CARE AT WORK: A FEMINIST ANALYSIS

OF THE LONG-TERM CARE INDUSTRY IN THE UNITED STATES

by

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ABSTRACT

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This research provides a feminist perspective on the lowest paid sector of the United States long-term care industry, Certified Nursing Assistants. This research adds to current feminist scholarship on the modern professional caregiving industry by focusing on the perspective of the workers. As the population of older adults requiring care is expected to increase over the coming decades, the demand for paid caregivers will increase as well. Historically, care work was an expected duty done freely by the women of the family, but today much of the vital intimate caring labor is relegated to paid caregivers. I examine how alternative social, political and economic frameworks can transform United States society's attitude towards the increasingly relevant issue of caring labor. I argue that incorporating a feminist perspective will be helpful in

developing a sustainable model for caring labor that acknowledges the dignity of both patients and their caregivers.

DEDICATION

This manuscript is dedicated in memory of my grandfather, Daniel. I also dedicate this manuscript to my grandmother, Marilyn, to my mother, Mima, to my father, Ralph, and to my uncle, Mark. I also dedicate this to Clarette, who cared for my grandfather with great compassion and skill, and to all professional caregivers here and elsewhere.

CARE AT WORK: A FEMINIST ANALYSIS OF THE LONG-TERM CARE INDUSTRY IN THE UNITED STATES

INTRODUCTION

The United States is expected to face an increase in its over-65 population due to the changing demographics of society. According to a report by the U.S. Census Bureau published in May 2014, "In 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012" (Ortman, Velkoff & Hogan, 2014, p. 1).

The rising number of older adults increases the need for professional caregivers to provide assistance in activities of daily living (ADLs). As this population increases, the American Association of Retired Persons (AARP) predicts that much of the long-term care will be provided by direct care workers, such as Certified Nursing Assistants (CNAs). These workers assist elderly and disabled people with essential daily tasks such as bathing, dressing, and mobility, and in addition to physical assistance provide emotional support as well (Redfoot, Feinberg & Houser, 2013).

Although direct care workers play an important role in allowing their clients to live life with dignity, there is very little dignity associated with the job itself. This job is considered an entry-level position low on the medical hierarchy. As of May 2014, the median pay for direct care workers was $25,090 per year, or $12.06 an hour. (Bureau of Labor Statistics, 2016). Care worker training varies across the country, but on average, the training requires a few months and does not include certification for performing basic nursing care. Capable care workers are offered limited opportunities to advance their skills, and employers are hesitant to provide on the job training due to the up-front costs

and liability worries. Many times, hiring institutions are reluctant to design the workplace to encourage workers to stay in this job as a career; and in addition to low wages, there are few institutional or legal protections for these workers (Boris & Klein, 2012).

It is my intention to examine the complicated dynamic of professional caregiving relationships. Scholars have pointed out how these systems of exploitation stem from the problematic ways care work is situated within our social, political, and economic systems. Historically, care work is associated with women's traditional role in the home, and associated with the social expectation that women would care for sick family members in the private familial sphere. Kittay (2002) explained:

> The costs of caring for dependents are generally borne by individual families and sometimes by individual women, yet the social benefits of such care are distributed throughout society. While familial care robs the workforce of women whose skills and training are lost to the labor force, paid care always seems *too expensive*. And this despite the fact that those paid are paid poorly and generally work without the benefits other workers enjoy in industrialized nations. (p. 3, emphasis in original)

Feminist scholars have examined how the modern professional caregiving industry is based on false assumptions about women's predisposition towards nurturing, or people of color's predisposition to subservience (Glenn, 2012; Dodson & Zincavage, 2007). These attitudes are the source of the low pay, low status, and lack of acknowledgment of the important role professional caregivers have in our loved ones' lives.

This thesis examines some of the complex relationships that develop between direct care workers, their clients, and the institutions that employ them. My argument rests on the premise that it is necessary to reevaluate systems in place that discourage workers from making this work their career. The Bureau of Labor Statistics (2016) has a positive job outlook in this industry, yet the reasons for the industry growth are more than just high demand. These job openings are due to a high turnover rate and low reports of worker satisfaction stemming from difficult working conditions and the emotional and physical demands of the work (Bureau of Labor Statistics, 2016).

Because professional caregivers will have an increasingly important role in many of our loved one's lives, my goal is to examine the institutional structures in place that make it so difficult to choose care as a career. I examine the field of professional caregiving from the perspective of workers who perform this labor, many of whom experience genuine joy and fulfillment from the caring relationships that develop with their patients. I argue that care should be a social priority and collective responsibility instead of one based on individual self-interest, where marginalized sections of the population, such as women, immigrants, and people of color are exploited and undervalued.

I rely on Feminist Standpoint Theory to understand how direct care workers are perceived and treated in the healthcare industry. Feminist Standpoint Theory addresses the relationships between knowledge and power, and is a way of viewing lived experience as a legitimate form of knowledge with social and political impact. It is a way to give oppressed groups a method to include their subjective experience in knowledge production. Haraway (1997) defines a standpoint as "…not an empiricist appeal to or by

the oppressed, but a cognitive, psychological, and political tool for more adequate knowledge…" (p. 189). Standpoint Theory is valuable in feminist research, as it enables the researcher to understand structures of inequality, and the impact those structures have on people (Harding, 1991). The purpose of applying Feminist Standpoint Theory is to enable the researcher to uncover the specific experiences of marginalized groups, and provide scholars a more nuanced understanding of power relations. To explore the biases of those who use the workers, it is also important to examine how these workers react to these conditions, and they can provide valuable ideas on how to sensibly provide adequate elder care. Examining the standpoint of direct care workers helps society find a just way to treat the workers.

Organization

This work examines the attitudes of the employers, the clients, and the workers themselves to help address the broader issue of the rising need for elder care. Chapter 1 presents a review of the literature concerning the professional environment of direct care workers in the United States society and economy. My goal is to show the fragility of patriarchal and capitalist ideas regarding the gendered division of labor, and the challenges of commodifying caring labor. I frame this around Feminist Standpoint Theory to include the subjective experience of those who perform this work and to understand how such structures of inequality impact the lives of these workers

Chapter 2 discusses the methodology, which is based on feminist content analysis of narratives written by professional caregivers. I draw on the works of Reinharz (1992) and Riessman (1993; 2007) to inform my interrogation of the data to identify themes addressing professional caregiving relationships. The focus of the data analysis is to

understand the nature of the relationship between the worker and the patient, and the relationship between the worker and their institutional employer. I draw on Feminist Standpoint Theory to help locate and uncover the tacit knowledge and wisdom that these workers have on caregiving (Haraway, 1997; 2004; Harding, 1991; 1998; Hartsock, 1998).

Chapter 3 presents the data analysis of narratives written by direct care workers. The rigor of my analysis focuses on themes related to two aspects of caregiving relationships, the first being between the worker and patients, and the second focusing on the relationship between the worker and their institutional employers. The last chapter discusses the findings of my analysis and what they reveal not only in terms of how direct care workers are situated in society but also how these workers view their location and treatment in the healthcare industry. I look for practical implications for social policy, particularly in terms of establishing the work conditions necessary for good care.

CHAPTER 1: LITERATURE REVIEW

Much has been written about care work and the challenges of navigating a job that is physically and emotionally demanding, yet low paid and undervalued. The literature shows that complex relationships develop between direct care workers and patients. In their role as paid providers, they exist at the intersection of the public/private divide and provide a service that was traditionally performed with no monetary compensation within the family.

I first review the literature regarding the history of informal and formal caring labor, and the development of nursing and caregiving from women's domestic role to a formal profession. I then address the economic challenges of providing care in an institutional setting. Using a feminist perspective towards formal care services, I argue that the intangible value of caring labor is hard to adequately measure, and its devaluation is associated with race and gender oppression. Then I discuss sociological literature describing the work of direct care workers who work as nursing home aides. I frame my analysis of this industry using Hochschild's (1983) framework of emotional labor, and Hughes' (1951) framework of dirty work and Gilligan's (1982) feminist care ethics. Based on these conceptual frameworks, I argue that care workers are especially vulnerable to exploitation.

Historical Landscape

Many historians have described the system of exploitation affecting domestic workers and other care providers who work in a labor market that devalues their time, bodies, and careers. Care work has traditionally been considered low-skilled labor, with the underlying assumption that women are already qualified, given their roles as mothers and wives. Gendered occupational segregation is present in the field, since many women are tracked into the formal caring professions (Kramer & Kipnis 1995). Furthermore, many people of color and immigrants enter the field due to its low barriers of entry and a lack of other options (Glenn, 1991, 2012; Roberts 1997; Climo, 2000; Collins, 2000).

Taking care of the aged and the infirm was historically considered an obligation on the women of the family, and Ehrenreich and Hochschild (2003) described the consequences when women in the family abdicated their caregiving roles as they pursued other opportunities. The women left a care vacuum that is now filled by direct care workers. Yet, as daughters and wives who were traditionally burdened with elder care are now in a position to afford to pass the burden on to other women, new systems of exploitation emerge beyond the gendered division of labor. "Women in Western countries have increasingly taken on paid work, and hence need other paid domestics and caretakers for children and elderly people – to replace them" (p. 7). This raises issues of economic inequality on a global scale, which is reflected within the United States direct care industry. Many direct care workers stay in this field because their job mobility is limited due to experiencing discrimination based on their race, class, ethnicity, and/or immigration status (Rothenberg, 2002)

Glenn (2012) analyzed how caregiving and domestic work in the United States are implicated in the history of social coercion, especially for poor, immigrant, and/or women of color. She further explains, "The social organization of care has been rooted in diverse forms of coercion that have induced women to assume responsibility for caring for family members and that have tracked poor, racial minority, and immigrant women into positions entailing caring for others" (Glenn, 2012, p. 5). Her historical analysis traces the origins of the paid caregiving industry in the United States, and explains the reasons why the legal and economic systems reinforced the belief that "paid care work has long been treated as though it was an extension of women's unpaid domestic labor rather than as a legitimate form of wage labor with its own standards, training requirements, and pay scales" (Glenn, 2012, p. 9). Many direct care workers, many of whom are women, must deal with problematic assumptions that caregiving is women's calling, as opposed to a legitimate career. As an extension of their informal caring labor within their own households, women are tracked into jobs where they do the same under-appreciated work in other households and/or institutions. Many follow a career trajectory where they go from providing unpaid care for their own families, into low-wage professional caregiving through a continuum of exploitation in a society that does not place much social or economic value onto such work, regardless if it is done formally or informally.

The history of professional caregiving has parallels with the history of the nursing profession, and caregiving is rarely acknowledged for its impact on patient outcomes. Certified Nursing Assistants are marginalized within the nursing profession, which itself has had to struggle to gain respect and fair compensation within the medical field.

Reverby (1987) described the origins of the nursing profession in the United States, examining the challenges that nursing and other caring professions face in having their work seen as legitimate work, and not as a duty, religiously motivated, or with an expectation of self-sacrifice. These ideologies excuse poor working conditions, and the emphasis on virtue and sacrifice fails to acknowledge the hard work and skill involved. Dealing with poor working conditions is not the sign of a virtuous woman, but a sign of exploitation. Wagner (1980) described how the medical profession built itself up by exploiting the labor of nurses. Gender stereotypes influenced the expectations placed upon nurses, and direct care workers today face similar challenges in garnering respect as workers. While medical advances are credited to the male dominated medical field, such beliefs, Wagner argued, deny the great impact of the care provided by nurses and other caregivers. "By the late 19th century, it was clear that without antiseptic conditions, adequate nutrition, pre- and post-operative monitoring, and rehabilitative care, no amount of diagnostic or surgical skill would save lives" (Wagner, 1980, p. 273). Although care has a great economic impact, it is difficult to quantify.

Nurse's aides played an important role in the medical profession because they provided vital care to patients. A 1943 article in a public health nursing journal describes the success of a national defense program to train volunteers as nurse's aides during World War II. "A generous share of nursing procedures not calling for highly skilled training and knowledge are being carried by aides and that work is being done to the hospital's satisfaction, the nurse's relief, and the patient's comfort" (Deming, 1943, p. 889). As their role became more important over the next decades, Congress passed the Federal Nursing Home Reform Act in 1987 which set national training and certification

standards. Today, Certified Nursing Assistants are employed in hospitals and long-term care facilities nationwide, and contribute significantly to patient care (Eaton, 2000).

Feminist Perspectives

Although there is little controversy that the compassionate caring labor performed by nurses and nurse's aides is valuable to society, there is great difficulty in quantifying the value of what is colloquially referred to as "a labor of love." Scholars in the field of feminist economics describe the challenges of calculating how care work fits within economic calculations, especially when care is taken out of the traditional family setting, and is performed in institutions such as nursing homes and long-term care facilities.

Kane, Kane, and Ladd (1998) provide a detailed analysis of the role direct care workers play in the long-term care industry. Although these workers perform a majority of the hands-on caregiving, and are instrumental in achieving quality care standards, the authors provided examples of how managers refuse to invest any up-front cost in the aides, and their failure to hire any more personnel than the bare minimum required by law (Kane et al., 1998, p. 44).

Foner (1994) provided an ethnographic study of Certified Nursing Assistants that discusses the drawbacks of caring within a highly regulated, profit driven institutional environment. Her in depth analysis of workers is useful in understanding how an institutional setting changes the dynamic of caregiving relationship:

> Nursing homes are institutions that aim, in a sense, to bureaucratize or rationalize affective care. Administrative rules regulate staff who, as part of their jobs, are expected to provide personal attention and sympathetic care to patients. Bureaucratic rules can come into conflict with workers'

> emotions and personal relations with patients, and patients are often the ones to suffer (Foner, 1994, p. 53).

Diamond (1986) interviewed nursing home workers who felt that their ability to care was overshadowed by medical tasks. He argued that the dominance of the medical model led to their exploitation, and a "climate of trouble" for nursing assistants, who were punished for spending extra time forming relationships. Genuine caring work is incompatible with the nursing home structure, the capitalist medical model, and profit motivated care. He suggests one reason may be because it is so difficult to standardize and regulate; "[I]n the charts, job descriptions, textbooks and training, caring work remains invisible and unnamed. It is not officially recorded or rewarded" (Diamond, 1986/1992, p. 273).

Another challenge of caring labor is that cost saving measures that may work in other industries do not work here. Twigg (2008) described how care workers do not create a tangible product, but instead leave their patients in a different state. The assistance they provide needs to be constantly repeated; they may help a client take a bath, but the client inevitably will get dirty again and need another bath very soon. Twigg also described the unique way time passes when the body is cared for, and discusses how hours of care:

> [C]annot be accumulated in the classic sense that commodified, abstracted time can be. You cannot, for example, save up taking someone to the toilet for a week, and then do it all in one go. This limits the capacity of the service provider to rationalize the labor process on classic efficiency lines. (Twigg, p. 233)

Another challenge of a market approach to care is the human element. Kleinman (2012) argued that the market model towards caregiving makes it hard to fully express the complexity of the work, and states:

> The market model seems to have infiltrated so thoroughly into human lives and medicine that in certain circles—policy making and analysis, hospital and clinic administration, and even clinical work—economic rationality with its imperative of containing costs and maximizing efficiency has come to mute the moral, emotional, religious, and aesthetic expressions of patients and caregivers. (Kleinman, 2012, p. 1550)

Kleinman believes that a market based system for providing care leads to losing sight of the people receiving the care, and argues that protecting their complex emotional and physical needs should take priority over the profit margins of the care provider. The unique attributes of care work, the complicated client needs and the needs of the institution make it difficult to quantify and reimburse within market-based systems. The indefinite aspects make effective caregiving in a professional context challenging.

Care workers receive low wages for emotionally and physically demanding work. The following section discusses emotional labor and dirty work to analyze the dual components of the work, to better understand how the workers are vulnerable to exploitation, and the influence it has on patient care.

Emotional Labor

Emotional labor applies to the types of jobs in which personal relationships become commodities of exchange (Hochschild, 1983). Professional caregiving, where the client is cared for and made to feel emotions, fits within this category. Hochschild's

examination of how certain occupations fit into the definition of emotional labor is valuable in that it reconsiders the reasons behind the view that emotional relationships should be excluded from the market arena. Viewing a caring relationship in pure capitalist terms is problematic because it ignores the toll on the psyche of the person who provides that labor; it "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others…the sense of being cared for in a convivial and safe place" (Hochschild, 1983, p. 7).

Direct care work is a type of job that can be easily included under the definition of emotional labor because the requirements transcend the physical activities, but include intangible feelings. Clients are likely to have emotional needs too, and even if the worker is just helping with activities of daily living, the worker may need to provide reassurance, express patience, and calm a scared person – the emotional component is inextricable from the physical work. Emotional labor "calls for a coordination of mind and feeling, and it sometimes draws on a sense of self that we honor as deep and integral to our individuality" (Hochschild, 1983, p. 7). Workers have to leave their real self at the door and turn on a professional smile, and manipulate their emotions to achieve a work goal.

Using the example of flight attendants, Hochschild (1983) described how the airline instructs them to act in a certain way so the passengers feel comfortable and happy and will be more likely to return to the airline (p. 16). She argued how emotional labor jobs are highly gendered; how the expectation of self-effacement and suppressing the self in favor of the customer's happiness mirrors women's traditional expectation of putting other people's needs first; as "emotion management has been better understood and more often used by women as one of the offerings they trade for economic support"

(Hochschild, 1983, p. 20). She argued how the fact that female dominated fields are more likely to require the use of emotional labor reinforces gender inequality on an institutional scale:

> Schooled in emotion management at home, women have entered in disproportionate numbers those jobs that call for emotional labor outside the home. Once they enter the marketplace, a certain social logic unfolds. Because of the division of labor in the society at large, women *in any particular job* are assigned lower status and less authority than men. (Hochschild, 1983, p. 181, emphasis in original)

In the context of direct care work, the emotional toll of this work is very difficult to measure. In a sociological study of the work experiences of home health aides, who perform direct care work to clients in a home setting, Stacey (2011) examined the emotional toll of professional caregiving:

> The conditions under which low-skilled, low waged caregivers provide for the needs of the elderly and chronically ill, paying particular attention to the material forces, (namely wages) and nonmaterial impulses (such as altruism, emotional attachment, and the drive for autonomy) that propel women into the job and sustain, or undermine, their occupational commitments. (pp. 5-6)

Stacey's conclusion regarding the reasons people stay in this job, apart from economic necessity, shows how workers form positive relationships with their patients that outweigh the negative experiences of the job. Direct care workers know their work allows their patients to stay healthy for longer; they prevent the disease from getting

worse through their preventative care. They value the appreciation and satisfaction from forming intimate attachments with the patients and families. Stacey (2011) called this construction of identity a "caring self" (p. 117). Conversely, care workers may experience such emotional distress from the escalating demands of the job, its stressful conditions, and lack of adequate wages or benefits that they leave the field of patient care entirely (Stacey, 2011, p. 158). Stacey extols future care policies to place a greater priority on encouraging these relationships, by creating policies that are not based on an expectation of sacrifice, but encourage caring people to enter this field and stay there:

> Even though some aides struggle to define their relational commitments as work worthy of compensation, they are unequivocal that intimate ties with clients produce a sense of job satisfaction and dignity. Rather than taking this as further evidence of home care as familial in nature and therefore outside the realm of paid labor, it behooves us to push for a broader understanding of paid carework that unapologetically places companionship at center. (Stacey, 2011, p. 167)

Feminist economists address the tension between paying for activity that is love based and care based. Does the work environment allow such emotional bonds to form? How could we create a practical system of putting a price on this emotional connection, to incentivize it? A worker is not paid any extra for working with a smile; the smile is not the product, it is a means to an end, but the work can still be given a wage—we need to overcome the apparent paradox of paying for what seems like it should be based on love not money.

Emotional labor is economically significant in healthcare – where care is the product. Discussing the importance of a bedside manner, Stacey (2011) shows how the challenge of reassuring frightened patients typically requires emotional labor:

> Doctors, in treating bodies, also treat feelings about bodies, and even patients who are used to impersonal treatment often feel disappointed if the doctor doesn't seem to care enough. It is sometimes the doctor's job to present alarming information to the patient and to help the patient manage feelings about that. (Stacey, 2011, p. 151)

Despite the trend of dismissing the impact of emotional labor, it is very important in many fields, especially professional care work, nursing, and medicine. When a healthcare professional is paid to care, the relational dynamic becomes complicated as patients demand sincerity, but the limitations of the job and the professional constraints of the relationship require professional boundaries too. Green-Hernandez (1991) studied professional nurses to "discover whether the nurse's caring exists as a direct and intentional professional process, or as a spontaneous human response, or perhaps a combination or integration of both of these" (Green-Hernandez, 1991, p. 111). Her findings are helpful in explaining the caregiving relationship between healthcare workers and their clients.

Certified Nursing Assistants spend the most time interacting with the clients and provide care that is not considered professional nursing, yet is very important to ensure a patient's quality of life. They are the ones most likely to see variations in a patient's condition, notice problems and provide preventative care. Direct care workers are very

important, and it is important for policy makers to understand what they need. They need to be supported while they form emotional relationships.

Shenk (2012) interviewed direct care workers who were told to photograph themselves interacting with patients in a nursing home and describe what the images meant to them. The consensus was a focus on emotional labor. "Although they have been instructed to step back and not get emotionally involved, these dedicated caregivers agreed that it is through forming relationships and getting emotionally involved that they do their jobs so well" (Shenk, 2012, p. 553). Shenk emphasized the emotional and interactional aspects of caring in addition to the physical tasks. The caregivers in her study reinforce the importance of acknowledging the emotional aspect of care. "The benefits of person-centered caregiving, as opposed to instrumental, task-oriented care focusing only on physical or medical needs, are important for both the residents and those providing care" (Shenk, 2012, p. 554).

Dodson and Zincavage (2008) provided further examples of institutional support or nonsupport for the emotional labor of caregiving. Their interview with nursing home workers found that the emotional labor, exemplified by the nursing home's "family model" expected the workers to perform the emotional labor on their own time. Workers were expected to bond with the patients, but only when it did not impede the workflow. It was not formally acknowledged or supported, but it was expected.

Dodson and Zinkavage (2007) described the mistreatment of workers in institutions using a "family model" of care without also treating the workers like family. As part of the tensions of providing the informal care traditionally provided by families, the employers expected the workers to invest intense amounts of emotional resources into

the patients. However, the burden to keep up the pretense of the family model fell on the shoulders of the Certified Nursing Assistants, who were paid so little to do so much. The emotional labor was used to pad the nursing home's bottom line. It was "good for business."

Encouraging caregivers to form deep bonds with residents and thus go out of their way to take good care of them was discussed as humane as well as a boon to the institutional bottom line. Without a doubt, the family model was good for business. Certified Nursing Assistants who performed the majority of these duties framed within the family model, expressed a more ambivalent attitude. Most workers valued their role as caregiver and regarded themselves as the people who actually knew each resident. They also valued the affection that some residents were able to offer in response to their care. Yet as the primary direct care providers, Certified Nursing Assistants also pointed to the stress and physical exhaustion involved in caring for 7 to 14 dependent people (as many as 22 in the evening and during the "graveyard shift"). In the survey, 93% reported that they work short-staffed occasionally, often, or always (44, 36, and 13%, respectively). One summed it up, indicating "it's really just a big rush, the whole day. . . . like an assembly line, you know?" (Dodson & Zinkavage, 2007, p. 915).

The assembly line model for care is the crux of the problem. Professional caregiving requires emotionally complex relationships, even if the tasks can be cut down to the sum of its parts. This is exceptionally important in the face of historical trends that show how caring relationships and caring labor have undeniable economic significance. It was the 19th century economist and political theorist, Friedrich Engels (1884) who argued it is women's domestic labor that allows capitalism to function. Karl Marx (1847)

referred to a similar concept regarding a reserve army of labor that was readily available to be exploited and to do the work no one else wants to do in society. Today, the labor conditions of direct care jobs consist of such poor conditions – low wages, difficult and stressful work, and very little recognition of the work's importance. Marx warned of the problems inherent in such a system of exploiting the workforce.

Dirty Work

Dirty work as a sociological concept refers to a type of labor that is socially marginalized. Hughes (1951) provided three categorizations on why work could be considered dirty, and described professions that consist of physical, moral, and social taint:

> It may be simply physically disgusting. It may be a symbol of degradation, something that wounds one's dignity. ...It may be dirty work in that it in some way goes counter to the more heroic of our moral conceptions. (Hughes, 1951/1994, p. 62)

Nursing home work is dirty work because workers deal with the unpleasant emotional and physical parts of end of life care. Nursing assistant work can be classified as dirty work because "as primary caregivers to the sick, the 'crazy,' and the dead in nursing homes, nursing assistants are constantly threatened with becoming symbolically polluted" (Jervis, 2001, p. 84).

Nursing assistants provide physical patient care to patients; it is physical work. Gubrium (1975) categorized the work of nursing home aides as "bed and body work" (p. 126). Dealing with bodily functions is part of the job. Toileting is part of the "bed and body" routine, and Gubrium described the requirements as including "rinsing stool from

patients' clothing and bedding, cleaning bedpans, cleansing patients of fecal matter that may have been smeared on their bodies, keeping track of the frequency and texture of bowel movements, and keeping rooms free from odors" (Gubrium, 1975, p. 137). Dealing with feces, and the disgust associated with such bodily processes is what makes this job classified as dirty work, and perceived so by society.

Gubrium's (1975) discussion is useful in understanding why certain jobs are classified as dirty work. Such work requires workers to deal with such objects or situations that elicit disgust. Jobs associated with physical contact with the body and waste products are more likely to be considered stigmatizing and tainting. Therefore, as Jervis clearly describes, this work is also embedded within social inequalities:

> Like other dirty work in America, aide work remains for the most part devalued socially, if not downright invisible. The occupation's lowliness, however, is not only the result of its association with bodily waste, but also derives from the gender, race, and class backgrounds of its workers. That women, people of color, and those who are economically disadvantaged are overrepresented in nursing assistant work is hardly surprising. As a stigmatized occupation, aide work draws those with few alternatives. (Jervis, 2001, p. 94)

Although these ideas cannot make the physical aspects of the work any easier, it may help us redesign a work environment that acknowledges the importance of dirty work, instead of allowing it to remain invisible and undervalued.

Ethic of Care

Many studies and policy reports on the United States long-term care industry demonstrate the problems with exploiting both formal and informal caring labor, but very few studies have systematically considered the perspectives of direct care workers on improving the conditions of a professional caregiving work environment; and there are very few feminist studies focused on the status of direct care workers. My review of the literature on formal and informal caring labor indicates that direct care workers are consistently fighting towards better working conditions and greater acknowledgement of their work. They face challenges from an occupational environment that has the potential to be physically difficult and emotionally draining, and poorly compensated. Workers are often ignored within the professional hierarchy, and their work often remains hidden and unrecognized.

The changing demographics of a longer life expectancy of the aging population in the United States requires a view of collective responsibility and the need to reevaluate existing approaches to care, particularly reevaluating the effort that goes into caring. An economic and social system of professional caregiving based on the philosophy of care ethics would give care more value because it argues that care should be a social priority and should be viewed as a collective responsibility, instead of one placed on oppressed groups like women, immigrants, or people of color.

The ethic of care was first described by Gilligan (1982) in her research about women's moral and psychological development. She challenged the dominant psychological theories, which until that point considered women's viewpoint as secondary or failed to include women at all. She discussed the androcentric bias in

theories that described moral reasoning as based on justice and individual rights, arguing that women's tendency to take into account other people's needs when making decisions did not make their moral decisions less legitimate. Gilligan described the tensions between the male dominated concepts of autonomy and the female dominated concepts of care:

> Illuminating life as a web rather than a succession of relationships, women portray autonomy rather than attachment as the illusory and dangerous quest. In this way, women's development points toward a different history of human attachment, stressing continuity and change in configuration, rather than replacement and separation, elucidating a different response to loss, and changing the metaphor of growth. (Gilligan, 1982/1993, p. 45)

Gilligan (1982) pointed out how care is an important issue for feminism. Women are not only expected to care for others, there is the expectation of their sacrifice while simultaneously penalizing them for performing it. Caregivers may be forced to give up paid work to take on the responsibility of providing care, which if done within the family has the expectation of being unpaid. Nussbaum (2002) also criticized how the obligation society places on women to care, without providing resources to make it easier, is a source of gender inequality. She argued that "This is a central issue of feminism since in every part of the world, women do a large part of this work, usually without pay, and often without recognition that it is work" (Nussbaum, 2002, p. 188).

Gilligan's (1982) focus on women's experiences was a positive step in legitimizing women's experiences, yet her work inspired much scholarly debate, "Feminists either took up with excitement the seemingly new valuation of '"feminine"'

morality or reacted against the gender differentiation and possibly even biological determinism underlying Gilligan's claims" (Larrabee, 1993, p. 4). Critics argued Gilligan was universalizing the female experience, overgeneralizing from a small sample of young, white college students, which could not address how other sociological factors such as age, culture, class, and race also influence women's moral development. Gilligan failed to discuss in enough detail the multiple systems of domination in patriarchal society which have tracked women into the less financially lucrative caring responsibilities, and how economic, social, and religious systems have undervalued women's productive and reproductive labor. Notwithstanding, an ethic of care would be helpful in protecting members of society who depend on others due to their inability to care for themselves.

In sum, a philosophical framework acknowledging the importance of care in society can better address the needs of caregivers and care recipients, and reduce the stigma they face for being dependent or have others dependent on them. The need for care manifests itself across the lifespan, and an ethic of care values interdependence and responsibility to others instead of viewing people solely as individuals.

By examining the narratives of workers, I will show how these professional caregivers care under circumstances that are not designed for caring. Their experiences can help us imagine how much better caring can be if we as a society were willing to reform the industry in a way that would improve the lives and working conditions of caregivers in the long-term care industry.

CHAPTER 2: METHODOLOGY: NARRATIVE AND FEMINIST CONTENT ANALYSIS.

The following section discusses the methodology of the study, which is based on feminist content analysis and narrative analysis of the narratives of eleven Certified Nursing Assistants (CNAs). This chapter examines the importance of caregiving in society based on narrative analysis and feminist content analysis of a sample of direct care workers employed in an institutionalized setting. I examine the relationships between the workers and their patients and between the workers and their institutional employer.

I use the narratives of a study conducted by Amy Haddad, editor of the Narrative Symposium published by the Johns Hopkins University Press (2011). The narratives are written by eleven Certified Nursing Assistants who provide formal caregiving in an institutional setting in the Midwestern region of the United States. According to Haddad (2011), their experiences are important to study because "stories from CNAs [Certified Nursing Assistants] who are the closest to the most vulnerable among us are important for us to hear because care giving of this type is not valued, is desperately needed, and will become increasingly necessary as the population ages" (Haddad 2011, p. 134). The first-hand accounts of the challenges these workers face provides a nuanced understanding of the role caregivers play in society.

Feminist Research Methods

Reinharz (1992) analyzes different feminist methodologies, and explains why the choice of methodology is a feminist issue, "of the two ongoing discussions about the nature of knowledge: the first is between feminist and antifeminist or non-feminist scholarship; the second is a discussion among feminist scholars" (Reinharz, 1992, p. 4). Since there are many different kinds of feminist research, Reinharz attempts to examine what makes research feminist:

> Some feminists argue that there is no special affinity between feminism and a particular research method. Others support interpretive, qualitative research methods; advocate positivist, "objective" methods; or value combining the two. Some imply "use what works," others "use what you know," and others "use what will convince" (Reinharz, 1992, p. 14).

Reinharz describes many different types of feminist methodologies, and here I have chosen to apply feminist content analysis and qualitative narrative analysis to my research.

Feminist Content Analysis & Qualitative Narrative Analysis

I apply feminist content analysis guided by the work of Reinharz (1992) to interrogate the data and identify themes within narratives written by Certified Nursing Assistants. Reinharz (1992) defined feminist content analysis as a way to "study a set of objects (i.e., cultural artifacts) or events systematically by counting them or interpreting the themes contained in them" (p. 146). Her method of content analysis provides a framework to give the researcher a better understanding of the subject's experiences. She also discussed the power of the written story, how "a feminist research method may

consist of soliciting written statements about a particular topic, without prior interviewing or written analysis" (Reinharz, 1992, p. 143). These methodologies are a good way to uncover voices and stories rarely heard in the dominant narrative, because, as Riessman (2007) explained, "thematic narrative analysis is most similar to qualitative methods such as grounded theory and interpretive phenomenological analysis, and even approaches to data analysis not typically associated with qualitative traditions, such as oral history and folklore" (p. 74). One of the strengths of thematic analysis is its versatility in enabling a researcher to interpret many different kinds of data, place their analysis within broader contexts, and gain potential ideas for how people can transform their marginalized status.

Feminist content analysis is more than just analyzing the voices of the narrators, but as a feminist method, it seeks to examine the underlying structures that influence their lives, and illuminates the reasons behind the injustices within this industry. Using the methodology of both feminist content analysis and narrative analysis achieves the feminist goal of uncovering untold stories. Understanding the experiences and perspectives of this sample of Certified Nursing Assistants in the long-term care industry provides valuable knowledge about how United States society looks at health and aging, with important implications for developing and implementing policies to protect those who perform and need care. Holloway and Freshwater (2007) explained how narrative research is valuable in the healthcare context; "Narrative, whilst focusing on the subjective experience of narrators, also takes into account the bigger picture by exploring wider societal and cultural experiences" (Holloway & Freshwater, 2007, p. 42). Abrams (1991) viewed narrative analysis in feminist research as a valuable tool to uncover marginalized voices.

By using these methodological frameworks, I will be able to analyze how the workers feel about their relationship with their patients, and the relationship with their employer. These narratives are an insider's perspective of the nursing home industry, in contrast to assumptions people have towards these workers based on stereotypes and lack of information. This misrepresentation of their contributions to the industry reflects how the culture fails to appreciate their caring labor. Reinharz (1992) also discusses how another benefit of content analysis is a way to better understand cultural attitudes. "Many feminist scholars are troubled by the cultural expression, production, and perpetuation of patriarchy, ageism, racism, and intrigued by the resistance of subgroups to these forces" (p. 150). Because these narratives are about a rarely acknowledged and commonly misunderstood segment of the medical profession, a detailed analysis of the worker's own narratives can be used to challenge the cultural images and stereotypes of Certified Nursing Assistants. Using qualitative content analysis of narratives allows me to look for common themes within the narratives. I can thereby gain a greater understanding of the worker's experiences and situate them within feminist discourse. Reinharz (1992) describes an example of this method in how feminist historians use qualitative or interpretive content analysis to study both individuals and the broader trends that impact their lives:

> Feminist historians use cultural artifacts to study individual women or groups of women, the relationship between women and men, relations among women, the intersection of race, gender, class, and age identities, and the institutions, persons, and ideas that have shaped women's lives. In line with these goals, feminist historians are expanding the range of

> cultural artifacts to include items related to private life, and are using feminist theory as an interpretive framework. (pp. 155-156)

Feminist Standpoint Theory

I am applying Feminist Standpoint Theory as a methodological tool because it allows me to study the workers' perspective. One of the underlying assumptions of Feminist Standpoint Theory is that valuable knowledge comes from many places, including from groups of people who have been traditionally excluded from the dominant narrative. Certified Nursing Assistants are at the bottom of the healthcare hierarchy, and their opinions are not commonly included when discussing healthcare policy, despite their first-hand experience of the long-term care industry.

Collins (2004) describes the concept of the "outsider within" status, using the example of African American domestic workers whose standpoint within their white employer's house allowed them to gain a nuanced understanding of the dominant society, but their perspective was not considered legitimate, even though they were able to understand things in a way members of the dominant group could not. "As an extreme case of outsiders moving into a community that historically excluded them, Black women's experiences highlight the experience of any group of less powerful outsiders encountering the paradigmatic thought of a more powerful insider community" (Collins, 2004, p. 121). Certified Nursing Assistants qualify as an example of "outsiders within" because of their low status in the medical hierarchy. They have intimate knowledge of how the long-term industry works, but as members of the low-wage, unskilled workforce; their voices are ignored due to the negative social attitudes about the nature of the work,

and for many of these workers, this marginalization is also compounded by gender and race discrimination.

Harding (1998) explains how "standpoint theories thus begin from the assumption that power and knowledge are inevitably linked, but not all power and knowledge belong to the powerful" (p. 75). She discusses how epistemology is impacted by the perspective of the person creating the knowledge, and people who are not in positions of power may possibly have a clearer perspective of power relations in society.

Drawing on standpoint theory is helpful here because it helps explain the experiences of Certified Nursing Assistants who are at the margins of the long-term care industry. By utilizing standpoint theory as my analytical framework, I aim to bring these workers to the center of the discourse on long-term care. The workers' perspective is valuable in order to understand what is necessary to establish a positive, caring, work environment because of their direct contact with patients. Focusing on their experiences will help me better understand the industry than if I asked the CEO of a long-term care facility, or someone else who is not in the front lines caring for the patients every day.

Demographics of Sample

Eleven participants submitted a written narrative of 2-6 pages, although one was a letter instead of a narrative. The title of the journal was "Personal Narratives: Certified Nursing Assistants Working in Long-Term Care Facilities". The participants were from geographic locations around the Midwestern United States. Their years of work experience varied from 10 years to 43 years. They described going through a training and certification process of between a few weeks to a few months. One was retired, and one was no longer working directly with patients. The demographics of the participants were

eight women and three men. They do not disclose race or immigration status. Most described themselves as taking this job due to economic necessity and are of lower socioeconomic status. The call for stories sent out by the editors describes what the editors wanted the workers to contribute in their narratives:

> We would like stories written by nursing assistants that describe their work – what is most rewarding and challenging, and what concerns they have about the care they provide and the care patients need. We are especially interested in stories that give the reader a 'back stage view' of the life and work of nursing assistants. (Haddad, 2011, p. 134)

My analysis began with reading each narrative and extracting statements about caregiving relationships. I categorized the themes concerning the participants' experiences regarding paid caregiving. My goal was to understand what caregiving means to the direct care workers in the study, and if they were encouraged or discouraged to care by the institutional setting.

Although I focused my research on the study participants, their experiences reflect broader employment trends. In 2016, the Bureau of Labor Statistics reported that over 90% caregivers leave this type of employment after less than a year, and hiring institutions struggle to ensure sufficient staffing due to the high turnover rate (Bureau of Labor Statistics, 2016). One possible reason for these negative employment trends is that workers like the study participants are responding to the fact that their hard work and contributions to the patient's quality of life are not adequately acknowledged.

One goal I hope to achieve from this study is to find if the statements by the study participants are consistent with my prediction that negative ideologies about the nature of

the work serve to marginalize these workers and perpetuate the low wages and poor conditions that make this job so difficult. I aim to demonstrate the importance of prioritizing and supporting caregivers, because of their important contributions to the long-term care industry, and the difference they make in their patients' lives.

I highlight the repeated characterization of this work as "unskilled" and aim to examine the flawed rhetoric that 'anyone can do it'. I compare these ideas to the reality of the work, how incredibly demanding and complex it is, and whether the institutional organization encouraged or hindered their ability to do the work and deal with the challenges of caring for difficult patients.

In conducting research on direct care workers, it is important for me to acknowledge the links of my background with this study. Feminist scholars advocate using reflexivity to situate the role of the researcher in the production of scholarship. England (1994) explained the benefits of using reflexivity in feminist research, because "reflexivity is a self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher" (p. 244). For many years prior to his passing, my grandfather received daily care from a direct care worker. I have firsthand experience witnessing the important role a Certified Nursing Assistant can play in an elderly patient's life. My family's experiences made me question why these workers face a constant struggle to have their work fairly compensated and be viewed as capable, skilled members of the healthcare team; and the ideological structures that cause harm to or limit the opportunities for professional caregivers.

CHAPTER 3: DATA ANALYSIS OF DIRECT CARE WORKER NARRATIVES

In this chapter, I examine the work experience of direct care workers in their interactions with clients in a long-term care institution through thematic analysis of a sample of narratives written by Certified Nursing Assistants who describe their professional and personal relationships with their clients and employers. I analyze the ways in which this category of providers conceptualize the care relationships they have with their clients, as well as ways in which an institutional setting impacts their ability to form relationships with their clients. To form an accurate conceptual framework for my thematic analysis, I rely on the theories of emotional labor, dirty work, and feminist care ethics to help better understand the narratives.

The first section of my analysis describes the personal relationship between the worker and the clients they care for. One theme identified as a key indicator of this relationship is the worker's feelings of competency and pride in their work. I evaluate this in terms of (1) physical workload, and (2) a performance/skill component, as these were frequently mentioned in the narratives. Another key indicator of the relationship between workers and their clients is the emotional and relational aspect of their labor. I evaluate this in terms of (1) grief and loss, and (2) caring for the dying.

The next section describes the institutional relationship between the worker and their employer. Themes identified in this relationship are (1) economic exploitation, (2) job related stress, and (3) professional courtesy. Economic exploitation is a consistent theme identified in the respondents' comments about their low wages and lack of

benefits. I evaluate job related stress in terms of the frequency of workers' complaints about limitations on their autonomy due to institutional constraints. In assessing the issue of professional courtesy towards workers, I focus on consistent comments by workers about the failure of their employers to acknowledge and value the impact of their work on the patient's quality of life.

By focusing on these two relationships between the worker and their client and the worker and their institutional employer, I hope to enhance understanding of the complex and interactive nature of physical, emotional, and economic relationships that undergird caregiving in the health industry. These workers are expected to perform physically demanding work that is dismissed as dirty work, enter into emotionally taxing relationships, which vary from joy to frustration to grief as they assist elderly and disabled clients, all for low wages and few material benefits in compensation. Above all, the experiences of workers on the front lines of the long-term care industry tend to be ignored by the wider public, and social policies usually fail to take into account the importance of ensuring fair working conditions to allow paid care workers to form these complex caring relationships with their clients without being exploited.

Relationship between Worker and Patient

In this section, I discuss the attitudes and feelings of study participants regarding competency and pride in their work. I examine their perspectives on the physical workload involved in their relationship with their client as well as how they view their performance and skills on the job. I also examine the emotional and relational aspect of their work in terms of how they viewed issues of grief and loss as well as caring for a dying patient.

Competency and Pride

How professional caregivers describe their work experience is the focus of Stacey's (2011) qualitative study of home care aides. Her findings concluded that many workers find their caregiving relationship truly rewarding; how they are proud of their skill in assisting difficult clients, and are proud of their ability to do work that others may find too difficult or unappealing. This attitude was exemplified in the narratives, and in examining the attitudes of care workers regarding competency and pride in their work. I found that most wanted their labor to be respected. All of them included a description of the day-to-day requirements of the job and interactions with patients, and expressed pride in their abilities. All but two listed a daily schedule of tasks, focusing on the busy daily routine and intense workload. Although the study participants chose to include their full names in their submissions to the narrative symposium, I have chosen to refer to them by their initials in my analysis.

Most study participants made a point to rebut negative social attitudes towards the nature of their work, resisting the classification of what they were doing as dirty work and choosing instead to focus on the importance of their job. A majority described how their work enabled their patients to regain their dignity by ensuring that they were clean and comfortable. Many expressed a desire to be treated with a greater degree of professionalism by all members of the healthcare team, such as Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and physicians.

One respondent, N.R., stressed how hard she worked, although despite all the effort she put into her job she faced a constant struggle for professional legitimacy. She

felt that much more needed to be done to increase respect for and to change the undervalued perception of direct care workers on an individual and societal level:

> I am a very good CNA and am proud to do something that helps my community. We deserve the same respect nurses, firemen, and police get, yet sadly we don't get it. Activities of daily living (ADLs) may seem like no big deal but when you can't do them for yourself or your loved one, they become very important. (Haddad, 2011, p. 150)

N.R. compares this job to a public service position, but unlike other public service sector workers, it is difficult for society to comprehend and value the extent of its reliance on the work of direct care workers. She is aware that when her patients lose the ability to care for themselves, workers like her step in to provide the care in a competent and compassionate manner. When she argues that it is wrong to say her work is "no big deal," she is tapping into deeper cultural attitudes towards the invisibility of the work that goes into protecting the body. In sum, her role in returning dignity to her patients' needs to be seen as dignified. Further, in her narrative, she argues strongly against the concept that such work does not require skill, and she decries such misrepresentation of her work:

> We provide a very important service to our community, and when someone says they are a CNA, they should be able to say it with pride. Images of caring, compassionate, and educated people should come to mind, not someone holding a bed pan. (Haddad, 2011, p. 151)

To encourage her own work and the work of other direct care workers, she advocates for radical changes in how caregivers, and the work they do, are valued by society. Having worked as a nursing assistant for over 30 years, a male direct care

worker, J.B., expressed discontent in hearing how his job was associated with spirituality and religion. His narrative discusses problems that arise when negative social attitudes are used to marginalize direct care workers. He believed that associating his job with a religious calling took away from acknowledging the level of skills required for such jobs. While people may enter this field because they want to help people, an expectation of altruism and sacrifice is unreasonable, given that these jobs fall within paid employment and are not necessarily religiously motivated. It is professional employment, which deserves respect, not praise or an expectation of sacrifice:

> I feel that citing nursing as a calling detracts somewhat from its professional image and is something I have difficulty with. We are professionals, doing an excellent job of care, under sometimes very trying circumstances. There should be no scope for anyone to think that we should accept low standards and conditions because it is our 'calling'. (Haddad, 2011, p. 137)

J.B. was also critical about how gendered assumptions that women are innately suited to jobs requiring care and nurturance undervalued the legitimacy of his profession. As a man working in a female dominated field, he was confronted with particular challenges because of his gender:

> I am a carer. A hands-on, at-the-bedside, hand-holding, bed-bathing, carer. Not only that, I am a male carer. I am not a failed doctor, I am not 'hired muscle,' nor am I gay and I certainly didn't enter the profession to be amongst so many women, as the stereotype would suggest. (Haddad, 2011, p. 134)

His narrative shows how gender ideologies work to reinforce perceptions of women's innate talents as nurturers and caregivers, while dismissing the training, skill building, and hard work required to undertake these positions as care workers in the health industry. These gender stereotypes lie in the way of having care work seen as professional and competent, and such stereotypes discourage other men from entering this field. These stereotypes lead to a disproportionate amount of women in the field, reinforcing patterns of gender inequality in society. With these central issues at the forefront of my analysis, I examine some of the challenges workers face as they form caregiving relationships with their clients.

Grief and Loss

Dodson and Zincavage (2007) described the emotional pitfalls of institutions using a family model of care, without also treating the workers like family. The authors interviewed nursing home workers who felt that the model was one sided. The employers expected the workers to invest intense amounts of patience and compassion into their patients, but only when it was convenient. "Several CNAs [Certified Nursing Assistants] said that while they had been encouraged to care for a resident as a grandmother, they were discouraged to mourn her in that way" (Dodson & Zincavage, 2007, p. 917). The workers felt that their bosses expected them to repress their emotions if their feelings impeded the workflow.

This is in concordance with Foner (1994), whose nursing home ethnography of direct care workers showed how effective caring is impeded by bureaucratic rules. The unfair expectations placed upon the workers, who only are allowed to express feelings when it is convenient and will not influence the profit margins of the institution, show the

exploitative potential in jobs requiring emotional labor. The outcome of such a situation where a worker is forced to suppress job-related grief can be described as a form of burnout stemming from the industrialization of the workforce. Hochschild (1983) described burnout as a consequence of emotional stress stemming from a job. The worker may respond by entering a state of "emotional numbness" where "the human faculty of feeling still 'belongs' to the worker who suffers burnout, but the worker may grow accustomed to a dimming or numbing of inner signals" (Hochschild, 1983, p. 188). To create a healthy environment for caring, an employer must allow workers to acknowledge difficult emotions.

In examining the emotional and relational aspects of care work, a prevalent theme in the narratives is how care workers dealt with grief and the loss of their patients. Several wrote about the challenges of dealing with the grief and loss that is an inevitable part of working in long-term care. While many encountered various experiences with the loss of a patient, several narratives emphasized the experience of grief. At the same time, knowing that they had done their best to comfort their patient throughout the dying process played a significant role in how many caregivers in the study experienced loss of their patients.

One study participant, L.R., reported experiencing emotional trauma at the loss of her patient, which she attributed to the failure of her employer to give her the necessary support she needed at that time. During her first week at the job, she unexpectedly found a resident lying dead on the floor. She had not been instructed on what to do in such a situation and did not know who to call for help. She caused quite a commotion amongst the residents when she had to use a resident's phone to call for help:

> The hall of the retirement community was quite long and it wasn't until I was halfway down the hall before I realized it was a resident lying on the floor. I ran the rest of the way, only to discover the person was dead. I was very shaken.
>
> It took me a few weeks or more before I could close my eyes at night without seeing the body lying in the hallway. I wasn't offered any support from the agency; the next day was business as usual. (Haddad, 2011, pp. 151-2)

She went on to describe how painful it was for her that her employer expected her to show up to work the next day as if nothing happened; "I cared about my clients, but for the agency the clients meant money and I had to remain focused and keep on working (Haddad, 2011, p. 152). No provision was made for her to access grief counseling in the aftermath of losing her patient; a fact she attributed to the agency's desire to cut costs at the expense of her emotional well-being.

Her sense of disappointment was clear in her writing, as she talked about feeling overwhelmed by negative experiences with loss, and an ensuing lack of support. She felt that her employer failed to adequately prepare her to deal with death, and did not provide resources to deal with the aftermath. Her overall feeling was that her employers expected her to keep on working as if nothing happened and to repress her negative emotions. She described the negative consequences she experienced in dealing with death at work:

> I believe that if I had grief support opportunities available to me in my professional life, my level of care and compassion would have been much more resilient from the very beginning of my work as a CNA. Instead,

> only after sorting through emotions affecting my personal life and learning they were a compilation of what I experienced professionally, only then have I become much more resilient in the face of grief and mourning. (Haddad, 2011, p. 153)

Inclusion of a care worker by the family in the funeral arrangements of a deceased patient was helpful to care workers dealing with the grief they experienced in the loss of a patient. In contrast to L.R's experience, another study participant, T.D., with 15 years of experience caring for patients, described how having the family include her in the funeral arrangements was a very meaningful, positive experience amidst the loss:

> Another elderly gentleman I cared for was very special to me. We hit it off from the time of his admission. The day after he passed away, his son called to ask me to be a pallbearer for him, of course I did and was honored that I had touched his life in a special way. (Haddad, 2011, p. 138)

T.D's narrative shows how recognition of a care worker and their inclusion in the funeral arrangements showed how the patient's family acknowledged and appreciated how the care worker had made a positive impact on the life of the deceased patient. The family's request to have her pay final respects at the funeral of the deceased patient was testimony of the family's gratitude. The above narrative shows that families can play an important role in letting caregivers know that their work is important. The following section examines the role of care workers in caring for the dying, another very emotionally draining segment of the health industry.

Caring for the Dying

The importance of caregiving relationships in the dying process is discussed by Roy (1988) who defined a requirement of dying with dignity as "dying in the presence of people who know how to drop the professional role mask and relate to others simply and richly as a human being" (p. 36). Many of the care workers in the study demonstrate Roy's requirement of helping a patient to die with dignity in their narratives.

A female care worker, D.P., who was employed in the direct care profession for 43 years, provides an example of the type of compassion expected of care workers in caring for the dying. Working in the field for so long meant that she had seen many patients die, although her feelings of grief were tempered with the knowledge that she was there to ease their suffering. Her narrative explains how painful it was for her to lose someone she had grown extremely close with, even though their relationship was strictly professional. Knowing she did her best to help her patient made the eventual loss easier to bear emotionally:

> Unfortunately, getting close can be difficult. If I have an elder who is starting the dying process, I find myself wanting to spend as much time as I can with them. So often I have gotten so close to them that that it almost feels like I am losing one of my own family members. This can be very hard, but I do realize it is part of life. I find that I am grateful that I became part of their life, cared for them, learned from them, and was able to help maintain some dignity for their remaining days. (Haddad, 2011, p. 144)

Direct care workers such as the narrator are one of those people Roy (1988) would consider vital to ensure such a death. Her narrative gives the impression that she

felt privileged to be there to assist a dying person in transitioning towards death. Although she experienced grief from losing people she had grown to care about, she realized it was the nature of the work and was grateful to be there for the patients who needed her. An awareness of the important role she played in helping the patient made it easier for her to deal with her grief.

Providing a sense of dignity for those going through the dying process is a significant role performed by these direct care workers. Another study participant, R.J.T., a female care worker who worked in the field for 37 years, described an experience with a dying patient early in her career when she was only 25 years old. This particular patient experienced a very difficult death, bleeding to death from a giant tumor less than 24 hours after admission into a long-term care facility. All the direct care workers involved in this case were told how the woman would die, and instructed by fellow healthcare workers on what to do to make her comfortable. The workers made sure not to leave the dying woman alone in her last hours:

> The day she died, her tumor started a heavy flow of blood. She knew it was the end. We had dark towels for her, she lay in her bed, she was never left alone. We had our work to do, but she was never left alone. What I remember most is her eyes; you see, she could not speak that day. She looked at us as if to say "Thank you, thank you so much for treating me so good and not like a monster." (Haddad, 2001, p. 155)

With this anecdote in her narrative, R.J.T. expressed that what she remembered most was the gratitude of the dying women, not the trauma of losing a patient. Her perspective on experiencing the loss of a patient is different than that of L.R., discussed

previously, who described her trauma of finding a dead patient on the ground. One potential reason for the different perceptions could be because R.J.T. was told what to expect. L.R. mentioned how her training did not prepare her for this, while R.J.T. described how her superiors spoke to all the workers assigned to the dying patient and explained what was happening.

A significant difference between these two worker narratives is how the employing institution prepared and supported the workers by providing information about what would happen and what their role would be. This advance preparation could be one reason R.J.T's narrative focused less on the negative shock of losing a patient like L.R.'s narrative did, and more positively on the gratitude of the dying woman. Although the two cases are different because in L.R.'s case, the patient died suddenly, while in R.J.T's case the patient's death was expected, losing a patient is a common experience among long-term care workers. In caring for the dying, workers commonly have to deal with the difficult emotions that come along with end of life care, so employing institutions should be held accountable to prepare their employees accordingly.

The overall findings from the foregoing analysis of care workers' experiences with grief and loss show that direct caregivers play an important role in caring for the dying. Grieving over the loss of a patient was a common experience and a relevant challenge faced by direct care workers. Many formed emotional bonds with their patients and being in such close proximity to death had an emotional impact on them. Some of the narratives suggest that expressions of appreciation made witnessing the dying process easier to bear for the care worker. Others show that when they were supported through

their grief, when they were told what to expect and felt that they had helped the dying person, care workers were less likely to have regrets or suffer ill effects.

Analysis of these narratives demonstrate the complex nature of caregiving work and show the ways in which overlap can occur between emotional and professional demands in a task oriented model of care. The following section examines the relationship between direct care workers and their institutional employers.

Relationship between Worker and Institution

Shifts in the economy and evolving family structures have made it increasingly difficult for individual families to provide all the long-term care needs for their elderly members. As a result, the healthcare industry has stepped in to provide professional long-term care services. An analysis of the relationship between paid caregivers and the institutions that employ them is useful to understand how an institutional setting changes the dynamic of the caregiving relationship between workers and patients. Examining this relationship from the perspective of the worker broadens understanding of how constraints imposed by the bureaucratization and commodification of care lead to the exploitation of workers.

Low-level care workers in the healthcare industry such as Certified Nursing Assistants typically earn low wages with limited or no benefits. They also experience job-related stress between having to balance their employer's need for efficiency with the complex needs of their patients. Direct care workers are also subjected to a lack of professional courtesy stemming from social assumptions that their work is not important. I examine this institutional relationship by singling out from the narratives attitudes concerning (1) economic exploitation, (2) job related stress, and (3) professional courtesy

or lack thereof. My goal in analyzing the narratives is to understand the worker's specific experiences within broader thematic contexts.

Economic Exploitation

The difficulty of finding an economic method of valuing and compensating paid care work is a continual challenge for our society to solve. In their discussion of health care at home as opposed to in an institution, Howes, Leana, and Smith (2012) described the attributes of an effective method of organizing care that leads to high quality work conditions, and high quality care outcomes:

> The most effective forms of work organization mimic the organization of high-quality care provision in the home when the care provider is motivated by deep commitment to the care recipient, has sufficient autonomy and discretion to respond to the specific needs of the care recipient, and is able to collaborate effectively with other care providers. (Howes et al., 2012, p. 87)

The workers in the following narratives provided examples of how their current job lacks these attributes, and a consistent theme identified in the relationship between the institutional employer and care worker is how workers feel exploited due to their low wages and lack of benefits. A common complaint raised in almost all of the narratives was that they were not paid enough to become economically self-sufficient. The sample of study participants was skewed in favor of workers who had performed direct care work for their entire careers. Despite having made this work their careers, many expressed a valid fear that they would eventually have to leave to seek other employment because they could no longer support themselves with this job. This state of affairs shows how

exploiting the worker in the short run leads to high turnover and is especially harmful to the patients who would benefit from being cared for by familiar faces. This is in accordance with a statement made by the study participant T.D., who mentioned feeling that the lack of a living wage corresponded to a lack of respect for her work:

> This country needs to respect the important work direct care workers do before it is too late. We need to make the direct care profession an appealing one. We need to pay a living wage with affordable benefits. (Haddad, 2011, p. 139)

T.D.'s narrative criticizes hiring institutions that refuse to make this type of work more appealing by improving work conditions. Presumably, the low wages are one of the reasons for high turnover rates among workers. According to a policy report published by *Better Jobs Better Care*, a national research group focusing on healthcare policy in the long-term care industry, the cost of this turnover has a substantial financial impact on long-term care institutions. "Each time a direct care worker leaves a long-term care provider organization, financial and human resources are lost to new recruitment and training, and either overtime is paid out to an often increasingly stressed workforce, expensive replacements are hired in from temporary staffing agencies, or care hours simply go undelivered" (Seavey, 2004, p. 8). Because of the negative impact turnover has on the industry, these narratives by direct care workers shed light on the reasons for leaving and provides a valuable insight for policymakers. In addition, another worker, D.K., stresses how he also feels that the low wages are one of the top reasons that discourage workers from remaining in this job long term:

> I know in every profession everyone thinks they deserve higher wages. When I started ten years ago as a nursing assistant right out of training, I started out at $8.25 an hour. Today, a nursing assistant right out of school starts out at $8.50 an hour. That amounts to a 3% raise in starting wages over ten years. This is what some of the nursing assistants are getting to care for residents and do 90% of all hands-on care for your loved ones. (Haddad, 2011, p. 143)

Some of the problems that arise with the rationalization and commodification of care under capitalism are raised by another worker, D.P.:

> Without the proper funding from the federal and state government, how are we going to be able to keep up with the quality of care that we want to give, and that elders deserve? My facility depends greatly on reimbursements for many of the cares and therapies. Cutbacks in funding mean staffing reductions. How will we care for them? These issues seriously need to be addressed by our government. We are talking about human lives. (Haddad., 2011, p. 144)

This narrative addresses the issue of funding for institutionalized care from the Federal and State governments. Nursing homes are funded by government programs such as Medicare and Medicaid, and a reduction in such funds means a reduction in the money earmarked for staffing and care for the elderly. D.P. argues that care cannot be an individual responsibility, but can only be sustainable when the burden is shared amongst social entities that have the infrastructure to provide it. Caring for human lives cannot be solely based on a profit driven cost benefit analysis since moral and ethical dilemmas

arise when caregivers and care recipients are harmed and exploited (Howes et al., 2012). An additional pressure on care workers, in addition to the low pay, is job-related stress which results from the interaction between care workers and their institutional employer.

Job Related Stress

A consistent theme identified in this relationship is how workers perceive the impact of juggling the physical and emotional demands of caring for their patients and meeting the bureaucratic demands of a task oriented model of care. Foner (1994) described the difficult role direct care workers have in ensuring residents' quality of life in the face of a strict, highly regulated institutional environment:

> Nursing homes are institutions that aim, in a sense, to bureaucratize or rationalize affective care. Administrative rules regulate staff who, as part of their jobs, are expected to provide personal attention and sympathetic care to patients. Bureaucratic rules can come into conflict with workers' emotions and personal relations with patients, and patients are often the ones to suffer. (Foner, 1994, p. 53)

The task-oriented model of the bureaucratic institution inhibited the time workers could spend cultivating caring relationships, yet they would be the first ones blamed by their superiors if something went wrong (Foner, 1994, p. 77). Many workers describe the difficulties they experience due to the fast paced nature of the job; they have so much to do that they cannot always take the time needed to cultivate emotional relationships.

Diamond (1986) interviewed nurse aides who complained that their ability to care was overshadowed by medical tasks. He argued that the dominance of the medical model led to their low job satisfaction, their low wages, and created an environment

discouraging care, and a "climate of trouble for nursing assistants" (Diamond, 1986/1992, p. x). A common complaint raised by almost all study participants was that there was not enough time to do all they wanted to do. Many acknowledged nonetheless that it was the nature of the healthcare field to be fast paced and highly stress related.

Almost all the narratives noted that patient/aide ratios led to stress among the workers, stopping them from having the time they wanted to cultivate relationships with the patients. One worker, D.K., described the challenges of high patient/aide ratios:

> Would I like to give more time to each resident? Yes, we all would. How could this happen? Let's explore this idea for a minute. One way to have more time with the residents is for the federal government to lower the aide-to-resident ratio. Will that happen? Only if we aides and the public get our elected officials to do so. (Haddad, 2011, p. 142)

In his narrative, D.K. goes further to argue how he feels that because the institutional patient/caregiver ratios are artificially constructed, the fast pace of the work sets workers up to fail, or makes them feel burnt out and exploited. He contends that this is not a good feeling to engender in the people tasked with taking care of society's most vulnerable. He argues that the low priority placed on worker satisfaction means that healthcare institutions are not set up to encourage long-term work relationships with their employees. Given that the well-being of the patients is inextricably linked with the well-being of the workers, such problems will persist if changes recognizing the need to improve working conditions are not made at the policy level (Haddad, 2011, pp.142-143).

While nursing homes are highly regulated environments, many of the narrative participants felt the regulations are either not adequately enforced or enforced too strictly,

discouraging the quality of care and exercise of initiative on the part of the care worker. D.R. a male Certified Nursing Assistant who worked in nursing homes for over 30 years described the highly regulated nature of his workplace, and noted the paradox of how the regulations inhibited genuine caring relationships:

> Regulations cannot enforce caring attitudes nor create a caring atmosphere. People do. As a consequence, these caring people are subjected to what I call the law of escalating demands whereby they are mandated by law to uphold standards on demand with unpredictable and unstable resources that continuously call upon their instinct to care more, do more, and go above and beyond, endlessly…. Again, whether the exception or the rule, regulators and regulations do not stop the oppressive environments if the system allows it. (Haddad, 2001, p. 147)

The study participant N.R. is critical of the way employers refuse to hire more workers and then use emotional manipulation to extract more work from the care workers. She is especially critical of how abandonment rhetoric blames the individual for an institutional problem:

> "Your residents need you." Or "abandonment" when I hear this, my thought is: the residents need the facility to hire more of the 'right' people. They don't need me to overwork and burn myself out. …. trying to insinuate that it is abandonment and pull on my heartstrings or even worse to make me feel like I have *no choice* is just wrong. (Haddad, 2011, p. 148)

N.R.'s narrative demonstrates clearly how making workers feel guilty for situations not of their own doing made her feel that her employer was showing a lack of respect to her as a person, and as a worker. The narrator is quite clear that the employer should be blamed for creating these oppressive conditions by refusing to invest money on hiring more workers, or improve working conditions to attract workers that are more qualified. She is highly critical of her employer placing the stress and blame on the workers instead of being held accountable for creating such conditions. N.R. is critical of her employer's unwillingness or inability to pay for more aides, and resents how the burden to care for the clients is placed on her, instead of having it be acknowledged that much of the responsibility to provide an environment conducive to caring is on her employer and on society as a whole

Many workers in this field go above and beyond their job requirements as they form genuine relationships with their elderly and infirm clients. These workers, many of whom are women, are aware of the injustices and unfairness in their work environments, and are fighting to have their professional contributions to patient care better acknowledged ideologically, professionally, and economically. Since women have traditionally provided care for elderly and infirm relatives in the private setting, the impossible economics of care work remains obscured by problematic gender ideologies. Hochschild (1983) described how certain jobs, many of which are disproportionately made up of women, require workers to perform emotional labor in addition to the actual requirements of the job. Emotional relationships are an intangible expectation of the job that is difficult to measure or compensate fairly due to the forces of capitalism that reinforce the idea that caring is done for love, not money.

Professional Courtesy

Finally, another issue that care workers face is that of respect and courtesy, an underlying problem related to issues raised about economic marginalization and job related stress discussed in the previous two sections. A dominant theme in the relationship between direct care workers and their institutional employers is how workers experience professional courtesy and acknowledgement of their physical contribution to patient care, how their work is perceived by other healthcare professionals, and by their institutional employer. The dominant staff in long-term care institutions are nurse aides, who interact the most with the residents who have highly complex medical needs. Kane, et al. (1998) described the complex task of providing care to people with chronic health problems, who require "appropriate and parsimonious use of medications, management of incontinence and the underlying problems that cause it; detection of acute illnesses…consciousness that foot care, hearing, vision, and dental care may improve functional abilities; and detection of untreated depression" (Kane et al., 1998, p. 166). The Certified Nursing Assistant's role in caring for the resident is very significant for their overall well-being, and despite the fact that the scope of their practice does not include actively treating patients, their role in preventing and caring for patients with complex health needs is unfairly marginalized within the professional hierarchy.

J.B., a male narrator who had worked as a care worker for 30 years, described the challenge of having his opinion dismissed because of his poorly respected job title and lack of professional status:

> It is negligent to ignore the valuable experiential input from nurse assistants simply because they are not deemed professional in the

> hierarchy of things. The front line carers are only too well aware that we are dealing with people, not products, profits and budgets. (Haddad., 2011, p. 136)

He is critical of the way workers like him are excluded from the decision making process regarding patient care. Although the respondents spent a lot of time directly interacting with patients, and are most likely to notice any health condition changes, J.B. was not alone in expressing the belief that Certified Nursing Assistants are not treated with the respect they deserve as part of a healthcare team. A culture of disrespect for care workers ignores the commitment they have towards their work, and discourages open communication that would be in the best interests of the patient and the institution as a whole.

Some of the narratives provide alternative solutions to foster a more open and improved work environment that does not rigidly adhere to professional hierarchies. For example, R.J.T., a female hospice and palliative care nurse assistant who had worked in the field for 37 years wistfully described a solution that was no longer in place. She recalled working at a former institution where the manager encouraged on-the-job advancements and education programs for Nurse Assistants:

> The incentives were what they called the Leader Ladder. This Ladder was there for you to climb to the highest occupation in the nursing field you wanted to go, with the help from the scholarship program in place. The goals of the employer were retention, reliability, support, and dedication from the employees. This is not in place today, especially in the long-term

> settings. There is a revolving door in most places…. we are the forgotten, the invisible. (Haddad, 2011, p. 155)

The narratives indicate the extent to which extending professional courtesy towards care workers will improve their work experience and commitment to the job. Despite their lack of technical experience or medical training, their professional and experiential input is valuable because they perform daily care and may notice minute changes or deterioration in the patient's condition. As such, these narratives broaden our understanding of how care workers perceive the complex and interrelated conditions that shape their relationship with employers and about their desire for greater professional acknowledgement of their tangible contributions to patient care.

Discussion

My goal in analyzing worker narratives was to get an insider's perspective on the long-term care industry. By focusing on the frontline workers who do most of the hands on caring of the disabled and/or elderly patients, I attempted to gain a nuanced understanding of what the patients need to have as comfortable an aging process as possible. It would be impossible to care for society's loved ones, the long-term care recipients, without also caring for the workers who care for them and perform a much needed service to society.

Despite the important work they do, professional caregivers face many challenges. One challenge is the difficult nature of the work itself, how it involves cleaning intimate bodily functions and requires direct contact with patients who may suffer from a variety of medical conditions. Caregiving is also classified as low skilled, unlike other medical professions which come with high prestige and status. Here, many

study participants mentioned a desire for their work to be appreciated instead of having the stigma of dirty work follow them; for example, one respondent said she wanted the job of a caregiver to be seen as public service, not "somebody holding a bed pan" (Haddad, 2011, p. 151).

Many narratives also addressed the economic aspect of the work. Caregiving is different than other medical career paths because it is a relatively quick process to receive the qualifications for it, on average requiring less than a year training. The lack of barriers to entry, and the minimal training requirement can be considered a positive aspect of the profession because it allows many people to start working immediately and helps ensure a steady supply of job applicants. However, over the long term, such a system backfires because these initial standards do not work well at getting the workers to stay, or encouraging qualified applicants to remain in the position for long, and instead pushes them out to a more lucrative career path. Many of the respondents seemed to be the type of caregivers most people would want to have with them in their final days, but unless the job conditions and wages become more appealing, caregivers like the study participants will have few motivations to make this job their career.

Caregiving is also a very emotionally rich field of work because workers get to familiarize themselves with the individual patient's personality, and develop both personal and professional relationships. Here, the narratives showcase a sample of professional caregivers who remained in the job an average of over ten years, which gave many of the workers time to become familiar with the individual characteristics of clients who they got to know on a personal level. The emotional aspects of the job came into sharp relief in the anecdotes describing losing a patient. While loss is inevitable when

caring for patients of such a demographic, the anecdotes about patient loss show that having a supportive work environment and adequate training makes a difference in the emotional toll losing a patient has on the workers.

These issues all reflect the values of care ethics and an equitable system of healthcare. A just society requires that these workers are appreciated instead of being rendered invisible. A way to do that is to ensure that they are compensated fairly and have their contributions acknowledged and respected within the healthcare industry.

CHAPTER 4: CONCLUSION

My research examined the role of professional caregivers within the long-term care industry from the worker's perspective, with the goal of discovering ways to reduce turnover and increase job satisfaction by implementing ways to improve their work environment and labor conditions. Understanding the vital role these workers play in the long-term care industry, and how healthcare policies can be adapted to address their needs, is important because over the coming years the over-65 population in the United States is expected to increase as the Baby Boomer generation ages, and demand for these workers will likely outrun supply. As more families are unable to meet their loved ones' growing need for care as people live longer and with more complicated medical conditions, paid caregivers will become a vital necessity in order for families to ensure their loved one is protected and cared for.

The study was based on thematic analysis of narratives written by Certified Nursing Assistants and focuses on the perspectives and experiences of frontline care workers. The narratives were procured by a Bioethics Journal which sent out a request for Certified Nursing Assistants to send in written narratives telling the story of their experiences throughout their careers. The majority of study participants had made this work their career and had been doing this job for at least a decade.

I used Feminist Content Analysis and Feminist Standpoint Theory as a method to analyze worker narratives in order to enhance our understanding of the long-term care industry. This method enhances our understanding of the complexities involved in

examining the long-term care industry because it is designed to study the impact of traditionally marginalized voices. Here, the workers play a very important role in the

long- term care industry, but they are marginalized and rarely are included in the decision-making process at nursing homes and other institutions that provide care. Listening to the workers describe the challenges and joys of their job provides a valuable, nuanced look into long-term care industry, its flaws, and ways it can improve and increase positive patient outcomes. This would be helpful in implementing a more worker-centered attitude towards healthcare policy. Certified Nursing Assistants are expected to be in high demand as the United States population ages, and a focus on promoting worker well-being can help ensure a supply of qualified long-term care workers who will be needed in the coming decades.

My goal was to analyze their responses in order to and to find out what would make workers today more likely to view a job as a Certified Nursing Assistant as a desirable, long term career option. I looked for themes in their narratives describing their work relationships, and the two main thematic categories I identified in the narratives were (1) Relationship between worker and institutional employer; and (2) Relationship between worker and patient (and patient's family). Specific themes I identified in my research as the main sources of worker dissatisfaction were the low pay, the lack of professional courtesy, and the physical and emotional toll of the job. Many respondents recognized that their job does not satisfy the traditional requirements of a good job, yet many also discussed their non-economic rationales for choosing this career, which included pride in their skills, and satisfaction from serving patients. Yet they recognized that their work experience would improve if they would be guaranteed the essential

elements required for worker satisfaction in any profession, namely fair wages, respected professional status, and a supportive work environment and employer.

Throughout this work, I discussed how the attitudes towards care work underlying current healthcare policies do not create a work environment conducive to caring, nor do they acknowledge the important role professional caregivers play in the healthcare industry. The overall argument for this thesis is that although professional caregivers play an important role in society by taking care of the old and sick, the current structure of the caregiving industry hinders their ability to do their jobs effectively.

This work was theoretically informed by feminist theories towards care work, including the feminist ethic of care, (Gilligan, 1982; Nussbaum 2002, Feder & Kittay, 2002); and theories of feminist economics about the market provision of care (Folbre, 2001; Fineman, 2004). In addition, the sociological theories of emotional labor (Hochshild, 1983) and dirty work (Hughes, 1951) were used to analyze the daily tasks these workers were expected to perform on the job.

I chose these theoretical frameworks to apply in my analysis because of their value and relevance in providing depth of analysis of the issues. Hochschild's (1983) theory allowed me to understand how economic relationships interact with caring relationships. Because the daily tasks performed by professional caregivers may need to be tailored to each individual patient, many workers gain a nuanced understanding of the individual's unique personality, and a complex bond based on professional obligations and personal feelings ensues. The framework of emotional labor allows a researcher to delve deeply into the feelings and emotions that are not necessarily part of the formal job

requirements, but occur during the course of the workday because of the intimate nature of the work.

Hughes' (1951) theory allowed me to understand how care work is perceived by society, and how negative social attitudes influence how workers see themselves. By examining how some professions become stigmatized. Multiple factors, including the emotional and physical aspects of caring for sick people, coupled with stigmatizing attitudes about the workers themselves, combine to make professional caregiving unnecessarily difficult. Using this framework, I was also able to examine the many ways workers create a counter-narrative that allows them to feel pride and satisfaction with their profession.

Feminist Economics (Folbre, 2001; Fineman, 2004) allowed me to understand why these workers are at high risk for exploitation. Certified Nursing Assistants are a segment of the labor force who are vulnerable to labor and human rights abuses because of low wages, lack of legal protections, and the dangerous conditions rampant in unskilled labor industries. Certified Nursing Assistants are marginalized within the healthcare hierarchy, and suffer due to the negative social attitudes about the nature of the work, which is compounded by gender and race discrimination. Feminist economics theory is used to understand the historical origins of deeply ingrained ideologies that view care work as a "labor of love" that does not require adequate compensation.

The feminist ethic of care (Gilligan, 1982; Clement, 1996; Nussbaum 2002, Kittay & Feder, 2002) allowed me to try to come up with a philosophy that would remedy the abuses inherent in the current system, and find potential ways to improve healthcare policies.

This research has contributed to existing understanding of professional caregiving because the themes I found have been consistent with preexisting theories of care work. When the respondents described their discontent with the lack of professional courtesy and low wages that did not increase over time, their complaints were consistent with the feminist ethic of care, which is a philosophical framework critiquing how care is perceived and valued in the current socio-economic system (Gilligan, 1982; Nussbaum 2002). Care work cannot cleanly fit into the post-industrial capitalist economy because it is hard to quantify the intangible value of making an elderly patient feel cared for.

In the context of feminist care ethics, Nussbaum argues that the social organization of care work is a significant challenge for society, and that all people are dependent on others for care at some point or another in their lives. "[A]ny real society is a caregiving and care-receiving society and must therefore discover ways of coping with these facts of human neediness and dependency that are compatible with the self-respect of the recipients and do not exploit the caregivers" (Nussbaum, 2002 p. 188).

Many respondents decried the understaffing and escalating obligations placed upon them that they felt made it impossible to provide sufficient time to each patient. Such an "assembly line" model of care may be good for the employing institution's bottom line, but bad for workers and patients because the time pressure adds unnecessary stress and prevents workers from having the time to provide a high standard of care. Unfortunately, many workers felt that they were discouraged from providing the high standard of care that they would have liked to provide because any additional time that was taken to care for a patient risked disrupting the strict schedule of the institutional environment.

Additionally, the institutional environment impacted the worker on a personal level too. One of the challenges faced by workers was accommodating their personal emotions and feelings towards their patients within the strict parameters of their employer's profit-driven institutional environment. Hochschild (1983) described how emotional labor is a source of stress:

> [W]orkers experience a dimension of work that is seldom recognized, rarely honored, and almost never taken into account by employers as a source of on the job stress. For these workers, emotion work, feeling, rules, and social exchange have been removed from the private domain and placed in the public one, where they are processed, standardized, and subjected to hierarchical control. (Hochschild, 1983, p. 153)

The respondent's narratives describing the difficult emotions they experienced while caring for the dying about grief and dying were consistent with Hochschild's framework of emotional labor that describes jobs that require workers to school their emotions while on the job, in addition to the ways the job emotionally affects workers' personal lives.

The loss of their frail and sick patients was inevitable due to the nature of long-term and end of life care, but workers also described instances where they had to perform emotional labor while dealing with living patients. The daily interactions with patients required the schooling of emotions when patients or family members directed their frustration onto workers. Some workers were able to intellectualize the uncomfortable outbursts and not take it personally by viewing it as not the patient's fault, especially with

patients who exhibited such volatile behavior due to physical and psychological disorders.

In addition to the emotional demands of the work, respondents described the actual physical requirements of the job as part of the difficult nature of the work, which included assisting incontinent patients and cleaning waste. This was consistent with a specific element of the theory of dirty work by Hughes (1951). Hughes discusses the challenges faced by healthcare professionals who deal with intimate aspects of patient care, but also take on the role of providing much needed spiritual and emotional comfort to the patients, and the rewarding aspects of the job provide a sense of satisfaction that makes up for the more difficult or messy parts of the job.

My findings link to this theory because many respondents expressed how they considered themselves members of the healthcare team whose professional role included a variety of tasks necessary to preserve the patient's physical and emotional well-being. They decried the negative stereotypes about their job – stereotypes which corresponded with the factors Hughes (1951) had listed as endemic to professions considered "dirty work". Many respondents felt they were denied the respect given to doctors and nurses, because although they were part of the same team, the Certified Nursing Assistants were not using any advanced medicinal or surgical techniques, but rather providing care that maintained the patient's status quo, instead of a path towards a cure. The difference between skilled and unskilled healthcare, and the different attitudes towards caring vs. curing, meant that the higher ranking medical professionals did not experience as much stigma as the caregivers. Many pointed out the logical inconsistencies in the negative

perception towards their work because of how important it was in protecting the patients' overall health.

Another issue many of the respondents called attention to was the important role they played in patient care by assisting patients with the activities of daily living. Their familiarity with the patient's daily routine meant the Certified Nursing Assistant was usually one of the first members of the healthcare team to notice something was medically wrong. The workers wanted to be viewed as professional members of the healthcare team, not just as accessory staff performing menial labor, and wanted to be acknowledged as performing an important function in society by caring for the sick and dying. Some respondents rejected the stigma and misperception of their work and instead asked to be perceived as performing an important public service and making a positive difference in their patients' lives.

In conclusion, I believe this research adds to the current literature on professional caregivers because narrative analysis provides a more nuanced understanding of the industry than employment statistics or demographic data. Narrative analysis can provide a window into the individual experiences of caregivers, and can provide a more comprehensive understanding of the caregiver/patient relationship. I hope that conducting this research allowed me to draw attention to the opportunities and obstacles of a career in the professional caregiving industry.

Limitations

This study was not able to address certain issues relevant to the long-term care industry because of the small sample size and the fact that the data is based on written narratives, instead of in person interviews where I would be able to ask follow up

questions. Another limitation is that these narratives were designed to answer someone else's research question, and I was only able to access the study once it was published in the Narrative Symposium. The sample size consisted of only eleven narratives, and all the respondents were from a narrow geographical area within the Midwestern United States. Of the eleven respondents, three were male and eight were female. The respondents did not disclose their race or immigration status. The lack of this information limited my ability to make generalized conclusions based on these findings because this sample does not represent the majority of the workers, many of whom are immigrants and/or people of color.

Another limitation was selection bias of the respondents, who were all career Certified Nursing Assistants, and most had been doing the job for over 10 years. This sample does not represent the majority of professional caregivers, who, according to the Bureau of Labor Statistics (2016) job report, are likely to leave the job after less than a year. Many of the research participants had been in this career for longer than a decade, meaning that their experiences could not be used to make conclusions about the average worker who spends less than a year in this job. However, the small sample size of workers with many years of experience was beneficial because their narratives contained a lot of information about their various experiences working in this industry for so long, and allowed me to place their experiences within multiple theoretical frameworks.

Suggestions for Future Study

Future research on how the work environment of Certified Nursing Assistants could be improved to encourage worker retention could be based on longitudinal data from workers who are at the start of their careers to determine what would encourage

them to remain in this job for a substantial period of time. Future studies can analyze workers from a wider geographic area in order to more fully represent the demographics of this workforce. In many areas in the United States, this field is disproportionately made up of people of color, minorities, and foreign born workers who may lack U.S. citizenship status. Incorporating additional factors into the analysis, such as the race and immigration status of the Certified Nursing Assistants can be studied to determine whether racism or anti-immigrant bias impact to the poor working conditions and low rates of worker retention in this industry.

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