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CNAs Making Meaning of Direct Care

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Abstract

Using qualitative data from 87 focus groups with CNAs in 16 nursing homes in Massachusetts, this study explores ways CNAs make meaning of their work despite devaluations such as lack of respect from management and residents, and the physical and emotional demands of such low status work. CNAs' meaning-making represents an effort to assert a positive identity rather than accept the stigmatization associated with their work. Assertions of the value help CNAs reconstitute their identities. Assertions of meaning, which depend upon providing good care to residents regardless of financial reward or management respect and support, make CNAs vulnerable to exploitation.

Keywords

CNAs; nursing assistants; nursing homes; care work; meaning making

Certified nursing assistants (CNAs) provide close to 90% of direct care to nursing home residents (Galloro, 2001). Everyday they are faced with difficult and competing demands, chronic understaffing (National Citizen's Coalition for Nursing Home Reform, 2001), lack of support and respect from superiors and the public, and various forms of abuse (Bonifazi, 1999; Bowers, Esmond, & Jacobson, 2003; Levin, Hewitt, Misner, & Reynolds, 2003; Muntaner et al., 2004). They receive low wages, have high numbers of workplace injuries (Myers, Kriebel, Karasek, Punnett, & Wegman, 2005), and work in physical environments unconducive to quality care giving. Despite these difficult working conditions many CNAs describe satisfaction with their work (Pennington, Scott, & Magilvy, 2003) and a sense that their work is meaningful.

How do CNAs attach positive feelings to their work in the face of understaffing, poor treatment by management, lack of respect, and low pay? This paper explores ways in which CNAs make meaning of their work within less than optimal work environments. We explore how and why CNAs create positive meanings. This is an important question since the meaning CNAs attach to their work may have significant implications for resident quality of care, safety, and CNA satisfaction.

The term "meaning making" in itself is variably defined across different literatures. Kegan (1982), states that being human is the process of meaning making; the construction and organization of meaning. According to Gee (2005) meaning making is "the primordial process." Blumer, the founder of symbolic interactionism, defined meaning as arising through interactions: "The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person" (Blumer, 1969 p. 5). Meaning making is thus a "social product" (Blumer 1969) and occurs "in relation" to an "other" (Neuman, 2003), whether that be the environment, another individual or group of individuals. Therefore, the meaning one makes depends on the social context in which it is made. As such, organizational and societal structures influence meaning making (Giddens, 1979).

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CNAs make meaning of their work in relation to their managers, supervisors, coworkers, and residents and families. Management transmits both tacit and explicit messages (Lopez, 2006; Sorauren, 2000) about how meaning should be made of care work. These messages are also about the specific ways care should be delivered and interactions with residents should occur (Lopez, 2006) and are underpinned by the structures – the work organization, resources, practices, rules, and norms – that define the CNAs' job. Typical explicit messages might include, "This is the resident's home," or, "CNAs are the heart and hands of care." Nursing home practices may provide rewards for CNAs who keep family members informed of their loved one's condition or conversely, penalize them for not directing family members' questions to the charge nurse according to the prescribed chain of command. Tacit messages, in contrast to explicit messages, fall within the realm of emotional rules or unspoken expectations. Tacit messages might include the unspoken expectation that CNAs come in early off the clock to ensure that residents are up and dressed for breakfast or that CNAs not get too attached to any one resident. These tacit messages may be further reinforced by work practices that, respectively, prohibit CNAs from clocking in before shift or from scheduling that frequently rotates aides' assignments to residents. Moreover, management's reactions to the behavior of other CNAs – rewarding, ignoring, or punishing it – provide additional messages about the meanings of those behaviors. Finally, structures, such as hierarchies that disallow CNA autonomy, reimbursement mechanisms that do not acknowledge the value of the CNA's labor, low pay, and lack of formal mechanisms for CNA input into work design and team functioning, all serve to reinforce to CNAs that their work is of little worth to the nursing facilities and society.

While CNAs make meaning of their work in relation to messages from others, these meanings do not necessarily accept others' definitions or meanings. Rather than accept the stigmatized identities communicated in the tacit and explicit messages and structures that characterize nursing home work, perhaps CNAs, like Goffman's asylum inmates (Goffman, 1961), resist these otherwise imposed definitions and assert different ones. As Lofland, Snow, Anderson, and Loftand (2005) observe, "How one views oneself as a kind of person (one's self-concept) is among the most important meanings associated with one's life. Indeed, our self-concepts and identities are not only reflections of how we are situated in relation to others, both vertically and horizontally, but they are the central orientational devices with which we navigate and negotiate our everyday lives" (p.135).

In this study we explore the meanings aides attach to their work in relation to the attitudes and actions of managers, coworkers, residents, and the surrounding work structures. This is the first study to examine the meaning that CNAs attribute to their work and the role of pervasive, suboptimal work conditions that characterize the nursing home industry. To our knowledge, only one prior study examined CNA meaning making, in particular their mental models and sense making related to work with nursing home residents (Anderson, Ammarell, Bailey, Colon-Emeric, Corazzini, Lillie, et al. 2005). This qualitative study determined that CNA mental models, which guided care delivery, were based on personal life experience and that CNAs required increased training in order to develop alternative, more appropriate mental models. The significance of our study is that, using a large sample of CNAs from 16 nursing homes, we go beyond an individualistic conception of meaning making and explore a social one. We explore the ways CNAs construct meaning in response to devaluing structures and processes in their work environments. Ours is the first study to explore the connections between CNA meaning making and the stigmatizing nature of organizational structures.

Method

Data for this study come from a larger study of high performance work practices and organizational structures in skilled nursing facilities and their effects on quality of work life

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and resident quality of care. The study was approved by the governing institutional review boards of all institutions involved in the study. CNAs provided written informed consent prior to each focus group.

Nursing homes in Massachusetts were purposefully sampled (Patton, 1990), being chosen for their status as high quality nursing homes and a variety of characteristics including location, ownership status, bed size, union status, and self-designation as engaged in culture change. Nine of the nursing homes reported being engaged in culture change, which is any one of many organizational strategies to transform the nursing home from its traditional medical model to a model of person-centered care or “regenerative community” (Eaton, 2000; Grant & Norton, 2003). Three nursing homes were religiously affiliated and one was sponsored by a specific ethnic group. Seven of the nursing homes in the sample were part of regional chains while one was part of a national chain. Three of the facilities were unionized. Seven of the 16 facilities were for profit.

Eighty seven focus groups were conducted with CNAs from 31 units within 16 nursing homes. Focus groups were carried out between January and June 2003 at the various nursing facilities across day and evening shifts. Locations within the nursing facilities were selected for maximum privacy, for example, break rooms or administrative offices. Each focus group was conducted by either a senior investigator on the study or one of three PhD students trained in focus group methodology. CNAs received no incentive for participation. Focus groups were audio recorded and lasted approximately half an hour. The number of CNAs per focus group ranged from 2-4 with a few solo interviews conducted in cases where the facility could only spare one CNA from the floor at a time. Focus group participants were primarily female, with a diversity of first languages. Although we did not directly collect data on the races and ethnicities of CNAs in the study, the majority of participants were women of color, particularly African Americans, Africans, and West Indians. Several of the nursing homes also had large numbers of Latina employees. CNAs were asked five questions about issues pertaining to their work in their nursing facility and unit. These questions were: What do you like best about your job?; If you could change one thing about your job, besides being paid more, what would it be?; How would you describe the "feeling" of your facility?; How well do people work together here?; and What does management really care about here?

Atlas-ti v. 5 (Scientific Software, 2004) was used for data coding and management. Field staff developed codes through duplicate coding of the same documents until they came to consensus about the primary codes and their supporting definitions. Coders then divided transcripts for coding with regular meetings to resolve questions about coding consistency. Periodically, a random sample of transcripts was chosen for comparison of codes. There were very few differences, and any inconsistencies were resolved in coding meetings through negotiated reassessment of decision rules. Once the coding team came to a consensus, agreed upon changes were incorporated into all previously coded documents. Analyses for this study were based on the following emergent codes: Relationship with residents (Anything pertaining to relationships the CNAs had with residents; both positive and negative); Meaningful care work (Expression of finding positive meaning in doing care work; Personal identification, i.e., ‘if it were me…,’ ‘if it were my mother…’); and Attachment (Fondness for residents; Memories about residents; Grieving or loss over residents; Sense of surrogate family on part of CNA; Expressions of love of residents.) Using these codes, we examine the ways CNAs describe their work as meaningful. We presented preliminary findings to representatives of each of the nursing homes, including CNAs from each facility, in order to confirm the accuracy of our interpretations.

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Results

Across focus groups aides reported experiencing a lack of respect from their mangers and nurse supervisors. The extent differed by nursing home but nonetheless was both universal and salient to daily experience. Aides experienced a devaluation of themselves and their work through both explicit and tacit messages from managers and nurses. As one CNA from a culture change facility put it,

> I feel there's not much respect for our position…. [Management is] always looking at us to see what kind of mistake we're going to do next. That's something that I notice a lot here…..But we can't say anything back because then…. They're looking at you in a certain way, maybe you'd get fired for it…

Organizational practices also demeaned their efforts, knowledge of residents, or personal worth. CNAs were not involved in decision making, as another CNA points out,

> Oh, no respect, here there's no respect. We just get these, "You're doing this and that's it." It's not, "This is what's going on so this is why you need to do this, this is why this needs to change."

In most cases, CNA input into care planning was neither sought nor utilized when offered. Even when management espoused the value of CNA input into care planning, the nature of CNA work (i.e. provision of the bulk of hands on care) precluded CNAs from attending care planning meetings if no provisions were made for direct care coverage during these times. As one CNA put it,

> There's a lot of non-explanation and I think that ends up with a lot of hurt feelings or feeling like you're out of the loop. You tell us we're important, and you treat us like we're not.

CNAs were also routinely penalized for absences due to ill health or time needed to care for sick family members. In addition, in a number of cases CNAs typically worked short staffed, were sent home early and unpredictably when bed censuses dropped, had little control of their own schedules, and in many cases had little autonomy to structure their daily work. Low pay provided another example of the devaluation of CNA work. According to one CNA, "Sometimes we just feel like the CNAs are the bottom of the pack, as far as raises go."

In the context of these ongoing devaluations, three overlapping sets of themes emerged as expressions of meaning and value for aides' work. Some aides created meaning of their work as "good work or God's work." They described a sense of self-worth from caring for others, with worth often determined or expressed in spiritual terms. The second theme, "closeness to residents," involved personal relationships with residents. Within this theme, CNAs described attachment to residents and areas of reciprocity. The third theme was "caring for those who cannot care for themselves." Here, residents' vulnerability and need provided the basis for claims of the value of CNAs' work.

These themes of expressed meaning were consistent across nursing facilities, regardless of their status as culture change or non-culture change facilities, union, ownership status, or religious or ethnic affiliation. They were often intertwined, with multiple themes appearing in the same focus group. However tied they were together, each adds to an understanding of the CNAs and their work with and perceptions of residents, and each provides a response to a different set of meanings attached by others to the CNAs and their work. Below, we develop each theme as an effort at meaning making in relation to the meanings imposed or asserted by others.

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Good Work

The theme of "good work" or "doing God's work" reflects CNAs' struggle to create a positive identity by insisting on the inherent value of direct care work. CNAs described the intimate and unglamorous tasks such as toileting, dressing, and feeding of the elderly and infirm as deeds of altruistic selflessness and caring. "Good work" encompassed the simple "good feeling" that CNAs described having when assisting a resident as well as a sense of spiritual calling to care work. Spirituality intersected with CNA meaning making in several different ways. First, while some CNAs described being spiritually "called" to care work, others described the emergence of spiritual experience through both caring for those with severe disabilities and through witnessing the experience of resident death. This notion of spirituality was a theme that emerged similarly within religiously affiliated and religiously non-affiliated facilities. Some CNAs spoke of a spiritual call to care work with elders. For example,

> … it's kind of a call, you know, as a Christian. I know it's a call from God, to take care for those that can't take care of themselves.

Some CNAs described the simple satisfaction that they were able to make someone a little more comfortable, to help a resident smile or experience a little bit of joy, for example:

> They might call you someone else's name, but you know who they're talking to. Yesterday I was Phyllis, and I was someone else. They depend on us, and if you're pleasant to them and nice to them, you get a good response, it makes you feel good, especially when you do something, even if it's a small task, that you did for them, it makes them feel great. It makes them feel like someone cares. And that's a good feeling I get. I love that feeling. I think otherwise I wouldn't be in this job.

Meaning in this case was made in relation to positive feedback from residents, but does not depend on the mutuality of the relationship. Nor did it depend on the residents' recognition that the CNA has helped them. CNAs' underscored the importance of helping as its own reward:

> …I listen to them, and I try to comfort them the best way I know. And that makes me feel good, knowing that someone is feeling better by me being there with them and listening to their problems. And I do go home feeling good, knowing I've done something good.

The various manifestations of the theme of good work converged in the value the CNAs themselves place on their work despite its devaluation by others. Their sense of "doing something good" provided a basis for elevating the value of their work and justifying their engagement in it in the face of competing demands and constant devaluation. For example, one CNA explained,

> I'm Christian, and I have three children…. Sometimes the resident ask me if I like this job, and I say -- all the time have the same answer -- that I like to help people. But I understand that is a really hard job … it's really hard…..and I'm in school now, and I have to do my housework, my homework, come here to work.

Helping people provided the rationale for this CNA to continue doing such a "hard job" while juggling so many other commitments.

Asserting that they did their work for God or for the residents, rather than for management or pay, also enabled CNAs to resist the low value others attached to their work. For example, a CNA explained,

> … A lot of little, simple stuff, small remarks [from management], I just don't mind them, because the residents are who I take care of, and that's who makes me want to come back… . it's the residents that make us want to stay here.

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More simply put by another CNA, “Basically I'm just here for the patients, nobody else but them. That's what I come into work for, for them.” In another focus group, CNAs emphasized that they worked hard because of God and their patients, and not because of nurses' orders or money.

> A2: God sees everything you do… . So God will find somebody's good to take care of my family because I'm good with the patients. I'm doing the work now for the [patients], not for the nurses.
>
> A1: Not for your money too.
>
> A2: Not for the money. I'm doing it for the patients.

Another element of this positioning of their work as God's work or work for the good of the residents involved emphasizing the demands of the job and the special character of those who do it:

> I love it dearly. That's why I'm doing the second shift… . I love to take care of elderly…. And believe me, if you don't love this job, you can't do this job, because there's a lot of commitment, a lot of dedication and all that….You have to be caring, have to be honest with them, patient, loving. All that counts to be a good CNA. If it was for the money, I wouldn't be here. I'm here because of the residents, I love them. Because even my days off, I will call up and find how they're doing.

As another set of respondents noted, being good CNAs requires special attributes that reflect value in their work.

> A1: To be a CNA, you have to have the heart to do it.
>
> A2: Not just anyone can do that.

Closeness to Residents

Within the structure of skilled nursing facilities, residents, like CNAs, face dehumanizing conditions. Residents have tasks done to them. In many facilities, they are essentially powerless. With little latitude for personal choice or self-direction, they are at the mercy of the whims and moods of staff. As performers of the repetitive daily tasks, which residents cannot perform themselves, -- such as bathing, dressing, toileting, and feeding -- CNAs could be cast as the chief dehumanizers of residents. CNAs invoked the connections they made with residents to resist the dehumanization of themselves and their charges. Moreover, relationships with residents provided an important source of gratification.

Discussions of residents' deaths, a common feature of the daily experience in nursing homes, highlighted the importance of closeness to residents as a source of meaning for CNAs. This issue spontaneously arose in numerous focus groups. The sense of loss that CNAs described relates to a casting of residents as family members, rather than as patients or clients. A CNA said,

> Even I don't cry. But it hurts me. It's like your own family, is the way I see it. It's not like for me it's a stranger anymore. You know that person deeply, and then that person one day is just gone.

Aides in another focus group echoed this sentiment,

> A1: It's like having 40 grandparents in one room. You got to love them all, and it hurts when they go.
>
> A2: We get very attached.

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> A3: Especially me. I'm working here for six years, and one day they have to send me home because I cry so much and they have to send me home.

Such attachments allow for a construction of CNAs' work, not as degrading work or intimate care related to tasks of daily living, but as showing care and concern, with relationships with residents an important component of the work. For example, a CNA explained,

> It's not always easy; it's hard….You find out she passed away during the night, and you crack up. That's hard. But the way I figure it is when you come here to work, to me, my job is to make them as happy as you can for the time that they've got left.

Attachments did not only run in one direction; residents actively related to CNAs and were not simply passive recipients of care. CNAs spoke with appreciation of such personal attention from some residents, for example:

> A: Really I just have the mind of helping people and just love being with that lady, they give you advice and they talk to you every day. …
>
> Q: The residents give you advice?
>
> A: Like we work too much hours. "You've been here since this morning. It's not good for you. No, no, no. You need to take time for your life. You need to take a rest…"

In another focus group, CNAs also noted residents' attentiveness to the CNAs as people,

> A2: They do sense even when you're sad.
>
> A4: They always pick that up, always. And I've noticed with some of the residents, when they see that I'm sad, they question me. They love to talk; they love to listen; and they do tell me, "Don't be afraid to talk."

A CNA enrolled in nursing school talked about the interest a resident showed in her future and the advice he gave her:

> ….I can remember one advised me to do what I'm doing now. They were like, "What is your plan?" I was like, "What do you mean?" He said, "Are you going to do this type of job forever? Why not go to school?" I was like, "I have it in my--" He said, "Do that, you will enjoy it later." And now I'm in school…

The connections between residents and CNAs serve to humanize both CNAs and residents in potentially dehumanizing circumstances, and CNAs described these personal connections as providing purpose to their work.

CNAs spoke about relationships with residents as ways to justify their efforts or their commitment to their job, for example,

> …I've been here close to three years, and I feel like I have to come to work. I have to come to work. It's like they're going to need me. The residents will need me. I promised one resident I was going to do some artwork with them. Or, I promised that I was going to do somebody's hair.

Personal relationships with residents affect CNAs' motivation. According to one CNA,

> It's like you are their friend. Like I have some patients saying "I am your adopted mother." Some of them say, "You make me think about my wife because you're taking good care of me." It's so nice to hear that from them. Any time they say that, too, it's like you want to do more for them.

Sometimes aides take on more family-like roles, such as providing for basic necessities. As one CNA described,

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> Then you get accustomed to the residents, because some residents don't have family members, so you find yourself going to Wal-Mart and pick them up this and pick them up that. And try to entertain them, too. You get attached.

Another CNA admitted that,

> A1: I'd buy underwear and stuff for them. They say they don't want it, but I don't care. They're here—
>
> A2: They have no one else.
>
> A1: They have nothing. They have no one who is coming in. I go out, I buy it.

CNAs often expressed attachment to at least some residents, and "checking in" on residents when they were off duty was not uncommon. For example,

> I have the nicest, sweetest people on my assignment, that I actually look forward to seeing them. When I go away for a week or so, I miss them. I have a daughter that works here and I'll ask her, I'll say, ***, how is this one or how is that one doing?

Closeness to residents functioned, not only as sources of satisfaction or meaning, but also as sources of obligation. Thus, attachments to residents also provided the rationale for providing extra care and exceeding their job descriptions.

Taking Care of People Who Cannot Care for Themselves

The theme of "taking care of people who cannot care for themselves" highlighted residents' frailty and dependency on staff, while at the same time emphasizing the CNAs' important role in resident care. The following CNA's admission captures the essence of this theme,

> It could be a very tough job. There's times when I don't want to come; I hate this place; I feel very negative. But I have to look at the bright side. This is my job, and these people need someone. If I don't do it, no one else will.

CNAs described residents as dependent upon them because they could not care for themselves or because they had no one else to take care of them, but also because they are confined to a nursing home.

> A1: They feel like in prison, like they can only stay in one area.
>
> A2: They're out there. They're able to do what they want, and all of a sudden they come in, and they have to stay on the one room with people they don't know….
>
> A1: They don't get out for fresh air. They don't get out to see the snow.
>
> A2: They're locked in there 24/7.

The commonly used script of "it's the resident's home" reflected just how un-homelike the facilities were and the residents' loss of autonomy. For example, a CNA said,

> After working in one, you realize what goes on in a nursing home, because if you were a family member just coming in, everybody seems nice…. I mean nice, but as far as, like I said, not having the help, they're [the residents are] being rushed, they're being told what to do, what time to do it. I mean, this is their home. I refer to them as residents, because this is where they reside. They're not patients, they're residents.

CNAs showed sensitivity to the plight of residents, who not only may have lost some of their physical, cognitive, and verbal capacities, but also had lost their freedom. The theme of "caring for those who cannot care for themselves" thus involved the importance of doing a job that no one else wants to do, that at times residents do not want the CNAs to do, but that is greatly needed.

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Framing their work as caring for those who cannot care for themselves encouraged CNAs to advocate for residents' needs. This theme could provide a moral authority for advocating for residents, even if managers or nurses disagreed. CNAs described some cases where their suggestions were taken seriously by administration and other cases where their advocacy efforts went unheeded. As one CNA expressed, “People in the upper level stick together, and even if you voice your opinion, they listen but nothing is done.”

CNAs stressed that since they had the most direct contact with residents, they could identify when something was wrong even if they didn't have the clinical training to identify the source of a resident's change in status. These simple observations of changes in resident status often went unheeded as well. For example,

> A1: We're with them constant, all day long, every day. [The nurses are] just passing a med to them, or doing a treatment, but we're there doing everything.
>
> A3: And you know when something is wrong with the resident.
>
> A1: Right, if they're acting different or if they're just not doing something they normally do.
>
> A3: Then you go to the nurse and let them know and the nurse say, “Oh, it's all okay.” But, no, it's not.

And in another case,

> We'll notice something, say somebody is having difficulties swallowing a certain kind of food or something, report it to the nurse because the patient is complaining, and it just doesn't seem to-- it doesn't move from there.

Speaking for people who cannot speak for themselves provided a justification for continuing to advocate for residents, even if CNAs' suggestions or observations were ignored.

The same framing could also promote passivity, an acceptance of difficult and demeaning situations for CNAs. For example, sometimes the belief in residents' helplessness led to putting up with various forms of abuse by residents, even when such episodes could perhaps have been prevented. Many CNAs, for example, reported lack of support and respect from the nurses around some serious instances of physical or racial abuse from residents.

> I just like taking care of people. That stuff that goes on with it is hell… Sometimes they get underneath your nails. I'm Afro-American, so you've got people who have been on earth for 100 years, and your name used to be “Nigger,” so when they do that, that irks you--but you move on, you know what I'm saying. You know they don't know what they're talking about, they just see a dark figure, and that's what they want to call you. So that kind of gripes you out, you know what I'm saying, and you can't really voice your opinion when they do say that, so you just keep going.

A number of CNAs at the same facility complained about a resident who was very combative around bathing. No interventions had been developed to address his aggression. As one CNA explained, the nurses didn't believe the resident was being so aggressive,

> One day they forced me …. and I tell them this guy is fighting, he's talking bad, and you can deal with somebody who's talking bad, and he don't understand you're helping him. So I tell the nurse manager I need somebody to come to listen, one person, to stay in the bathroom and listen to what this guy talking to us so you guys don't say we don't want to help the guy.

In another facility, CNAs detailed the physical assaults they experienced daily from residents, but excused these behaviors.

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A1: They fight, they slap you.

A2: They hit you but you know--

A1: You know it's not--

A2: You get used to it. They don't know what they're doing, so it's not--

A1: Your fault.

CNAs noted that even though many of the residents were still aware of their actions, albeit on a limited level, residents could not care for themselves and therefore deserved to be cared for. This theme could be used to excuse or normalize negative resident behavior, even behaviors that were personally directed against particular CNAs.

Discussion

This paper examined the ways that aides made meaning of their work in relation to the stigmatizing messages they receive from managers, supervisors, residents, and families. We find that CNAs articulated the meaning of their work as representing “good work” or “God's work,” in developing “closeness to residents,” and in “caring for those who cannot care for themselves.” Using the theme of “good work,” aides described their work as a spiritual calling, suitable only for those who really “love it,” and described the emotional and spiritual reward they experienced from making residents feel good. The theme of “closeness to residents” described the aides' attachment to residents, whom they tended to depict as adopted family members or friends. Whether reciprocal or not, these relationships were described as a source of motivation to provide good care. The theme of “caring for people who cannot care for themselves” stressed residents' dependency upon CNAs. Using this theme, CNAs cast themselves as the last defense for residents, as the ones doing the work that no one else will do, and they emphasized their sense of responsibility. Unlike Anderson et al. (2005) we found that meanings CNAs gave their work were not based solely, or even in large part, on their own life experience and lack of clinical understanding of resident issues. Rather, we found that the stigmatizing environment itself reinforced the creation of assertions of worth and technical expertise. Our findings support the social nature of meaning making (Blumer, 1969) and how meaning is made in relation to the context of the meaning maker's experience (Neuman, 2003).

There are a number of limitations to the study. Questions for the focus groups focused on CNAs' perceptions about management practices and the work environment, but did not ask specifically about the meaning aides attributed to their work. Thus, the meanings expressed in the focus groups were spontaneous, unsolicited expressions. Nonetheless, these themes were consistent across focus groups and across facilities. A risk in the interpretation of this data is that these common expressions of meaning reflected the circumstances of the focus groups. Although we made every effort to provide an emotionally safe space for the focus groups, we were not able to conduct them off site. Although the focus groups were conducted in privacy, supervisors knew which staff were involved in focus groups and may have been on site at the time they were conducted. Work conditions on site limited the amount of time we were able to spend with CNAs in the focus groups because they had only limited time that they could be off the floor, and, as a result, the focus groups were only scheduled for 30 minutes in order to maximize participation. Due to both the short length of the focus groups and the potential discomfort of talking about work conditions under the noses of supervisors and in the presence of their peers, CNAs likely censored their responses. Thus, we may be missing certain important dimensions of their experiences and sources of meaning. Consequently, we may be giving greater weight than warranted to the themes observed and their relation to work conditions.

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Nevertheless, the meanings we observed echoed those expressed by caregivers, both paid and unpaid, in other qualitative and mixed methods studies, for example Noonan, Tennstedt, and Rebelsky's (1996) study of unpaid family caregivers; Rhoades and McFarland's (1999) study of paid “adult foster care” families for adults with mental illnesses; Uttal and Tuominen's (1999) study of childcare workers; and Pennington, Scott and Magilvy's (2003) study of CNAs. Akin to “good work,” the themes of satisfaction with caregiving (Noonan, Tennstedt, & Rebelsky, 1996), making a difference (Rhoades & McFarland, 1999), and the importance of the work (Pennington, Scott, & Magilvy, 2003) emerged in caregiver descriptions of their work. Similarly, the theme of closeness to care recipients is salient, expressed as the mutuality and friendship (Noonan, Tennstedt, & Rebelsky, 1996), home and family (Rhoades & McFarland, 1999), and emotional ties (Uttal & Tuominen, 1999). Finally, the theme of caring for those who cannot care for themselves surfaced in caregivers' descriptions as family responsibility (Noonan, Tennstedt, & Rebelsky 1996) and helping others (Rhoades & McFarland, 1999).

The tasks and challenges of caring for the dependent and vulnerable engendered similar processes of meaning making across sectors of care. The similar expressions of meaning across studies may be due in part to the dependent and intimate nature of relationships between care recipients and caregivers. Our analysis suggests, however, that the nature of the relationships between caregivers and care recipients, and the type of emotional rewards it may entail do not fully explain these thematic expressions of meaning.

We contend that these similar expressions of meaning may be due to the devaluation of caregiving in general in our society and the stigma associated with the working of care giving. The primary contribution of this paper is to show that these expressions of meaning happen in relation. They happen not only in the relationship to the care recipient but also in relation to others, such as supervisors and the community at large. The positive meanings CNAs give to their experience of work are actually created as a response to stigma. In other words they are ways of asserting a positive identity even in the face of negative messages from these others.

CNAs encountered negative messages from their managers, supervisors, coworkers, and sometimes residents about the meaning and value of their work. These messages suggested that aides were engaged in low value work and were foolish for making any additional effort or for investing time and emotion in these jobs. CNAs resisted low-worth messages and asserted a positive identity and value for their work. This expressed value, though centered upon resident reactions to CNAs (e.g. smiles, gratitude, friendships), were not at all dependent upon them.

We found that the themes the CNAs used to describe the meaning in their work served to defend against the negative messages that could stigmatize CNAs and their work. Using the theme of “good work,” aides discounted negative messages signaled by low pay and disrespect from supervisors by framing the work as its own reward, or as worthy in God's eyes, CNAs rejected the notion that they work for the money or “for the nurses” and, thus, dismissed the devaluation signaled by low pay and disrespect from supervisors and others. Using the theme of “closeness to residents,” CNAs used their personal and emotional connections to residents as justification for expending effort beyond what the job supports and for exceeding job description. This theme also served as a mechanism for humanizing residents and the work that CNAs do. Finally, the theme of “helping those who cannot help themselves” provided CNAs with grounds for challenging management as advocates for residents' needs and a means of normalizing abuse from residents.

Our study is the first to explore the meanings that CNAs give to their work in response to structures that create and reinforce the stigma of paid caregiving. CNAs' assertions of the value of themselves and their work helped CNAs to reconstitute their identities in the face of negative and demeaning interactions and messages. At the same time, these assertions of meaning, which

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depended upon providing good care to residents regardless of financial reward or management respect and support, made CNAs, like caregivers in other sectors, vulnerable to exploitation. Moreover, these conditions threaten the continued provision of good care.

Positive meanings that CNAs, like other caregivers, attach to their work may be critical to humanizing care. Reimbursement systems for skilled nursing, as for other types of caregiving, do not acknowledge care tasks related to these humanizing aspects, namely quality of life and relational care. This shortcoming is compounded by the lack of value in general for the care of the disabled or vulnerable, whether humanizing or not.

To protect caregivers and the residents in their care, organizational structures and messages must be realigned to underscore the value of caregivers and the care they provide. Within organizations, like nursing facilities, structures and processes must be modified to include caregivers in decision making, support the real value of their work, and provide opportunity for the use and validation of their specialized, intimate knowledge. Because caregivers clearly value their own work and express commitment to residents, opportunities to capture and augment their “good work” abound.

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