The Language of Caring: Nurse’s Aides’ Use of Family Metaphors Conveys Affective Care

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Purpose: Using a conceptual framework from the field of care work and the theory of boundary work, we explore the use of family metaphors by nurse’s aides to describe their affective care for nursing home residents. We focus on how nurse’s aides can express affective care in spite of experiencing racial abuse.

Methods: Using the technique of domain analysis, we present a secondary analysis of semistructured interviews with 30 African American and immigrant aides working in three nursing homes about their experience of racism on the job.

Results: Aides used metaphors associated with family, relationships, and attachment to describe their affective care of residents. They expressed the value of their caring by contrasting it with “uncaring” families. Immigrant aides expressed a form of caring culture shock about the uncared-for situation of American elders.

Implications: Through their use of metaphors of family and attachment, these aides define family care as their gold standard of affective care and communicate that they are attempting to provide good care. Aides distinguished caring tasks from affective care in that they applied affective care in an elective way, so that the caring task was the minimum, universal form of care and added affective care created an enriched form of care. They held out informal elder care in their cultures of origin as a model that is superior to the system of formal elder care in which they work. We use the theory of boundary work to explain how these aides provided affective care in the face of racial abuse.

Key Words: Nurse’s aides, Institutionalized populations, Emotional closeness, Nursing homes, Minority groups

In this article we present a secondary set of findings from a series of semistructured interviews that we conducted with 30 African American and immigrant nurse’s aides working in three nursing homes about their experience of racism on the job. The main finding of our original study (Berdes & Eckert, 2001) was that three fourths of these nurse’s aides had experienced racial abuse on the job from residents, residents’ families, or fellow staff members. Aides described two kinds of racism that they experienced on the job. In the first type, which we call anachronistic racism, individuals addressed the aides by using terms that are not acceptable today but that were acceptable during an earlier point in history, in the context of remarks that were otherwise inoffensive. For example, residents referred to nurse’s aides as “colored,” “Negroes,” or “waitresses.” In the second type, which we call malignant racism, individuals addressed the aides by using terms that have never been acceptable, in the context of remarks that were otherwise inoffensive. For example, residents referred to nurse’s aides as “colored,” “Negroes,” or “waitresses.” In the second type, which we call malignant racism, individuals addressed the aides by using these same terms, or others that have never been acceptable, in the context of remarks meant to be offensive.

Strikingly, many of the nurse’s aides, when queried about whether they had experienced racism on the job, said that they had not, yet when those same aides were asked whether they had had been subjected to specific experiences associated with racially abusive behavior, they recounted such incidents. In the original report, we attributed this tendency to treat racism as something other than racism to three factors. First, aides seemed to distinguish between incidents of anachronistic and malignant racism and to discount the former as being due to the resident’s age. Second, they seemed to excuse racist behavior when it could be attributed to a resident’s dementia.
Third, although they were not asked about it, half of the interviewed aides expressed affective or emotional care for some residents (not those who were racially abusive), and this care seemed to offset their experiences of racism; it is these latter findings that are the focus of this article.

In this article we describe the use of metaphors associated with family, relationships, and attachment by these nurse’s aides to describe their affective care toward the nursing home residents with whom they work. The conceptual framework for the research comes from two sources: the theoretical underpinnings of the field of care work, and the sociological concept of boundary work.

**Care Work: Work That Incorporates Affective Care**

The literature of care work theorizes that work that aims to produce a condition in people is different than other types of work, because in order to achieve high quality, it must not only be technically good care but also incorporate affective care (James, 1992). Abel and Nelson (1990), Diamond (1992), Foner (1994), and others have variously stated the central problem of paid care work: There is a tension between the bureaucratic aspects of caring tasks (e.g., productivity, documentation of care) and the humane aspects of affective care. The frequent result, as outlined by Cancian (2000), is the persistent devaluation of caring work, as evidenced by the low prestige of the work and low wages of care workers. Cancian described how the devaluation of affective care in care work can be counteracted and how nurturance can be encouraged through the incorporation of standards of affective care into care work. There is a certain oxymoronic quality in such a bureaucratic solution to a humane problem, but others have echoed the approach. The nursing field, for example, has made progress in recent years in the specification and measurement of caring behaviors (Beck, 1999; Swanson, 1999; Watson, 2001), and such instruments have occasionally been applied in the nursing home setting (Marini, 1999; Smith & Sullivan, 1997).

Qualitative studies focusing on direct-care workers have described affective relations as a component of good care, finding that nurse’s aides have well-developed concepts about the quality of care they want to deliver to residents (Anderson, Wendler, & Congdon, 1998; Deutschman, 2001; Stone, 2000; Wright, Varholek, & Costello, 2003). Stone, for example, conducted interviews and reanalyzed the rare published reports of interviews with people in caregiving jobs to learn how they define good care. She found that they frequently use the care they would give their own relatives to create an ideal of the care they want to give their clients. “For every kind of caring work in the public sphere,” writes Stone, “there is an analogue in the private sphere that hovers around as a kind of inspirational doppelganger” (p. 94). According to Stone, paid caregivers use the word love to distinguish truly good care from merely technically good care, and they believe that love inevitably develops in a relationship between a good caregiver and a care recipient.

Accounts of affective relations between direct-care workers and their patients or clients can be found in the literature of both home care and residential care; they underline the key role of affective care in quality care and job satisfaction. In the home care literature, Chichin (1992) found that workers described close personal relationships as a rewarding part of what is otherwise not very rewarding work, and thus they are a cornerstone of quality work. As Neysmith and Aronson (1996) have pointed out, relationships between home care workers and their clients provide the “medium” for the negotiation that makes caring possible. Erdmans (1996) similarly found that positive relations between home care workers and their clients improved workers’ job satisfaction. Karner (1998) showed how home care workers reframed their relationship to their clients as one of fictive kinship, with all the responsibilities, though not necessarily the benefits, of actual kinship. In the residential literature, Bowers and colleagues (Bowers, Esmond, & Jacobson, 2000, 2003) found in their studies of nurse’s aides that aides view their relationships with residents to be “the central determinant of both quality of care and quality of life” and use the term family to denote “providing individualized care in a way that allowed residents to maintain their sense of competence and dignity” (2000, p. 58). In their companion study of nursing home residents, Bowers, Fibich, and Jacobson (2001) found that some residents also defined care as the closeness and caring they obtain in relationships with staff. Thus there are benefits to affective care, yet there are barriers as well.

**Barriers to Affective Care**

Studies that have gone directly to nurse’s aides for evidence of factors influencing caring have identified a number of factors that inhibit such attachments or that function as disincentives to provide such care, in short, that are barriers to affective care. In the organizational context, direct-care workers sometimes are made to feel that affective care is counterproductive to the bureaucratic requirements of productivity or the professional clinician’s stance of detachment. This is described as role conflict in studies such as that by Huller, McMillan, and Rogan (2000). In the interpersonal context, first, caring aides can suffer persistent grief when cared-for residents die (Moss, Moss, Rubinstein, & Black, 2003; Sumaya-Smith, 1995). Second, nurse’s aides may feel a lack of reciprocal caring from residents: Nurse’s
behaviors were motivated by affective care, they aides interviewed by Treweek maintained that their turn it to perverse uses. Treweek’s (1996) study of can become alienated from their apparent caring and they lose a sense of those emotions as authentic and burnout. If, on the other hand, workers take on two forms with disparate effects. If, on one hand, it requires acting, it is stressful and can result in Complying with emotional labor rules can have workers’ emotions are organizationally dictated. Hochschild (1983) de-

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- care may perversely be more satisfying than caring person. Thus, having to overcome barriers in order to satisfaction derives from the caring work and affect caring by those who experience it.

Why then, when faced with many barriers, do these aides provide affective care anyway? The care work literature offers three possible explanations. First, it is possible that aides achieve self-meaning through caring. DeVault’s seminal work (1991) argued that, particularly for women, caring is more than a labor of love. Rather, those who care get something out of it personally. MacRae (1995) showed how their family caregiving was a route to self-meaning for older women. When asked to describe themselves, nearly 40% of MacRae’s subjects spoke first in relational terms of “doing for others,” and only second about their personal attributes and familial roles (these also emphasized caring attributes and caregiving familial roles). Altschuler (2001) emphasized that caring activities provide a sense of meaning and continuity for women throughout the life course. It may be that by doing caring work, these nurse’s aides reinforce their image of themselves as caring people. Their satisfaction derives from the caring work and affect rather than from the relationship with the cared-for person. Thus, having to overcome barriers in order to care may perversely be more satisfying than caring without barriers.

A second possible explanation, also suggested by the work of MacRae (1998), is that these aides are performing emotional labor. Hochschild (1983) defined emotional labor as the process through which workers’ emotions are organizationally dictated. Complying with emotional labor rules can have two forms with disparate effects. If, on one hand, it requires acting, it is stressful and can result in burnout. If, on the other hand, workers take on emotional labor rules as their own emotions, then they lose a sense of those emotions as authentic and can become alienated from their apparent caring and turn it to perverse uses. Trewick’s (1996) study of nurse’s aides illustrates this point well. Although the aides interviewed by Trewick maintained that their behaviors were motivated by affective care, they placed that caring in the service of controlling and coercing residents.

A third possible explanation comes from the theory of boundary work (Gieryn, 1983, 1995, 1999). Boundary work is defined as the process of social construction through which people include some actions (or people, or social phenomena) and exclude others from a social category. In so doing, they define boundaries for that social category that, as they change over time or among groups, tell us much about cultural norms. An example of how boundary work is applied is found in the study by Berbrier (1998). This researcher studied the contested question of who belongs to the deaf community, finding that those in the community defined those who were actually deaf but did not, for example, use sign language as outside the community. The only study of boundary work in the nursing home setting is that by Åkerström (2002), who showed how physical abuse by nursing home residents toward nursing staff was not named by those staff as violence, but rather placed outside the boundary of violence in order to enable nurses to continue caring. Åkerström defined four ways in which the nurses she interviewed placed the abuse they experienced outside the category of violence. First, they pointed out that it came from frail old people, as if the abuse exerted by old people did not ever reach the threshold of violence. Second, they interpreted violence as “a normal reaction to those infringements of integrity that form part of geriatric care” (p. 523). Third, they described themselves as the surrogate or proximate objects of aggression that arises from fear of death, homesickness, or lifelong aggressive tendencies. Fourth, they recounted the experience by using humor to communicate that they are competent to deal with such behavior. In these ways, the nurses asserted that these aggressive residents did not intend to harm them and therefore cannot be held responsible.

The Use of Metaphor in Research

In this article we focus on the use of metaphors by nurse’s aides that are associated with family, relationships, and attachment to describe their caring attitudes. The use of metaphor in the context of caring has been described by Frogatt (1998) and by Moss and colleagues (2003). Both subscribe to Lakoff’s (1993) definition of metaphor as “the way we conceptualize one mental domain in terms of another,” (p. 203) and, in that sense, metaphors both create meaning and are socially constructed. Metaphor has been used as data by authors such as Watson (1987), Hockey (1990), and Hockey and James (1993). Previous studies of the use of metaphor in residential care facilities include that by Spencer, Hersch, Aldridge, Anderson, and Ulbrich (2001), who described a personal care home in which residents and staff use the metaphors of home and
family to evoke factors that foster social cohesion, and that by Moss and colleagues, who interviewed hands-on caregiving staff in two nursing homes about the deaths of residents, finding that staff members used a metaphor of family to structure the meaning of death and bereavement and thereby overcome barriers to the expression of grief when residents died.

Methods

We describe findings that emerged in a study of race relations between White residents and minority nurse’s aides. As part of a larger study of factors conducive to and inhibitory of the development of sense of community in residential care facilities, the study explored nurse’s aides’ experiences of racism while they worked in nursing homes. We undertook the research with the encouragement of the local nursing home ombudsman’s office, which had received numerous complaints from nurse’s aides about incidents of racism they experienced while on the job. We asked officials from four skilled- and intermediate-care facilities where such incidents had occurred to participate in the research; officials from three of the facilities agreed. Facility A was a 48-bed facility owned by a non-profit, ethnically based association; Facility B was a 190-bed facility owned by a non-profit foundation; and Facility C was a 124-bed facility owned by a religiously affiliated hospital. We obtained the approval of the University Ethics Committee, and all three officials gave corporate approval for the study to be conducted in their facilities.

Using a semistructured instrument, we interviewed 10 nurse’s aides working in each of the three facilities in person. Thus 30 aides in total were interviewed, because we believed that this number of interviews would capture the range of possible responses. We conducted 30 interviews with residents of the same facilities. No similar body of data emerged in the resident interviews; thus, we do not term the resident–aide relations as affectionate relations, and we do not deal with the resident interviews here. We randomly selected nurse’s aide interviewees from comprehensive lists, provided by each facility, of all employed nurse’s aides. In Facility A, we needed 13 selections to obtain 10 interviews; in Facility B, 20 selections; and in Facility C, 12 selections. This yielded a 66% response rate. As one might infer from these numbers, it was particularly difficult to develop trust at Facility B; we finally achieved this through an informal liaison with minority licensed nursing staff. We obtained written informed consent from all employed nurse’s aides. As part of a larger study of factors conducive to and inhibitory of the development of sense of community in residential care facilities, the study explored nurse’s aides’ experiences of racism while they worked in nursing homes. We undertook the research with the encouragement of the local nursing home ombudsman’s office, which had received numerous complaints from nurse’s aides about incidents of racism they experienced while on the job. We asked officials from four skilled- and intermediate-care facilities where such incidents had occurred to participate in the research; officials from three of the facilities agreed. Facility A was a 48-bed facility owned by a non-profit, ethnically based association; Facility B was a 190-bed facility owned by a non-profit foundation; and Facility C was a 124-bed facility owned by a religiously affiliated hospital. We obtained the approval of the University Ethics Committee, and all three officials gave corporate approval for the study to be conducted in their facilities.

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One of us (C. Berdes) conducted all the interviews by using a guide composed of questions about aides’ experience of racism on the job, its effects on them, strategies they used to cope with such behaviors while providing care, and their beliefs about how racism experienced on the job in nursing homes compared with racism outside the nursing home, and whether anything can be done about it. The interviews, lasting from 1 to 1.5 hours, took place in a variety of locations inside each nursing home that allowed for privacy. We conducted the interviews between March and July 1996. One of us (C. Berdes) audiotaped, transcribed, and analyzed the interviews by using the domain analysis techniques described by Spradley (1979).

Domain analysis, according to Spradley, is a search for “the system of cultural meanings that people use.” Thematic analysis, then, involves “a search for the relationships among domains and how they are linked to the culture as a whole” (p. 94). Spradley specifies six interrelated steps in domain analysis: first, to select a single semantic relationship (for example, a taxonomy: $x$ is a kind of $y$); second, to develop a domain analysis worksheet to inventory terms included in $x$ and a cover term $y$; third, to select a verbatim sample from the interviews and, fourth, use it to search for possible terms for $x$ and $y$. Subsequently, fifth, the researcher formulates structural questions for each domain to ask of respondents (or in this case, because this is a secondary analysis, of the data) and sixth develops a list of all hypothesized domains, revising the list until a final list is arrived at. One of us (J. Eckert) reviewed the analysis for validation purposes.

Results

Of the 30 interviewed nurse’s aides, 29 were minorities. Sixteen of these 29 were African Americans; 13 were immigrants from Africa, South Asia, or the Caribbean. There were 16 aides who worked the day shift, and 7 each who worked the evening and night shifts. Their ages ranged from 21 to 69 ($M = 47$) years, and they had worked as nurse’s aides for between 1 and 30 ($M = 9.6$) years.

The Nomenclature of Relationship: Metaphorical Family, Real Attachment

Nurse’s aides described their relationships with some residents as emotionally warm and even reciprocated. They used language associated with family and relationships to denote the closeness and warmth of the relationship. The terms used by nurse’s aides to describe the relationships they had with residents ranged across the continuum of intimacy from friend to girlfriend to family:

She’s my buddy. We know each other. We get along so well. We’re like the same type of person. She’s strong and I’m strong. … But you do build up a
relationship with some of them. Some more than others.

If you talk to them nice, pat them on the shoulder and say, “My boyfriend, it’s your girlfriend looking after you.” No problem, just talk to them sweet.

I had the same one all the time. When I first came, we floated. But now we have the same patients. You get closer to them when you have the same ones. They become like a relative, like someone in your family, to me.

Older aides and those caring for residents who had Alzheimer’s disease described their residents as their babies or children. Thus in describing the care they provided, they relied on the metaphor of parenting:

They’ve reached a stage now like the baby, you need love. The family may be so far away, so they depend on us to give them that care and warmth and love. Because we are a part, as a family, to that individual. That’s how I look to it. I love them all, [but] the one that get my special care is the one who really need me.

A lot of times when I get up in the morning, I think about what I have, I say, oh, my baby Ida, or my baby Alice. That’s what we call them.

[Mary], that’s the first patient I get up in the morning. And she gives me all the gossip, so I know what everybody else don’t know till we go to report, ‘cause I get it from her. Then after I see her, then I go to [Jane]. That’s my other girl. She sleeps with her shoes on. Other day [Jane] shocked me, she had her shoes off. I say, “Oh, [Jane], what’s the matter? Is you sick, baby?” They just make my day.

Younger aides described residents as their parents, or said they wanted to care for the residents as they would care for their parents:

I like to be with older people. When I saw them I saw my mom or my dad. Always open my heart for them. Even though it’s so hard, but I don’t care because I like to work. They don’t know what they’re doing. But you have to help them. You have to cooperate with them. They could be your mother, they could be your father. . . . You have to talk to them, sing for them. And then after that everything is okay.

I put these people in my father and my mother’s place. My mother’s gone, and my father’s a very sick man. And I know what I would do for my father, I would do it for the residents. And that’s do the best that I can.

In addition to the family terms they use to refer to their relationships with residents, nurse’s aides also use language relating to emotional attachment to describe their relationships with residents. There were both positive and negative aspects to the attachment:

I always, after I get them cleaned up and everything, I always hug and give them a kiss, and some of them needs that, some of them do. [One lady], I gave her a hug and a kiss one day, and she told me, thank you, honey, I needed that, and you know, sometime they, a lot of them do just need a hug and a kiss to let them know that somebody cares.

I will talk, I’ll pat her, and tell her I like her and I love her, you know. And so I’ll take her hand, I’ll kiss it and tell her I love her.

You laugh with them. They call you names, but you still laugh with them, and talk with them, and [they] say I hate you, but you don’t go and say, well, I hate you too. No, you say, well, you know what? I love you. And it stops.

You want to help them, and when you see them crying, you cry with them, and there was one lady, she wanted to go home, and she kept crying and kept crying, and she said, “I just want to go home,” and you know, a lot of times I’d sit there with them and I’d cry with them. It gets emotional, especially when you get too close to them, it gets emotional.

Attachment made it especially difficult for nurse’s aides to care for people who were dying, and it caused them to feel bereaved after the death of the resident. They did not seem to find similar difficulty in caring for people with dementia, but caring for dying residents exerted a special stress:

I said I don’t want to get too much closer, I been through it twice. I miss two, ones that I really love like my mother. . . . I have that lady on my mind for over 6 months. And I have to come in the office here with tears and I said, “I really don’t want to be so attached.” And believe me, all I’m trying, I’m still in the same situation again.

The hardest thing is when you get to love a person so much, when they die, it really hits rock bottom, you know. It really affects me. When I take care of them for awhile. I know they have to die someday but . . .

Valuing Affective Care: Caring Aides, Uncaring Families

Aides distinguished their family-like caring affect and caring behavior toward residents by contrasting it with (to their eyes) uncaring behavior of residents’
real families. In this way, they were able to express its value to the residents:

‘Cause a lot of them have family, and some of them family don’t come, maybe once or twice out of 2 or 3 months or something, and a long as you with them all day everyday, you know, they kind of look forward to seeing you as well as you look forward to seeing them.

A lot of them family don’t come see them. They say they don’t have no family. And then a lot of the patients tell you their problems. A lot of them have homes to go to, and the kids take them and put them here and never come see them. That’s the hurting part.

They put their parents in the nursing home, never come back. We had a girl here years ago, she bring her [mother] here and never come back, and when [the mother] died the owner of the building have to bury her. They couldn’t find her. She give a wrong phone number and they couldn’t find her. Everybody they call, they say, wrong number. But she collect the Social Security. That’s what they do here, most of them, collect the Social Security. And the husband—they try to get money. They come in here visit them. I know a lot, honey, lots.

Nurse’s aides pointed out that their own cultures do not allow them to behave as their residents’ families do. In fact, Wallace, Levy-Storms, Andersen, and Kington (1997), using the National Medical Expenditure Survey, have shown that Whites are one third more likely to use nursing homes than African Americans and that African Americans use informal care twice as often as Whites, despite having higher rates of functional disability. A study of rates of institutionalization among various immigrant groups using Census data (Kritz, Gurak, & Chen, 2000) showed that elderly persons from “developing” origin groups had rates less than half of native-born individuals or immigrants from “developed” origin groups. These nurse’s aides, who were African Americans or immigrants from developing origin groups, relied not only on family experience but also on cultural norms of elder care in creating personal standards of care:

Because I never, none of my people’s ever really been in a nursing home. We don’t do that. My father was sick, he died. My sister kept him. My mother’s sick now, my sister keep her.

I took care of my grandmother for like 3 years. Bathe, feed, whatever, take to the doctor. We just don’t put our old people away.

If I’m here taking care of your mother, that you’re not doing. See, ’cause if you notice, we don’t send our people away. We keep them. It’s just something natural to do. We don’t understand this. It’s very strange to see your mother in a place, she doesn’t know where she’s at, and she’s confused and they’re basically like babies then. You know, how could you do this to your mother or your father. We can’t do that, we don’t do that. I think they should keep them, you know. Just because they’ve gotten old, you don’t throw them away. No, it’s not that they’re not strong. It seems like they were taught to do that. We weren’t taught to do that. We were taught: which one of you are going to take care of granny? Well, I did, now it’s your turn. We go through things like that, but we’re all there to do it. It’s like when you have a baby born in the family. If something happens to the mother, someone has to keep this baby. It’s like that.

Immigrant nurse’s aides were even more critical than U.S.-born aides of the neglect of elderly American parents by their children. Immigrant aides seemed to experience a form of caring culture shock, a sense of disbelief that elderly people could be so ill treated. For many of them, American elders’ placement in a nursing home was prima facie evidence of lack of caring on the part of their families: So, but to me, in Africa, I wouldn’t put my mother in the nursing home. That’s one thing with Africans. We don’t put our parents, we take care of them at home. When they are sick we take them to the hospitals and other things. So sometime I feel bad when somebody’s in the nursing home and the family doesn’t visit or anything. That’s the worst part of it for me. Some people, you know, some people needs help from their family, but their family doesn’t come to help.

Oh my God, first time I see, I’m thinking, my God, what kind of children are they having? Why they don’t want to take them? But I never, I can’t believe it. When I came in this place, that time I see that much old people together, they sitting in the dining room, lobby, then I said, my God, they don’t want to take them. In our country, never. If they had any, all the kids are taking care very nicely. If they had five kids, five of them come together and go. . . When I came here, they crying, then I say, what happened? They don’t have no family? They had a family, they are very intelligent, they are working. What, they don’t have no house? They had a house, but they took the nursing home. Oh, that few months I can’t even sleep, then I’m write a letter to my country, to my daddy and mommy, oh, my God, this country’s no good. Everybody, nobody want taking their mother or father. They just leave them.

The analysis found that these nurse’s aides expressed a family-like sense of identification with some of the people for whom they care. This
identification fed the affective care that motivated the aides to do their caring tasks, even in the absence of reciprocal caring, even in the presence of racially abusive language and behavior. Indeed, the affection of these nurse’s aides for some residents seemed to serve as a counterbalance to the racial abuse they endured from other residents and thus to enable them to continue caring. The aides recognized the stress that this level of caring exerts on them, especially when residents die. At the same time, they expressed the value of the care they provide by contrasting it with less than optimal family involvement in the nursing home care, and held out family elder care in their own cultures as a superior model to the formal elder care system in which they work.

Discussion

What social mechanisms are at work, then, that enable nurse’s aides to care for residents in the face of racial abuse from some of them? We believe the findings of this study about the relations between residents and nurse’s aides contribute to the understanding of the interpersonal processes of caring from three perspectives.

Family Care is the Nurse’s Aides’ Gold Standard of Care

“It should not surprise us,” wrote Willcocks, Peace, and Kellaher in 1987, “that the ideals of domesticity and of family are employed in the construction of residential ideals” (p. 4) Willcocks and colleagues describe the family ideal as a “gentle facade” (p. 1) concealing total institutions. More recently, Hocken (1999) described how, in the facility she studied, “attempts are made to bring the institutional setting into line with figurative or mythical representations of the ideal home,” (pp. 110–111) whereas in reality, staff defines the metaphor of home as a rubric for the amenities provided there. In effect, Willcocks and colleagues and Hocken describe a feature of organizations in which the home–family metaphor is a commodifier, aimed at making the services they are selling more attractive and evoking a certain level of amenities.

However, how the family metaphor is used by caregivers differs importantly from how such metaphors are used by organizations. In this study, nurse’s aides used metaphors of family and other attachments to describe the genuine affective care in their relationships with some nursing home residents. But more, they invoked the family metaphor to evoke their personal standard of good care, in effect subscribing to family care as the gold standard of high-quality care and letting their listeners know that they want to provide, and indeed do provide, care of that quality.

Moreover, they seem to draw on their experience of family caring (their mothering skills, their daughtering skills) as a rich resource of knowledge for how to do their work in a caring way. In other words, they are using “family” not only as a metaphor, but as a fund of knowledge and skills that, in many situations, enables them to provide high-quality care. Where are we, then, to draw the line between “mothering” and “infantilization?” Surely we should not so easily dismiss perhaps the strongest resource available to some nurse’s aides to inform their concept, and their performance, of high-quality care.

Nurse’s Aides Electively Supply Affective Care

Theoretical and empirical studies in the field of care work have drawn a definitional distinction between two aspects of care: instrumental care (or the task of caring for someone) and affective care (or the caring emotion that motivates and rewards instrumental care). It is, in fact, the dialectical tension between these two aspects of care, by all its providers (mothers and others), in all its venues (in the family home and in all its substitutes), in all its applications (nursing, teaching, ad infinitum), that provides the material for care work research. Dalley (1988) first drew a definitional distinction between affective care and the task of caring for someone, saying that this distinction is blurred in the lives of women, in family care as in the world of work. Similar distinctions have been drawn by Tarlow (1996), whose conceptual map of caring distinguishes between “caring as feeling” and “caring as doing,” and by Bowers and colleagues (2001), who in interviewing nursing home residents about quality care, found themes of care as service, care as relating, and care as comfort.

This study showed that nurse’s aides also distinguish their caring tasks from their affective care, in that they supply their affective care electively, that is, to some residents and not to others. In effect, the caring task becomes the minimum, universal form of care, whereas any affect the aides proffer tends to enrich or expand care for those who receive it. In this context, the nurse’s aides’ use of metaphors of family and attachment is meant to show us that they are choosing to supply caring affect in their work; in effect, that they are providing affective care to a few lucky residents. In so doing, they are also seeking to distinguish themselves from aides who do not make this effort. The aide who cannot provide affective care to some resident, they seem to tell us, is not providing good care. The corollary, that the resident who does not receive affective care from some staff member is not receiving good care, is left for us to deduce.
Barriers to Affective Care

This study supported the idea that there are significant barriers to the development of affective care. Keeping in mind that the original study focused on the experience of racism by aides while they were on the job in nursing homes, we do not find it hard to see that the study found evidence of abuse in relationships as a barrier to affective care. However, although those nurse’s aides from different cultures seemed to experience a form of elder-care culture shock, both foreign-born and American-born aides seemed to enlist their cultural knowledge of caring in their caring for residents.

By their use of family metaphors, these minority aides, U.S. born and immigrants alike, are also seeking to convey to us a disparity they have noticed between the way their own families care for their elders and the way the families of their residents care for them. They have had the opportunity to observe up close how their residents’ families have cared for them, and they have found that care wanting, in the instrumental sense but especially in the affective one. For some, as we already noted, the fact of nursing home placement was evidence of families’ lack of caring. Others seemed to take a more nuanced view, that families could still provide affective care while paid workers provided instrumental care. At base, however, the aides held the residents’ families responsible for caring, and thus believed that the care work that they were doing substituted for care work that families had failed to do. In a sense they were a sandwiched profession, doing the care work of others while retaining the care work of their own families (Ward-Griffin, Brown, Vandervoort, & McNair, 2005). At the same time, they wanted to communicate that their cultures of origin do a better job of elder care than the culture in which they are working. Thus, the intercultural contact found in nursing homes becomes not only an occasion for interracial abuse (as described in our previous report of this study) but also a setting in which aides translate valuable informal caregiving knowledge into the formal care transaction.

A Rationale for Affective Care

This study did not support the idea that performing caring work produced self-meaning for nurse’s aides. Nor do they seem to be performing emotion labor. Rather, these results argue that nurse’s aides are performing caring work as demanding as that of any family caregiver, but they are neither burned out nor acting. Instead they seem to have found a route toward (to turn Hochschild’s [1983] phrase on its head) an “unmanaged heart,” or genuine emotion in work. The concept of emotional labor in long-term care was recently explicated by Lopez (2006), who proposes a continuum with emotional labor at one end and organized emotional care at the other. In our view, this model could only be improved by a clearer distinction between caring organizations and caring individuals, for although some nurse’s aides seem to provide caring affect in the context of caring organizations, others provide it in spite of working in uncaring organizations.

The results of this study, then, support the idea that aides use boundary work to redefine the racially abusive behavior they encounter in their work as “not racism,” and that this boundary work enables them to maintain a caring stance toward residents, even those who are abusive toward them. In the same way that Akerström’s (2002) aides declined to define the physical abuse that they experienced as “violence,” these aides did not define the racial abuse they experienced as “racism.” As pointed out in our earlier report, they attributed it to old age or dementia. In response to questions about their experiences of racism on the job, they replied with accounts of their affective care. They incorporated family metaphors in those accounts to communicate the high standard of affective care they want to achieve. They also described elder care in their own cultures to reference the source of their knowledge about high-quality affective care.

What is even more important is that the caring affect and even relationships they form seem to fuel the care they provide to all residents. In this sense, affective care becomes the foundation of care, because it provides a motivation to provide high-quality technical care to all residents. When neither good wages, benefits, nor job prestige are present to serve as motivators, when the hope of advancement is slim, when the work itself is onerous, one of the few motivations available may be the reciprocal relationship with residents or the opportunity to deliver affective care. The emotional “currency” generated thereby may benefit all residents, even those with whom aides have no reciprocal relationship, even those for whom aides provide no affective care, indeed even those residents who actively abuse them.

Thus, affective care is not merely a serendipitous by-product of technical care that expands or enriches care for those who receive it. It may be the sine qua non of care, at least of care that extends over time as long-term care does. Thus, although quality assurance still focuses exclusively on the quality of technical care, surely affective care deserves equal attention, and the interaction of the quality of technical care and affective care deserves special attention.

Limitations of the Study

Some limitations of this study are important to note. First, these were virtually all minority aides, raising the question of whether the conclusions would hold for nonminority aides. In general, the
answer is yes: Studies with nonminority aides (Moss et al., 2003; Stone, 2000) also report the use of family metaphors to invoke personal standards of care, and the use of affect to enrich care. However, it is also likely that racial dissimilarity between nurse’s aides and residents raises special issues: It is important to remember that this was initially a study of racial abuse of aides by White residents. Aides raised the issue of caring to indicate that their experience is not only one of abuse, but also of affection, and moreover, that this affection arose across racial lines. What reservoirs of affection, then, might arise between residents and aides who need not overcome racial dissimilarity, nor indeed racial abuse?

Second, these were mainly experienced aides, with an average of 9.6 years of work experience. Would the conclusions hold for less experienced aides? The answer is likely yes, but perhaps not in such clear relief. It seemed that these nurse’s aides had gained a depth of knowledge about old people and about caring that they were very rarely asked to share. It seems likely that their continued tenure was supported by their affection for old people, and conversely, that their affection for old people had deepened with their years of service. It is possible that younger, less experienced aides would not so freely speak of this source of their commitment to their profession; that, indeed, they would not experience it.

Finally, this was a small qualitative study, comprising interviews with 30 aides in three nursing homes. As we already noted, the interviews were intended to tap these aides’ experiences of racism on the job, and the findings about affective care were unsolicited. Nevertheless, the fact that such counter-intuitive findings were revealed argued more strongly for their validity.

**Conclusion**

People who work in the long-term-care field will not be surprised to learn that many nurse’s aides come to feel affective care for some of the patients with whom they work. The results of this study supported previous work (especially Stone, 2000; also see Bowers, et al., 2000) showing that many aides draw on their cultural images and personal experiences of family care to create a personal standard of care. They try within the constraints of their work to reproduce this high-quality family-like care, and they use the metaphor of family and attachment to communicate that they are engaged in this very active process. The attachment, in turn, serves as the foundation of an effort to produce not only further affective care but also high-quality technical care.

The challenge for the long-term-care field is how to capitalize on aides’ understanding of the connection between attachment and quality care in programmatic and research initiatives. Leaders in the long-term-care field must ask themselves what work conditions maximize the chances that nurse’s aides will deploy affective care for residents, what work structures and processes encourage and discourage aides from using their affective care for residents, and how aides’ familial models of high-quality care can provide fuel for the pursuit of high-quality care in nursing homes. Recent developments under the rubrics of culture change and person-centered care should stimulate further study of the effects of attachment between residents and direct-care workers. For example, does permanent assignment make it more likely that residents and aides will develop attachments? Are aides who are attached to residents less likely to change jobs than those who have not developed attachments? Does attachment, in short, lead to improvements in nurse’s aides’ job satisfaction and residents’ satisfaction with care?

This research suggests that the theory of boundary work may be a valuable framework for use in care work studies. Much research is needed. At an interpersonal level, research is needed about the relationship between nursing home residents and nurse’s aides, and its effect on both their emotional lives. Research about nurse’s aides should aim to distinguish between care provided by those who provide affective care in the context of their care work and those who do not, that is, whether in fact the sort of identification implied in the use of family metaphors provides a vehicle for delivery of superior care. It is necessary to know more about the other characteristics of aides who do provide emotional caring, in order to ascertain the components of an aptitude for caring. We do not know whether aides’ capacity for affective care must be part of their personalities (and whether they can be selected for that attribute) or whether it can be nurtured through training. Relationships between aides and residents deserve attention, to determine whether staff members are more likely to form attachments with some types of residents than with others. The effects of attachments between residents and staff are barely understood from either perspective. For example, do residents who form attachments to staff do better—emotionally or any other way—than those without staff attachments? What is the effect on staff of the repeated loss of residents for whom they care? What supportive services for aides are needed to enable them to continue caring in the face of repeated bereavement?

Finally, it might be argued that while metaphors are all very well, we ought to be able to assess whether attachments between nurse’s aides and nursing home residents actually exist (much in the way that attachment between mothers and children is assessed). If they do exist, do they reach levels of reliability, empathy, and consistency necessary for healthy attachment? Such a model, drawn from the parenting literature, has been proposed by McGilton (2002). Short of the parenting model, how can the quality of attachment between caregivers and care...
recipients be characterized? The answers to these
and similar questions will provide much ammunition
for the creation of a new and more humanistic
standard of care.

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