

WHEN NURSING THE ELDERLY DOESN'T END AT WORK: CAREGIVERS'

NARRATIVES IN THE PAID AND UNPAID SPHERES

by

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(ABSTRACT)

Caregiving to the elderly in both the paid and unpaid spheres involves a crucial component, emotion management, that is often invisible despite its importance to the delivery of care. As well, little is known about how caregivers' emotion management in one setting is related to its expression in another. This thesis is an exploration to gain a greater understanding of the ways in which the contexts of caregiving shape the emotion management involved, in hopes of contributing to the knowledge of an important dimension of caregiving and women's work in the two spheres.

Based on the narratives of women who work as caregivers in both the paid and unpaid spheres simultaneously, I use a socialist-feminist perspective to analyze the ideology and structure that shape contexts in which emotion management occurs in caregiving. I explore how these contexts affect the experience of emotion management, and how the contexts might impact one another and the emotion management performed in each.

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Chapter 1

Introduction

OVERVIEW

Caregiving is an essential activity involving both instrumental tasks and affective relations. Many factors have recently converged to bring even greater importance to this area of study (Abel & Nelson 1990). As increasing numbers of women have entered the workforce, concentrated mostly in service sector occupations such as nursing, child care and social work, due to recent reductions in government funding for human services, caring for elderly and disabled persons is primarily the responsibility of individual households. At the same time, the population of people 85 and older has been the fastest growing age group in the United States, and this trend is expected to continue (Hooyman & Kiyak 1993).

Regardless of the extent of labor force participation, work in the home, including caregiving responsibilities, has remained the primary responsibility of women (Abel 1992; Glazer 1993; Smith 1987; Stoller 1992). In fact, women constitute 70 percent of caregivers to the elderly in households (AARP 1995). As well, caregivers are primarily women in the paid sphere, as 87.9 percent of nurses aides and attendants and 94.4 percent of registered nurses are

women (Bureau of the Census 1994:407&409). In addition, 30.7 percent of nurses aides are Black (Bureau of the Census 1994:407&409). As Collins (1991a:45) explains, "understanding the intersection of work and family in Black women's lives is key to clarifying the overarching political economy of domination." She further argues (1991:44) that Afrocentric feminist analyses of Black women's work "investigate both the interlocking nature of Black women's oppression in the paid labor market and the dialectical nature of Black women's unpaid family labor."

The experience of caregiving in women's lives does not easily fit into the traditionally dichotomous split between public and private work. The belief that the public world of employment and the private world of home constitute two distinctly separate spheres is inaccurate (Ferree 1993). Because public and private take on a much larger meaning in feminist literature (Hartmann 1993; MacKinnon 1994), I will refer to the work women perform as taking place in the *paid* or *unpaid* sphere. I will focus on the work women perform as caregivers in the paid and unpaid spheres. I will use a feminist analysis to explore questions raised by Abel and Nelson (1990) concerning the ways the context of each sphere shapes the nature of caregiving. A feminist analysis allows for exploration of the meanings of caregiving in women's

lives and the possibility that it is both "labour and love" (Graham 1983).

STATEMENT OF THE PROBLEM

Researchers have recently demonstrated the importance of the links and interactions between the paid and unpaid spheres on women's employment for understanding both objective outcomes, such as productivity, (Coverman 1983) and subjective experiences, such as burnout and job satisfaction (Wharton & Erickson 1995). While the specific tasks involved in caregiving to the old in the paid and unpaid spheres are similar, there are important differences in the tasks based on the context in which the work is performed. For example, caregiving in the paid sphere has been demonstrated to be shaped by a bureaucratic, capitalist-patriarchal structure, in which task routinization and rationalization allows caregiving to be commodified (Diamond 1992; Fisher & Tronto 1990; Sacks 1990). In contrast, in the unpaid sphere, care is thought to be based more on affective relations between the caregiver and care-recipient (Abel 1991; Abel & Nelson 1990; Walker 1992).

In examining similar labor across the paid and unpaid spheres, the sociology of emotions offers insight to analyze the ways women negotiate the demands of simultaneous

involvement in paid and unpaid work. Gerontologists and feminists are knowledgeable about the caregiving performed by women in the two spheres and have established that paid and unpaid caregiving involve emotion management (Erickson 1993; Hochschild 1983; Wharton 1993; Wharton & Erickson 1995). Tolich (1993:378) has refined this concept to include "regulated emotion management," which occurs when "the conception and management of emotions is regulated by another person" and "autonomous emotion management" which occurs "when the conception and management of emotions is regulated by the individual."

While research in the area of emotion management has focused primarily on the experiences of service-industry workers in the paid sphere, such as caregivers, a great amount of emotion management is required of those who provide care to family members (Erickson 1993). In particular, a large and growing literature documents the emotional and psychological demands placed on family caregivers to the elderly (Abel & Nelson 1990; Aronson 1990; Allen & Walker 1992; Lyman 1993; Walker & Allen 1991). The concepts of regulated emotion management and autonomous emotion management offer a new and important lens to investigate caregiving to the old. This approach provides a tool for the exploration of the ways women simultaneously working in both spheres perform emotion management that is

both regulated and autonomous, alienating and liberating, and the context and meaning of this work in caregivers lives.

As Wharton and Erickson (1995) have emphasized, the literatures on caregiving and the emotion management involved in both the paid and unpaid spheres have remained fairly distinct. While research in this area is growing, it does not acknowledge the relations between the multiple contexts within which emotion management is performed. Little is known about how women's emotion management in one setting is related to its expression in another. As emotion management is an important aspect of caregiving in both realms, a greater understanding of the ways in which the contexts of caregiving shape the emotion management involved will add an important dimension to the knowledge of caregiving and women's work in the two spheres.

RESEARCH QUESTIONS

Through qualitative interviews with women who are employed as caregivers in a nursing home and simultaneously care for elderly family members, I will explore the following specific questions: 1) How does the context in which emotion management is performed in caregiving influence a) positive and negative experiences of emotion management and b) strategies used by caregivers performing

emotion management? 2) How does the interaction of the paid and unpaid spheres influence a) positive and negative experiences of emotion management and b) strategies used by caregivers performing emotion management?

The purpose of this study is to contribute to the understanding of how both the context in which caregiving occurs and the interaction of the paid and unpaid spheres shapes the experience of caregiving. By examining the regulated and autonomous emotion management that women perform in both spheres, I hope to broaden the knowledge of women's experience in moving from sphere to sphere and the strategies they employ in the process.

Chapter 2

Review of the Literature

THE THEORETICAL FRAMEWORK

A Gender Perspective

The basis of this investigation will be a gender perspective of work and family. As Ferree (1991:105) states, "This conceptualization of gender highlights the process of the social construction of maleness and femaleness as oppositional categories with unequal social value."

Viewing the home as a site of social reproduction, it is women who are primarily responsible for physical and emotional unpaid labor (Amott 1993). In the paid sphere, most women work in gender-segregated jobs, concentrated in those jobs that have been most devalued, both economically and socially (Andersen 1993). This has great consequences for women in terms of low earnings and little autonomy at work. Health care remains one of the occupations most segregated by gender. Nursing historically has been defined as "women's work" and this, along with the assumption that the skills involved in caregiving are inherently possessed by women, has led to the devaluation of the occupation and a justification for low pay (Diamond 1990).

The ways in which the workplace and the home are gendered underscores that the systems of patriarchy and capitalism are not so clearly divided between the home and workplace, but simultaneously reinforce and contradict one another (Westwood 1985). In the capitalist mode of production, workers sell their labor power to employers for wages and by doing so enter the "world of social production and relations of exploitation which give them a class position" (Westwood 1985:26). In addition, women are also unpaid and exploited laborers in the home for fathers and husbands (Westwood 1985). A new view of the family has emerged from the feminist attempt to analyze the gendered nature of work-family connections, in which "...family-and-work is a single, historical variable, gendered system" (Ferree 1991:108).

Reverby (1990:133) argues that an historical-material view of caring must accompany theories of the subjective experience of caring: "Particular circumstances, ideologies, and power relations...create the conditions under which caring can occur, the forms it will take, and the consequences it will have for those who do it." Because of the connections between work/family and capitalism/patriarchy, socialist-feminism provides a well-suited framework to investigate the intersection of paid and unpaid work in caregivers' lives.

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Socialist-Feminism

Socialist-feminists view production within and outside the family as shaped by patriarchy and capitalism (Hartmann 1994). The extent of gender stratification in caregiving to the elderly is significant, with women working as primary caregivers in both the paid and unpaid sphere (Walker 1992). Although psychological, sociological, and feminist perspectives have tried to answer the question of why it is women who predominantly provide care, each with differing levels of success, past research has tended to focus more on the psychological reasons and the psychological hardships that women encounter as a result (Stoller 1993). These psychological approaches hold that women are inherently more caring and nurturing than men and that caregiving is central to women's identity (Walker 1992). Generally, they fail to assess caregiving as "embedded in a complex network of social and economic relations, both within the home and the workplace" (Stoller 1993:158).

Hartmann (1993:191) argues that, "Both marxist analysis, particularly its historical and materialistic method, and feminist analysis, especially the identification of patriarchy as a social and historical structure, must be drawn upon if we are to understand the development of western capitalist societies and the predicament of women." Using socialist-feminist theory, I will analyze how

patriarchy and capitalism operate to affect women caregiver's lives in both the paid and unpaid sphere, as socialist-feminists view class and gender relations as intersecting in advanced capitalist societies (Hartmann 1993).

This theoretical framework is useful in examining caregiving as it views production/reproduction in the unpaid sphere as equally important to the paid sphere and necessary for the work that takes place in the paid sphere (Andersen 1993). Socialist-feminism reveals that women's activities constitute work in both spheres. As Stoller (1993) emphasizes, a socialist-feminist perspective redefines work to make visible both the caregiving activities that women perform without pay and the implicit role of gender relations, as defined by Ferree (1991), within work organizations defined as gender neutral.

Emotion Management

I will use Tolich's (1993) concepts of regulated and autonomous emotion management as a tool for investigating the intersection of the paid and unpaid spheres. They specifically address the paid and unpaid spheres and the ways emotion is managed within these spheres from a materialist standpoint, which compliments a socialist-feminist framework.

Hochschild (1983:7) defines emotional labor as "the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has exchange value." While emotion management shares this definition, these are acts "done in a private context where they have use value" (Hochschild 1983:7). Emotion management refers to the effort involved in intentionally regulating one's own emotions so as to influence others in a particular way.

Tolich (1993) expands on Hochschild's (1983) dichotomous view of emotion management only having use value and emotional labor only having exchange value. Hochschild (1983) explains that due to the shift from an industrial to service economy progresses, workers deal less with objects and more with people which will increase the value of the ability to deal with people, relationships and feelings. A major consequence of managing one's emotions is the potential to become alienated from them (Hochschild 1983). Similarly to physical labor, "the worker can become estranged or alienated from an aspect of self-either body or the margins of the soul--that is *used* to do the work" (Hochschild 1983:7). However, Hochschild's descriptions are somewhat limiting. Only emotional labor, which is sold for a wage would be alienating, closing off the possibility of understanding the ways in which unpaid emotion management

might also be alienating. This also leaves no room for autonomous acts of emotional labor that might be felt as liberating while performing paid labor.

Tolich's refinements of these concepts fit with the socialist feminist views of the dialectical nature of paid and unpaid labor, as women experience both alienation and liberation due to the gendered nature of the work they perform in both spheres. These experiences are not easily dichotomized but fluid and dependent on the context in which they are performed.

Most of the research on these concepts has focused on the emotional labor performed by those employed in the service industry because of the displays of emotion regularly required in these positions (Wharton & Erickson 1995). Within the service industry, health care workers have been identified as one group of workers most involved in front-line service positions, which demand the most intensive emotional labor and are occupied primarily by women (Hochschild 1983).

While emotion management has been shown to be an integral part of caregiving, this concept has been little used in the caregiving literature. Researchers have not recognized and explored "the links between the 'emotion management' components of women's work and family lives" (Wharton & Erickson 1995:274). Indeed, there has been

little systematic study of emotions and specifically the effects of emotion management on family/work life (Wharton 1993; Wharton & Erickson 1995). Because of their inherent theoretical link to a material, feminist analysis, and their important role in caregiving, regulated and autonomous emotion management are useful tools to explore the intersection of paid and unpaid work in caregivers' lives.

Black Feminist Thought

As Andersen (1993:348) explains, "Feminist theory is itself incomplete without an analysis of the intersections of race, class, and gender in society." Socialist-feminism provides a distinct analysis of class, however it tends to be limited in its emphasis on race (Andersen 1993). The inclusion of Black feminist thought is necessary to provide a more comprehensive theoretical framework for examining women's experiences of the intersection of race, class, and gender in their lives.

By starting from the perspective of women of color it is possible to see simultaneously the intersection of race, class and gender as systems of oppression (Thornton Dill 1995). "Centering knowledge in the experiences of those who have traditionally been excluded causes us to question all the assumptions made in studying not only people of color, but dominant groups as well" (Andersen 1993:350). As

Collins (1991:45) further emphasizes, "understanding the intersection of work and family in Black women's lives is key to clarifying the overarching political economy of domination." She further argues (1991:44) that Afrocentric feminist analyses of Black women's work "investigate both the interlocking nature of Black women's oppression in the paid labor market and the dialectical nature of Black women's unpaid family labor."

CRITICAL ANALYSIS OF RESEARCH RELATED TO THE THEORETICAL FRAMEWORK

Because the context under which caring is performed has an impact on the form it will take, uncovering the ways in which the values and structures of institutions shape the experiences of caregivers is crucial to understanding the experience of the intersection of the paid and unpaid spheres in women's lives. As Abel and Nelson (1990:9) emphasize, "the experience of caregivers is molded not simply by the settings within which they operate but also by the complex and constantly shifting relationships between these different arenas."

To understand the ways women experience caregiving/emotion management in the two settings, an understanding of caregiving in these differing settings is important. Given the lack of research on women who are

simultaneous caregivers in the paid and unpaid spheres, I will draw on the distinct literatures addressing caregiving and service work.

The Paid Sphere

Nurses face a dilemma: because they have been given the "duty to care" they are "forced to act as if altruism (assumed to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being, even human characteristics distributed along gender lines" (Reverby 1990:133). The literature on paid caregiving points to two important ways that the expression of the "duty to care" is shaped by administrative policies: commodification of care and routinization.

Commodification of Care

Diamond (1992) has addressed the commodification of care as typified in the nursing home industry. In order to construct "goods and services that can be measured and priced," work in the nursing home is defined in terms of medical tasks (Diamond 1992:176). The relationship between nurses and residents becomes formalized through the recording of these tasks. This charting defines what is and is not considered legitimate work. Diamond (1992) notes that much of the work nurses perform involves social and

emotional caring for residents who are often lonely and confused and in need of human contact. However, this latter type of interaction is largely "unchartable" because it does not fit into the predetermined medical categories available for charting. It is also not officially rewarded. In fact, it is discouraged in the name of efficiency--and therefore remains devalued, unnamed and invisible (Diamond 1990). Reverby (1990:133) argues that this is one of the crucial dilemmas faced by American nurses: "the order to care in a society that refuses to value caring." This dilemma is further emphasized for nurses caring for the old because of ageism and the devaluation of the elderly population.

The power to define reality in the nursing home is an important aspect of the commodification of care. As Diamond (1992) illustrates, whether a shower is hot or cold, it becomes "cleaning," whether a meal tastes good or bad, is eaten or not, it becomes "nutrition;" each are documented in order to pass various inspections. Through the power of documenting daily life in a prescribed manner, residents' lives become terms and numbers on the charts. Neither the nurses nor the residents have any real power in defining the situations they encounter--this "power over knowledge" belongs to the administration. It "descends from an administrative logic that is far removed from the moment" (Diamond 1992). And because of the distance of the

"administrative logic" being applied, there is little chance of the reality of the nurse-resident interaction and relationship ever being realized by management.

Routinization

Leidner's (1993) discussion of the service industry provides an important context for understanding both paid caregiving of the old and the nursing home industry. She explains the unique interaction of employer, employee and "service recipient" as "interactive service work." In order to control effectively the labor process in service work, employers try to routinize and rationalize employees' self-presentation and feelings. She argues that this affects customers as well, and as a result, employers' attempts to control work also affect the larger culture (Leidner 1993).

Routinization is complicated by service recipients, who may or may not play their roles accordingly (Leidner 1993). This is significant in the nursing home setting for several reasons. Nurses experience intensive interaction with the "service-recipient" (resident), who unlike in most other service industry settings, often has not chosen to participate in the "exchange" and resists the procedures/"services" performed. This severely complicates the delivery of care. In the nursing home setting, the situation is further complicated by the fact that it is

unclear whether it is the residents themselves or their families who are seen as the actual clients. Because nurses' performance is judged on completion of a given set of tasks, interference from the person on whom the tasks are performed is an obstacle to their job.

However, one of the many contradictions involved in the routinization of service work is that there are circumstances in which routinization is beneficial to workers. Workers may use routinization as a shield from the abusiveness of service-recipients, whether these recipients are patients or families (Leidner 1993). In the case of nurses, routinization may also act as a buffer against the emotional pain of the interaction as well.

It is important to understand this component of paid labor, as routinization plays a critical role in shaping the relationship and interaction of nurses and patient in the nursing home. This is the context in which nurses provide care for the elderly in the paid sphere, a context which is assumed to not be present in the unpaid sphere.

The Unpaid Sphere

Dwyer and Coward (1992) point out that if caregiving refers to the definition offered by Horowitz (1985), "care provided to an elderly person who has some degree of physical, mental, or emotional impairment that limits his or

her independence and necessitates ongoing assistance," family caregiving "begins in earnest when an older person becomes sufficiently impaired (physically or mentally) to require assistance in order to function effectively in a noninstitutionalized setting and a family member begins to provide or facilitate such care." However, they make the important distinction that caregiving can also be seen as a "lifelong series of interactions between the caregiver and the care recipient" (Dwyer & Coward 1992:11), and thus caregiving is a more "diffuse phenomenon that exists over a number of years and evolves, only during periods of increased impairment, into the type of caregiving typically addressed in the aging context."

Dwyer and Coward (1992) point to three factors that caregiving: love and affection, a desire to reciprocate for past assistance, and a generalized norm of responsibility (Doty 1986). This has led to an oversimplified and dichotomous distinction between caregivers who care about and those who care for; the first out of love and affection, the latter out of obligation (Dwyer & Coward 1992). However, there are many diverse and complex motivators for providing caregiving that are not so easily separated (Blieszner & Hamon 1992).

Caregiving in almost any setting involves both instrumental tasks and affective relations (Abel 1991). In

the unpaid domain, caregiving frequently involves providing complicated medical procedures to someone with whom you are intimately tied. This challenges the split between reason and emotion, and at times makes the rational delivery of care difficult for the caregiver.

Emotional support, financial aid, instrumental activities such as transportation, shopping, housework, personal care are the primary forms of assistance provided to elderly parents. The type of assistance provided is largely determined by the older parent's functional level, the availability of other informal caregivers to share in the work, and access to formal resources (Cantor 1991). The gender of the caregiver is also important as personal care is most often provided by women (Stoller 1990).

Research on caregiving has focused almost exclusively on the stress and burden caregivers, with caregiver's health, employment, personal freedom, privacy and social relationships documented as being negatively affected (Hooyman & Kiyak 1993). Emotional burden appears to be the greatest cost associated with caregiving, experienced more by women than men (Abel, 1993).

This focus on caregiver burden has been challenged by feminist researchers as distorting the reciprocity and meaning involved in the mother-daughter relationship. For example, Walker and Allen (1991) employed qualitative

example, Walker and Allen (1991) employed qualitative research methods to focus on the meanings of caregiving experiences not only to caregivers, but care-recipients, as well. Their findings show evidence of positive outcomes and the active roles of mothers in the relationship and indicate a need for further research in this area.

Research on the Intersection of the Paid and Unpaid Spheres

In one of the few studies which examines the links between the emotion work that women perform in the paid and unpaid spheres, Wharton and Erickson (1995) found that women hospital workers' job-related well-being was influenced by their and their partners' degree of involvement in family emotion work. They also discovered that the women in their sample who performed emotional labor on the job were more likely than other women to perform emotion work at home (Wharton & Erickson 1995). Research indicates that nurses and social workers who also perform family caregiving are at a "high risk for psychological distress, poor health, and reduced well-being" when they experience family caring that "taxes their personal and material resources, or when they experience contagion stress from exposure to the problems of others" (Marshall et al. 1990:275). For these women, their paid work did not serve as the "buffer" against domestic sphere strains that research indicates work outside the home

provides other women (Marshall et al. 1990).

Contradictions and Connections Between the Spheres

In contrast to the unpaid sphere, in the paid sphere there is an attempt through routinization and rationalization to separate the instrumental and affective aspects of caregiving through rigid rules, regulations and procedures to increase efficiency (Diamond 1990). There are correlations between institutional rigidities and stress and burnout, and in these settings demands by patients for more than a mechanistic approach to care can seem like another "oppressive feature of their jobs" (Abel & Nelson 1990). There are no clear-cut answers for the responses of workers to their varying caregiving responsibilities. In addition, Abel (1991) argues that unpaid caregivers have a distinct pattern of thought that differs from scientific rationality; rather than learning through instruction, they use knowledge that has been gained through knowing the person they are caring for and past experience. Through the medical model, their confidence is eroded and knowledge delegitimized.

Caring for elderly disabled parents is often sudden, unexpected, and typically unplanned. Similar to caring for children, it can disrupt labor force participation (Abel 1991). The women Abel (1991) interviewed worried about the effects of caregiving on their jobs and also saw their jobs

as a respite from the demands of caregiving. But as mentioned earlier, caregiving in both the paid and unpaid domain can also have negative effects on the mental and physical health of the caregiver, and that women who are responsible for both are even more likely to suffer these negative effects (Marshall et al. 1990).

As emphasized by Wharton and Erickson (1995), emotional labor should not be studied in isolation from the larger networks of emotion work in which women are involved. Their findings indicate that "family emotion work may be a critical factor in understanding job-related outcomes, such as burnout, which are associated with a depletion of emotional resources" (Wharton & Erickson 1995:286). As these findings suggest, the paid and unpaid spheres of emotional labor and emotion management have important impacts on one another. The importance of understanding these links lies in its potential to broaden the knowledge of caregiving, which remains one of women's primary responsibilities in both the paid and unpaid domains.

Race and Class

Women's differing experiences in the paid sphere on the basis of race and class have been documented; however, a flaw of most research on unpaid caregiving is its failure to adequately examine the impacts of race and class on the

caregiving experience (Abel 1990). The few studies investigating the differences women experience in family caregiving by race and ethnicity have had difficulty distinguishing cultural values from socioeconomic necessity (Abel 1990). In spite of this, it is clear that cultural variations do alter the caregiving experience and present problems in providing care. For example, although elderly members of minority groups are most likely to experience functional disabilities, they are least likely to be present in the nursing home population. This has been attributed to various geographic, economic, discriminatory and cultural factors, but regardless of the explanation, a higher proportion of members of ethnic and racial minorities, with higher levels of functional impairments than whites, are receiving informal care in the community (Abel 1990).

In terms of class and unpaid caregiving, Abel (1990) notes that low-income people face several special problems in providing care. These include rigid work schedules that may not allow special flexibility for caregiving responsibilities, limited access to formal services, difficulty obtaining home- and community-based services, and difficulty affording medical equipment and supplies.

Both the paid and unpaid spheres of caregiving involve a negotiation of relationships shaped by the context in which they occur. This context in which caregiving occurs,

along with the interaction of the paid and unpaid spheres, influences the experience of caregiving. As the following chapters describe, interviews with nurses and nursing assistants working simultaneously in both spheres revealed a complex mixture of similarities and differences, contradictions and reinforcements experienced between the spheres.

Chapter 3

Methodology

OVERVIEW OF THE RESEARCH DESIGN

Discourses on difference provide a central theoretical orientation in which to examine the challenges presented when conducting research which involves participants of differing racial/ethnic and class backgrounds than the researcher. These perspectives have guided my choices of methodological tools and procedures.

Standpoint Theory

Standpoint theory is based on the belief that less powerful groups in society have the potential for a more complete knowledge of society than more powerful groups (Neilsen 1990). Because of their disadvantaged position, in order to survive they must be observant of the dominant group as well as their own, and their relationship to the dominant group. The resultant "double vision" provides the potential for a more complete knowledge of society (Neilsen 1990:10).

Standpoint theory is a potentially valuable tool in conducting research from a socialist-feminist perspective because as feminist theorists have argued, all research is conducted from a particular standpoint and location in the

social structure and all observations are made from the perspective of the researcher (Fonow & Cook 1991; Hartsock 1983; Smith 1987). The observer is not a neutral party; what researchers bring to their work influences what is studied, how, and the conclusions that are drawn (Andersen 1983). Smith (1987) maintains that social research and theory must situate actors in their everyday worlds, and analysis should begin with the immediate experience of social actors but go farther by uncovering the social-institutional context of their lives.

Reflexivity is necessary to utilizing standpoint theory as a source of insight and a critical examination of the research process (Fonow & Cook 1991). My social location played an important role in shaping the research process involved in this thesis. I am a white, middle-class woman in my late twenties. As such, I am very different from the participants in this study, the majority of whom are African-American and working-class. My awareness of our differing locations and the greater power and privilege associated with mine, along with my desire to conduct research that captures the meaning of the participants' experience as accurately as possible, created a tension which I experienced and explored throughout the research. While this was uncomfortable, I believe it helped me to conduct the research with a deference to the participants

that improved the resulting data and subsequent analysis.

To do an analysis that places women's experiences at its center of discourse, it is necessary to connect the abstract to the everyday. "The challenge -- conceptualizing the interrelationship of social structure and the individual experience -- is one that lies at the core of theorising in the social sciences" (Aronson, 1990:63). This provides the opportunity to gain a greater understanding of how women work to connect their everyday experience with these wider social processes and vice-versa (Smith, 1987). As Aronson (1990) emphasizes, women's personal realities often do not fit easily into commonly held assumptions about families, responsibilities and need in old age. Making the translation between the theoretical and the real experiences of women's lives and their connection to wider social processes provide a more complete basis from which to work to improve women's lives (Aronson, 1990).

Black Feminist Thought

Collins (1990:22) suggests that "Black feminist thought consists of specialized knowledge created by African-American women which clarifies a standpoint of and for Black women." According to Collins (1990), Black women intellectuals are critical to the production of Black feminist thought because their unique standpoint on Black

womanhood is unavailable to other groups. However, this leadership of African-American women does not mean that others cannot participate in the advocacy, refinement, and dissemination of Black feminist thought.

Qualitative research methodology can provide a valuable tool to conduct research which places Black women at the center of knowledge production. "Qualitative research starts from the assumption that one can obtain a profound understanding about persons and their worlds from ordinary conversations and observations" (Gubrium and Sankar 1994:vii). Through this search for meaning, qualitative methodologists focus on the commonsense understandings that people have about their lives, and treat this understanding of experience as something to be "examined and explained rather than second-guessed" (Gubrium and Sankar 1994:ix).

DATA COLLECTION PROCEDURE

From the perspective of Black feminist thought, dialogue is an important tool in assessing knowledge claims because of its emphasis on connectedness rather than separation (Collins 1991).

As Collins illustrates in a quote by bell hooks (1989:131), "Dialogue implies talk between two subjects, not the speech of subject and object. It is a humanizing speech, one that challenges and resists domination."

Critical to the success of this epistemological approach is that the dynamics of dialogue are fluid, everyone has a voice, and that through the sharing of common causes dialogue is fostered and differences transcended . As feminist qualitative researchers have theorized, the research must not only be *about* but *for* the participants and that they have a voice in shaping both the direction and the outcome of the research process (Collins 1991).

Because oppressed groups must be involved in the process of knowledge construction, the research strategy must "allow them to speak, and the researcher to speak out on their behalf" (Seitz 1995:18). In-depth interviews provide one potential avenue for women to participate in the construction of knowledge (Seitz 1995). As Kaufman (1994:123) explains, "In-depth interviewing is a data-gathering technique used in qualitative research when the goal is to collect detailed, richly textured, person-centered information from one or more individuals." It is useful for investigating what is meaningful to the individual. To protect from silencing respondents, the interview format should be open to change and be more of a guide for conversation than a strict set of questions (Seitz 1995).

I conducted loosely structured, in-depth interviews (see Appendix A for interview schedule). This means, as

Gilgun et al. (1992) explain, the questioning style did not follow the rigidity of a formal interview schedule, but remained somewhat unstructured in order to allow the exploration of what the subjects found meaningful. I followed an outline of broad, topical questions, following with "reflective comments, probes and clarifications" (Gilgun et al. 1992:41).

Interviews lasted between thirty and ninety minutes. They took place in the participants' homes when possible, and otherwise at the nursing home at the end of their shift or during their lunch break. While my mother and I would initially suggest their home, this decision was left to the participant. All participants were amenable to having the interviews tape-recorded; this provided a more accurate and detailed record of the meetings.

Observer comments are another important way to capture the context of the interview setting, describe processes, and reflect on meanings (Gilgun et al. 1992). Immediately following each interview, I tape-recorded verbal comments concerning my impressions, the interview, the setting, and so forth. All interviews and comments were transcribed.

DATA ANALYSIS

In analyzing the participants' interviews, I was guided

by standpoint theory (Nielsen 1990), discussed earlier in this chapter; the perspective of institutional ethnography (Smith 1987; DeVault 1995); and the methodology of thematic analysis (Luborsky 1994). In the following paragraphs I will discuss how each approach was used to aid in addressing the research questions of this thesis in a way that corresponded to the theoretical framework which guides the research.

The institutional ethnography is a concept, which used in conjunction with interviews, is useful to illuminate the social relations in which participants are involved through their training and the organization of their daily activity in their field of work (Smith 1987). In this method of research, the focus is on the organizing contexts that shape individuals' activities, and the opportunities and constraints these positions provide (DeVault 1995).

Work within settings is shaped by both visible and invisible activities, and the institutional ethnography attempts to make visible the latter. It begins with close attention to the people who work in a setting. "The idea is that their knowledge and practices should serve as a point of entry for analyses that look beyond official, ideological accounts of what happens in the setting" (DeVault 1995:615).

Thematic analysis is the method I utilized to achieve the goals of the institutional ethnography. I conducted

multiple readings of the interview transcripts to search for emerging themes and patterns (Luborsky 1994). Thematic analysis provides the opportunity for "direct representation of an individual's own point of view and descriptions of experiences, beliefs, and perceptions," as well as insight into the cultural beliefs and values that shape experiences and motivations (Luborsky 1994:190).

Through the use of standpoint theory, institutional ethnography, and thematic analysis, I have conducted an analysis which addresses my particular research questions while meeting my overall research goal. I begin with the immediate experience of the participants and attempt to go farther by uncovering the social-institutional context of their lives (Smith 1987). I focus on the organizing contexts that shape individuals' activities (DeVault 1995) by searching for emerging themes and patterns in their interviews.

PARTICIPANT DESCRIPTION AND SELECTION PROCEDURE

The eight participants in this study are all health care professionals who work in a nursing home located in a major metropolitan area in the South. These certified nursing assistants, licensed practical nurses, and registered nurses simultaneously provide or have recently provided care for an elderly person residing in their home.

The participants were identified using selective sampling techniques, meaning that prior to beginning I decided on a set of criteria based on my research questions. The criteria limited the participants to women who worked as nursing staff in this nursing home and were caring for or had cared for an elderly family member. Based on these criteria, the participants were initially selected and contacted by my mother, who is a registered nurse working in this nursing home. The group includes both women that she knows personally, and women suggested to her because of their known caregiving for family members.

The eight participants included three women who are white and five who are African American, an important subject I will return to discuss shortly. Their ages range from 23 to 57. Five of the women are married. The amount of time they have worked as paid caregivers ranges from three to 23 years. Two are registered nurses, three are licensed practical nurses, and three are certified nursing assistants. While I did not specifically ask for information concerning the participants' income, nursing assistants' starting pay is generally \$5.50 per hour and L.P.N.s begin at approximately \$8.00 per hour. Registered nurses' salaries in nursing homes vary somewhat based on education, experience, and position. In this nursing home, an R.N.'s pay ranges from \$15.50 per hour and for entry-level

employee, to \$18.50 per hour for the director of nursing. Among all the women, their training in nursing also represents their highest level of education attained. A total of five have children, all of whom are teenaged and older; three of the women have children who live with them. The amount of time they have been caregivers for a family member ranges from six months to 10 years. Family members for whom care was or is provided include: four mothers, one father, two mother-in-laws, and one father-in-law. I will provide further information on these care-recipients below.

I will now introduce each of the women by providing further information about her life and experience as a caregiver in both spheres. None of the participants' real names have been used in order to protect their anonymity.

Frances

Frances, a 53 year-old African American, has worked as an L.P.N. in this nursing home for 23 years. She had been assisting as an instructor in the nursing assistant training course on a part-time basis while continuing to work as a L.P.N., but she recently suffered a heart attack, and since returning to work has become a full-time instructor. She and her mother shared a household for ten years, during which time she was unmarried. The first few years her mother continued to work, but increasingly in the last years

of her life, due to arthritis and chronic pulmonary disease, she required a great deal of Frances' care. Frances has two adult children who did not live with her during this time; she was fully responsible for her mother's care. Her mother died three years before our interview. I interviewed Frances in her home.

Joan

Joan has been a nursing assistant off and on for about ten years. She is African American and 36 years old. She is married and has two teen-aged sons. Her mother-in-law has lived with them for about two years, and Joan describes her as not totally dependent, but requiring a great deal of supervision as she is unable to cook or clean, due to such things as forgetting to turn off the stove. Joan is her mother-in-law's primary caregiver, as well as performing the majority of household responsibilities for her family. I interviewed Joan in the breakroom of the nursing home after she completed her shift.

Nancy

Nancy is an L.P.N., and a charge nurse on the Alzheimer's unit. She has been a nurse for approximately 10 years. She and her sisters cared for their mother for four months, until she died in October, 1995. Her mother required daily injections for pain she suffered related to cancer, which Nancy administered. However, she was

ambulatory until the last few days of her life. Nancy is African American and in her 30s. Nancy and I talked in the breakroom of the nursing home after she completed her shift at work.

Tamara

Tamara has been a nursing assistant for three years, and she worked in the laundry department at the nursing home for about five years prior to this. Her mother has lived with her off and on for short lengths of time during periods of illness, such as when her arthritic condition worsens. Her mother is very overweight and has little cartilage left in her knees. Tamara also does her shopping and cleaning once a week, manages her financial responsibilities, and takes her to the doctor when necessary. Tamara is white, 38 years old, and married. She recently underwent surgery and was returning to work the week after our interview after a six-week absense. I interviewed Tamara in her home.

Lauren

Lauren has been an R.N. for approximately 30 years. She has worked in several different medical settings, such as the emergency room, medical/surgical halls, and was head nurse of an intensive care psychiatric unit and a geriatric psychiatric unit. She is white and 52 years old. Her father lived with her off and on during periods of illness, mostly related to heart problems. Most recently, after she

divorced they shared a household for approximately one year, until he moved into a retirement community. During part of this time, her adult daughter and grandchild also shared their household. Her father died in October 1995. At the time of the interview, Lauren had remarried and she and her husband live alone. She was interviewed in her home.

Gloria

Gloria is African American and in her 40s. She is an L.P.N. and charge nurse on the Alzheimer's unit, and has worked at the nursing home ten years. She expressed pride in having started the Alzheimer's unit and recently having won an annual, state-wide job-related award. She cared for her father-in-law, who has Alzheimer's disease, for almost three years, until he was completely unmanageable and was admitted to her unit in the nursing home. She and her husband have teen-aged children, and while her husband's family does live nearby, they provided only minimal assistance. Her husband hired someone to live with them and help care for his father when he began to need 24-hour care. Gloria explained that due to the stress involved, she began to suffer both physical and emotional problems. Gloria and I talked in the day room of the nursing home after she completed her shift for the day.

Eleanor

Eleanor is an R.N. and worked as Director of Nursing in

the nursing home for 20 years. She recently resigned due to health problems and job dissatisfaction stemming from disagreements with the administration. She now works part-time in another nursing home. She is a white, married, 57 year-old, with three adult children who had move away from home before Eleanor's caregiving responsibilities began. Her mother-in-law lived with them for approximately ten years, initially due to mild confusion which made it difficult for her to live alone. This advanced until she was unable to stay alone even for brief periods. She is now in a nursing home, and Eleanor suspects she has Alzheimer's disease. Her interview took place in her home.

Robyn

Robyn is a 23-year old African American who began her training to become a nursing assistant in high school. She has now worked in the nursing home for six years. She and her sisters cared for their mother who died of cancer in October, 1995, three months before our interview. While her mother had been sick for nearly three years, she did not tell Robyn until almost the end of her life. Her sisters and hospice care shared in the caregiving responsibilities. But because Robyn shared a home with her mother, and because of Robyn's training as a C.N.A., Robyn provided most of her care in the last months of her life. During this latter time, her mother was bedridden, and the care was intensive.

I interviewed Robyn in the break room after she completed her shift at work.

LIMITATIONS AND CONSIDERATIONS

I learned a variety of methodological lessons during the process of conducting this research. For example, I realized that the interviews tended to be more successful if I began by asking questions concerning participants' family caregiving. The participants seemed to be more comfortable answering questions than when I began with questions concerning their work in the nursing home. I was especially sensitive to this issue due to the fact that my mother was my key informant and an R.N. in the nursing home, which places her in a position of greater power in the nursing home than most of the participants.

As well, participants interviewed in their homes tended to be more comfortable than those interviewed at work. However, the interviews that took place in the nursing home were at the participants' request and, I feel, could have been partly due to their possible discomfort with having me in their homes. In both cases, in each interview a feeling of rapport developed shortly.

My mother performing the role of key informant had both possible positive and negative impacts on the research. It did create what I perceived to be tensions within my

relationships with the participants. As I stated earlier, I was aware of the power differential between my mother and the participants, racial differences, and that a relationship existed between the participants and my mother prior to the research project. I was aware that my mother recommended women that she respects to participate, and I was also aware that the women could be concerned that I would not uphold my promise of confidentiality.

There are important positive aspects to my mother acting as key informant, as well. I had the opportunity to spend a great deal more time gathering information, such as background information and more detail or "translation" of information from other participants, from her than I would have in a more formal relationship. Additionally, as biases shape all of our experiences, I had the benefit of knowing in much fuller detail those that influence her. All of these points guided my position and approach to the research, and I tried to take them into consideration as I interviewed each participant. Working with my mother on this project enabled me to gain valuable insight into and understanding of the experience that she and the women who participated in this study share as caregivers, and made this thesis even more important to me.

The small number of participants certainly limits my research in some respects. However, sampling for

qualitative research differs dramatically from quantitative research in objective. Most importantly, the unit of study is personal meaning and experience (Rubinstein 1994), and sampling is guided by "the desire to learn in detail and in depth about the *experiences of individuals*" (Rubinstein 1994:80; emphasis in the original). With this goal in mind, there are several factors which shape the research process and decisions concerning numbers of participants. These factors include the purpose of the research, which in this case, is exploratory; theoretical saturation; and available resources (Rubinstein 1994).

First, the exploratory nature of this research shaped broad research questions, allowing for discovery in an area which is largely undocumented. Despite the expansive nature of the research questions, several key themes emerged from the interviews, and were present in each, comprising a rich data set. This led me to believe that I had reached, at least on an initial level, theoretical saturation, which Rubinstein (1994) describes as a point in which patterns become repetitive and thematically saturated, and inquiry stops. Further, the purpose of exploratory research is to identify areas in need of further research, which I believe was accomplished in this study. Lastly, reality dictates that there always exist the practical consideration of limited resources. This of course had an impact on the

number of participants included in this study.

At the same time, I feel that, in several ways, the small number of participants was actually an advantage in this stage of my development as a researcher. It allowed me to personally transcribe the interviews, enabling me to listen to the interviewing process and note strengths and weaknesses. Second, the data were more easily managed and organized, which at this stage was important to thorough analysis. For these reasons, I believe the number of participants included in this master's thesis are adequate and appropriate to the nature of the project.

REVIEW OF RESEARCH QUESTIONS

To review, the research questions I will address in the following chapters are: 1) How does the context in which emotion management is performed in caregiving influence a) regulated and autonomous experiences of emotion management and b) strategies used by caregivers performing emotion management? 2) How does the interaction of the paid and unpaid spheres influence a) regulated and autonomous experiences of emotion management and b) strategies used by caregivers performing emotion management? In the following chapters, I will first discuss findings concerning the organizing contexts of caregiving, followed by the those concerning the emotion management performed in each sphere.

Chapter 4

The Contexts That Shape Caregiving

OVERVIEW

Women who are caregivers in both the paid and unpaid spheres move almost daily between two very different settings which shape their experiences and the form that their caregiving activities will take. Understanding these settings is the first step in examining the caregiving, and the subsequent emotion management, that caregivers perform in each sphere; therefore I will first discuss the contexts of caregiving, then, in chapter 5, the emotion management involved in each.

Both the paid and unpaid spheres of caregiving are shaped by specific a ideology and structure, which then determine the actual organization of physical tasks and emotion management and how these are carried out. However, these characteristics do not occur in a vacuum; caregivers working in both spheres brought their knowledge of each domain into the other as they perform their caregiving responsibilities. I will discuss the ideology, structure, and organization of each sphere, and then the interaction that occurs between the spheres and how these influence emotion management in caregiving.

THE PAID SPHERE

Caregiving in both the paid and unpaid spheres draws on two contrasting ideologies, one related to family and the other to work (James 1992). Examining these ideologies provides insight into the context in which caregiving in each sphere occurs.

The Ideology of the Paid Sphere

As detailed in chapter 2, the paid sphere includes a formal health service ideology involving paid professionals and "scientific" knowledge (James 1992). "It is about 'doing,' and treating with physical interventions" (James 1992:491). Under capitalism, the nursing home is an industry, and caregiving in nursing homes becomes a commodity that is sold in the marketplace.

In describing this phenomenon, Diamond (1990:126) emphasized the ways that capitalist medicine has turned nursing into an "administrative reality of categories and documents" that becomes defined in terms of abstract management ideologies. In this way, nursing becomes cost-accountable and profitable.

The Structure Which Shapes the Organization of Tasks in the Nursing Home

As an industry, the nursing home is organized

bureaucratically and hierarchically. Nursing assistants, providing the majority of personal care to residents, are at the bottom of this hierarchy, with L.P.N.'s and R.N.'s gaining minimal status and power above them.

In an attempt to effectively control the labor process in the nursing home, the caregiving that the nursing staff performs is highly routinized by the administration. This routinization organizes the actual tasks and responsibilities of caregiving and sets the context within which both the physical labor and emotion management are carried out (James 1992).

This work routine is defined in terms of medical tasks, and is most visible in the charting, or recording of each resident's care (Diamond 1990). The chart is a record of not only the resident, but of the work of the nursing staff and the formal relationship between the staff and the resident. Because in the course of their work, much of what the nursing staff do is not chartable, it is not formally recognized and becomes invisible. As Diamond (1990) emphasizes, and the caregivers I interviewed described, much of this invisible work is the emotion management that caregivers perform.

The dialectic of routinization

In both the paid and unpaid spheres, routinization brings both positive and negative consequences for caregivers. Some of those consequences in the paid sphere are discussed here.

Routinization can be complicated by the residents, who as "service-recipients" may or may not play their roles accordingly (Leidner 1993). In their interviews, caregivers stressed that the formal policies of the nursing home do not always fit each patient; that to provide the best possible care, often each patient must be viewed as an individual with individual needs.

This creates a tension between the power of organizational demands versus those of the residents and the residents' families, and nurses and nursing assistants face the contradiction of attempting to apply their values of individual and family care to a hierarchically and bureaucratically organized institution (James, 1992). Lauren explains the contradiction between providing "quality care" for an individual and living by state regulations that, at best, are based on group norms:

"These residents, maybe they don't want a shower. We have to give them a bath at least two days a week. That's our policy, and partial baths the other days. Well, maybe they don't want a bath at that time of day. We try to make accommodations because then you get into patient rights. If they say

they don't want to get up at a certain time of day they shouldn't have to. But if these poor people [nursing assistants] are going to get through in the morning and get everyone ready for breakfast, they have to. It's just a circle. They [State regulations] tell you everything you can do and these residents, that's not how they want to live. If they say it's a home, it's not. You try and make it a home, but it's still an institution. It's governed by what the state and federal government tell you to do."

At times, the nursing home staff may be able to more efficiently accomplish their tasks by performing them in such a way as to meet individual needs rather than in blanket fashion. Within the dominant medical system, the nurses and nursing assistants do resist the prescribed routine in organizing the details of resident care. Tamara describes her interaction with one particularly difficult patient:

"You go in there, 'How you doing Mrs. Jenkins?' 'That's not my name, why do you call me that?!' You know, she wants to argue about everything. So I don't address her. I throw the rulebooks out the door when it comes to her. The say you're supposed to say, 'Mrs. So and So I'm going to do this...'. You start doing that with her and she's going to become combative, she's going to ignore you, she's not going to help you. So I just go in there, I say 'Hello' and I start working. I don't explain to her, because when she sees that pan of water, she sees me with my stuff, she knows what I'm fixin' to do, and she cooperates. But if you try to communicate with her, she's gonna get very hard headed, she's gonna resist and all. And I've learnt sometimes the rulebook don't need to be in the rules."

Lauren provides another example of balancing residents'

needs and state regulations:

"You just try and appease the resident and do what they want to do and still keep up with what we're supposed to be doing. They [nursing assistants] let them have food they're not supposed to eat. When they're [residents] 95 years old and want a piece of cake you think I'm not going to give it to them? But if the family comes in and knows they're a diabetic, you catch it. Or if the state walks in and sees the wrong thing being served to them, you catch it. But the resident is sitting there looking at everyone else having cake. I can't take it. I can't take that. I give it to them."

It is these details of daily life that are likely to play a major role in determining quality of life, and domestic and workplace caregiving differ in the flexibility with which caregiving can be individualized (James 1992). In the paid sphere, the commodification of care and routinization of work sometimes conflict with what the staff views as the most efficient way to accomplish tasks or desirable manner in which the work should be performed.

There are positive aspects of the routinization of the nursing home, however. Planning and organizing gives the order necessary for effective care, and this order is necessary for both for the givers and receivers of care. As paid caregivers, nursing assistants, for example, are not creating the rules, they are merely carrying them out, and have a higher authority to turn to for support. Tamara explains how this is helpful when residents resist personal care:

"If they're just refusing, to like, have a bath, I try to talk to them. I explain that, 'You know today is your bath day, you've got to have it; I'm not going to let you be unclean.' You never go in and say, 'Are you ready for your bath?' You say, 'It's time for your bath.' That usually works."

In this way, Tamara is able to turn to the prescribed routine as leverage in the negotiation of care. As discussed earlier, however, this does create a tension at times between wanting to fulfill the residents' wishes and having to fulfill the duties of their job.

A second organizational aspect that can be positive for nursing assistants is that the structure of the nursing home can be a buffer against burnout and emotional strain suffered as a result of abusive residents. In the nursing home in which the participants of this study are employed, if a nursing assistant and resident are continuously reaching an impasse and the C.N.A. begins to suffer from burnout with the resident, the charge nurse can switch staff/resident assignments.

These aspects of the structure of the nursing home are very different in family caregiving, and are dialectical in nature in this setting, as well. I now turn to the ideology, structure, and organization of care in the unpaid sphere.

THE UNPAID SPHERE

Family caregiving, generally occurring in the unpaid sphere, is assumed by researchers and the public to be based on familiarity and closeness. Caregiver and care-recipient are familiar with one another and the care involved is considered a component/expression of the intimacy of the family (James 1992). Family care is thought to combine "caring for" with "caring about," where "caring for" is assumed to follow from "caring about" (James 1992:490).

More generally, in the U.S., great emphasis is placed on the privacy of the family and the individual responsibility of the family to provide care to its sick and disabled. Caregiving in this domain is frequently romanticized by policymakers who exalt the past as a model for caregiving. This contributes to the isolating effects of caregiving, and the fact that the burden of care tends to fall on a single individual (Abel 1991).

The Structure Which Shapes the Organization of Tasks in Family Caregiving

The responsibilities associated with caregiving in this sphere vary dramatically according to the needs of the care-recipient. As well, the delivery of care varies depending on the other family responsibilities of the caregiver, and resources available to aid in the delivery of care. As the

biographic information on the participants in this study indicated, there was a great deal of variation among the participants in this respect. Despite this, however, there are several important areas in which they shared similar experiences, and these will now be discussed.

While in the nursing home there is limited room for staff to play a part in organizing the tasks involved in caregiving based on individual needs, in the unpaid sphere the caregiver is placed in the position of complete responsibility for the organization of care and imposing limits on flexibility.

In the unpaid sphere, care-recipients may be able to negotiate their requirements to a greater degree, but organizing tasks such as planning the menus, cooking, cleaning, and other requirements, remain the overall responsibility of the caregiver. Such tasks were the most frequently listed by participants in the interviews I conducted, and also as the area which caused the most tension and demanded the most emotion management.

In this setting, there is no pre-determined schedule that is established by others outside the caregiving relationship. Frances explained that the difficulties she had with her mother, who was ambulatory, were not so much getting her cooperation with tasks such as bathing and medications, but in working out a schedule that allowed

Frances time to unwind and rest after work. She drew on her work experience to help alleviate this:

"I used to think when I came home alot of times, well this is not my mother, this is a patient. So I had treat her as that sometime. And when I didn't I worked myself to death, because they would have you hoppin'. Time I sit down, she would say, 'I need this, do this, do that.' And I'll say, 'Now what do you want me to do before I sit down? Let's get it all under control and then I'm gonna sit down and take a breather.' So we had this routine: she knew when I came home, I was gonna take a breather. You know, I happen to think, hey, I'm the caregiver. So we need to change this role a little bit. It worked fine, it worked fine."

While the responsibility in this sphere does lead to greater autonomy, it can also lead to tension between the caregiver/care-recipient.

Frances brought her knowledge of organization in the nursing home into the domestic sphere to aid in the effective, and less stressful delivery of care. Some of the caregivers I interviewed were not as successful at accomplishing this balance and compromise. Tamara talked at length about enjoying the challenge and feeling of accomplishment she has working with and helping patients who are difficult; however, she was unable to carry this over to caring for her mother, who she feels has always tried to control her, and has lived with her off and on during periods of illness.

"It's different because with her I get angry.

Residents I can laugh it off because I know when 3:00 comes, that's it. But when it's mama, it's 24 hours. And it seems like it shouldn't be that way, but it is. No matter how good you try to hold up and no matter how hard you try to smile and act like its ok, the anger is there. You know, like at night, I'll say 'Mama do you need anything while I'm up?' Because I will have cooked supper and gotten the dishes washed and I'm just ready to conk out. 'No.' And I'll sit down, 'Well, if you don't mind you could get me a glass of water?' And that's funny, but then, she don't pay no attention to me, and it does make you angrier. That's why I know it would really never work, me taking care of her on a full-time basis."

As these comments demonstrate, there are both positive and negative experiences of the degree of routinization present in the spheres. While at times the routinization of the nursing home seemed to leave no room for individual needs, in the case of the nursing staff, it does provide a buffer and obvious break from caregiving duties. In the unpaid sphere, the lack of routinization created a situation in which the caregiver was never "off work." In each case described above, the caregiver attempted to establish a routine so that there would be a break or "end" to that day's work, with varying degrees of success.

A second aspect of the responsibility for organizing caregiving in this sphere is the strain that is placed on a relationship in which the care-recipient has a history of being the decision-maker and caregiver. The women who provided care for a parents spoke of their awareness of this shifting of responsibility, and the way it affected the way

in which they organized caregiving. Frances explains:

Frances: "I had to make sure she took her medicine on time, because she wouldn't do that sometime, and then she'd get mad because she didn't want to take like the water pill cause it would make her go to the bathroom and I had to...it became a thing where, you become the parent, and the parent become the child. And they resent that. And you don't feel comfortable doin' it. I did not feel comfortable sayin', 'Hey you got to do this. Yes, you will do this.'" I didn't feel comfortable doin' this, but this is the role you take when you have to take care of a sick person. They depend on you."

AW: Were there things you did to kind of help her feel like she was a parent?

Frances: Yes, I always came to her for advice, even if something I could do myself, I would always say, 'Mama, I need your advice on this.' Because I didn't ever want her to lose her self-esteem. I didn't ever want her to feel low, like a child. I always tried to make sure that she felt like she was the mother."

As her earlier comment indicated, the caregiver/care-recipient relationship was an ongoing negotiation for Frances and her mother. As well, it was likely to change over the ten-year period in which she and her mother shared a household and her mother's health declined. For Frances and the other participants, unlike their work in the nursing home, their roles in family caregiving were not prescribed and authorized by a schedule or set of regulations.

Another point that underlies many of these interview excerpts from both spheres is that the caregivers transferred knowledge and skills obtained in each sphere between the settings. This will be elaborated in the

following section.

THE INTERACTION BETWEEN THE SPHERES

While there were many obvious examples of medically-related skills that were learned through training as a nurse and used in family caregiving, this discussion will focus on the organization of the "mental work" involved in the social relations of caregiving and its relation to emotion management. This transference often involved contradictions, both within and between the settings. The participants described three areas in which the interaction of the spheres in regard to structure, ideology, and organization were most evident. First, bringing aspects of the ideology of the family to work; second, adopting strategies for coping with frustration; and third, experience in understanding residents and family members.

Bringing the ideology of the family to work

The caregivers repeatedly described their patients in the nursing home as "family" to convey the feelings of warmth and closeness they feel in the caregiving relationship. They discussed these family-like relationships as the reason they stay in a difficult and low-paying job. Joan and Robyn, both nursing assistants, had this to say:

Joan: "I just fall in love with my patients, I guess that's why I'm still here, because I get attached to them. Really it's just like family to me. You get close to them for some reason, being around them so much."

Robyn: "I love what makes patients, they are very kind, they are very gentle-hearted, they have such a warm feeling you know, it makes you reach out to them in their time of need. You know, once again, we all don't have the type of family that we all would like to have, so where a sister or brother don't take place, that's where you come in."

These feelings of "caring about" that the staff bring to work from the domestic sphere contribute to both positive and negative experiences. While the closeness helps them to perform work that is often unpleasant and demanding work, it is obviously painful for them to grow close and then lose a patient, as Lauren explains:

"It's a very emotional job. I don't think people know who have never worked in a nursing home how emotional it is. Some of those residents have been there 10 years. You have nurses and nursing assistants who have been there that long and they have watched them come in. We know probably more about these people than their families do because we do everything for these people. When they die I stand there and cry for them as much as the families do. You can't help it. We go to the funeral home. The only reason anyone does nursing is for the people part of it, believe me. The attachment. And the support you give them. Sometimes we're all they've got. That's the only reason that keeps you there, believe me, because a lot of times the ugly part of it is much worse than the good."

Expressions of feeling and attachment for residents not only illustrate the contradiction of the possibility both positive and negative experiences derived from "caring

about," but, additionally, the contradiction of job satisfaction derived primarily from emotion-filled relationships with residents. This source of satisfaction is all but invisible in the formal recognition of what the job of caregiver in the nursing home entails.

Strategies used in coping with frustration

Coping with anger and frustration and not retaliating against the abuse received from patients is crucial to providing care in the nursing home. At times it is also necessary to cope with the same anger and frustration in family caregiving. This is also one of the most important aspects of emotion management, which will be discussed in depth in chapter 5; however, in this section, I will focus on the ways in which the participants described employing strategies for dealing with frustration, and transferred this knowledge between the spheres.

Eleanor, a director of nursing for 20 years, describes the advice she gives nursing assistants:

"What I tell the nursing assistants, and they are the ones who take the abuse and really get hit in the face with the difficulty, 'Stop what you are doing, especially if you find yourself about to get out of control. Just call in someone different, sometimes just a different face, and walk out and leave it. Get out of the situation. If they won't take their medication, don't force it. Come back in a few minutes and say something a little different about the medication and a

lot of times they'll take it.' I've offered nursing assistants and nurses pillows so they can go into the med room and scream. You have to; if you say something wrong, you can't take it back."

And the nursing assistants do heed this advice. Joan explains her technique for dealing with a resident who is refusing treatment:

"Well, I got one in particular, Lord, he done get me and fusses at me, and just everything. I just walk away, I say, I just come back when you've cooled down. Cause I'll just get mad just lose it too, so I just say I'll just come back when both of us have cooled down. Usually, if there is something they are refusing to do right at that moment, if you just leave them alone, just walk off, leave them alone and come back, is usually the best way to handle it."

Abuse from residents is also verbal, and often related to race. In her training sessions with nursing assistants, Frances explains that she shares personal experience:

Frances: "Like I teach them, that you'll be called different names and, I have been called the 'N' word, and I try to tell them that this is going to happen. I try to tell them, yes, I have gotten hit by a patient, and could not hit back, and I have gotten spit on and had to take it, you know.

AW: What kind of tips do you give them for how to handle that?

Frances: Well, the name callin' doesn't bother me because I can think of the age of people that I'm dealin' with. They came along at a different age, so, I try to think, well you can't change them. And when one hit you you just have to walk away. And count to ten."

In the home, caregivers described very similar

techniques for dealing with family members during difficult periods. When asked what she did when her mother was frustrating, Frances gave a similar reply to the one above:

"Well, some days she'd be crabbish and what I'd do is just walk on to the bedroom out of the kitchen, and [laugh] start doin' something else. I would leave the room but she would always come find me. Sometimes I would have to just leave the house for a few minutes to calm down."

As well, Joan's response was very similar concerning disagreements with her mother-in-law:

Joan: "She loves homecooked meals because she from way back in the country. So she says, 'I want vegetables, I want vegetables.' I have cooked vegetables she said, 'Too soft, too greasy.' She always complains.

AW: So what do you do when she...

Joan: I say well, I don't say anything, I just walk off. I don't say anything, I just leave."

So, as these excerpts illustrate, these caregivers attempt to employ techniques to cope with frustration with family members that they have learned through the organization of caregiving in the nursing home. A final example of the transference of skills and knowledge between the spheres is the general understanding of old people gained from their experience in nursing that the participants described as aiding them in the care of their family members.

"Learning how to deal": Understanding residents and family

Many of the participants stated that if they had not worked with old people in the nursing home, they would never have been able to handle the work involved in caring for their family members, primarily because of the enormous amount of patience required. Gloria, an LPN working on the Alzheimer's unit who until recently also cared for her father-in-law who has Alzheimer's, said:

"I feel like had I not been working on a unit like this then I could not have handled it. I could not have handled it at all. You have to understand old people and be patient at home. You just have to take a whole lot and be patient."

Frances also noted how the skills she had learned as an LPN helped her in caring for her mother:

"Because I never would have learned how to deal. I think taking care of people at the nursing home gave me the understanding of her. Families doesn't understand that people, if they have a stroke, their personality changes, or if they have a heart problem, their whole outlook on life changes."

As these excerpts indicate, caregivers experience interaction between the two spheres. This transference of knowledge of the organizing contexts of the two spheres can lead to both positive and negative experiences for the caregivers, sometimes simultaneously. At times, as when the autonomy and lack of routinization in the unpaid sphere

actually contributes to negative experiences in the caregiving relationship, to cope, the caregivers drew on their knowledge of the paid sphere. As well, in the case of bringing the ideology of familial closeness into the paid sphere, this can bring great joy and increase work satisfaction, while also bringing the potential for great pain and feelings of loss.

Abel (1990) raises the important point that little is known about the extent to which women feel distinction between being family members providing caregiving, and being professional workers performing similar services for pay for others, and further, the distinctions that they draw between these two activities. As I have attempted to demonstrate in this chapter, although the work they perform may be very similar, the ideology and structure of settings in which they work are very different. While the interviews with participants in this study indicate that contradictions do exist within and between the settings, they also indicate that to resolve resulting difficulties, the caregivers draw upon their knowledge of both sphere and adapt the skills and ideology of each. In the next chapter, I will discuss how this specifically impacts the emotion management that the caregivers perform in the paid and unpaid spheres.

Chapter 5

The Emotion Management That Makes Caregiving Possible

OVERVIEW

In their interviews with home health workers, Neysmith and Aronson (1996) found that beyond the tasks to be performed and social interactions handled, caregiving involved the exercise of considerable emotional and mental labor associated with negotiating the content and organization of the care to be provided. Rather than being marginal, relationships with the care-recipient were the medium for doing the negotiation that made caring for the client possible. In the following chapter, I will discuss the emotion management that similarly, I found to be critical to caregiving in both the paid and unpaid spheres.

Ideologically, family relationships provide the guiding framework for emotion management, because in the family it is assumed that "caring about" is what leads to "caring for." However, in the nursing home, the needs of the institution and physical care come first, while emotion management performed by the nursing home staff is largely informal and outside the dominant system of care (James 1992). In spite of this ideology, the reality of caregiving is that emotion management is a critical aspect in both

spheres. Each context in which emotion management is performed helps to shape its effectiveness, positive and negative experiences of emotion management, and inherent contradictions in each experience.

As I discussed earlier, Tolich's (1993) concepts of regulated and autonomous emotion management can be useful to understanding the dynamics of the emotion management caregivers perform in both the paid and unpaid spheres. Briefly, *regulated emotion management* occurs when the conception and management of emotions is regulated by another person, and *autonomous emotion management* occurs when the conception and management of emotions is regulated by the individual (Tolich 1993). While relationships and social interaction are most definitely not uni-directional, this conception of emotion management centers on the individual who is typically performing *work* in the encounter, and is managing emotional displays in order to produce a desired effect in others.

The significance of these concepts is that they focus on who is controlling the emotion display rather than who is displaying the emotion. Additionally, both regulation and autonomy can occur in both paid and unpaid emotion management (Tolich 1993). I will analyze and discuss the emotion management described by caregivers in this study in relation to regulated and autonomous emotion management,

first in the paid sphere, and then in the unpaid sphere.

THE PAID SPHERE

In this realm, two key themes emerged from the interviews. First, emotion management can be both stressful and satisfying, and includes both moments of regulation and autonomy. Second, at times emotion management occurs in a context with two different clients--the patient and the patient's family--who often have differing needs and demands. Each of these points can create contradictions for the nursing staff.

In the nursing home, emotion management is not explicitly regulated, as is flight attendants' instructions to smile and give a standard greeting as passengers board the airplane. Unlike other occupations such as flight attendant (Hochschild 1983) and supermarket clerk (Tolich 1993) on which studies of emotion management have been conducted, engendering customer loyalty and satisfaction are not among the stated organizational philosophies of the nursing home. The primary formal goal of the institution is to provide quality medical care while respecting residents' rights as defined by law (Diamond 1992; James 1992). Discourse surrounding the work performed by nursing home staff does not encompass "caring about." Instead, tasks are described as devoid of emotional content, as exemplified

in the following excerpt from the job description for nursing assistants working in this nursing home: "Give bed baths and make beds of bedfast patients, and assist ambulatory patients to bathe" (Nursing Home 1996:1)¹. This description does not include the procedure for dealing with a patient that does not want a bedbath or is combative when the nursing assistant attempts to assist with bathing. As well, it does not address how to perform this tasks while attempting to maintain the dignity of the patient. It is up to the nursing assistant and the individual patient as to how this will be handled.

The resulting contradiction of this invisible and crucial aspect of paid caregiving is that while interaction, specifically emotion management, is regulated to an extent by the institutional setting and demands, actual *moments* of emotion management are autonomous. As a result, emotion management in the nursing home can be both liberating and alienating, and is a source of both stress and satisfaction to the staff of the nursing home.

¹This is a fictitious name for the nursing home in which the participants work.

Emotion Management: Stress and Satisfaction

Lack of formally prescribed emotion management does not mean that emotion management is not a critical component of the work caregivers perform in the nursing home. This statement by Lauren emphasizes the first way in which the interviews revealed the importance of managing one's emotions on the job:

"It takes a lot of patience. I say it takes stupidity. [laughing] I think it takes stupidity to stay in a place that is...the nursing home industry is the second most regulated industry by the government. They tell you what to do all day long and they pay nothing for what is the most tremendous amount of care that you have to give and put up with the worst abuse you can imagine. It's not like a hospital where they're there two days and then gone. They are there in your life every day. I've seen people leave in three months; they couldn't take it. They go in the bathroom and cry. It's very depressing for one thing if you take it home with you. But mostly it takes patience. And, an iron stomach and an iron will to keep the job. It takes very little in this day and time to get fired from a nursing home."

As evidenced by Lauren's statement, beyond the nursing skills required to care for patients, to keep one's job also takes an "iron will" to control the emotions experienced while providing care.

Beyond the control necessary to handle what Lauren described, emotion management is primarily used by these caregivers in two additional ways: 1) to help make physical tasks easier to perform, and 2) to bring enjoyment and

satisfaction to their relationships with nursing home residents. For example, in the nursing home, one difficult patient can prevent medications from being passed in the amount of time specified by state regulations. The following excerpt from Nancy, an LPN on the Alzheimer's unit, illustrates the emotion management necessary to complete tasks, as well as the possible repercussions:

"You have to take time out and then that puts you behind with your other work, you know?. I have to lock my cart up and do whatever is necessary. If it takes sitting down talking with them, if it takes taking them for a walk, you know, off the unit, I do that. If I get behind, I get behind. You know what I'm sayin? And usually, it's my paperwork that suffers because they're gonna have their meds, and they're gonna have their treatments and all, regardless."

Thus, skill in handling this situation very much aids in successfully completing job tasks. Similarly, Frances describes how she uses emotion management to aid her in dressing a resident that is consistently difficult:

"Well, like I said, a difficult patient is...I got one now, you can't get her food right, you can't get her clothes right, you can't make the bed right, um, it's a complaint all day long. I mean, she's on the bell all day long, nothing satisfies her. And she takes up quite a bit of time. And um, she'll probably fight. And those kind of people you have to deal with, and it's very, very, mind-bending, it's very time-consuming. So, what I usually do is, I have a little game that I play. I go in and I say, 'Well, today, we'll wear the blue dress, you want the red one, but I like the blue one.' Then really what I be wantin' her to do is wear the red dress. But if I say the blue dress then she's automatically going to say the

red dress. So you have to use reverse psychology. And we've been playing this little game now for about two weeks. So, I have noticed that the difficult part of takin' care of her has decreased some."

Such emotion management is carried out autonomously; the job description simply states, "Give routine morning care and prepare the patients for breakfast...Assist ambulatory patients to dress..." (Nursing Home 1996:1). It is therefore left to the C.N.A. or L.P.N. to determine how best to carry this out with each individual patient. Some staff find this a particularly satisfying aspect of their job. For example, when I asked Tamara about the types of patients with whom she most enjoyed working, that made her day pleasurable, she replied:

"I like the stubborn ones. I like the challenge. I feel like I'm accomplishing something if I can get them to come around, but if they're already agreeable to it, you know, I'm just like, well, anybody can do this. I like the challenge. Once in awhile I've gotten like, why did I try this? But the day I got Mrs. Jenkins up, people in the hall, even the residents, just parted..and like 'How did you do it?' And I was like, what are they talking about? And the DON went and pulled the lady's chart and wrote in the chart, 'Miracle happened today.'"

These experiences of emotion management can be simultaneously stressful and satisfying. They take time, which may impede the progress of required physical tasks; yet they may provide the staff with many of their most

satisfying moments at work. Most of the caregivers stated that it is the relationships with residents that keeps them going, and the success of these relationships is heavily reliant on successful emotion management on the part of the caregivers.

Residents' Families

While the emotion management performed in relation to residents is perhaps the most pleasurable aspect of their work, the caregivers described the emotion management performed in interaction with residents' families as one of the most negative aspects of their work. This form of emotion management is more regulated, because the nursing home administration strongly encourages the manner in which family members are expected to be treated. Frances explains:

"In the nursing home, we have what they call 'customers'. And it should be the resident and the family, but it's really family and resident. You have to keep families happy. It should be resident first, but in alot of cases, you have to deal with family. Families are hard to deal with. Alot of them have guilt trips. They feel guilty that they had to put mama or daddy in the nursing home. So that way they take it out on the nursing staff. It makes it hard for you to take care of them. The way I handle difficult families, I know they coming, I know what they gonna look for and everything, so after that first run in, if I know it's your mama and I know you come in on Wednesday, I'm gonna take care of it so I don't have to hear it! Because one starts chewing you out, you have to look down and smile, and say,

'Yes, ma'am, yes ma'am, yes ma'am' because families are always right. Families are never, never wrong. They are always right no matter what. Because they are our customer and we are there to take care of them and their families. So you just have to do it."

Frances's comments also reveal that the relationships between nursing home staff and family member are shaped by race and class dynamics. Family members are in a clear position of power not only as a "customer," but also because they are typically white and middle-class, while the staff in this nursing home is typically African-American and working-class. Families' power, however, also affects Lauren, who is a white, middle-class R.N., and shapes her work, as well. She explains:

"They tell you what they want done. That makes it harder, too. It's not like a hospital where you can tell them to please leave the room. They are there dictating what care they want provided. If they walk in and Mama is wet, Mama could have just wet, it doesn't matter. They start with the nursing assistants and work their way up. By the time they get to me they're mad. They don't understand this is one person out of 184 in the building. They don't hesitate to call the State if they don't get satisfaction. They just go ahead and call them. What I've done is with every care plan meeting, or whenever the families come during the day, it doesn't matter when they come, I try and talk to them. I introduce myself and try and get to know each family and they know to come to me before they go anywhere else. If you act smart and you don't try to be friends with these people, you can forget it. I have never had the State called since I've been there. Simply because I've gotten very close to most of the families."

Generally, each caregiver spoke of the difficulty

involved in interacting with family members and, regardless of their position in the nursing home, used one of two emotion management strategies as a way of dealing with the situation. The first, as Frances described, involved monitoring family's visiting habits and making an extra effort to comply to their wishes for these visits. The second strategy, evidenced in Lauren's description, involved taking extra time to get to know the family personally and help them feel involved in the caregiving process. Gloria, explains this latter technique further:

"There are some difficult families, very difficult. You have to let them think they're making the decision. You ask them what they think, you answer a question with a question, you know? And let me tell you this, I get my families involved and find that it's less stressful as far as, if they think they're involved in the patient care of that patient, then you don't have a whole lot of problems."

While these staff-family interactions tended to be stressful and negative, this was not always the case. Several of the caregivers spoke of families they had known for years and with whom they had grown close. In the caregivers' descriptions, families with whom they felt close were those viewed as more trusting and less interfering in their work. Tamara described one such relationship in speaking of one of her colleagues and a family:

"This girl I work with named Sumi, Sumi is super. Sumi refuses to let them give up. This one patient couldn't get out of bed, and couldn't go

to the bathroom; now this lady's up going to the bathroom, gettin' her whirlpool, eating in the dining room, and everything. Gettin her hair done--within a week. And her family is so appreciative. And it shows, you know, at Christmastime they really showed Sumi that they appreciated her."

THE UNPAID SPHERE

As the participants spoke of their family caregiving experiences, two key themes emerged, and these themes share similarities with those which emerged from caregivers' experiences in the paid sphere. However, while similarities exist, the experiences originate from different sources, as will be discussed. First, in this context emotion management is also felt as alienating and liberating, a source of both stress and satisfaction. Additionally, caregivers can experience the interference of a third party in the relationship who impacts the interaction. These themes will be explored in the following section.

One would probably guess that in the unpaid sphere emotion management would be autonomous. While this was mostly true for the caregivers in this study, lack of formal organization in the domestic sphere does not mean that regulated emotion management does not occur. Tolich (1993) demonstrates this using the example of a daughter required by her mother to kiss her grandmother. The display of emotion is performed by the daughter but conceived and

supervised by the mother. Similarly, the caregivers I interviewed described occurrences of both regulated and autonomous emotion management, and both positive and negative experiences, as in the paid sphere.

Emotion Management: Stress and Satisfaction at Home

Just as was the case in the paid sphere, in the unpaid sphere, care-recipients are a source of both stress and satisfaction. When asked about the positive aspects of caring for their family members, caregivers spoke of the support and companionship they received from their family members.

Lauren explained:

"Well, he was a lot of emotional support for me, too, especially when I was by myself. Daddy was always there for me when I needed him. I can truly say that. He could really be a lot of fun and a lot of company. He helped me financially. There were a lot of positive things with him. He could be a lot of fun. But he was so sour on the world the last few years it really was hard to come home to him. It was hard to pull in the driveway and know he was sitting in that recliner."

Lauren's experience also demonstrates one contradiction of emotion management in this context: the same person and relationship can be a source of both stress and satisfaction. Robyn describes a similar situation; she explained that while she struggled to remain strong and not show her fear as her mother was dying of cancer, her mother

helped her to cope with her coming death:

"My mom and I stayed in the same house together, and it's like, the nurse from the hospice would leave and my sister stayed there until I could get there. I would get off work...it was like leaving a job and going to another job. I would get off work, you know, go in there and talk to my mama, and she would talk to me to the best of her ability. I would cry, I would cry on her shoulder, and she would look at me and she'd say, 'What you crying for? It's going to be ok. It's going to be ok. Cause you know, you're a strong person.'"

Similarly, Nancy described her mother's support during difficult periods at work:

"When I get upset, I fuss. Me and the nurses have it out, because they're going to defend this that and the other. If I find a situation that's really bad and I approach that nurse about it and she says that didn't happen, etc...and I don't like being angry because you know, you can't function properly when you're upset. So I've learned how to go into the bathroom and say my Serenity Prayer and start my day over. I had to learn that, I have to apply that daily, my mother taught me that. And even working with people that are lazy, and you know that they're just here for a paycheck, I get so angry with them because they don't care, and I'm thinking, 'Well how in the world could she not care about somebody?' You know? And that used to frustrate me so, to the point where I would cry alot, and I had just stop and say, well, I can't make people care about people, but I can pray for those people. My mother taught me that too."

As evidenced in these excerpts, when the caregiver/care-recipient relationship had a history of closeness, mutual respect, and support, the emotion management performed sometimes involved suppressing feelings of sadness in order to provide moral support to the ailing

family member. However, there is not a one-to-one correspondence between the extent of closeness and the nature of emotion management, including alienating or liberating experiences. In the following example, closeness actually acted to constrain the performance of emotion management, and its effectiveness in aiding in caregiving tasks. Tamara, the nursing assistant who earlier described problems in caring for her mother, elaborates:

"I went into nursing three years ago because my mother was getting completely dependent on certain areas and within a short period of time she's going to be totally dependent and I wanted to be prepared for that. But she wants to go into a nursing home. She's agreed to let me TRY, but even on the little minor things now she won't let me. She says she will, but like when I even take her to the doctor she'll push me away, she won't let me help lift her or do things like that. She'll let the doctors and nurses, but she won't let me. She says that I'm her daughter; she don't want to hurt me. If they do it and get hurt they're on their job. But it's just that she's always said as long as I can remember that she never wanted to be a burden on anybody."

While in paid work resistant patients can be a positive "challenge", Tamara's established relationship with her mother dictates much of their interaction. As a result, the emotion management that Tamara performs to help her mother with physical tasks is less effective.

Emotion Management and the Involvement of Other Family Members

As in the paid sphere, the caregiver/care-recipient relationship does not occur in isolation. In the context of the nursing home, residents' families may be involved in the delivery of care; in the home, other family members may intervene in various aspects of the delivery of care, including emotion management. In this situation, the caregivers I interviewed typically described negative experiences that were related to instances of regulated emotion management occurring due to powerful family members intervening in the caregiver/care-recipient relationship. This regulated emotion management was most evident for women caring for an in-law. Joan, whose mother-in-law has lived with her family for two years, explained that although her mother-in-law is very frustrating, she tries not to react because it is not her mother but her husband's, and she feels that he dotes on her. Her husband also directly shapes the emotion management strategies that Joan uses, as she explains:

"She wash dishes and I tell her not to wash dishes, and I go back and redo the dishes. And she thinks she's helpin' out, but she's not. She real stubborn. And I told my husband and he said, 'Yeah, but it gives her something to do.' And I said, 'Yeah, but that's more work for me too.' So I just let her go ahead and wash dishes cause just let her do it and I can go back later. And I don't fuss about it. It just still upsetting to

me because he shows more attention to her than anybody. He's the baby boy, so he gonna take care of mama. So, I try to understand, but I just pray every day, something's gotta change. 'Cause she got three babies, and he's the only one to see about her. And it's only me to take care of her. They don't thank me for it. I feel like I'm workin' for nothing."

Gloria's father-in-law came to live with them after he began to show signs of Alzheimer's disease. She attributes both the emotional and physical problems she suffered during this time to the stress involved in caring for him, and the lack of understanding she received from her husband and his family. Long after she believed her father-in-law's illness had progressed past a point that care could properly be provided in the home, her husband's denial of the problem forced Gloria to provide both physical tasks and emotion management that she saw as ineffective. She says:

"And it took two years and eight months, and I had to just leave home in order for my husband to come to his senses and let him know that I couldn't take it anymore, that we could no longer handle him."

Negative experiences and regulated emotion management were not the rule for caregivers providing care to in-laws, however. Eleanor's mother-in-law lived with her family for ten years as her Alzheimer's disease and other illnesses progressed. However, while Eleanor explained that her mother-in-law required increasing care and her behavior became more difficult, she did not describe the events

leading to her recent admission to a nursing home in negative terms:

"My mother-in-law was with us for 10 years or more. She's in a nursing home now, but we kept her here as long as she was able to stay alone, at least during the daytime. She got to where she didn't like to stay alone, especially after dark. She would really fuss if we had to go somewhere after dark. When she could stay alone we could manage quite well with her here. Then when she had to go to the hospital it really took a toll on her mentally. We could see her changing the last two years mentally. She wasn't nearly as sharp and she was afraid of everything. Gradually we could see her memory was going. It was gradual. It took about two years. Then she went to the hospital and had more pain and stuff in intensive care. She had blood clots in her leg. It really took a toll on her mentally. She got to the point where she couldn't be trusted at home anymore at all and we had to go ahead and do the nursing home admission after the last hospital stay. She wouldn't have been safe."

Interestingly, while caregivers described most emotion management in the unpaid sphere as autonomous, they also described less positive experiences overall than in the paid sphere. Possibly this is due to the difficulty involved watching a close family member deteriorate and the responsibility involved in becoming their caregiver. While in the paid sphere most of the caregivers spoke of the difficulty and great sadness they experience when they lose a patient, they are, in relative terms, somewhat protected by the ability to extract themselves from the context of the nursing home. As Robyn described tearfully:

"Well, when you're at work you give your heart,

you know you, give your best ability with taking care of residents. But when it's strikes home, it's a little bit more difficult, you know? And then you have to, there's more depression that you go through. You know, you never think that its really gonna hit your home. It's not, it's not something that I...I give my heart out to anyone that has to go through it."

In contrast to other service occupations in which the interaction involving emotion management has the potential of an endpoint that is positive, caregiving to the old in either sphere in most cases only ends with greater deterioration, and eventual death. Women caring for an elderly family member at home while also working in a nursing home are all too familiar with this. In the next section, I will further discuss the interaction that occurs as a result of simultaneously working in both spheres.

In conclusion, autonomy and familial feelings of attachment do not lead to unequivocal, positive experiences of caregiving. Similarly, regulated, commodified caregiving does not always lead to alienating and negative experiences. Each has contradictory elements, and each experience is a possible source of strength and tension when moving from sphere to sphere.

THE INTERACTION OF CAREGIVING BETWEEN THE SPHERES

What happens when women must be caregivers in both spheres simultaneously? As discussed earlier, many skills

and values are carried from one sphere to the other, and aid the caregiver in performing her work both in terms of physical tasks and emotion management. In a very positive way, these caregivers discussed the understanding of the elderly that they gained through their work in the nursing home. As Lauren explains, however, even with this knowledge, when it is a family member, understanding their behavior is more difficult. As a result, emotion management is more difficult as well.

"You still expect them to feel like they've always been. Many family members tell me 'Mother has never acted like this.' They aren't prepared for the personality changes. They're not prepared for their meanness. They may have not been particularly like this in their past, then everything comes out. I think being in psych nursing so long, too, helped me. It still was really hard to play games. Daddy liked to play mind games as much as anything. You kind of know at work when they act out to try and remember it's because they feel bad. They're not themselves in any way. They're bored. They have nothing to live for, so they're just going to drive you crazy at work, so why shouldn't they at home?"

As I discussed in chapter 2, Wharton and Erickson (1995) indicated that family emotion management could be an important factor in understanding job-related outcomes, and that the paid and unpaid spheres have important impacts on one another. The caregivers I interviewed reported impacts that were bi-directional. At times, the mental exhaustion felt at the end of a shift at the nursing home left little to take home to the next shift. Several of the caregivers I

interviewed expressed a feeling that Joan describes:

"Sometimes when I get off work, I'll be just plain tired, you know, tired of it. Just tired of old folks. I go to my room and I take a bath, and I just lay there and I say, 'I just can't cope tonight, I'm sorry, I just can't do it. I don't want to see no more old people, I mean I'm sorry.' I say, 'I can't do it no more, I just close the door and say, y'all leave me alone.' So I just, that's my breaking point when I just can't take it. I just come home and close my door."

Robyn also explained that while her mother was ill she felt she had little left to bring to work.

"I would leave home, and it's like, my mom came first. And nothing else ever mattered. I would leave home, come in here, and I would, you know, I wouldn't be here. I would have the thought that sometimes, you know, 'Well hey, it's time for me to do my patients,' or 'Let me get my head together and take care of them,' but you know, when I got them situated, and settled, I would just totally go back out."

However, working in an occupation in which their co-workers are also caregivers did provide these women with a support system. And surprisingly, some support is provided by the patients themselves. Nancy describes a situation in which an Alzheimer's patient comforted her on a day that she was particularly upset about her mother's illness:

"I was there working, and one was going out the door, and I'd get him and bring him back in, and then this one was doing something and I'd go over there and do that, and this one, you know. And Mrs. Jefferson looked at me that day, and I was real depressed and I had been crying alot that day, and Mrs. Jefferson looked at me, she said, 'Maggie [the name she calls Nancy],' I said, 'Ma'am?' she said, 'You are so brave. You are so brave to be here with all of us, just you by

yourself." She didn't know what that meant to me. But that really made me feel better, you know, I felt good when she said that. She's a darlin'. She is a darlin'. Working, being with these people, doing something positive, you know what I'm saying? That helped pull me through."

The women I interviewed described very ambivalent feelings about working as a caregiver in both spheres. All said that their nursing training had helped prepare them for family caregiving, as my earlier discussion indicated; however, all described it as an extremely difficult experience, both emotionally and physically, as well. As I will discuss in the following chapter, part of their ambivalence in the face of the extreme difficulties of their work comes from the great pride and feelings of satisfaction they do experience as caregivers.

Chapter 6

Discussion and Conclusions

DISCUSSION

Caregiving to the elderly in both the paid and unpaid spheres involves a crucial component, emotion management, that is often invisible despite its importance to the delivery of care. As well, little is known about how caregivers' emotion management in one setting is related to its expression in another. The purpose of this study is to contribute to the understanding of how both the context in which caregiving occurs and the interaction of the paid and unpaid spheres shapes the experience of caregiving. By examining the regulated and autonomous emotion management that caregivers perform in both spheres, I hoped to broaden the knowledge of women's experiences of caregiving and moving from sphere to sphere, and the strategies they employ in the process.

To do this, I utilized a socialist feminist perspective, viewing the caregiving activities which women perform in both spheres as work. This approach also recognizes the gendered nature of these activities and the impact of capitalism on caregiving.

I used my research questions, theoretical framework,

and the literature on paid and unpaid caregiving to analyze what caregivers told me about their experiences of caregiving in the two spheres. I started by exploring the ideology and structure that shape the contexts in which emotion management occurs in caregiving, in this case, the nursing home and the family setting. I then examined how these contexts might affect the experience of emotion management, and how the experiences within these contexts interact and influence the emotion management in each.

There were several findings that I consider important. First, I found that these women's descriptions of their caregiving activities further support the feminist argument that there is not a dichotomous split between the paid and unpaid spheres. As I indicated in the literature review, researchers are beginning to demonstrate that there are important links between the work that women perform in both spheres, particularly for the many women who perform similar labor in both domains. As the caregivers I interviewed explained, they transfer both ideologies and skills between the spheres, and the work they perform in one sphere affects the work they perform in the other.

A second key finding is that in both spheres, the caregivers comments demonstrated that there are both positive and negative experiences of the degree of routinization present in the spheres. While at times the

routinization of the nursing home seemed to leave no room for individual needs, in the case of the nursing staff, it does provide a buffer and obvious break from caregiving duties. In contrast, in the unpaid sphere, the lack of routinization at times created a situation in which the caregiver was never "off work" and thus she attempted to establish a routine.

Third, the emotion management performed by the interviewed caregivers is both dynamic and dialectical. Emotion management is not simply regulated in one sphere and autonomous in the other; regulated emotion management is not always alienating, and autonomous emotion management is not always liberating. Moments of each occur within both spheres, with both positive and negative results. These moments are often filled with contradiction for caregivers, as when a regulated and potentially alienating situation is experienced as satisfying, or when the person to whom a caregiver feels extraordinarily close is source of stress and emotion management is ineffective.

And finally, another important insight that I gained from this research is related to emotion management but somewhat outside of my narrower research questions. This involves the meaning that caregivers attach to their responsibilities.

The Meaning of Caregiving: Labor and Love

Based on the participants in this study, it would be incorrect to assume that only family caregiving is based on familiarity, closeness, and "caring about" the elderly person, while in contrast, caregiving in the nursing home is restricted to the impersonal, scientific, medical model.

As the following interview excerpts demonstrate, without the emotional bonds that develop between caregiver and recipient in *both* spheres, caregiving could become extremely difficult and problematic, as it sometimes does. Frances describes what it takes to be an L.P.N. in the nursing home:

"An L.P.N. has to be understanding, has to be willing to give of themselves, has to be willing to go beyond the call of duty, has to be dedicated, has to know how to be able to communicate...You have to be ready to deal with the good, the bad, and like they call it on television, 'The good, the bad, and the ugly.' And to be a caregiver at work or at home, you have to have love and compassion, and show tender loving care. It really just boils down to those three things."

Joan had a similar response when I asked her what it takes to be a caregiver:

"Understanding, patience, lot of love. Alot of love and patience. Gotta have love and patience or you couldn't deal with them."

This was Nancy's response:

"It's a job, girl. It's nothing to play with. But you know, you have to be a person that really cares for people to be able to do this kind of

thing. You really have to care. You just can't do it, you know do good work, give good care; you really have to care. I can remember one of my supervisors when I started here said, 'It's just a job, you can't take it personally.' I looked at her and I said, 'How can you not care about it? How can you not care?'"

This creates a delicate balance that caregivers negotiate. At times, emotional attachment actually helps to make the both physical tasks and emotion management easier to perform; however this attachment is also painful, as when a patient dies. At times emotional distance helps to protect the caregiver from this pain, and make the delivery of care somewhat easier, but this is hard to maintain, particularly when caring for a family member. Regardless of the degree to which emotional attachment occurs, as these caregivers emphasized, negotiating it is a key element of their work and the satisfaction they gain from it. Consequently, an increased understanding of this experience can hopefully contribute to a greater understanding of the caregiving that women perform in both spheres.

DIRECTIONS FOR FUTURE RESEARCH

Throughout my work on this project, I have been struck by the extensive opportunity and need for further research in the area of emotion management and caregiving indicated by the data I gathered. While there are many questions left

to explore, I will briefly discuss some of these.

First, greater analytic emphasis on the macro-level structures which shape caregiving would contribute significantly to understanding the dynamics of this experience. Such an analysis could explore the contradictory historical and material conditions of the nursing home and society and how these affect the experience of caregiving.

Second, the our understanding of emotion management and the caregiving relationship would significantly increased by an in-depth analysis of the role of power in the emotion management interaction. The caregiving relationship generally involves a reversal of positions of power, and one dynamic of this of this reversal is emotion management, which can be viewed as a potential area for power through manipulation. Feminist theory is useful to inform an exploration of the gendered understandings of power and to expand our definitions of power and how it is accomplished and used in the caregiving relationship.

Finally, as Glazer (1993) has indicated, distinctions between public and private continue to blur for women as the labor process becomes reorganized and increasing work is transferred to customers and clients. Particularly in the area of health care, this increasing burden falls largely to women, and relies on and reinforces the current system of

class, gender, and racial/ethnic inequalities (Glazer 1993). Much more knowledge is needed to understand this phenomena and its effect on caregiving, both paid and unpaid.

CONCLUSIONS

Increased life expectancy and the growth of the numbers of elderly in the U.S. are accompanied by fears of insufficient economic resources to care for this population. At the same time, in the health care industry, public policy and capitalism have combined to place a larger burden of care for the sick and elderly on family members, primarily women. As a result, for women the distinction between the public world of work and private world of home has become even more blurred (Glazer, 1993).

It is increasingly important to understand the experience of caregiving, and the inaccuracy of viewing the social world as "divided between the public world of labor and the private world of love" (Glazer, 1993:8). This thesis has been an exploratory attempt to identify the dynamics of an aspect of caregiving that deserves further attention.

Acknowledging the dialectic nature of this hidden labor across the spheres is a step towards expanding the theoretical boundaries that surround caregiving in both the

paid and unpaid spheres. First, it presents a more complex and experience-based view of emotion management. Second, it is a step towards understanding the links between two areas of women's lives that current research is only beginning to address. Most importantly, it is my hope that a greater understanding of the caregiving work that women perform in both spheres can lead to an increased value placed on caregiving, and the women who do this work.

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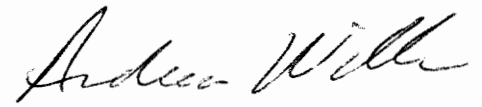
Appendix A
Interview Schedule

- How long have you been a nurse/LPN/CNA?
- How many hours per week do you usually work?
- Could you describe a typical day at work?
- What are patients like who are enjoyable?
- What is a difficult patient like?
- How do you deal with difficult patients?
- How would you describe your interaction with patients you like?
- Don't like?
- What kinds of things about your work in the nursing home do you like?
- Not like?
- Do you get angry at work?
- [If so] How do you handle anger at work?
- Can you describe how you came to be a nurse/LPN/CNA?
- How long have you cared for your (mother/father/etc.)?
- How old is your (mother/father/etc.)?
- What are the typical caregiving responsibilities you perform in taking care of your (mother/father/etc.).
- Is there anyone who helps you with these responsibilities?
- Can you describe any skills you have learned at work that make taking care of your (mother/father/etc.) easier?
- Can you describe anything you've learned through taking care of your (mother/father/etc.) has helped you in your job?
- Can you describe things about caring for your mother/father/etc. that make caring for him/her difficult?
- How do you handle this?
- Can you describe aspects of caring for _____ that are enjoyable to you?

- Describe the characteristics you feel an ideal nurse/LPN/CNA has
- Describe the characteristics you feel an ideal family caregiver has
- Would you tell me how old you are?

Vita

Andrea Willson received a B.A. in Communications Studies from Virginia Polytechnic Institute and State University in 1989. After working in video production and administrative positions for several years, she returned to Virginia Tech in 1994 to pursue a Masters of Science in Sociology.

A handwritten signature in cursive script, reading "Andrea Willson". The signature is written in dark ink and is positioned to the right of the main text block.