Mr. Wong's shoulder which occurred because "I was on one week vacation." Evidence of shoddy care, attributed to a generalized Other, was said to appear after an aide was away from work, and longer absences created more serious concerns. Letty informed me that if she had not been on vacation, the resident's difficult-to-treat skin condition would not have returned. Missing items of clothing, neglected hygiene, and abraded skin and new bruises confirmed inattention towards "my patient." Implicit boundary work constructed the gulf between themselves (as competent) and others (not so) while the condition of the resident and her living space verified this conclusion.

> Ellie: You gonna react because you've been very organized before your day off, fix everything…And then you check them. There's a bruise. You have to react, you have to report. The others say "Oh, did you report that? I didn't see that". You have to check everything after your day off, because there's a lot of changes. That's why before I start my job, I check. Yeah, like Virginia…she fell down last night.

Before time off, aides are particularly attentive to maintaining surveillance over residents and reporting problems. Aides understood that not reporting a resident's "change of condition" to a nurse could result in a disciplinary action, so were mindful of this directive. Field notes: Sylvia looked at his feet and wasn't happy because his skin was dry. "I wasn't here yesterday. Today is my last day" She's off for two days so tells me she checks her patients' skin well and reports it to the nurse. She found an open area on his back and called the nurse who cleaned and covered it.

Other critiques were not bound to formal consequences but were sufficiently troublesome to fall outside the border of acceptable care. Raul reflected on mealtimes and aides who say residents "refuse" their meals rather than feeding residents:

> The resident can't go to the refrigerator to look for food after they hungry. You have to try. The CNA have to try and sometimes it's hard but usually I try. If no drink, no eat, I have to [try] drinks or go to milk shake or Ensure... But not everybody do that. Some CNAs say "Just refuse." [But] after that, if the patient hungry, [there's] no more food. The kitchen is closed.

Boundaries concerning rules were extended "upwards" towards licensed staff as well as across with co-workers. Sometimes CNAs were reluctant to designate those "above". In this case, giving medication to residents is, by law, the responsibility of licensed nurses and not that of aides. This practice was not always followed. The CNAs knew this, but challenging a supervisor would be difficult.

Field notes: Lisa is feeding Mr. Kelly. He's a hospice patient and never opened his eyes. The LVN came in, squirted a dropper of meds in his mouth, and when Lisa told her he didn't like them, left the liquid and other meds for her to give him. Lisa managed

to give them all by figuring out the best medication-food combination and talked about this process. She commented that the LVN shouldn't leave the meds for an aide to administer.

Manny produced another boundary "up" issue, spoken about and negotiated variously by other aides. Gastric tubes, surgically inserted in residents who could no longer safely swallow, are often in place for months—or years, becoming a taken-for-granted object to both resident and aide. Connecting and disconnecting tubes is not within the aides' purview but is a simple procedure which interferes with work flow. Some aides ignore the stricture and proceed with their work (How did you learn? "The nurse taught me. It's easy"), while others, like Manny, chafe at this restriction:

> The nurses they do it. G.T. Feeders. [disconnect gastric feeding tubes]…When I want to give him shower, I have a problem to disconnect. I know how to disconnect it, but I don't have permission to do it. And I have to ask the nurse and [wait] about 15-20 minutes with him… If I did it in the course, how to disconnect it, it's good for me. I took him to the shower. When I come back, I connect it. You need more education for the CNA in order be easy, their job.

*Foundations for practice: Knowing, Independence, Deep attention*

The resident is central to the work of these CNAs, not because someone is considered a family member or because their presence provides a job. The relationship exists because everyone grows old and some older people need more care than they are capable giving to themselves. Since residents may no longer be able to attend to their own needs, one task for the aide is to find out what the person would do and how they would do it if they could care for themselves.

*Knowing*

"Knowing" accommodates a social acknowledgement, an intellectual understanding and a visceral comprehension that evolves through a mutually shared history. Unlike the aides in the resident-as-commodity group who report knowing a resident in a few days, these aides declare that knowing unfolds over several weeks. It begins with recognizing that the resident may be fearful, angry or in pain the first days in the nursing home.

> Helen: The new residents. I think they are not used to stay here the first time. They don't want you to do something to them… "Get away from here, I want to be alone." And then later on, everyday we see, we take care of them. They understand that we're here for, here to help. And then, the following day again it will be changed. LOTS of changes everyday, everyday. But if you will be patience to them, the more they're gonna love you, the more they will like you. And that's the technique for taking care of them.

For residents who do not speak English, or speak at all, aides become intimately attuned with facial and body expressions. They "use sign language, check them, inspect them, get their vital signs because maybe they're in pain." A surveillance process may accompany the social act.

Field notes: Mrs. Yang, an immigrant from China, has her eyes open but otherwise looks unresponsive. Letty says softly, "I'll clean your face, Mrs. Yang; I'll clean your back." Letty tells me "When she pees she's crying so she needs to be changed." Mrs. Yang has most teeth and as Letty cleans her mouth, I smell a foul odor. "I told the dentist last month, but I don't know…"

Sylvia: With James, for example. Him he have aphagia. He's not able to speak…But I know him for long time, so I know his routine. I know he always get excited because he wants to talk and he can't… He's alert but he just wants the thing quickly. I say OK, listen to me and relax. I have to guess and show things to him or tell him [and] he says yes or not.

The process of intimate knowing includes interacting in such a way which allows choices, an aspect of autonomy. Decisions may be simple and mundane, preferences for one or two sugars or the timing of a shower. Such preferences, however, take on increasing importance in a diminishing social world. But giving choices is not absolute and aides recognize that resident decisions, usually "refusals", may be detrimental to the resident's well-being. For example, some aides understand that depression or anxiety may underlie a poor appetite or refusing to get out of bed. The discourse surrounding choices ranges widely and includes the limits of choices. In speaking about a resident who lacked interest in eating, an aide mulled over the definition of "resident's rights" and whether rights were unconditional. What choices are proffered and to whom, under what conditions, how choices are presented, when options are withdrawn, and the consequences of refusing negotiation are some of the issues directly addressed or spoken obliquely in care giving among these CNAs.

Sometimes residents do not easily accede to care. In these situations CNAs may request the intervention of a nurse. They may use their knowledge of the resident to perform bodily care they consider necessary. In this way, aides have some autonomy to perform care that others would, and could, avoid. Aides creating this construction feel an ethical imperative to persist, giving them purpose to their work.

Carol: First of all you have to maintain their dignity. Give them choices. You don't "Oh, this is what I want you to do" but no, you always ask them…Its part of privacy, but most of all, especially those people who still can interact, give them choices. Would you like this, would you like that?…Then if they don't, you cannot force them…There are certain residents that don't like showers but you have to talk to the nurse… They'll be the ones. There are ways to convince them.

Raul: I try different ways to convince. Sometimes I lie, like "You have doctor appointment today" or "Your son called me yesterday and he said "You have to shower." Sometimes I have to lie because all the time she refused. I check the ADLs and no have shower 2 weeks, 3 weeks, so I try.

For some aides, one of the complications of personhood, "knowing", and reciprocity may be theorized by Hochschild's (1983) concept of emotional labor, defined as work that "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others" (p.7). In the discourse of emotions and knowing residents, one CNA stated as taken-for-granted that "being professional" includes showing positive emotions ("smile even if you have a personal problem"). Others were troubled, conceding that "it's hard to control your emotions" but "They [management] told us don't involve your emotion because that's your resident…that's the rule, but you cannot avoid too. How can you do that if you're very close to your resident?" Another agreed "You know what they say. [They say] you can't be too close to your patient, but I can't help it. You can't help but get close to 'em."

Since many spoke of attachment to those they cared for, "becoming a part of you", the feeling rule was particularly distressing when residents were dying.

> Hazel: When their [family's] loved ones die, I become my most uncomfortable because they're crying and distraught and so upset and what do you say? And I know what I'm taught to say but I can't say it because it's not what I believe [going to a better place].

> Raul: Sometimes the family's nice. They go to the nursing station and talking about [their] mom or father and say thank you everyone for good care ... I like it when people think like that because it's true. Sometimes the people have 99, 92 [years old], 10 years with the cancer, a lot of pain. It's good, resting, let her go. But sometimes the family's no want to accept. Sometimes the resident's family complain for everything. We try to do the best care. We can't do nothing after, you know.

*According Deep Attention*

Work of the CNA is simultaneously private and public. Concealed from the casual observer, "inside work" is performed in private spaces. Aides are taught in training and in-services to maintain these spaces as a resident's right, the right to privacy. Curtains are drawn, doors are closed, and sheets are placed over naked bodies. Deep attention is very often invisible work that can be purposefully or inadvertently hidden. Public work is the realization of acts in private spaces.

Manny describes his job as situated in two places:

> Take them [residents] to the activities, push the [wheel]chairs. The people they saw you from outside, they come, they don't have idea about nursing assistant. They think your job is pushing the chair and feeding in the dining room. They don't know about inside.

Aides who construct residents as persons confer deep attention to inside work. It is attention to detail that is simultaneously universal and specific to the individual. In this interaction, Pushpa considers the comfort of Mrs. Singh's small, older body. She told me this resident "loves a shower".

Field notes: Before taking Mrs. Singh to the shower, Pushpa changes the bedding. She says she does this because residents are still wet after a shower and might get cold waiting. Pushpa points to the statue of Krishna at the bedside. She says she suggested to the resident's son that he bring some religious music and yesterday, he brought a CD player. She says if he didn't, she would have bought a "cheap one" because Mrs. Singh has nothing to do during the day.

Showers do not perform the same function of baths (Twigg, 2000). They do not warm the whole body in the ways that a hot bath could, and contain a sense that something is done to you. Residents sit in a "shower chair", dependent upon the actions of an attendant. An aide who hands a wash cloth or shower spray to a resident weighs the value of time lost against preserving independence for the person. Without a bath tub in the nursing home, Pushpa offers what she can.

Time is an ever present concern to provide attentive care. For some aides, there is sufficient time but extra duties, particularly new ones like waitressing and bussing tables, are considered extraneous to direct care work. Those CNAs who take issue with "other

duties as assigned" in job descriptions say they make their distress known to management. Others who need more time for residents forego or shorten scheduled break times, thereby preserving their own ethic of care.

(Fisher, 1990) and Tronto (1993) outline three areas of caregiving that are central to an ethics of care grounded on relational values. First is attentiveness to the needs of the other; second are questions related to autonomy and authority; and third, the problems of competence and responsibility which arise out of the particularity of caring for another. The discourse of CNAs who constructed the autonomous person affirmed these values of caregiving. They are also aware of constraints to act fully on these values, requiring them, as Fisher and Tronto assert, to make judgments about needs, especially conflicting needs.

> Lisa: I want... to care for my residents, but I feel bad because sometimes I don't have enough time. Sometimes that's difficult for me to finish. Some of my residents they are slow moving, so I have to be so fast. If I give her a shower I spend 30 to 45 minutes, so there's no time for the others. I have three guys to shave everyday. Sometimes I cannot do it. We have small paperwork to fill out too.

*Preserving and Promoting Independence*

Independence is coupled with and dependent upon knowing the resident through passages of time and deep attention to details of the embodied self. In other words, the CNA acknowledges personhood in the moment and the possibilities of being in the world.

Preserving and promoting independence may be enacted into practice by readying space for residents to care for the self. Aides encourage residents to do their own self-care, simply giving a resident a washcloth or fork and spoon or having a resident stretch their

arms to maintain flexibility. Such activities are more time consuming for the aides than doing it for a resident and reveal how dignity is played out.

Acts of self-reliance are most often transitory and commonplace but not necessarily:

> Sylvia: I feel so good one time…His name was Tony. He don't know how to do the wheelchair, so I teach him…I teach that resident to do that. Later on he do very good, 'cause he had dementia and…he improve a lot. When he come to us he was total, total care. He was kind of combative, but I training him to walk to the bathroom…He stand up, and I teach a lot of things and he went to a ...How you call a house? Board and care. I teach him good so he was able to do that.

## Conclusion

This study focused on the personal care component of the everyday work on nursing assistants in order to further our understanding of how their construction of the bodies of those for whom they care informed and shaped their approach to their work. Three primary constructs were derived from intensive interviews and participant observations: Resident as fictive kin, Resident as commodity, and Resident as an autonomous person. These three constructs illustrate a more complicated, less essentialized portrayal of nursing assistants than in some previous work. For example, while Gubrium (1995) critiqued the standpoint he used in Murray Manor (1975) as narrow and partial, he nevertheless drew a generalized portrait of "floor staff" as assembly-line workers. In addition, foregrounding dirty work as a complement to these constructions allowed me to examine another influence on caring practice, that of how members of a stigmatized job give meaning to their work. Others, mainly but not

exclusively in the field of work and occupations, have investigated how people find dignity in work (Ashforth & Kreiner, 1999; Chiappetta-Swanson, 2005; Lamont, 2000). This project builds on but extends this broad work with a specific focus on the scholarship of Emerson & Pollner (1975) and Lamont.

The significance of both processes contributes to a fuller understanding of the influences of CNA caring practices. The next chapter will discuss these findings in the context of implications and further research.

# CHAPTER FIVE: DISCUSSION

## The Body/Work Nexus: The Work of Nursing Assistants in Nursing Homes

In this chapter, I present a review of findings as well as address potential implications for nursing research and practice. I first revisit the questions and concepts raised in Chapter One. Next, I discuss my findings with particular emphasis on how they extend and complement or not, existing understandings in nursing aide work. I discuss the methodological implications of the study, paying particular attention to study design and the limits of the findings. I conclude by identifying directions for future research and practice.

In the first chapter, I raised broad research questions about how nursing assistants give meaning to their work and how they go about performing care. The project proposed two areas for investigation: how nursing assistants construct the bodies of nursing home residents and how these shape day-to-day practice. In answering these questions, sensitizing concepts alerted me to attend to issues of gender and cultural values, and in particular, the concept of dirty work. To broaden the study and examine the discourse of bodywork from "official sites", I briefly attended aide training classes and reviewed the content of text books and job descriptions. Ultimately, these initial questions, the sensitizing concepts, and examination of CNA training, text books, and job expectations proved useful and valid frameworks to guide a study of the caregiver experience.

This analysis is a grounded account of the central finding of this dissertation: the practice of everyday work is influenced by how nursing assistants construct the resident and how they assign meaning to a stigmatized job. This project provides a glimpse of the

complex nature of nursing home aides, those they care for, and meanings of work. The findings, while validating previous work, expand and broaden our current understandings of nursing aide work. This data-based interpretation will be discussed in the context of previous literature which complements and facilitates understandings of this analysis.

## Discussion of Findings

### *Constructions of the Body*

The three constructions of residents that evolved from the current study are dominant discourses that emerged from the data. Although some aides tended to espouse one view of residents rather than another, most tacked back and forth among all three. These views were situationally determined. That is, representations were not generated by the CNA alone but colored by details such as time and place and mediated through larger cultural understandings.

Each construction was found variously in the literature but not addressed in ways that always understand their relationship to practice or meanings of work. Whether CNAs are represented uni-dimensionally or as complicated, contradictory, and complex workers, current studies do not directly link how residents are regarded with enactment of the CNA's job. Thus, while several studies richly describe aspects of the aide-resident relationship and structural, cultural, and ethical influences on care, they do not explicitly couple these findings with practice nor do they specifically tie stigma and dirty work to the work of nursing assistants (Foner, 1994; Diamond, 1992; Laird, 1979; Savishinsky, 1991; Shield, 1988).

The concept of fictive kin is found in several studies. References range from a brief note using fictive kin as a "trick" to make unpleasant work less so (Diamond, 1992)

to a fuller treatment of "family images" by Foner (1994a, 1994b). In most of these studies aides regularly referred to residents as fictive kin but the researchers made little attempt to discuss the influence of these perceptions on practice. One exception is Bowers (2000) who linked aides who spoke of residents "like family" providing individualized care in a way that allowed residents to maintain their sense of competence and dignity.

A recent study in two diverse nursing homes asked the question of fictive kin from another standpoint, that of family noninvolvement (Jervis, 2006). Jervis found that metaphoric kinship relationships between staff and residents existed and compensated somewhat from the aide's perspective for perceived absence of residents' families. In my study, a subset of aides took particular note of residents without families, reassuring me and demonstrating that they provided extra attention to residents who were "alone". These findings suggest that additional research is warranted to explore the potential protective care that CNAs may take on when dealing with persons without families. This is in contrast to the impression that persons without families receive poorer quality care. Some questions related to this issue include what conditions promote and hinder this relationship, under what circumstances does this occur, and how is care affected.

There also are extensive references to the idea of resident as an object, but like that of fictive kin, these are infrequently coupled with practice or with how CNAs find meaning in their work. Erving Goffman (1961) guides us to the possibilities of nursing homes as total institutions and patients as "products and objects" of work. Others who see evidence of an assembly-line approach write of nursing home residents who are cared for in a pre-planned predictable order (Chambliss, 1996; Lee-Treweek, 1997); aides who are authoritarian and indifferent (Kayser-Jones, 1981); or head nurses who emphasize

custodial care, safety, and medical attention (McLean, 2007). The assembly line metaphor has also been extended to psychiatric patients who were "sorted, held, and then disposed of" (Rhodes, 1991, p. 8).

In contrast, McLean (2007) wrote a detailed account of an aide who regards the resident as an autonomous person. In that ethnography she describes how this aide thinks about and conducts her work with residents with behavioral disturbances of Alzheimer's dementia. Similarly, Foner (1994a, 1994b) regards aides neither as "saints nor monsters" and presented one aide as consistently gentle and affectionate. Except for brief descriptions in other studies, this construction of residents is not a popular representation. Perhaps as with Tellis-Nayak & Tellis-Nayak (1989) and some others, a binary, universalizing description is a simpler and more dramatic portrayal. Data from the current study suggest that a broader range of CNAs view residents as autonomous individuals with rights and act accordingly. These findings also suggest that having such role models could potentially influence the climate of care.

*Dignifying Discourses*

Hughes' (1971) notion that workers seek dignity and meaning in stigmatized jobs was a powerful theoretical construct supported in this study. Aides acknowledged the stigma attached their work but managed it by interpreting and narrating their work through a cultural and moral lens. The discourses in turn were enacted in care relationships and work practices, what Emerson and Pollner (1975) proposed and presented in their extension of Hughes' initial work.

Nursing assistants in this study endorsed the belief that what they did was considered dirty work. However, they produced a myriad of ways to create pride, dignity,

and hope in their job. CNAs employed divergent, but dignifying discourses to refute a negative self-image, a view reinforced by people they encountered or a generalized "other". Although the enactment of meaning-making for stigmatized work has been investigated for several occupations, research on issues of job satisfaction and turnover, prominent in nursing home literature, has not explored the effect of this discourse on job tenure (Atchison, 1998; Burgio, Fisher, Fairchild, Scilley, & Hardin, 2004; Castle, 2005; Castle, Engberg, Anderson, & Men, 2007; Denton, Zeytinoglu, Davies, & Lian, 2002; Mercer, 1993; GAO, 2001). While some aides in this study did support conventionally regarded reasons for turnover and job satisfaction, others held more uniquely situated reasons for commitment to their work.

In this study, morality played a prominent role in affirming the dignity of CNAs independent of their relatively low social and organizational status. The orientation to residents as fictive kin and autonomous persons confirmed altruism and a calling to care work. Because of this dominant cultural frame, aides sought ways to downplay pecuniary interests in favor of altruistic motives (Stacey, 2005; Solari, 2006). Existing social mores suggest that receiving pay for care sullies or profanes the meaning of care.

This rhetoric is not without contestation. In their discourse, some aides voiced that aide work is "in demand" and called for better compensation for their work. They note that doing dirty work was part of their job and felt insufficiently rewarded for performing their duties. They were able to foreground pecuniary interests by comparing themselves to hospital-based CNAs who were paid more, had "boring" jobs, and shouldered less responsibility for care. Thus, aides made moral justification for better pay to compensate

fairly and justly for jobs equal in training and more burdensome than the work of hospital aides.

Another prominent discourse was taking a higher ground of sacrifice. These CNAs said they immigrated to America to give their children a better life and were doing work that would be beneath them in their home country. In professing to take a job only for their children's sake, these aides declare a kind of moral distance from the stigmatizing aspects of this work. This social context promotes and sustains the moral logic of work. Performing dirty work for others (their children, for others' parents and grandparents) provides moral justification. These individuals employed a unique cultural standpoint to interpret and justify their actions.

Related to sacrifice but also drawing on other culturally defined values, the precept that a "debt which can never be repaid" to one's parents weaves duty, obligation, and family ties. This deeply held belief pulls some to CNA work as well as provides a morally defensible reason for selecting and remaining in a dirty work job. Aides who cited this rationale for work most often could not care for their own parents or grandparents, either because they were too young to do so or because they immigrated to the U.S. without their extended family. Thus, this culturally produced imperative was fulfilled by caring for others' parents and grandparents.

The aides' discourses not only exposed moral language but also revealed how the use of "boundary work" enabled them—however they might define residents' bodies—to manage their poor social standing. The concept of "boundary work" was developed by Lamont (2000) in her study to examine how white and black working men created social categories to construct a sense of self worth. The working class men in her study

constructed moral boundaries between themselves and others, both above (professionals) and below (the dependent poor) their social and economic class. Lamont referred to this process of differentiation as “boundary work.”

Nursing assistants also created boundaries in their dignifying discourses. Instead of primarily doing boundary work in a larger social world, however, aides created categories within the nursing home. These included manufacturing borders between themselves and other aides (“across”) or with those above them in the nursing hierarchy. This is unlike Lamont’s (2000) project wherein the working men created boundaries both above and below. One possibility for the lack of a “lower” reference is that a class “below” in a nursing home may be housekeepers and food workers. They are paid less and are often literally located in a basement. Since several aides entered CNA work through these routes, the distance may be too recent and too close. Moreover, there are few shared duties in the jobs of aides and support staff, providing minimal opportunity for boundary making.

The two primary boundaries that CNAs created were with other aides and nurses “up” the hierarchy. They measured themselves favorably against other aides by presenting themselves as conscientious and hard working, discovering and making public others’ lapses in care, and being able to “handle” difficult residents. Aides use these and similarly themed discourses to distinguish themselves against other aides, deriving purpose and satisfaction from their work. Place of birth also enters this border arena, in comments about others who “speak good English but they still don’t like the work.”

My findings support Lamont’s (2000) formulation that workers in the working class create moral boundaries to dissociate socioeconomic status from moral worth. The

boundary work that nursing assistants create "across" to co-workers extends this analysis, allowing similarly situated workers to claim moral superiority over others.

Nursing assistants also referenced those "above" them in the organizational hierarchy. They employed two formulations to define jurisdictional boundaries as well as situate themselves vis-à-vis their superiors in the nursing home hierarchy. The first formulation conceived nurses as unable to do CNA work, a reversal of the usual sorting of rank. Declaring that nurses can't—or won't—do basic nursing care, the aides privilege their moral position above those higher in rank. The second allusion to nurses "above" is work delegated to aides but not in their legal purview. As some expert aides in Hartig's (1998) study, some CNAs performed tasks not in their scope of legal practice but judged the nurses as violating moral norms. While these sets of discursive practices led to differing ways of performing and experiencing carework, they also allowed workers to distance themselves from being categorized as stigmatized dirty workers.

*Practice: What it is and Where it Comes From*

In my analysis I argue that foundations for practice are constructed from aides' orientations towards the body and from discourses which dignify their work. Practice in turn is embedded in larger social worlds and aides draw from cultural resources. One of these cultural influences is a universal emphasis on instrumental tasks in CNA training. The curricula for classroom training, text books, and certification exams prioritize physical needs and requirements of bodywork. Photos on WEB instructional sites depict aides in scrubs and stethoscopes, linking the aide to the "medical" rather than a home. One of the best-selling text books for nursing assistants devotes 16 out of 779 pages to the resident as a person (Sorrentino, 1996). The remaining chapters include topics such as

cleanliness and skin care, bowel elimination, and bed making. Similarly, the certification exam for aides consists of 40 hands-on skills, such as positioning residents in bed and mouth care for an unconscious resident.

Aide training also privileges physical care. In two days observing community college classes, I watched aides cleaning dentures (taken from and returned to a cabinet, rather than a person), giving bed baths to mannequins, and making beds, all tasks included in their certification exam. The instructors cautioned students that they would see CNAs "taking short cuts" in their clinical experience the following day but otherwise did not prepare them for differences between the classroom and a nursing home. In a state government-mandated training limit of 150 hours, the goal of CNA training is passing the certification exam.

Aide-resident interactions are nominally shaped by job descriptions. All three nursing home job descriptions reiterated the skills learned in training and ended the list of required tasks with "other duties as required." However, in the end, aides discounted written texts. When I asked CNAs about performance evaluations, responses were vague and written evaluations were uniformly disregarded as unimportant. What mattered most were the personalized comments, notes, and small gifts from residents, their families, and other staff. Thus, social actions and dominant discourses arose from the aides themselves and played up situated knowledges learned and reproduced in the nursing home. Specific knowledge, most salient to their work, was from *doing* work rather than extracted from official texts. Their practice was local, pragmatic, and personal.

*Influence of Settings*

Although situationally determined, dignifying discourses are not generated by individual actors alone, but larger cultural understandings created and reinforced these at a meso level. As I have just discussed, institutional forces include the reach and authority of physical care in the aide-resident relationship. Another influence shaping discursive practice is the nursing home setting itself.

Beyond the similarities of government licensure and regulations, two aspects of the nursing home industry stand out as influencing constructions of the body and care practices. The first is money—how much, who controls it, how decisions are made and disputed--the commodification of care. The second is reflected in the intangible feel, the "climate" of the home.

In these three nursing home settings, the effects of money spilled over to resources and beyond. Medicaid insured residents, such as those living in the for-profit home, provide lower reimbursement for care than private insurance or rates required from personal funds. Payment structures were one contribution to fewer, or more resources, services, amenities in the environment, and staffing ratios. Several CNAs at the non-profit setting made positive comparisons of the quality of "their" resources and residents. Indeed, some residents were quite debilitated but I saw no one with behavioral disturbances. Most residents were "alert", and aides in all homes said they preferred to care for individuals they could engage in a satisfying relationship.

The second institutional influence on care practices may be seen in the micro-interactions between staff and residents. Bound in space and time, aides were subject to workplace rules, assigned to a group of residents, and presented with tools of their trade. These elements of work shaped discourse. The construction of the resident as commodity,

for example, may be seen as a response to institutional expectations of heightened work capacity as proof of good performance. “Categorizing bodies” and “dividing minutes” while perhaps impersonal and mechanistic, was also a point of pride for some aides. Efficiency was a challenge and those who were, claimed a special talent.

*Men, Gender, and Caring*

Because women are overrepresented in paid carework, few studies compare the way women and men perform and experience paid caring labor (Solari, 2006). The participant sample of this project also reflects this gender difference, with five male aides and 22 women. In their discourses, a sub-set of men presented a gendered notion of care that opposes one of the dominant cultural views of masculinity.

Conceptually, there are “multiple masculinities” and one prevailing frame has been termed “hegemonic” in which men are expected to be independent, agentic, assertive, and task oriented (Connell, 2005). This concept is contested and these male CNAs resisted this particular view. They presented instead “feminine” qualities that male aides should possess and, conversely, characteristics of men unsuitable for aide work. Renegotiated standards for males include gentleness, attention to emotional needs, and a “clean mind” especially towards women. Clear borders separated those who meet these criteria and those who don’t. According to these men, work habits such as working long hours or holding professional positions are not sufficient to meet requisite criteria. In this discourse, boundary work “across” rests on moral standards. Personal values and work ethics are critical, such as “thinking about residents 24/7” and insuring that residents eat well at mealtimes.

Other male CNAs invoked conflicting discourses on masculinity. One expression was the belief that their greater physical strength gave them advantage in their work, confirmed in other studies of direct care workers (Williams, 1989 as cited in Solari, 2006). These men spoke of being asked by female aides to help them perform heavy physical tasks and said they were able to work quicker and more independently because of their strength.

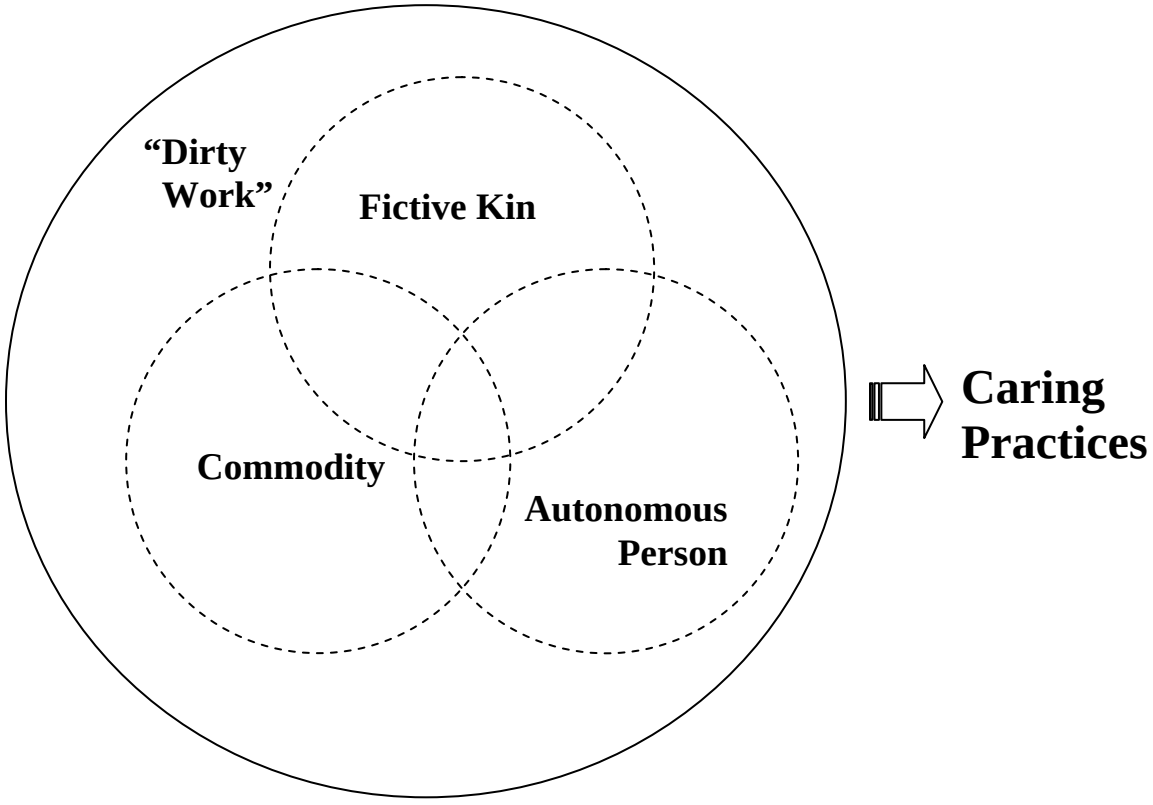
The men in Twigg's (2000) study of homecare workers in England provide contrast to these findings. Only one male study participant, unlike most men in Twigg's ethnography, was interested in becoming a licensed nurse. Twigg also notes that the men were confronted by issues of sexuality. They were conscious of working in a female-dominated occupation and reasoned that was the cause of their low public status. The second gender-based issue concerned the cultural assumptions that since this is women's work, men who do it must be effeminate and therefore gay. Because the British men were only assigned to care for male clients, some had to endure the homophobia of male clients, or at least from male anxieties about intimate care by another man.

It is possible that the notions male aides offered as qualities of ideal CNAs were actually the characteristics of men who were attracted to personal carework. Certainly, the three who worked in non-care jobs in nursing homes before training in aide work were able to witness for themselves what the job entailed. It is not to say that steady work, opportunities for overtime pay, and career advancement do not figure into the meanings of work. Rather, two men who actively negotiated dominant notions of masculinity, like a subset in Solari's (2006) study, argued that carework is a Christian calling. However,

with the small number of men in this study, these findings may be provocative but are less certain.

The three constructions of residents' bodies have, thus far, been presented as separate and distinct categories. However, the typologies are in fact *discourses* rather than linked to individual or groups of nursing assistants. The model below, with intersecting and dotted circles, illustrates the overlapping and porous boundaries of these constructions. In addition to the reinterpretations of "dirty work", examples of other influences on these discourses are the invisibility of aide work, staffing ratios, nursing home mission and values, and state and federal regulations.

Discourses of Constructions, "Dirty Work" and Caring Practices



## Methodological Limitations

This study takes as its focus the examination of nursing assistants working in nursing homes. Methodologically, the project design may be limited by three factors: selection and number of nursing homes; number, composition, and recruitment of aides; and sources of data. The first limitation is selection of nursing homes to one geographic area of the country. However, the three sites represent the three major types of U.S. nursing homes. They not only include the most common types (for-profit, non-profit, and government operated), but vary in size from 67 to 281 beds and are located in urban and suburban areas in three state counties. These characteristics provided a range of settings and in the end, a variation of field experience.

The second factor concerns the sample participants who were aides. The group does not reflect the demographic characteristics of the country's aide workforce. Nationally, about 70% of nursing aides are white and about one-quarter is African-American. Over 85% are native born (GAO, 2001; Yamada, 2002) In contrast, all my participants were people of color and except for three African-American women, were also immigrants. On the other hand, California has the highest percentage of foreign-born NAs and almost 90% work in metropolitan areas (Redfoot & Houser, 2005). In the few studies which note the ethnic/racial backgrounds of CNAs conducted in urban areas, the aides were also immigrants and people of color (Berdes & Eckert, 2001, Diamond, 1992; Foner, 1994a; Jervis, 2002; Mercer, 1993; Twigg, 2000). It is likely that the urban-rural

location is an important determinant for features of race and country of birth of nursing assistants.

The second possible limitation regarding aides is that more conscientious, ideal caregivers might have been over-sampled. My recruiting procedure, which was limited to aides approaching me at the sites or by aide-referral (snow-balling), may have attracted CNAs who wanted their practice made public and talk about their work. Time in the field may have compensated for this, allowing me to observe and speak informally with a variety of aides, and on one occasion, witness a possible abuse situation. This incident was reported to the Ombudsman's office as proposed in the human subjects application approved by the institutional review board for this research. Finally, the sample of 27 aides although a respectable size for a qualitative study, is a modest fraction of the nation's 1.5 million nursing assistants.

The third limitation is the perspectives of the resident and RN supervisors are largely absent from this narrative. Aides had multiple and conflicting views of both residents and the RNs and LVNs who supervised them. This project, however, has its focus on nursing assistants, who are comparatively absent from nursing literature. The invisibility of this stigmatized work deserves attention because of the unique position of CNAs in the nursing home.

## Implications for Nursing

These findings provoke a re-examination of the length, teaching methods, and content of CNA training. For example, over the years, aides have reported that emotional attachment with residents is a primary reward of their work (Anderson, Wendler, & Congdon, 1998; Atchison, 1998; Berdes, 2003; Black & Rubinstein, 2005; Bowers &

Becker, 1992; Ibsen & Klobus, 1972; James, 1989; Moss, Moss, Rubinstein, & Black, 2003; Sumaya-Smith, 1995).Yet as described earlier, aide text books, training, and government regulations privilege instrumental care. Moreover, one issue greatly affecting aides was the transition from classroom training to the real world of work. Because many aides learned essential skills such as diapering and bed baths through videos and simulation rather than actual practice, it is not surprising that aides described their first weeks on the job as quite troubling. Several recalled aides who left the job after a few days.

Unfortunately, CNA training is but one concern to achieving dignified and respectful care for the elderly. Since the Hill-Burton Act of the 1950's when nursing homes were built and funded as a medicalized setting, legislation to improve nursing home quality rests on oversight by economic sanction and increasing regulations and innovative programs receive little federal support (Harrington et al., 2000; McLean, 2007; Wunderlich & Kohler, 2001; www.gao.gov/new.items/d01750t.pdf).The status and influence of the elderly and those who care for them remains low in American society and that of market forces remains high. Moreover, as many have noted, paid caring work has long been devalued (Abel & Nelson, 1990; Cancian & Oliker, 2000; Harrington Meyer, 2000; Tronto, 1993). In California, training for manicurists require more hours than aide training and the median hourly wage for all direct-care workers is significantly less than the median wage for all U.S. workers (www.barbercosmo.ca.gov ; www.directcareclearinghouse.org, 2004).

Returning to the level of the nursing home, improvements can be made for residents if aides are supervised by suitably trained RNs and LVNs. Charge nurse RNs

are rarely mentored or educated to provide clinical support or administrative leadership. Rather they are often caught between wanting to be one of the staff but expected to supervise and discipline CNAs. This personal and professional conflict is difficult to negotiate without training and on-going support. Licensed nurses also are squeezed by time pressures and policies imposed by government and corporate mandates.

At all three research sites, many CNAs expressed interest in on-going education. Some planned to continue formal training. Others were eager to learn from nursing home staff and initiated opportunities with nurses. They proposed specific content of interest (e.g., Alzheimer's and other dementias) and were impressed by particular in-service classes that affected their thinking and practice. Others said they learned from residents and found that others' life stories satisfied a curiosity for new information. As a group, the CNAs concurred that state-mandated topics were repetitive, not useful for practice, and perfunctory.

The state requires that every nursing home employ a director of staff development (DSD) to offer 24 hours of in-service training each year for CNAs. The DSD is in a position to create an atmosphere for learning, practice, and support. CNAs cited only one DSD as an imaginative instructor who taught issues relevant for practice. She was also perceived as interested in their welfare and newly hired aides called on her during distressing first days on the job. Directors of nursing and nursing home administrators can support resident care by insuring that DSDs provide education that aides find pertinent and useful for their work and presented in ways that respect adult learning principles. In addition to more thoughtful resident care, an unintended benefit may be a higher retention rate of nurses and aides.

One large study of turnover and job satisfaction among aides recommends improvements in training, rewards, and "work schedule" (staffing ratios) (Castle, 2005; Castle et al., 2007). However, more specific prescriptions were unavailable through their data-gathering instruments. Surveys are indeed useful to highlight broad issues but grounded research permits learning what questions and issues are relevant directly from those affected—in this situation, the CNA.

## Directions for Further Research

This study raised at least three issues for research and practice. First, the central inquiries deserve examination across several contexts, including aides, RNs, residents, and nursing home organizational structures. The findings would be enhanced with a study of aides who more closely reflect national demographics (www.gao.gov/new.items/d01750t.pdf; Yamada, 2002). Since my participants were largely immigrants and all were people of color, particular attention to native-born and White aides would help discern how broadly the constructions and discourses are supported. Expanding the study to include RNs might allow for a greater understanding of the link between CNA practice and those of their supervisors. Since RNs are organizationally accountable as supervisors of CNAs, future research is required to explore the interactional dyads of aide and supervisor regarding aspects of resident care. Parallels—or not—between views and discourses of aides and their supervisors might assist in shaping training for both sets of staff.

Further inspection from another standpoint, that of residents and their families, would add a critical dimension to practice. This project has theorized the links of body constructions and dignifying discourses on resident care. Perspectives of those receiving

care and of their family members adds a necessary scrutiny to maintain a grounded account of nursing home aides.

Finally, inadequate attention was given to whether (and if so, how) nursing home organizational structures and cultures shape constructions and discourses. There were suggestions that a well-regarded DSD, a higher aide-resident ratio, and a non-corporate setting contributed to constructions of resident as family and autonomous person. However, these are conjectures. Further problematizing aide practice would be a necessary step in planning an extension of this project into this area.

In a second direction for further research, there is a small but growing literature concerning immigrants and paid caring labor (Hochschild, 2002; Hondagneau-Sotelo, 2000; Solari, 2006).The increasing globalization of healthcare workers as seen in this study requires a closer look at the way immigrant workers experience and perform carework and the effects of differing cultural values and language on staff-staff interactions and resident care (Cancian & Oliker, 2000). Besides the obvious need for more bi-lingual, bi-cultural staff in nursing homes, there were perceptions of systemic favoritism by nursing home management and differences in care by aides to residents of other ethnic groups. Particularly in urban settings, there are increasing numbers of immigrants in the aide workforce and among nursing home residents. These factors alert us to examining the effects of these changes for immigrant caregivers and those who receive their care.

Third, the discourses of the male CNAs in this study provided an intriguing look at how they view employment in a dirty work job composed primarily of women. The divergent discourses of masculinities voiced by these men presents questions about how

others—residents, older aides, native-born aides, female aides—consider the presence of this minority group. One suggestion for the repudiation of difficulties by male aides in their work is offered by (Calasanti, 2004). She brings forth the complexities of class, race, gender and age in terms of "how age relations shape masculinities, resulting in lower status…for old men (p. S307). She asks if people value old men's care work as much as younger men's. Since the cohort in this study are young (28-45 years old), future explorations might analyze the constructions, meanings, and practices of older CNAs and other direct care workers. Focused research on this area might untangle some of the complexities of age and gender in nursing home carework, an issue as yet to be addressed.

## Study Summary

While this study validates previous research about nursing assistants and their hands-on work, it also deepens our knowledge about how some aides think about their work and how this translates into practice. This research also extends the concepts of dirty work and boundary work to this group of direct-care workers.

Early chapters offer a summary of where our attention has been focused and where our current interests lie. I suggest directions for future research built on this legacy of nursing and social science scholarship to improve on what I have identified as limitations in our knowledge base. More important, we can approach our inquiries with a more sensitive eye that captures the rich diversity among nursing assistants and their work cultures in the context of our changing society.

APPENDIX

TABLE 1: CNA Demographics

| Gender (N = 27) | Age | Years experience | Ethnicity | Immigrant | Shift |
|---|---|---|---|---|---|
| F = 22<br><br>M = 5 | Range: 24-64<br>Mean: 40.8 | Range: 1.5 - 25<br>Mean: 8 | Filipino: 16 (59%)<br>African American: 3<br>Mexican: 2<br>Fijian/Indian : 2<br>Eritrean: 1<br>Chinese: 1<br>Vietnamese: 1<br>Tongan: 1 | Yes = 24<br><br>No = 3 | Day shift: 18<br>Evening shift: 9 |

TABLE 2: Research Sites

| Type of nursing home | Location | Bed capacity | Staff ratio* | Unionized |
|---|---|---|---|---|
| Private, for-profit | Large urban center | 140 | 1:8 | yes |
| Private, non-profit | Small suburban town | 67 | 1:7 | no |
| Government owned and operated | Medium-sized suburban town | 281 | 1:8 | yes |

* The staff ratio on the day shift is 1 aide assigned to 7 or 8 residents.

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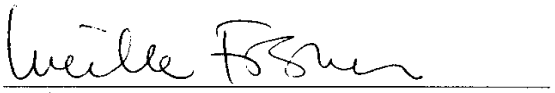

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