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“It’s a Dignity Thing”: Nursing Home Care Workers’ Use of Emotions¹

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Abstract

This article examines how nursing home care workers use emotions to construct dignity at work. Previous scholarship has shown how the financial and organizational characteristics of nursing homes shape and constrain emotion work among staff. Using evidence gathered during 18 months of participant observation in two nursing homes and 65 interviews with staff, this article analyzes how, despite obstacles, nursing home care workers generated authentic emotional attachments to residents. Surprisingly, some staff members said they particularly appreciated working with residents difficult to control. They felt accomplished when such residents successfully transitioned from life at home to life in institutional care. Emotions created dignity for staff and induced compliance among residents. Emotions are not only generated by organizations and imposed on workers; staff themselves produced emotions—sometimes in ways consistent with organizational demands, and sometimes not—and they consistently found in their emotions a resource to manage the strains of their work lives.

Keywords

aging; care work; dignity; emotions; ethnography; health; nursing homes

INTRODUCTION

Care workers in institutional settings such as nursing homes face a unique set of challenges. Their work lives are marked by routine acts of intimate care that are usually done alone in the privacy of home. In nursing homes, these everyday activities—bathing, dressing, and feeding—are transformed into bits of labor to be carried out by low-paid paraprofessionals who often work under difficult conditions that prioritize profit over emotional care. The profit motive in nursing home care drives the intensification of work, makes an already challenging job even more demanding, and ultimately constrains and limits the capacity to feel emotional attachments that spring from care work.

Nursing home care was once a mostly nonprofit enterprise administered by religious organizations and government-owned facilities, but in recent decades it has become a market-driven and highly competitive industry (Kaffenberger, 2001). In 2008, more than two-thirds of the nation’s approximately 16,000 nursing homes operated for profit, and more than half were owned by multifacility organizations (Harrington et al., 2008). Trends in

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recent years have shown a gradual expansion of the for-profit sector and contraction of the market share for nonprofit and state-owned facilities. Additionally, nursing home ownership by private equity groups is growing, often with complex management structures that obscure ultimate responsibility for residents' care and safety (Stevenson and Grabowski, 2008).

The aging of the population may exacerbate these trends. Thirteen percent of the U.S. population is over the age of 65 and this is expected to rise to 20% by the year 2030 (He et al., 2005). More than half of the 1.5 million people living in nursing homes are over the age of 85. The U.S. Census Bureau reports that the number of individuals over age 85, currently about 5 million people, will double by the year 2030 and increase even faster to about 20 million by 2050. On the other hand, the percentage of the 85-plus population living in nursing homes has been dropping. About 16% of them lived in a nursing home in 2006, down from 21% in 1985, according to the National Nursing Home Survey.

Despite the organizational demands that limit the scope and character of emotions, nursing home care workers, like all workers, strive to construct a feeling of dignity and meaning in their work. Recent scholarship has illuminated the various ways in which workers struggle to craft dignity in the context of their work (Hodson, 2001). Such research usefully extends our knowledge of the experience of work, but has not given enough attention to the role emotions play in the process. This article extends previous scholarship by analyzing how workers use emotions in novel, creative ways to dignify their work.

Arlie Hochschild's classic, *The Managed Heart* (1983), is the most influential recent scholarship to examine the connections between work and emotions. Hochschild coined the phrase "emotion work" to signify how we alter our emotions to fit the norms and standards of a given situation. She argued that the repeated display of emotions that are not authentically felt, when performed for a wage, represents a new form of worker control and intense labor exploitation. However, subsequent research showed how emotions are not only generated by organizations and imposed on workers; workers themselves actively generate emotions, sometimes in ways consistent with organizational demands, and sometimes not, and they consistently find in their emotions a resource to give their work meaning and significance to suit their own purposes.

The organizational devaluation of emotions in nursing homes put limits on workers as they struggled to connect with the individuals for whom they cared. Nevertheless, nursing home care workers often grew emotionally attached to residents for a variety of reasons, and sometimes for no obvious reason at all. Furthermore, staff especially valued caring for the most challenging residents because it gave them a sense of accomplishment to help residents adjust to life in institutional care. Emotions were a source of dignity for the staff, but they did more than that: emotions were also a resource to exact compliance from residents. Ultimately, managers may attempt to organize and control emotions, but workers push back and use emotions to create independent systems of meaning.

EMOTIONS AND PAID-CARE WORK

Emotions are a central component of doing paid care-work. Recent scholarship has argued that paid care-work transcends a simple market-exchange precisely because of the emotions that permeate the transaction between care recipient and care provider (England, 2005). Feminist economist Nancy Folbre (2001), for example, defined care work as labor that provides a service involving close, personal contact that is motivated partially by concern for the welfare of another. The essence of care work defies its complete commoditization (Himmelweit, 1999); it has personal and emotional significance that cannot be adequately captured or regulated by the market in which it is bought and sold.

Long-term care settings are unique in the world of care work because they involve intimate interactions with residents for extended periods of time within an institutional setting. Nursing home care workers have emotional attachments to the individuals they provide care to, even as those emotions are constrained by structural characteristics of long-term care (Diamond, 1992; Foner, 1994; Lopez, 2006). Staff say that residents become “like family” (Bowers et al., 2000; Dodson and Zincavage, 2007). Describing attachments with familial metaphors is particularly pronounced when nurses care for individuals who are on the verge of death. In managing the difficult emotions that accompany the death of someone who is “like family,” staff use their own personal experiences of death to make sense of death in the public sphere of the workplace (Black and Rubinstein, 2005; Moss et al., 2003). Extending the family-like relationship even further, nursing home care workers and residents’ families desire and appreciate caring relationships with each other (Duncan and Morgan, 1994; Kemp et al., 2009).

In the increasingly market-oriented field of long-term care, it is perhaps not surprising that managers encourage staff to think of residents “like family” only to turn around and use those emotional ties to exploit poorly trained, low-wage workers (Dodson and Zincavage, 2007). That is one way that the financial demands of the long-term care industry undermine authentic emotions between nursing home residents and staff. There are others. For example, Tim Diamond’s *Making Gray Gold* (1992) vividly examined how the drive for profit blocked opportunities for authentic emotional connections with residents. Diamond’s findings presaged the now dominant trend in long-term care in which large for-profit corporations and private equity firms are buying independently owned nursing homes, expecting more labor from fewer workers, and profiting at the expense of authentic emotional care. Emotion work, particularly among nurses, must now be situated within the corporate logic of capitalist accumulation (Bone, 2002). In addition, the bureaucratic structure of long-term care hinders the formation of emotional attachments between staff and residents (Foner, 1994). A preoccupation with regulatory compliance, the hierarchical organizational structure, and a fixation with operational efficiencies hinder the formation of the emotionally strong relationships that have been shown to improve staff satisfaction and residents’ health (Bishop et al., 2008; Hannan et al., 2001). As Cancian argues, “organizations undermine care work by maximizing profits, creating hierarchical systems of authority that give little power to care workers, enforcing rigid procedures and rules, and promoting a system of values, incentives, and training that recognizes only medical knowledge” (2000:143).

Paid care-work is devalued in a wide variety of contexts (Harrington Meyer, 2000). Individuals who do paid care-work endure a “wage penalty” when compared to other occupations, even after controlling for a slew of variables (England et al., 2002). Caring is presumed to be a natural instinct among women with its own set of incentives and rewards that need not be fairly compensated. Nonfinancial rewards—emotional gratification—also allow employers to pay care workers less than the wages they deserve. Emotions, apparently, take the place of earnings. Furthermore, the assumptions, norms, and policies of the marketplace challenge and undermine care workers privately held notions of care, and insist they conform to the public world of work (Folbre, 2001; Stone, 2000).

Nurses and nursing assistants are faced with a set of challenges in properly calibrating their emotions to their employers’ demands. Hochschild (1983) describes how employees in the service economy are required to align their inner emotions and outer emotional displays with “feeling rules” and “display rules” established by employers and an institutional context that drives how emotions are to be managed. Service workers, particularly the flight attendants in her study, manipulated their emotions to be consistent with the wishes of their employers, at the potential cost of alienation from the self or feelings of inauthenticity that could result

from the repeated display of emotions that are not honestly felt. Combining the diverse perspectives of Erving Goffman, Charles Darwin, and Sigmund Freud (see Hochschild, 1983:Appendix A), Hochschild showed how organizations impose emotions on workers to create a new form of labor exploitation.

Hochschild's central finding that emotion work happens has been validated time and time again, which has led some to describe the legacy of *The Managed Heart* (1983) as "pervasive but shallow" (Smith-Lovin, 1998:113). Although that is true in a sense, it elides some real advances and new directions in how sociologists make sense of emotions on the job. One line of critique inspired by Hochschild's work concerns the extent to which managers can truly control workers' emotions. For example, insurance sales-people studied by Leidner (1993) came to see their highly routinized scripts as a source of power over customers, which even acted as rhetorical shields against insults slung at them from irate customers. Wharton asserted that emotion work "does not have uniformly negative consequences for workers" and argued that worker autonomy was one of several job characteristics that conditioned the character of emotion work (Wharton, 1993:205). Expanding on this theme, emotion work among supermarket checkout clerks has been shown to be self-directed, not driven by management, and created a sense of personal fulfillment by creating friendly relationships with favored customers (Tolich, 1993). Waitresses at a truck stop diner autonomously used emotions to manage customers and manipulate them into giving bigger tips (Paules, 1991). Indeed, workers appear to have much more control over the production and deployment of emotions than Hochschild's formulation had originally allowed.

The organizational conditions that shape emotion work create obstacles for workers, but they also create possibilities. Lopez's concept of "organized emotional care" (Lopez, 2006) theorizes how organizations set conditions for authentic, emotional relationships to grow. Rather than the oppressive view of emotions gleaned from Hochschild's account, his analysis restores a positive vision of how care organizations such as nursing homes create cultures that foster genuine emotions. In long-term care, for example, one researcher found that although managers used a medical model to treat residents with dementia, nursing assistants used a social model that credited these individuals as socially responsive agents who have a "real" self, even if it is masked by a cognitive disease (Vittoria, 1999). Another study found that nurses in long-term care settings used emotions as a form of power to create social order among residents (Lee Treweek, 1996).

The effort to recast emotions as a strategy that care workers use with some degree of autonomy is part of how workers strive to create dignity. Hodson argues: "The achievement of dignity at work depends on creative and purposive activity on the part of workers" (Hodson, 2001:4). The contours of dignity in health and medicine is a thriving field of scholarship, although a recent review noted the varied, and often vague, definitions of dignity that permeate the research (Jacobson, 2007). In addition, the term is generally used to focus on patient dignity rather than care worker dignity. In this article, I take a more limited view of how dignity operates. Consistent with Cooley's "looking-glass self" (Cooley, 1983), the dignity individuals see in themselves mirrors what they see in the eyes of others looking back at them and is strongly mediated by social norms and practices. That is, dignity is constructed through an interactive, relational, and contextual social process. Elucidating this process, Stacey (2005) shows how home health aides construct dignity in the "dirty work" of care for others. Elsewhere I have argued that staff attributed agency to dying residents, but denied the agency of aggressive residents, to construct a dignified workplace (Rodriquez, 2009). Dignity among staff was the outcome of a relational process that was contingent on maintaining residents' dignity.

SETTING AND METHOD

This article builds on Hochschild's approach to the study of emotions at work. Smith-Lovin argues that the mixed legacy of *The Managed Heart* resulted from scholars who reproduced Hochschild's study design—participant observation of a single occupation (Smith-Lovin, 1998). Most research on emotion work has examined rather perfunctory and sporadic interactions between customers and service workers (for a review, see Leidner, 1999). The character of work in nursing homes is notably different because the worker and “customer” engage repeatedly in deeply personal and intimate exchanges every day for months or even years. Notions of reciprocity and closeness are different in long-term exchanges than in short-term or one-time interactions. Second, this study utilizes a comparative design that spans wider sections of the occupational and class structure to gain new insights into the contours and consequences of emotion work. There are severe inequalities in nursing homes between managers, nursing assistants, and residents. Those inequalities shape how emotions work (Erickson and Grove, 2008). The inequalities among staff are not only based on earnings, but also status and decision-making power. Meanwhile, the staff has power to control much of how residents' daily lives unfold. This study takes advantage of the hierarchical structure that shapes how staff and residents experience and use emotions.

I gained access to Rolling Hills Extended Care and Rehabilitation³ in November 2006. The facility is a two-story brick building, built in the 1980s, and located on a side street off a major highway. Just inside the large white front doors that are wide enough for a wheelchair, visitors encounter a big octagonal foyer that leads to the front hallway. The carpeted, wallpapered foyer is often decorated with ornaments that mark an upcoming holiday, especially in December, when the staff invites residents and their families to decorate the large plastic Christmas tree and Hanukkah decorations. There are small couches and chairs for friends and family to use, often to chat with residents away from the noise and energy of the units. In the corner, on a small table, lay the results from the most recent survey by the Department of Public Health, which by law must be easily accessible.

The first floor is shaped like a T. After passing through the front foyer, managers' offices are in the front hallway, which stops at the main dining room. Down the hallway to the left are the locked doors to the Dementia Unit, and to the right is the Sub-Acute Rehabilitation Unit, which is for individuals who are recovering from a procedure or injury (such as a hip replacement or broken clavicle) and will likely return home. The Long-Term Care Unit, for individuals who are no longer able to live at home but are not cognitively impaired enough to be on the Dementia Unit, is upstairs on the second floor of the facility. The floors throughout the units are carpeted with a pattern designed to hide stains. Some walls are painted, others are wallpapered. A large wooden handrail lines the walls to assist residents. The hallways are spacious and easily fit two wheelchairs across. Many residents' doors remain open throughout the day, and residents are often lined up around the nursing stations on the units or in the dayrooms located on each unit.

I gained access to Golden Bay Nursing and Rehabilitation Center in February 2007. The facility was designed by the same architect as Rolling Hills, and has a very similar T-shaped layout. Located off a hilly side street, Golden Bay has a brick exterior and is set away from the street by about a hundred yards of grass. The foyer of the facility has a few chairs and loveseats and is wallpapered and carpeted. A rarely played grand piano sits along the wall, and a receptionist, seated at a window much like those found in doctors' office, greets visitors. After signing in with the receptionist, visitors walk through another large white door into the front hallway, which leads to the main hallway of the building. The main

³The names of nursing homes and individuals mentioned in this article are pseudonyms.

hallway is perhaps 500 feet from end to end. On the south end of the hallway are the locked doors to the Dementia Unit and the elevator to the Sub-Acute Rehabilitation Unit; on the north end is the Long-Term Care Unit.

Rolling Hills and Golden Bay were similar in many ways. Both facilities, like many other nursing homes in the United States, were organized as nearly identical vertical hierarchies and horizontal departments. Both nursing homes share other features as well. Each has three units, Sub-Acute Rehabilitation, Long-Term Care, and a locked Alzheimer's/Dementia Unit. Each nursing home houses very similar residents. Residents on the rehab unit typically stayed in the facility for around 40 days, depending on the injury, and received intensive physical, occupational, or speech therapy to recover, and they fully intended to go back home. Most residents in the Long-Term Care Unit lived in the facility until the end of their lives. Many were alert and able-bodied but were no longer able to care for themselves independently. Residents of the Dementia Unit were in various stages of cognitive decline. Some were more mentally capable than others, but all had lost the ability to live safely independently and required supervision. Almost all residents were white, most likely due to the rural locations of the nursing homes. Consistent with the typical nursing home, most residents were women and ages ranged from about 50 to over 100 years old. Both facilities were a bit larger than the state average of just over 100 beds. The staff:resident ratio was higher at Golden Bay, which had one nursing assistant for every 10–12 residents, while Rolling Hills' ratio was 1:8–10.⁴ At the level of nursing assistants, Golden Bay had more racial diversity than the all-white Rolling Hills. An ample number of Latinas from a mid-sized city not far from Golden Bay worked there, while Rolling Hills was about 20 miles farther away and recruited staff from nearby all-white farming towns. Whatever race, class, and gender differences existed between the two facilities largely ended there, as nearly all the nurses and managers were white women in their 40s and 50s. None are unionized.

The facilities are similar in many ways, but they do differ in one important respect: Rolling Hills is part of a small, nonprofit chain; Golden Bay is part of a large, for-profit chain that includes hundreds of facilities in dozens of states. For decades, scholars have examined how for-profit and nonprofit health-care organizations compare with respect to the experience of care (for a particularly useful review, see Schlesinger and Gray, 2006). Yet few if any studies have examined how ownership type shapes the experience of work. This article is one piece of a larger project that explores how the financial and regulatory systems of long-term care shape the emotional lives of nursing home care workers, and uses ownership type as the key dimension of variation. Although the nursing homes were different in some important ways, the social processes I examine in this article were salient in both facilities and did not differ significantly. Therefore, I have pooled the data for this article.

Typically, I arrived in the morning before the daily managers' meeting and left sometime in the afternoon after lunch. From November 2006 until I gained access to Golden Bay, I visited Rolling Hills about three times per week. Between February 2007 and May 2007, I split my time at both facilities evenly and visited each once or twice a week. I observed some evening shifts to get a sense of temporal variation, but I usually observed during the day so I could attend staff meetings. The summer of 2007 was a more intense period of fieldwork; I usually visited each facility two or three times per week and conducted interviews with staff. In the fall of 2007, I scaled my observations back to presummer levels and conducted interviews until fieldwork concluded in April 2008.

I observed in as wide a variety of settings as possible to collect evidence about the character and scope of care work. I spent time in and around nursing stations, shadowed nursing

⁴Industry standard is one nursing assistant for every 10 residents, and one nurse for every 20 residents.

assistants and licensed nursing staff in and out of residents' rooms, and I occasionally lent a hand serving meals or escorting residents around the facility. To hear informal conversation between staff, I observed in breakrooms, at holiday parties and other staff functions, and I spent time having lunch, or outside at the "butt hut" on smoking breaks, with the staff. In addition, I routinely observed staff meetings, including the daily managers' meeting and nursing report, care-plan meetings with families and residents, staff training sessions, and other meetings. I recorded my observations in detailed fieldnotes written soon after I left the facility. To recall events accurately, I jotted down quotes or keywords in bathrooms or other unobtrusive spots and expanded on them at the end of each day.

I interviewed staff members throughout the organizational hierarchy, including certified nursing assistants, nurses, physical and occupational therapists, social workers, activities assistants, unit managers, directors of nursing, and the administrators. Conducting interviews midway through my fieldwork allowed me time to build rapport with staff members and gain knowledge of particular events I could follow up with key players and decisionmakers. All interviews were semi-structured, and almost all were recorded and transcribed.

I asked everyone I interviewed a core set of questions, although each interview was shaped by my observations and tailored to each individual, occupational group, or organization. I asked about their daily job tasks; work history; the emotional bonds they have created with residents (or not); how the documentation and reimbursement process shapes their work; the problems and challenges they face in their work; and what it feels like to care for people they could expect to die on their watch.

My analytical process was consistent with the grounded theory approach (Glaser and Strauss, 1967). I read and reread entire interviews and fieldnotes, scanning for themes upon which to begin making interpretive judgments. I used ATLAS.ti (v.5.2) to code interview data and Microsoft OneNote 2007 to organize fieldnotes and documents. Substantive material was grouped around broad themes, and then from those themes, more specific and limited codes were created to deepen the analysis. I began with observational data and compared those to interviews and documents collected from the field to generate a theoretical framework. During the process, I repeatedly went back to the literature, wrote analytical memos and early drafts, and talked to people about the themes and ideas that emerged from the data.

ORGANIZATIONAL DEVALUATION OF EMOTIONS

Managers at both Rolling Hills and Golden Bay held different attitudes about the value of emotions in the performance of care work. Cynthia, the administrator at Golden Bay, thought it was good for staff to think of residents "like family," but she made no concerted effort to cultivate this attitude. In contrast, Heather, manager of the Long-Term Care Unit, said emotions were counterproductive to good care. She worried about staff who treated residents like family: "Sometimes that line—they may talk to them like they're talking to a family member, perhaps. And you know, *they're residents*. It's kind of hard to describe ... I know they don't mean any harm by it, but you kind of have to remind them sometimes, you know you're still the nurse, and they're the resident. And this is their home. And you need to treat them respectfully." Heather was concerned that emotional connections undermine the staff's professionalism toward residents and lead to unfair favoritism toward particularly rewarding residents. The management had established modest policies to mitigate favoritism, the most prominent was a ban on gifts between staff and residents or their families. These policies were hard to enforce but established a formalized set of organizational boundaries on emotions.

Regardless of what individual managers said, there is an institutional context that exerts control over the realm of emotions at work. For example, Medicare and Medicaid reimbursement policies render emotion work invisible. These agencies monitor, value, and reward instrumental acts of medical care, and it is not surprising that managers, who were often preoccupied with the technicalities of documentation and reimbursement, did not spend much time or energy encouraging emotional connections between residents and staff. At Rolling Hills, Nancy, the Staff Development Manager, felt the floor staff resented documentation, much like she did when she worked on the floor rather than behind a desk. She said, “I as a staff nurse resented documentation because I always thought patient care’s first and don’t bother me with your paperwork and there’s too much of it and I’m going to do patient care first. And if that doesn’t get done, well, too bad.” As she moved into management and learned the financial imperative and legal protections of solid documentation, she came to a new understanding of its importance. She can tell the staff resent the documentation from their body language: “I can almost feel it and I don’t know if it’s just me projecting it because that’s how I used to feel, but yeah. Partly yeah, it’s like ‘I’m going to do the patient care first’ and it’s just that they have so much to do. It’s almost like humanly impossible to do everything you have to do and when you have the paperwork on top of it, where’s the priority?”

Nancy’s assessment was correct. The floor staff prioritized the provision of care, while management prioritized regulatory compliance and securing reimbursement money. This was no small matter; in fact, it organized much of how nursing home care workers crafted occupational identities. While managers focused on documentation, reimbursement, and regulatory compliance, the floor staff generally viewed documentation as a nuisance that got in the way of their “real” work, caring for—and about—residents. Angela, a gentle and well-liked nursing assistant at Rolling Hills, described the tensions she and her colleagues faced between documentation and care. Angela said: “When we’re doing our charting as a group, and there’s all kinds of talking, then you’ve got lights to answer,⁵ and then you’ve got nursing saying, ‘Could so-and-so please bring Mr. Papadakis down to the podiatrist?’ So, ‘Okay, I’ll get up’ and so I went over, got Mr. Papadakis. He was resting in bed, so I told him that the podiatrist was here, wanted to look at his toenails. So I helped him up in the chair and brought him down there to the podiatrist. But then on the way back, instead of going to the charts I stopped in to answer another light and brought that resident to the bathroom and then back. So I’m thinking, ‘Oh man, if I sit down across from the nurse’s station again and have to get back up and answer lights.’ So I ran, got my charts, and I do need to go to a quiet spot, because in order to chart on ten residents you need a good block of time.”

Some nursing assistants saw the documentation as a mere nuisance; others begrudged the time and attention taken away from the residents. For example, Cindy said the documentation was “[a]wful. It’s absolutely awful. You know, we’re taking care of the real things, the hands on, and it doesn’t stop from the time you’re there ‘til the time you go home. And they’re concerned about documentation. And if they’re so concerned about it, they need to make a space, a timeframe where you can go and do that. We don’t have that. We are hands-on 24/7. It irritates the hell out of me.” June, a career nursing assistant said, “I personally care more about the residents—I mean than if paperwork gets done. *Hello!* The resident comes first. If the resident’s up and acting out, doing whatever, you spend your time with the resident. Paperwork is paperwork, something the state wants. It’s ridiculous to me that the state looks at everything that they shouldn’t, and overlooks the things that they should.”

⁵When residents are in their room and require assistance, they pull a cord that connects to a light outside the room.

The floor staff saw themselves primarily as caregivers, responsible for the well-being of individuals who can no longer care for themselves. The management's first and most important task is to sustain the financial and regulatory well-being of the facility. The two levels in the occupational hierarchy had different ideas about what comprised "work" in nursing homes. Cindy exemplified the view of many other nursing assistants when she said: "As far as the facility goes, that's probably the first thing that they want done [documentation]. But you know what; that's not the way it is. To us that's the least problem. If our residents are taken care of, that's all we care about." Bonnie added: "Honestly, I'm like I could care less what it costs. I mean yes, I do my documentation to the best of my ability, but we're here to take care of the residents, the dollar doesn't matter to me. They're the ones that have to worry about that and are concerned about meeting that almighty budget, not me." In case it was not already obvious, she added: "Residents are more important than the documentation."

Unlike hospice volunteers who are trained to show concern (Fox, 2006), nursing home staff were not instructed how to manage their emotions. Their emotions were still "managed" by the organizational structure of long-term care, but even within that structure, nursing care workers formed emotional attachments with residents for a whole host of reasons, and sometimes for no obvious reason whatsoever.

CARING FOR, CARING ABOUT

Behind the desk of the nursing station of the Dementia Unit at Golden Bay was a tattered card, held in place by a piece of scotch tape. The card was from the daughter and son of a man who had recently died. It read: "You are all angels of mercy" and thanked "all the staff for your compassion and kindness with Jack. Especially thanks for whoever got his pillow and brought it to him in the hospital. He was holding it when he passed. We will never forget this. Thank you."

Stacey, the wound care nurse at Golden Bay, kept a hand-blown glass angel in her car. It was given to her by the first resident to whom she became emotionally attached. She told me: "It was a long time ago, like eight years ago." Stacey worked the overnight shift and the resident was often awake all night and knew she was dying. "We spent a lot of time just hanging out and talking. She died, but you know what? Before she died she handed out little blown glass angels to all of her favorite people. I got first pick, and I still have it, it's in my car."

Thank-you cards, flower arrangements, and photos from family members of residents who had recently died often lingered on the units for weeks. This in itself is a form of impression management, in that the nursing station is a stage that shows off the close ties between staff and residents and their families. In addition, such items materially codified gratitude. In a work life replete with opportunities to undermine the dignity required for a satisfying work environment, staff took pride in making residents' lives as dignified, comfortable, and enjoyable as possible. The attachments staff formed with residents generated pride, dignity, and added meaning that extended beyond their wages. This was reinforced in the small gifts families gave to staff.

In long-term care facilities, emotional connections between staff and residents are unavoidable. Intimate interactions of personal care are routine and widespread. Emotional attachments developed for a variety of reasons, and sometimes for no reason at all. Insofar as these affinities are based on similarities, they are deeply social. The staff and residents tend to be demographically similar—white women—even though separated by age and perhaps social class. Yet the attachments are deeply asocial in that they exist outside of, and perhaps prior to, social interaction.⁶

Sometimes, staff and residents became emotionally attached because they shared a similar life-defining experience. For example, Daphne, a nursing assistant on the Dementia Unit at Rolling Hills, clearly recalled the first time she became emotionally connected to a resident. “That was back in 1996. That was very emotional,” she said. Daphne and Ronald, the resident, were both estranged from their biological families, except for one sibling with whom they each remained close. “So that really hit home,” Daphne said, “and I really knew where they were coming from, so I just kind of formed that bond with them.” Both went through the experience of being ostracized from their family and, as a result, Daphne was easily able to relate to Ronald, but especially with his sister. Daphne said:

And the day he died his sister just totally broke down and she said, “What am I going to do without you?” She said [to her brother], “You can’t leave me. I have nobody else. You’re the only one that I have. You’re the only family that I had. I have nobody now.” And it was like something you would see on a TV show, it was so dramatic. And I just stayed in there with her, you know, and I just *felt like it was me* in that situation, and what if my brother had died, where would I be left? And I remember coming out and crying and crying and crying in the linen closet.

One of her co-workers could not understand why Daphne was so upset, particularly since death is a common occurrence at nursing homes. Daphne said she cried because she cared about him, but that was not the only reason; she had connected with Ronald’s life story in a personal and intimate way. Family ideology is a powerful force that connects residents and staff in long-term care (Dodson and Zincavage, 2007; Moss et al., 2003). Daphne could not help but reflect on her own life and similar it was to Ronald’s. She also empathized with Ronald’s sister, and imagined how she would feel if it was her own brother who died. Daphne said that the grief experienced over the death of a resident had less to do with years on the job and more to do with the unique relationships that develop with residents. A life-altering experience that she shared with Ronald made it easy to connect.

Shared life experiences were one of the ways emotions were generated between staff and residents. They also sprung from shared interests. For some, it was a hobby such as crochet or following the Red Sox, and for others the interests ran a bit deeper. Frankie, a nursing assistant on the Sub-Acute Rehab Unit at Golden Bay, developed a particularly close relationship with one resident, Maude, based on their Catholic faith. Maude had terminal kidney cancer, Frankie said, “and my heart went out to her ‘cause she was such—just one of the nicest ladies here.”

Frankie went to church, as he did often. His priest gave instructions for everyone in attendance to bring someone they knew a rose. Frankie decided to bring Maude a rose, and told me: “You know, I just had this feeling that I should do this.” Frankie bought a rose, went to Golden Bay, but realized there were no adequate vases. He left and purchased a vase, and found Maude’s family in her room upon his return. “They asked me,” Frankie said, “Why did you bring this rose? It’s very very nice. We asked St. Teresa to send my mother a rose.” Frankie replied: “It’s a funny thing, ‘cause I had a feeling I should bring her this rose.”

Maude, like Frankie, was Catholic: “Very pious woman, very pious,” he said, “and she had a special devotion to St. Teresa.” Her family told Frankie: “You know, we were praying in church today and we said, ‘would you send us a rose, so that we know that you’re gonna take care of mom?’” The family asked God to send their mother a rose and only hours later Frankie showed up with one. After Maude died, her family sent Frankie a special gift to

⁶See Karakayali (2009) for a theoretical elaboration of how and why this process might occur.

remember Maude by, “and I keep that and I treasure that. It’s not the thank you card. It was the funeral card, with the prayer on the back. And she’s in my prayers.”

Maude and Frankie had something in common—their religious faith—which transcended the resident-caregiver dyad. Maude’s family acknowledged that with the funeral card they sent to Frankie. Frankie said: “If they had given me a basket or something, I’d be like ‘oh that’s nice,’ but the funeral card meant a whole lot more, and for that reason I’m going to carry it awhile, at least in my heart I’m going to carry it with me for the rest of my life.” The primary reward for caring *about* residents, in addition to caring *for* them, is the gratification that comes from feeling the job has a sense of purpose greater than the paycheck. Though shared life experiences and belief systems typically gave rise to emotional connections between residents and staff, emotions are not always so simple and clear-cut. Natural sympathies, raw emotional connections between residents and staff were also generated for no obvious reason; they simply happened. The bond shared by Cindy and Mary typified such a connection.

Cindy was a certified nursing assistant and a leader among her peers. She was talkative and frequently spoke out in their interest. Cindy quickly became interested in my project and she spoke candidly about her job as she let me follow her in and out of residents’ rooms during the day. When I asked Cindy to tell me about a resident she became emotionally connected to, she said: “If I do I’ll start crying, ‘cause what stays in my head is Mary, you know, ‘cause she broke my heart.” Then she chuckled and said: “You know, Mary used to be a pain in the ass. It’s funny ‘cause the ones that you really don’t like at first, that are like a pain in the ass, they’re the ones that you end up getting really attached to. It’s amazing.”

When Mary came to Rolling Hills she expected to stay a few weeks for rehabilitation and return home; but she did not regain enough strength to safely reenter the community. When she first met Mary, Cindy thought: “Oh my God, how am I going to put up with her? Cause she was kind of obstinate about doing anything ... she’d drive me nuts, and then I turned out loving her so much.”

Everyone knew Cindy and Mary shared a special connection. Their relationship did not include heart-to-heart talks about life and death, or private conversations about the intimate details of their lives, yet the relationship was close in a way that was uniquely theirs. “I loved her so much, we had so much fun,” Cindy said. They enjoyed inside jokes only they understood, and at times they seemed to have their own secret language. When Cindy worked 16-hour double-shifts, Mary let Cindy nap in her bed while on break. They shared a bracelet: one day Mary wore it, Cindy wore it the next. They even had a morning ritual: Cindy woke up Mary to the tune of Frank Sinatra’s song, “On the Sunny Side of the Street.” Cindy told me: “We put on Frank Sinatra and—this is no lie, Jason—it would say, ‘Come on to the sunny side of the street’ and then it would go, ‘Start walking, boy’ and I’d go ‘Start walking, girl.’ I mean I’d sing it to her every morning. Every morning.”

Cindy was distraught when Mary died; she cried and told me she had lost a good friend. A few weeks later, Mary’s daughters stopped by the facility to thank the staff personally for their care. They sought Cindy in particular, but she was out on her lunch break. Her co-workers correctly guessed she was at the Applebee’s nearby. Mary’s daughters walked into the restaurant to find Cindy sitting at the bar. Cindy told me:

Mary used to wear this little blue—my favorite color is blue, and she’d tell me hers was too, I think ‘cause it was mine. And her daughter came and I go, “That’s my bracelet” and she goes, “It’s Mary’s.” I go, “It was mine too.” I mean it just, I started crying, so I’m like, “Oh my God” because we’d share that bracelet; one day she’d wear it, the next day I’d wear it. And she [Mary’s daughter] took it off her

wrist and gave it to me. And then she gave me an envelope and she goes, “We just want to thank you so much for giving mom all the care.” And it just broke my heart, you know. And then I opened it, and they gave me \$100.00 bill. So I mean it really, it meant a lot. It wasn’t the money thing, but it meant a lot for me that they came to find me.”

The cash bonus made an impression on Cindy, but there was far more value and impact in this interaction. It validated the emotional authenticity between Cindy and Mary. Nursing homes typically value instrumental acts of care *for* residents, and this experience reminded Cindy of how meaningful it can be to care *about* them. Evelyn Nakano Glenn, in rethinking care in institutional settings, defined care “as a practice that encompasses an ethic (caring about) and an activity (caring for)” (Glenn, 2000:86). Caring about, she argues, encompasses thought as well as feeling, and includes an awareness and concern for meeting another’s needs. Caring for refers to the instrumental activities required to provide care for the needs and well-being of another. In both nursing homes, the floor staff used emotions as a resource to construct dignity at work.

There were many positive aspects of the emotional attachments staff felt toward residents. Most importantly, they gave the staff a sense of pride and dignity in their work. But emotions also came with a set of costs. When individuals they cared for died, staff members felt grief, sadness, and experienced the loss of someone they often considered a friend or “like family.” Sometimes, as with Daphne, it triggered deeply personal reflections on their own lives. I asked many staff members if they felt that work would be easier if they did not care about residents, and with near uniformity they said that it is impossible not to care about residents.

I expected that being around illness, disease, and death, as staff in nursing homes are, would require “detached concern” or “affective neutrality” to avoid emotional burnout (Lief and Fox, 1963; Smith and Kleinman, 1989). Yet what I found was far from detachment. I found genuine concern. Given this workplace context in which such attachments formed, the staff took full advantage of them. The staff used emotions to manage residents but, more importantly, they used emotions to manage themselves.

CONSTRUCTING DIGNITY, INDUCING COMPLIANCE

The staff marshaled emotions to give their work dignity, but also as a strategy to induce compliance from residents. Consider Louise, a nurse on the Long-Term Care Unit at Golden Bay. She described her favorite part of the job as getting to know residents, many of whom she knew for years. She enjoys working with “really difficult and grumpy residents” the most. She said: “You just have to learn their ways, butter them up, make them laugh” and that, ultimately, they come around. “I have residents that will refuse their pills for thirty days and then you just have to make them laugh and BS with them and they learn to trust you, and then they start doing what they’re supposed to.” Residents have the right to make decisions detrimental to their health such as refuse medications, and Louise enjoyed the challenge of working with those individuals. Emotional attachments were gratifying, yet at the same time they were a tool to generate consent.

Like Louise, Randi gravitated to the elders who were not necessarily the friendliest or most charming. An activities aide at Rolling Hills, Randi elaborated: “And the amazing thing is a lot of the ones that end up being your favorite are not the nicest people and they’re not the sweetest people. They’re just interesting, you know. I can remember one lady, that, oh my heaven, she could be a real witch, but we just loved her.” Randi said everybody paid attention to the nice, friendly residents, and sometimes the less outgoing people needed more attention. Surprisingly, the most endearing residents were sometimes the most “difficult”

too. Randi noted that such individuals pose a challenge to the staff: “If you’re persistent enough, they’ll let you in.” They felt skilled and special to be the rare person who cracked an ornery shell. Encouraging “difficult” residents to be sociable was more than simply Randi’s job; it was an important source of dignity that shaped her self-conception as a needed caregiver.

Bonnie took particular pride in assisting residents as they adjusted to their new life in a nursing home. She was hired a few months after Rolling Hills opened and has been on staff for 19 years. She told me, “I like the feisty ones, the ones that put up a fight.” It is not a coincidence that a nursing assistant who likes “feisty” residents would stay on the job for 19 years, as care workers who do not think like Bonnie would more likely find work elsewhere. She empathized with new residents in their adjustment from home to a much more confined living space, and said: “You just took away all their freedom.” Bonnie further explained: “When you get through the spunk and the fight in them and they trust you and they cooperate with you, it’s like you have done something amazing. You have helped this person adjust to a life that they have no choice but to adjust to, and it’s really rewarding to see them adjust. You know what I mean? It’s very fulfilling.” Bonnie, like Louise, does not think for a second that her emotional attachments with residents are a form of social control; however, residents’ behaviors are manipulated through such connections.

Laura was a career nursing assistant with more than over 10 years of experience in nursing homes. She told me a story from when she worked on the Dementia Unit at another facility. Laura reminded a resident, Dorothy, of her estranged daughter, “and she was very happy I was back,” Laura told me. She continued: “She called me her daughter, and out of respect I called her mother. It made her feel good.” Laura wondered aloud if there was a “boundary issue” when she allowed Dorothy to call Laura by her daughter’s name, but surmised that even if it was a problem, it was worth it because Dorothy ate and slept better, was more relaxed and generally better off because she believed Laura was her daughter. Dorothy was physically and verbally aggressive toward other staff members, but not with Laura. She said: “When I was there I was able to bring her back, and everyone thought that was wonderful I was able to pull her back.” Dorothy’s health improved, and Laura found working with Dorothy rewarding. Laura returned from a weekend off to learn that her “mother” had had a severe stroke. “I was feeding her every meal. I worked my shift. I went home. I fed my kids. I came back and fed her supper. That’s how close we were.” A few weeks later, Dorothy died, and although Laura had accepted death as a part of her job, it was still emotionally difficult. But:

Everybody made me feel good that I did a really good job with her. And it was difficult, but she was happy. She was happy. She felt like she had her daughter back, and I gave that to her and I was very pleased to be able to do so. And I’ll never forget that. I’ll never forget it.

Laura had an immense sense of pride in her work with Dorothy. The sense of being “like family” was in part used to control the resident, but it was also used to create an independent meaning system and generate dignity. It reinforced her view that care work is about much more than a paycheck.

Beverly’s story was most compelling. The Admissions Coordinator at Rolling Hills, she spent her entire career in long-term care. She is in her 60s, with graying hair, glasses, and a thick New England accent. She told me one of her earliest and most memorable stories about the emotions involved in care work, which she explained “has driven me all these years to be in long-term care.” She described her previous workplace, County Nursing Home, back in the early 1980s: “It was sort of like a warehouse type thing” and said it was six floors high and had room for more than 200 residents. At the time, Beverly worked with

very debilitated residents, most of whom were unable to get out of bed and did not speak due to advanced Parkinson's disease or dementia. Although the residents could not talk, Beverly said: "You know, there was just a spot in my heart and I would always say, 'good morning, how are you?' and blah blah blah. They never talked to me. You know, they couldn't."

Undeterred, Beverly made one-sided small talk. A nursing assistant overheard her in a resident's room: "This little CNA came and she said, 'why in the heck are you talking to her?' and I said, 'I'm talking to her because she's a person and some place, some level, I believe that every one of these people is there. Not on our level, but some level. It might be just a smile, but they're there.' I said, 'that's why I'm here, because I want them to know they are cared for.'"

Beverly became particularly close with one resident, Patty. Although Patty could not talk, staff thought she was mean because she would pinch them when they tried to assist her, and she refused to take her medications. Beverly said she thought the pinches were sending a message: "Maybe that's the only way they can communicate with you. So, instead of thinking that she's mean, maybe you need to look at whether or not that person is really in there." As months passed, Beverly continued to chat with Patty even though Patty did not chat back. She said, "I'd do the same thing every day. The CNAs thought I was kind of weird, but I'd go in and I might sing, or I'd make small talk, just do my own thing with them."

Finally, all the chatting paid off. Beverly had a moment she never forgot and it taught her a principle that organized her approach to care work. She walked into Patty's room, "I was kind of teasing her a little bit." Then, she said, she got really close and asked Patty to open her eyes. "And she opened her eyes and smiled at me." What was initially a delightful surprise became a routine occurrence as Patty opened her eyes, smiled at Beverly every day, and took her medications easily. The way Beverly told the story, one day she brought the nursing assistant who said she was "weird" and made her watch as Beverly worked on Patty. Patty again opened her eyes, smiled, and took her meds without hesitation. "And I said, 'and that, right there, is what this is about. So if you're having a lot of trouble with these people, you need to change how you're acting with them, because they're there.'" Beverly's moral tale concluded when the nursing assistant who doubted her admitted to having learned her lesson: "One day she comes up to me and she said, 'You know Bev, you're right, I can give Patty her meds now, because I'm talking to her, but the other girls they can't.'"

This story highlights how staff use emotions to manage residents and, more importantly, manage themselves. This double-edged use of emotions clarifies the relational character of emotions in nursing homes: for the staff, emotions generated dignity; for the residents, emotions generated compliance. There is no way to know how much of Bev's tale is accurate, particularly since the event happened so long ago, but its accuracy is not nearly as important as its meaning. That she made a point to tell me the story in such detail is itself evidence of how it frames her philosophy of care. The story was a lesson about the seemingly priceless value of emotional attachments borne from good care. It was also about treating residents as dignified individuals who deserve respect and are worthy of personal care, even if it may appear otherwise.

DISCUSSION

I do not want to give the impression that everyone walks around nursing homes happy and dignified all the time. Nursing assistants face difficult and even hazardous work conditions because they frequently need to lift and turn residents, which can cause lower-back injuries.

They are also exposed to infections, diseases, and physical aggression from residents. These are physically, as well as emotionally, demanding jobs that take a toll on care workers. Nursing assistants earn an average of \$11 an hour and often have unstable work schedules. Beyond the material conditions of work, nursing homes are generally thought of as depressing and sad places that people try to avoid at all costs. Indeed, there are good reasons why the one-year turnover rate among nursing assistants reaches over 100% (Castle, 2006). It is precisely because nursing home care work is materially and socially devalued that staff members turn to the symbolic world of emotions.

Structural barriers hinder the development of genuine emotional attachments in nursing homes in a variety of ways (Diamond, 1992; Foner, 1994; Glenn, 2000; Gubrium, 1975). Given the history of institutional abuses in long-term care settings, managers in contemporary nursing homes spend much of their time and attention on maintaining regulatory compliance (Gittler, 2008). This monitoring contributes to the well-being of current and future nursing home residents, but it also generates demands on the emotional lives of workers, over and above managerial intent. An increasingly market-driven model of care, work in nursing homes devalues emotions in favor of profits and operational efficiency. One study lamented the “nearly complete absence of attention to emotion work in official time allocations and staffing criteria” in contemporary nursing (Bone, 2002:146). The intensification of work among staff in nursing homes increases demands to do more work with less support, leaving less time for vital social and emotional support for residents (Adams et al., 2000; Diamond, 1992; Foner, 1994).

Yet the staff managed, through the creation of independent meaning systems, to revalue and reward sincere emotional attachments with residents. Dignity at work was constructed on a foundation of emotional attachments. Nursing home care workers pushed back against the organizational limits on emotions. Hodson has argued: “Workers from all walks of life struggle to achieve dignity and to gain some measure of meaning and self-realization at work” (2001:4). The care workers I learned to know were strategic actors whose emotional attachments created dignity.

This article, and the larger project it is a piece of, is concerned primarily with the experience of work, as opposed to the experience of care. I did not seek to understand the world residents lived in so much as the world staff worked in, and as such I never sought the consent of residents to interview or collect data about them. Nevertheless, given the relational character of emotions (Clark, 1987; Lawler and Yoon, 1996), it is reasonable to speculate that emotions worked similarly for residents as they did for staff. Life in institutional care is one of daily and repeated indignities and entails a loss of freedom that few who experience it have ever imagined. Emotional ties to staff can become an anchor for residents as a crucial source of dignity. For most residents, family visits are few and far between. While very few residents used the kind of family ideology that was prevalent among staff, it was obvious that many residents genuinely appreciated and valued chatting with staff members. The staff were, in most cases, their tightest attachment to a wider world beyond institutional care. Although staff members rarely revealed personal information about themselves, and usually did not have the free time to do so, they still took time to engage in routine social pleasantries that residents appeared to like.

It is likely that these attachments generated dignity among residents, but it is not difficult to imagine that some residents used emotions to manipulate staff to do what they wanted. One resident, for example, admitted to a staff member that she faked crying to get the staff's attention. Another occasionally received flowers from a manager with whom she shared a close relationship. A third resident routinely threatened to call the Department of Public

Health if his requests were not granted. In all these cases, residents more or less explicitly used emotions to make the staff do things they wanted.

There was more variation in how emotions worked within organizations (floor staff vs. managers) than there was between organizations (for-profit Golden Bay vs. nonprofit Rolling Hills). Managers played a supervisory role and in some ways “managed” the emotions of workers. The institutionalization of such a perspective has implications for the structure of job duties and expectations. In other words, an individual’s job consists of a particular set of assigned tasks that must be completed within a given amount of time and staff are held accountable to these expectations. This impeded the floor staff’s ability to establish and nurture relationships with the residents, which requires intent and substantial time on the part of individual staff. Yet overall, my analysis points to the power of emotional attachments, an essential piece of paid care-work. Workers created their own meaning systems to suit their purposes. This dynamic operated in both facilities. All staff members acknowledged the centrality of emotions, whether they thought emotions were beneficial or detrimental to good care. Managers who had little direct contact with residents, such as Beverly, recalled emotional attachments made years earlier when they worked on the floors. Others fondly remembered residents now gone. These attachments, and memories of attachments made, dignify paid care-work.

The staff by and large did not view their workplaces as sad or depressing, even though it had its moments. Instead, they said they were grateful for the emotional attachments with residents and they welcomed opportunities to make residents’ last days a bit happier, brighter, and more comfortable. Staff who continued to work in nursing homes, rather than leave the field, had developed rhetorical strategies and self-conceptions that moved beyond the obvious sadness of working with individuals who get sick and die much more often than they get well and go home. Take the surprising finding that some staff members identified with “feisty” residents. Residents who “resisted” care are in some ways the most recognizable images of fully able individuals who have not succumbed to illness, disease, or the obedience that life in institutional care exacts. Perhaps staff imagined that if the shoe was on the other foot, they would be “difficult” too.

More generally, my analysis shows how nursing home care workers use emotions to create dignity in the workplace, despite an institutional context that devalues authentic emotional attachments. Moreover, this research suggests that the relational character of emotions may be useful for nursing home residents, as well as staff. In what other ways, in what other settings, for what other purposes do people use emotions as a resource? Future research should explore these and other questions about the contours and consequences of emotion work.

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