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LOYOLA UNIVERSITY CHICAGO

AN ETHNOGRAPHIC STUDY OF PSYCHIATRIC ASSISTANTS:
THE SOCIAL PROCESSES INVOLVED IN THE
SUBORDINATION OF WORKERS IN A PSYCHIATRIC HOSPITAL

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIOLOGY

BY

TERRENCE (MA'RUF) ALLISON

CHICAGO, IL

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vii
ABSTRACT.....	viii
CHAPTER ONE: ENTERING THE FIELD HOW I GAINED ENTRY TO MIRAGE PSYCHIATRIC HOSPITAL	1
CHAPTER TWO: RESEARCH QUESTIONS	22
CHAPTER THREE: LITERATURE REVIEW	26
CHAPTER FOUR: HOW THE WORK STRUCTURE OF MIRAGE PSYCHIATRIC HOSPITAL SHAPES THE WORK EXPERIENCES OF PAS	28
CHAPTER FIVE: THE SOCIAL PROCESSES INVOLVED IN ACCOMPLISHING WORK HOW PAS AND OTHERS AT MIRAGE PSYCHIATRIC HOSPITAL ACCOMPLISH WORK.....	65
CHAPTER SIX: WORKPLACE RELATIONS HOW WORKPLACE RELATIONSHIPS AT MIRAGE AFFECT THE ATTITUDES AND PRODUCTIVITY OF PAS AT MIRAGE	100
CHAPTER SEVEN: ATTITUDES AT WORK THE INFLUENCE OF MIRAGE'S STRUCTURE ON THE ATTITUDES AND BEHAVIOR OF PAS TOWARD THE CARE OF PATIENTS	120
CHAPTER EIGHT: DIGNITY AT WORK HOW PAS STRUGGLE FOR THEIR DIGNITY IN THE FACE OF THEIR SUBORDINATION	147
CHAPTER NINE: CONCLUSION	170
CHAPTER TEN: FUTURE RESEARCH MY SUGGESTIONS FOR FUTURE RESEARCH AREAS.....	187
APPENDIX A: METHODOLOGY	190
APPENDIX B: PSYCHIATRIC ASSISTANTS	209
APPENDIX C: NURSES AT MIRAGE.....	235
APPENDIX D: MIRAGE PSYCHIATRIC HOSPITAL AND ITS WARDS	270

BIBLIOGRAPHY	287
VITA	292

LIST OF TABLES

Table 1. Racial Composition of PAs.....	18
Table 2. Gender Composition of PAs	18
Table 3. Race and Gender Composition of PAs	18

ABSTRACT

This research examined how the structure of a modern day psychiatric institution shapes the work experiences of subordinated, non-licensed-workers. I found that that the work experiences of PAs are shaped by their institutional positions. The PA position by default is one of subjugation and servitude, and these carry meanings. PAs are positioned on the ward to service and control patients. In spite of their absolute importance to the day-to-day running of the hospital, frontline PA work is devalued institutionally. This devaluation is internalized rationally (what bureaucracies do) by PAs, who often work understaffed and underappreciated. I found that PAs lack control over their work, which impacted their sentiments toward their work. This caused PAs to perform a type of emotional labor in order to do their jobs. In spite of this, PAs are the unsung heroes of patient service. They are the frontline patient experts. They work to survive and find dignity in having a job to sustain their livelihood. Short staffing was found to be the number one institutional practice that makes work difficult for PAs and undermines the values and mission of the institution. Further research is needed in areas of gender, race, and long-term coping skills for workers in these positions.

CHAPTER ONE

ENTERING THE FIELD

HOW I GAINED ENTRY TO MIRAGE PSYCHIATRIC HOSPITAL

How did I come to study psychiatric assistants? This chapter will provide the context to how I came to study Psychiatric Assistants (PAs)¹ at Mirage Psychiatric Hospital.² Psychiatric Assistants are frontline-psychiatric workers.³ I use the descriptive frontline workers because PAs are on the frontlines of acute psychiatric care and service in this hospital.

How I Learned about Mirage Psychiatric Hospital

I learned about Mirage Psychiatric Hospital (MPH) from my mother who is a registered nurse, and she learned about Mirage from the job ads in the local newspaper. She never worked at MPH. It was not my academic or professional goal to become a PA. In fact, none of the workers I interviewed stated they planned to be a PA directly. Why? There is no direct educational training for being a PA; one becomes a PA by default of their educational background and psychiatric/social service experience.⁴ What do I mean by this statement? As long as you have a bachelor's degree, you can work as a PA.⁵ The PAs I interviewed had very diverse backgrounds. For instance, some PAs majored in

¹Psychiatric Assistant is the pseudonym job title I am giving to this position

²Mirage Psychiatric Hospital is the pseudonym hospital name given for the actual hospital. I will give a detail description of Mirage Psychiatric Hospital in another chapter

³The concept of frontline workers will be elaborated on in proceeding chapters

⁴A general education is all that is needed.

⁵This is evidenced by the variety of degrees that PAs have and have had ranging from English to Engineering.

economics, political science, journalism, as well as the traditional psychology and social work. The common factor that determined why these men and women I interviewed became PAs was the need for work. Work, in various forms, has always been an intrinsic part of human life. It serves to enable human beings to function and survive based on what their particular society's cultural and institutional arrangements (Vallas, Finlay, and Wharton 2009).

In addition, having a bachelor's degree is a relatively new requirement for the PA position. Today's PAs are really yesterday's orderlies or attendants who only had, at best, high school diplomas. Even today, there remains a small number of PAs who only have their high school diploma. These PAs first started work at Mirage when the requirement was only a high school diploma. Essentially, PAs do the same work as yesterday's orderlies. Their work is virtually the same. The PA and yesterday's orderlies have the same general work responsibilities. Both work-group responsibilities are to do frontline psychiatric ward work of keeping order on the wards. This became a revelation to me over time. I initially felt very privileged to be a degreed worker, only to later be challenged by another PA who said that we were nothing but orderlies.

I always intended to become a professional.⁶ I just was not certain what I would study. I thought about nursing, social work, psychology, and sociology. After working as a childcare worker in a group home, and various other social service related jobs, something my undergraduate sociology professors advised, I decided to return to school.

⁶A professional such as a medical doctor, pharmacist, sociologist, or profession requiring an advance degree.

After lengthy conversations and debates with my wife,⁷ whom I had married shortly after I got my bachelor's degree in 1998, I decided I wanted to be a sociologist. It was my passion in school. I enjoyed how the class discussions, the readings, and sociological concepts explained society and the world. I had been working as a case manager for a social service agency prior to working at MPH. I decided to follow up on MPH as a potential employer to accommodate my wife and I goal to obtain our doctorates.

My initial objective in finding employment at MPH was to make ends meet, increase my pay if I could, have time flexibility for my family, go back to school, and get take advantage of the tuition reimbursement and other benefits. MPH is a 24-hour, 7-day week hospital; it never closes not even during the holidays or snowstorms. Hence, MPH offered three potential work shifts; the first shift (7a-3p), the second shift (3p-11p), and the third shift (11p-7a). My wife and I had a 10-month-old baby boy at the time, thus we needed to balance out our school schedules, childcare arrangements, and work. I agreed to move from working the first shift to working the second shift to accommodate our family schedule. Additionally, MPH offered tuition reimbursement and an increase in pay. Hence, MPH offered what I was looking for in terms of my objectives I mentioned.

Since obtaining my BA in sociology in 1998, my only work experience had been in the social service/mental health/welfare fields because those were the type of jobs that matched my educational background and my work experience. My first job out of college was working in a group home with "abused and neglected children."⁸ Honestly, those few months that I worked as a child care worker were all I would need to understand

⁷Former wife now.

⁸This was the categorization of the work by the welfare agency for which I worked.

“psychiatric patients.”⁹ Why do I say this? I say this because the children bit me, called me “nigger,” screamed and yelled profanities, needed to be restrained and controlled, and ran away (elopement risks in psychiatric terminology). All of these behaviors I experienced again working at Mirage for about 10 years. We were told that a childcare worker should never hold grudges against these clients. Every day is a new opportunity to provide a therapeutic environment. The group home was eventually closed after I had worked only three months there. There were many tears from the workers when it closed. The agency continued on, but the childcare workers were let go. The reason the group home was closed was due to complaints from the neighbors in this affluent suburb. This is what the agency administration told us. This first job working in a group home was the real experience that I needed for the job of a PA. Now, let me continue to explain how I became a PA.

MPH indicated on its employment website that a bachelor’s degree in psychology, social work, or a related field and at least one year of psychiatric experience were the qualifications to become a PA. I had more than enough experience working in the mental health/psychiatric field. I faxed over my resume and was eventually called for an interview. I had a job, which I generally liked, so I was not desperate to find another one. I was called by the nurse manager in for an interview; I do not remember her name, but she was a middle age white woman. I will never forget my first interview at Mirage and my first impressions of inpatient psychiatric treatment. It was so disturbing of a first psychiatric experience that I wanted to literally run away from the ward. I remember

⁹Who and what is a psychiatric patient is a contested idea, especially in the sociology of mental illness, which sees the issue as heavily related to the social construction of mental illness by power groups

seeing patients all over the halls. My first impressions of MPH's wards were intimidating. The ward, which was Ward-6 an adult ward that housed all kinds of adults, from the elderly to the young, from those depressed to those who were mentally challenged. It shows you the power of the psychiatric diagnosis to hospitalize and medicalize human behavior (Weitz, 2013; Bentall, 2009). Bentall (2009) demonstrated how psychiatrists labeled people as schizophrenic, for example, and caused people to buy into this psychiatric category and only view psychiatric drugs and hospitalization as remedies. Viewing medical problems through the medical model only dismisses other social and psychological treatments (Glasser, 2007; Bentall, 2009; Whitaker, 2010; Weitz, 2013). The power of the psychiatric diagnosis is that it forces people to only look through the lens of psychiatric care (primarily hospital and psychiatric medications) instead of other social and psychological remedies, which might not emphasize hospitalization or medication. Labels, this is ironic in that just as mental health patients wear labels, I found that so do the direct care workers who care for them do as well.

The short-staffing in MPH, which I found to be a major factor in shaping frontline work experiences, works differently than the short-staffing in a nursing home. Historically, asylums have been places of custodial care for those who had many social problems (Shorter, 1997). It is not that there are not enough staff at MPH to change diapers (Diamond, 1992), it is that there are not enough PAs and frontline nurses to supervisor patients who might be confused or disoriented, and thus relieve themselves wherever whenever. The climate of the ward seemed chaotic; everybody seemed to be walking around. I saw, what seemed like, many PAs walking in the hall back and forth, phones ringing, and patients scattered about the hallway. Shorter (1997) points out that

the original institutions of care for the mentally ill were custodian or hospice in nature and housed mixed populations of the mentally ill and elderly, poor, and biologically sick. Their objective was not to give therapy, but to house the mentally ill. These institutions (workhouses, almshouses, jails) existed because there was a need to deal with homelessness, severe mental illness, and poverty has always existed (Shorter, 1997). I also recalled the stench of odor from the wards, its urine drained carpets, and the odor from the patients. In this sense, it was like many nursing homes in terms of odor and condition (Diamond, 1992). According to Diamond (1992), this is the natural result of not having enough staff on the floor to deal with patients who sit around in diapers left unchanged. This was not totally the case. Many patients simply did not care where they relieved themselves at times. Some were so disorganized mentally; they would urinate in a corner, in front of everyone, and urinate on the carpet. It was hard afterward to remove the urine odor. I remember feeling like I could not breathe. This might be an unflattering depiction of a psychiatric ward and its patients, but it was my first observation. The short-staffing in MPH works differently than the short-staffing in a nursing home. It is not that there are not enough staff at MPH to change diapers (Diamond, 1992), it is that there are not enough PAs and frontline nurses to supervisor patients who might be confused or disoriented, and thus relieve themselves wherever whenever. If you think this is somewhat strange, Rothman (1971) noted the comments of investigatory board of the original asylums of the 19th century as saying, "...is the sight of so many persons of each sex, in the prime or middle of life, sitting or lying about, moping idly and listlessly in the debilitating atmosphere of the wards, and sinking gradually into a torpor, like that of living corpses" (p.266).

The initial cultural shock of working frontline in a psychiatric hospital was difficult for me because I had been working out in the field with clients (I had a mental health outpatient job) transporting them to shopping centers, other agencies, and back and forth from their homes to other places. I could smell the air and feel the wind when I worked outpatient. Therefore, this was a bit of a culture shock for me initially (the making of good ethnographic work no doubt). I hated the job initially, and I was honestly disgusted. I intentionally tried not to get hired. The nurse manager took me behind the nurse's desk to her back office and asked me, "What do you think?" I had been reading books on interviews and considered myself a good interviewee. I knew what not to say, and I said it anyway hoping not to get hired, "How much do you pay?" Ignoring this response, or simply needing a new body on the floor, she complimented me and said, "You seem very patient." I was shocked that she would ignore my comments and lukewarm response. I knew this was the wrong answer to give, but I did not want to turn down a 6,000 dollar pay raise. She was honest with me. When I asked her if I would need to change a diaper, she answered that I might. I was not even afraid to ask this question, although former co-workers told me I would need to change diapers on patients. The fact that PAs work under these difficult conditions; short-staffed, disgusting work areas, chaotic, and sometimes traumatizing is a testimony to the strength and resiliency of the type of men and women that do these jobs. Diamond (1992) found the same strength in underpaid and overworked nursing aids, and Chambliss (1996) concluded the same of hospital nurses. Their expertise can be found in their ability to work under these institutional conditions (Katz, 1987; Goffman, 1961; Weitz, 2013) that might have some running for cover or quitting.

I was directed to go to human resources and ask about the money. The human resources recruiter was a fairly confident and good-looking white male. He was very nonchalant. I remember him saying that the hospital was “doing quite well” and was on the stock exchange. I initially asked for a higher salary than what MPH typically pays for the position of Psychiatric Assistant. However, when MPH did not reply sooner than I expected, and I faced pressure from my wife to commit to a job, for she would be starting graduate school soon, I took what MPH offered at that time.¹⁰ MPH hired me on July 14, 2003; a week of orientation came next.

Orientation

I had heard from my former co-workers at the agency I previously worked at before coming to MPH that morale of workers had been really low a one point at Mirage, and something about a “patient killing himself there.” I was skeptical about working at MPH for this reason. However, to my surprise, I remember the orientation video showing workers at a fish market in New York throwing fish at themselves and customers. Administration showed this video to new workers to demonstrate how work should be, fun. I remember the medical director, a white middle age man name Dr. Fine, being very cordial that first week. He came into the week-long orientation with smiles and cheer. Later when I saw him in the halls, he never smiled and never said hello unless I spoke first to him.¹¹ He would walk onto the wards and always say, “Do we have any

¹⁰MPH offered around 32,000 compared to what I was previously making at 26,000.

¹¹This phenomenon of higher ups within Mirage Hospital not speaking first is something I never paid too much attention to until I began to focus on the interactions between workers. I hope to revisit this phenomenon throughout this dissertation.

locked seclusions?”¹² in a joking way. Although at the time I perceived him as partially joking, Diamond (1992) showed how many doctors and administrators are interested in the documentation, not really what is going on throughout the wards. The documentation proves it happened, without it, nothing happened (Goffman, 1961; Diamond, 1992; Chambliss, 1996). If a patient ever accused a worker of abuse, only the documentation would prove the patient’s charge against a worker.

Orientation back then in 2003 was a honeymoon to what would become a “strange marriage” between MPH and I. We met the various administrators and nurses during our first week. Out of the 14 of us who started on that day in July, only two of us remained nine years later. I would say that this is probably the norm in terms of the number of people hired and those who manage to stay for many years. In this sense, I should feel proud. However knowing the politics of short-staffing, commodification, objectification, and profiteering (Fein, 1990; Diamond, 1992; Chambliss, 1996), I feel cheated. Goffman (1961) noted that the frontline attendants were the group of workers who stayed the longest in the asylums in spite of their low status. The fact that PAs (and other similar low status workers) tend to stay longer in spite of the relative grueling work, indicates that there are social mobility problems for PAs and similar workers, which contribute to this reality. This also suggests racial and gender questions about why these mostly black men and women stay longer than others in this line of work. Diamond (1992) emphasized in his study of nursing aids that these workers were mostly women of color. The racial disparity in the labor market is located at the top and bottom end of the

¹²Lock seclusions are patients who are locked away in the quite room. This requires a doctor’s order. Often times, frontline staff would do this without a doctor’s order initially because it took time to page the doctor and have him respond immediately to this psychiatric emergency.

private job sector where blacks are underrepresented at the top end (higher paying) and underrepresented at the bottom end (lower paying) (Lewis et al., 2004).

The orientation training week was fun and challenging. Many of us joked and teased one another whether they would make it at Mirage. I did not have the background of a correction officer, as many did. Nor did I have the swagger of someone really urban-street smart. Many teased me about my questions and reactions concerning how I would deal with this environment. I guess I seemed too academic (or by the book) in my approach. I remember one worker saying to me years later, “You black!” in a teasing manner. Another black female worker one time said to me, “many blacks are intimidated by you.” This could explain why I sense someone of a gap, however small, between myself and most of the black PAs who could verse word for word without feeling uncomfortable with street-wise patients. Not only this, many PAs said “I will fuck them [the patients] up if they touch me.” I remember one PA telling me, “you take them in their rooms, and you throw them upside the walls.” At least three PAs told me their method of dealing with a threatening patient.

The atmosphere was indeed dangerous at times on the wards of Mirage. For example, some patients attempted to intimidate, harass, or threaten to attack other patients and staff; they would curse you out, threaten to “kick your ass” beat you up. I saw patients jump over nursing stations, break walls, yell and scream, and do other intimidating things. The street way to deal with this is to threaten violence in return, not to use “therapeutic skills.” In order to handle such behavior, many PAs responded aggressively toward certain types of patients, they fought “fire with fire.” This was a skill. Not everyone has the capability to do this. I was inquisitive and analytical when I

asked trainers of emergency training intervention (ETI).¹³ I can remember being somewhat teased by older and bigger black workers. All of the PAs were black; I do not remember any white workers other than one older white nurse trainee. I was concerned about being hurt, as many of us were, when we were trained to do ETI. I remember one black trainee nurse, who later became our ward manager briefly, talking about how a man had come up behind her and put her in a choke hold in one of her previous jobs. We were told never to block your exit way when meeting with a patient, any patient. All of these things make us acutely aware of the dangerous nature of doing frontline psychiatric work. How does one really prepare for the danger? How did I make it through the orientation process? I always had in mind, “I needed the money, and I wanted to go back to school to obtain my doctorate.” Those are the two things that made me endure and keep enduring what I was going through. The rest has been, “history.” I have been working at MPH since 2003 using my existential power (Rapport, 2009) of thinking one day I would finish my Ph.D. I have just about achieved all of my objectives at this point. My son is 10, and I have a 5 year old. My wife finished her doctorate in psychology and is soon to become licensed, and I have received tuition reimbursement at MPH. The only thing that is missing is for me, is to obtain my PhD.

My First Thoughts

Once orientation was over, I was an emergency training intervention (ETI) and CPR-certified Psychiatric Assistant (PA). I started working the second or evening shift at MPH in 2003, PAs had no uniform then. We only were supposed to wear our name tags

¹³ETI, is a pseudonym I am using for the intervention PAs and other workers are taught to use to intervene with patients who are out of control or non-compliant with rules.

indicating our first name, and last initial, and our regular¹⁴ clothes. The last initial only was so that we had some confidentiality from the patient. It is ironic that from time to time you will hear announced over the loud speaker a worker's full name. What about confidentiality? Nonetheless, still today I do not give out my last name to patients. We got paid a shift differential of two extra dollars for working the evening and night shifts. I remember that at least four PAs and one MPA¹⁵ were working on one shift together. Nowadays, the norm is around two PAs per shift. The ward's climate and motion often seemed chaotic to me back then. The capacity of patients was 37, and many times it exceeded this. Ward 6 housed patients from all kinds of backgrounds and with various psychiatric diagnoses.¹⁶ I still remember to this day, one elderly white male patient who constantly fell. I will call him grandpa because he puts you in the mind of an old grandpa. He was a white man in his 60s who could barely talk. He would fall often and he was what we call SAO (sexually acting out). He would attempt to touch female patients, and thus the method of controlling him was by giving him powerful psychotropics such as Haldol, which is a sedating drug. I assume he is dead now, as I have not seen him in years. So, grandpa, the patient I just described, and patients who were mentally challenged, patients who were drug addicts, patients who were depressed, and patients who were difficult to understand why they were hospitalized were all housed together on one wild-wild ward 6. The age of the patients ranged from 18 to 67 years old. Scholars discussing the original "mad houses" such as almshouses or poorhouses (Katz, 1987;

¹⁴ETI is a pseudonym for the actual training name.

¹⁵Managing PA, a PA put in the position to help PAs and the ward run smoothly. This position was eventually cut or modified.

¹⁶ As Goffman (1961) pointed out, this adds to the mortification of patients by denying their individuality. The mental health patients are all lumped together.

Goffman, 1961; Weitz, 2013) have documented this mass housing of many types of behaviors. This mass grouping of many different populations sabotages individual therapy, and shapes the mortification of mental health patients (Goffman, 1961). The mere speeds of the interactions were daunting. It felt chaotic and out of control. It felt like entering into a stadium for a concert or game, people are going through different entrances and aisles and it is somewhat difficult to grasp everything at once. Patients could be seen down the long hallway corridors, patients were in the day rooms, patients were at the nurse's station, and patients had many requests. I will hold off on the physical description of ward 6,¹⁷ but this definitely factors in the chaos. The focus now is merely to recapture my first impressions of the ward 6 and Mirage Psychiatric Hospital.

The toughest things for me to adjust were seeing the naked body, smelling the body odors, and dealing with the chaotic labile nature of the wards. The one thing that took time for me to get used to, and not pay too much attention to now is seeing the naked body. I recall seeing almost every day a woman or man walking or running down the hallway naked. Chambliss (1996) talks about the objectification of the body in hospitals (the body is no longer viewed as special and private) by medical staff, and the same can be said of patients in MPH, because workers see it so often, it loses its sacred nature. Seeing the naked body was not something particularly appealing for the eye to see because usually patients are not in good physical shape. In fact it was often appalling to out of shape buttocks and stomachs running down the hallway. I mention this point here to explain the cultural transformation a worker goes through once he/she has become a

¹⁷See the appendix for a detailed description of the wards of MPH.

PA. Mental health patients are typically overweight due to the high correlation between psychiatric medications and weight gain (Whitaker, 2010).

Qualitative Studies

As I entered graduate studies at DePaul University first, and then at Loyola University Chicago, I took qualitative classes that enabled me to experience what Lofland and Lofland (1995) suggested, which was to study “where you are.” My first qualitative class where I explored the idea of studying the work of PAs in MPH was in 2004. I took a subsequent qualitative class at Loyola University Chicago in 2006 and further explored the idea. However, at this point in my career, it was merely a consideration to study what it was like to work in Mirage; I was not very serious or interested in studying what I did to make ends meet. I was focused on learning qualitative and ethnographic methods. I guess I did not view my work from a sociological perspective, it was just a job I did while I was in graduate school. Nonetheless, when I reflect back on my thoughts about work as a PA in 2003 and 2006, sociological theory was written all over them. For example, I noted how the information being passed from one PA to another may not always be valid. The really critical information for determining if you are walking into a good situation when starting a shift is dependent on the relationship one has with the PA giving the information. So this observation was rooted in human relations theory. In a 2004 personal field note I state:

Sometimes one can get a sense of how the day has gone for the PAs that are ending their shift by looking to see if PAs are documenting on charts. If so, this means the day has been busy and they have not had a chance to sit down and chart on their assigned patients until the last moment of their shift. This is not a good sign. I asked a

male staff member, “How has everything been?” He says, “Fine I completed this,” At times this can be an accurate and honest report by staff, at times it may not. The last thing as an on-coming worker you want is to walk into is a “set up” a situation where work was left undone or where a volatile situation is waiting.

Work place behavior studies focused on the relations between workers, and on the relationship between workers and technology (Thompson, 1989). Organizations studies focused on how organizations use control in the workplace (Thompson, 1989). And finally, industrial relations studies focused on the conflict between labor and capital in bargaining (Thompson, 1989; Hodson and Sullivan, 1995; Vallas, Finlay, and Wharton 2009). It was time for me to begin to think more sociologically about my work.

The Recognition That This was Sociological

The longer I worked at Mirage, the more my view changed that what I was doing was worthy to be studied for my dissertation. In fact, I saw it as my mission to study the work of PAs. The culture at Mirage started to change, and I believe I started to change too. The economy changed for the worse in 2007/2008 with the financial market crash, and Mirage made the local news causing an internal shake up. According to Fenwick and Tausig (2007), the labor market (unemployment rates for example) affects the organizational structure which directly affects work conditions. Employers then to take advantage of the labor market situation by making fewer workers do more work (Fenwick and Tausig, 2007). I had seen so much, done so much, and was barely seeing through the trees to understand my purpose. I think I was psychologically burned out. What I mean by this is that I had ceased to see the reasoning and benefit of my work. I felt beat up. Pines, Aronson, and Kafry (1981) defined burnout as:

...a state of mind that frequently afflicts individuals who work with other people (especially but not exclusively in the helping professions) and who pour in much more than they get back from their clients, supervisors, and colleagues. It is accompanied by an array of symptoms that include a general malaise; emotional, physical, and psychological fatigue; feelings of helplessness, hopelessness, and a lack of enthusiasm about work and even about life in general...It is insidious in that it usually does not occur as the result of one or two traumatic events but sneaks up through a general erosion of the spirit. Tragically, burnout impacts precisely those individuals who had once been among the most idealistic and enthusiastic. In other words, if individuals entered a given profession (e.g., nursing) with a cynical attitude, they would be unlikely to burn out; but if those who entered had a strong desire to give of themselves to others—and actually felt helpful, excited, and idealistic during their early years on the job—they would be more susceptible to the most severe burnout (pp. 3-4)

I really wanted to leave this line of work (frontline social and psychiatric work).

However, I knew that the news was right in that the culture of MPH caused certain patients to be put at risk for abuse and even death. Now, I felt that what happened in 2009 in Mirage could be explained sociologically. At this point, I began an early dialogue with one of my professors at Loyola about studying the work of PAs. I became determined to finish up all of the requirements to do my dissertation on PAs and nurses working frontline in Mirage Psychiatric Hospital. This was my new purpose of being a PA.

In addition, I honestly felt that this would be one way to give voice to the voiceless (Madison, 2005) workers of the world by highlighting the work experiences of PAs. Additionally, there existed almost no literature on work within psychiatric institutions from the frontline perspective of workers. I felt I had to study this as a means of validating the work that I felt was devalued by Mirage and by society as a whole.

Concentrating on What Workers Say and Do

Once I had met with IRB and had gotten approval that it was feasible to study the work of PAs at Mirage, I started to write up field notes of as much interactions, ways of doing work, and comments of various workers. I started to look critically at what workers did and said. Additionally, I begin to read literature on the sociology of work to further crystallize what I was observing.

Conducting Interviews

I got official IRB approval on June 16, 2012 to conduct interviews of frontline workers at Mirage Psychiatric Hospital. I conducted my first interview a week and half later on June 27, 2012. I concluded my interviews one month later. I got the opportunity to interview 25 people. The interviews validated my reasons for wanting to conduct them. I learned a great deal about these frontline workers, nurses and PAs, which I would never have known without conducting the interviews.

The PA/Researcher

Timothy Diamond (1992) was asked why he as a white man wanted to work as a nurse's aide because most nursing aids were women of color, and the pay was low. A similar question could be asked of white PAs. Psychiatric Assistants¹⁸ (PAs), the group I have been studying, and to which I belong, are predominantly black men in their middle to late thirties. As of April 9, 2013, there are a total of 87 PAs (give or take a few who may have been recently hired or recently fired). Out of the 87 PAs, 68 are black¹⁹ (78%)

¹⁸Psychiatric Assistant (PA) is the pseudonym of the hospital title that Mirage gave to these workers.

¹⁹Black and White are racial social constructions based on phenotypes and American racial politics. Some PAs might reject these labels for other categories such as Polish, Nigerian, bi-racial,

(45 black males and 23 black females), 12 are white (7 white females and 5 white males), 5 are Latino (3 Latino males and 2 Latina females), and 2 Asians (all males). There are 55 male PAs (63%) and 32 female PAs (37 %). Tables 1, 2, and 3 below, show the race and gender demographics of PAs.

Table 1. Racial Composition of PAs

Race	Percentages
Black 68	78%
White 12	14%
Latino 5	6%
Asian 2	2%
Total 87	100 %

Table 2. Gender Composition of PAs

Gender	Percentages
Women 32	37%
Men 55	63%
Total 87	100%

Table 3. Race and Gender Composition of PAs

Race and Gender	Percentages
Black Men 45	52%
Black Women 23	26%
White Men 5	6%
White Women 7	8%
Latino Men 3	3%
Latina Women 2	2%
Asian Men 2	2%
Asian Women 0	0%
Total 87	100%

African, etc. I am using these racial categories because this is how many in our society would commonly categorize these people based on their phenotype and the historical one drop rule or race (Davis, 1991).

Sixty-seven PAs are regular workers; they regularly work in the hospital and have rights to health insurance and other benefits. The rest (20) are registry staff. Registry employees (PAs and other workers) do not receive benefits and are not regularly guaranteed to be on the work schedule. Registry employees sign up to work, and if there is a need, which often there is, they are called in to work. They sign up by filling out a sheet that asks them to write down the dates and shift they are available to work. They leave this slip with the nursing supervisor in the nursing office. They will work the hours they signed up to work based on their availability. Many of these registry workers have second jobs. Mirage is just “hustle”²⁰ I have heard many say. Nonetheless, it is an important source of “hustle” when you consider Americans spending habits, the cost of rent, and other economic factors. They work at Mirage in order to supplement their income. Many of them are college educated. Out of the 25 workers I interviewed, all had their bachelor’s degree or higher (92%) save two people, one had her associate degree in science and the other had her education as a nurse’s assistant. PAs are predominately black and most-likely male, in his middle-thirties, who has a bachelor’s degree in a social science field (psychology, sociology, social work, economics) or humanities (e.g., history)

After having conducted the interviews, I am known by many frontline workers as the “guy who is writing a book,” as one nurse confessed. I asked Christina, one of the registered nurses I interviewed, if anyone had been talking about what I was doing under the radar of Mirage Hospital. Many workers will call to me to say hi, or smile at me in a

²⁰A hustle in PA terminology means a way of earning money, nothing less and nothing more. This term comes from urban black language.

shy way, or ask “how is that paper coming along.” This also gives me the opportunity to informally follow up on questions or answers during our interview.

Conclusion

I “entered the field” on the first day I arrived at Mirage Psychiatric Hospital hoping to pay my bills, have flexibility for family, return to school, and take advantage of employee benefits. It was not my intention to study frontline psychiatric work, or even work in general. It was not until I had a deeper knowledge of sociological theory coupled with my own feelings of subordination, frustration, and desire to chronicle the lives of frontline workers that I developed the interest to study what I was doing to pay the bills. From that point on, which I would say crystallized in 2009, I knew I wanted to study frontline psychiatric work. Lofland and Lofland (1995) recommend “starting where one is socially located and most interested” (p. 3). Madison (2005) states: “It is important to honor your own personal history and the knowledge you have accumulated up to this point, as well as the intuition or instincts that draw you toward a particular direction, question, problem, or topic...Ask yourself questions that only you can answer: “What truly interests me?” What do I really want to know more about?” What is most disturbing to me about society?”... “What is the work my soul must have?” (p. 19) As a result, I became committed to studying where I have been socially located as a worker, i.e., within Mirage Psychiatric hospital as a psychiatric assistant, from a critical ethnographic perspective. This choice of what to research has been reinforced throughout my college years, from my undergraduate years throughout my graduate school years. In summary, I came to study what I am proposing to study because it served as a commonsense and intellectual social location to study. In addition, studies involving work as a tool of

sociological analysis have been at the foundation of sociology (Thompson, 1983). In a way however, one could say that I entered the field back in 2003 when I started working at MPH, although I did not realize it. For whatever reason, the qualifications that allowed me to enter into this line of work over nine years ago are the same ones which prevent me and many other PAs from advancing within this psychiatric institution.

CHAPTER TWO

RESEARCH QUESTIONS

Psychiatric Assistants (PAs) fall under the category of psychiatric aids. According to the United States Department of Labor (2014), there are over 142,000 psychiatric aids working in various health care settings. There are over 400 private psychiatric hospitals in America of which many psychiatric aids work. In addition, in 2006, according to Healthcare Cost and Utilization Project [HCUP] (2014) there were approximately 1.4 million hospitalizations for mental health issues. Given the number of psychiatric aids, and the trend toward increasing psychiatric services, there is a need to understand their work.

The main questions I wanted to answer were related to the structure at Mirage and how it impacted frontline psychiatric work. Specifically, I had five research questions:

1. How does the work structure of MPH shape the work experiences of PAs?
2. What are the social processes involved in accomplishing work for PAs and others at MPH (i.e., how work gets done)?
3. How do workplace relationships at Mirage affect the attitudes and productivity of PAs (and other workers that come into contact with PAs) at Mirage?
4. What is the influence of Mirage's structure on the attitudes and behavior of PAs toward the care of patients?
5. How do PAs struggle for their dignity in the face of their subordination/mortification?

Work shapes one's identity (Hodson, 2001; Vallas, Finlay, and Wharton, 2009), and therefore self-esteem. According to the *Primacy of Work Thesis*, what you do for a living, defines who you are and how you are treated by others in society (Vallas, Finlay, and Wharton, 2009). Hodson (2001) explains, "Life demands dignity, and meaningful work is essential for dignity. Dignity is the ability to establish a sense of self-worth and self-respect and to appreciate the respect of others" (p. 3). Given the role of work in shaping self-identity, we need to have a greater understanding of how work shapes workers' identities in general, and certainly those at the bottom of hierarchical organizations in particular. Analyzing work from the lower ends of the organizational structure of Mirage is what my research sought to accomplish. It is my hope that it did accomplish this noble goal. Through his analysis of organizational ethnographies, Hodson (2001) found four major areas that workers gain dignity at work: resistance, citizenship, the creation of independent meaning systems, and social relationships at work. Briefly, resistance involves individual or small worker groups resisting claims by employers or advocating their claims. Citizenship involves taking pride in one's work accomplishments independent of the actually official job demands. The creation of independent meanings involves workers gaining dignity within the meanings they place on their particular work.

Another framework for understanding the impact of work on people is the *Primacy-of-Production Thesis*. This thesis indicates that work (the productive relations people enter to make ends meet) has tremendous effects on people's lives individually and socially (Vallas, Finlay, and Wharton, 2009). "The jobs we hold, moreover, shape us as individuals, affecting our health, well-being, and intimate relations—even influencing

the length of our lives and our personality attributes” (Vallas, Finlay, and Wharton, 2009, p. 16).

And finally, as the Hawthorne Studies showed, positive worker relationships are keys to workers having dignity at work and being productive at work. Indeed, my research showed how PAs struggled against attacks on their dignity at Mirage, and how they sought to obtain their dignity or simply cope with their work statuses (which impacts their self-identities on the whole). The ensuing chapters will answer the questions I outline. In the next chapter I will review the literature concerning subordinated workers in similar work settings (i.e., hospitals and nursing homes). In Chapter Four I address the question: how does the work structure impact the work experiences of PAs? The number of workers on the wards, types of admissions, and tasks assigned (work demands) shaped the work experience of PAs in ways that create more stress and more negative attitudes toward work.

Chapter Five describes how the work of the hospital gets done as the workers on the wards work together to keep the wards safe. Chapter Six explores how workplace relationships affect the attitudes and productivity of PAs (and other workers that come into contact with PAs). As far back as the research of Frederick Winslow Taylor (Vallas, Findlay, and Wharton, 2009), there has been an interest in what factors shape productivity or non-productivity, this chapter explains how workplace relationships at Mirage shape productivity (and thus safety) in psychiatric hospital work. Sociological work place studies have largely focused on productivity in inanimate terms, but rarely from the perspective of healthcare human terms. I found that workers, who hold back their products, in a frontline psychiatric sense, risk holding back on saving a patient,

doctor, or co-worker from getting severely hurt or killed. In Chapter Seven, I answered the fourth research question, what is the influence of Mirage's structure on the attitudes and behavior of PAs toward the care of patients. This chapter explained how demoralized workers (a demoralization shaped by the hospital institution) think and behave toward psychiatric patients. I found that understanding the nature of burnout and Marx's theory of *alienation* most useful in explaining the attitudes and behavior of many PAs at Mirage. In Chapter Eight, I address how PAs struggle for their dignity in the face of their subordination. The subordination or mortification is a product of PA position within the structure of MPH. This chapter used Goffman's (1996) conceptualization of mortification of mental health patients in institutions to analyze what I believe PAs go through at Mirage (a subordinating process of knowing their positions within Mirage that is internalized). This mortification leads to alienation from the beauty and importance of their work, which is to keep people safe. How important is the safety of our children or love ones if they were admitted to a hospital for care? In spite of mortification that PAs endure, PAs and frontline nurses overcome it to provide quality care day in and day out. It is important to understand this process to understand (and maybe value) how PAs (and other forgotten about similar workers) cope, and how they accomplish work on such circumstances. In Chapter Nine, I will provide a summary of the research findings including an elaboration on the main question. In Chapter Ten, I discuss potential future areas of research based on this dissertation study.

CHAPTER THREE

LITERATURE REVIEW

There have been few, if any, studies on the work of PAs. One reason for this is that a PA is a recent metamorphosis of many types of subordinated job positions: orderly, security guard, nursing aid, child care worker, and case manager. However, there have been studies involving similar subordinated health care workers. First, Goffman (1961) briefly discussed attendants (a very similar work group as PAs) in his study of asylums, but his focus was on how the institution influenced the identity of mental health patients, not workers. Goffman indicated how attendants were the governors of the wards and often times formed connections¹ with patients due to the common lower status backgrounds. One of Goffman's major contributions comes in his analysis of how attendants contribute to the mortification of mental health patients. The inhabitants (of these total institutions) Goffman analyzed were the patients, in which the attendants were in charge of mortifying. Goffman's analysis of mortification of mental health patients was illuminating, but it failed to show how other inhabitants (particularly the lower status workers) of such institutions might be mortified as well. I show in my research, as Rapport (2009) found of hospital porters, PAs are mortified or subordinated by the institution in which they work. The process of mortifying is important because mortification or subordination is institutional in nature. Institutions dominate our lives

¹Goffman indicated that these connections were potentially harmful when attendants had to enforce asylum rules.

and none of us fail not to be influenced by them in society. Mortification is the process by which one loses their sense of individuality (or even humanness) and internalizes the institution's meanings of subordination. Goffman's analysis showed the process by which patients become mortified, and from this we can learn how lower status workers who occupy the same physical surroundings of the institutional are affected.

Second, Chambliss (1996) examined the work experiences of nurses working in various medical hospitals. Nurses are subordinate to doctors and other medical administrators, just as PAs are subordinate to doctors, administrators, and even nurses. Chambliss demonstrated how nurses were impacted by the everyday realities of work within medical hospitals. For example, nurses deal with short-staffing, difficult patients, and a lack of resources. In addition to this, Chambliss (1996) showed how nurses lost their ethics of healing because of institutional constraints and lack of control over their frontline work. Chambliss' study provides an excellent example of healthcare service work at the intermediate (i.e., subordinate position) level of care. He mentions the tightrope that nurses walk between patients and administrators. The tightrope that these nurses deal with is trying to care for patients' needs while trying to please administrators and superiors. The nurse has two customers to please, who often have two opposing perspectives. I found this also to be true for PAs, who walk a tightrope between patients, administrators, and sometimes, other workers within Mirage. The examination of frontline nurses by Chambliss was extremely important in shedding light on how hospitals influence the work and attitudes of nurses toward their work. Nurses became overwhelmed, cynical, and even uncaring toward their patients as a coping mechanism for their workplace environments. Chambliss' analysis highlighted how medical

institutions shape the moral work processes of frontline nurses who do not have the institutional authority to dictate their own work. This phenomenon is similar to the emotional work blue collar service workers must endure (Hochschild, 1983). The institution causes nurses to overlook their moral responsibilities in order to accomplish their work. How are PAs sense of what is right or wrong tainted by the institutional restraints they find themselves positioned? This analysis points to how PAs accomplish work in Mirage Psychiatric Hospital because PAs are more often working with the patients than are frontline nurses.

Third, another important study in relation to mine is Timothy Diamond's (1992) *Making Gray Gold: Narratives of Nursing Home Care*. He detailed the struggles and obstacles that subordinated frontline nursing aids endure within the bureaucratic for-profit nursing home system through participant observation. Diamond (1992) showed how patients and staff were treated as commodities in nursing homes (which are mostly for profit) in lure of the bottom line (Weitz, 2013). The nursing aids (mostly women of color) were often understaffed, felt overworked, were constantly disrespected by registered nurses, and did not feel they had the time to give proper care to the patients. The for-profit political economy shaped the work structure of nursing aids according to Diamond (1992). For example, Diamond (1992) states:

For management, the lowest possible wage and the fewest workers signify good productivity, while for workers and residents they are counterproductive... Information about conflict is not available in official documents. On the wards it is hard to miss. (p. 222)

Diamond's (1992) work showed the struggles and subordination that low-status hospital workers endure. PAs face similar struggles in their efforts for dignity versus mortification by MPH.

Finally, Nigel Rapport's (2009) ethnographic study of porters (a type of hospital orderly) has many similarities to this study of PAs. Porters, similar to PAs, are subordinated hospital workers with "limited opportunities for promotion" (p. 3). Additionally, porters are not recognized as having specialized medical skills (for example, they are not licensed as nurse or doctor, and they do not perform medical procedures), consists mostly of men, and are on the frontlines of patient care. Porters struggled to find a positive self-identity or sense of wellness. Porters achieve wellness, to a degree, by using their power to be elsewhere, or as Rapport says, their existential power, to form a different meaning than their institutional position would indicate. It is the institution that shapes the identity of porters as "nobodies." However, some porters are able to overcome their mortification and achieve dignity by not internalizing the institutional meanings and creating their own. This analysis of porters suggests that similar workers (PAs) might be able to do the same.

Goffman (1961), Diamond (1992) Chambliss (1996), and Rapport (2009) described and analyzed similar frontline workers in similar workplace contexts, however there are important differences. For example, Goffman (1961) studied asylums; I studied a locked psychiatric hospital with many similarities to yesterday's asylums, although there are differences (Scott, 2011). The institution that Goffman (1961) studied is the most similar to the one I studied. Diamond's (1992) institutional study of nursing homes in Chicago were similar to my study in that both institutions are for-profit institutions that

practice commodification and objectification of patients (Chambliss, 1996) to make profits for their corporate ownership. However, there are important differences between those studies and my research. The most glaring differences involve the institution itself under study (I studied a modern day psychiatric hospital) and the type of worker (the PA is a jack-of-all trades frontline psychiatric worker). For instance, Goffman (1961) studied asylums (the closest to the institution I studied), which were designed to house patients for extended periods of time, the hospital I studied is a short term psychiatric facility which could be argued is not a total institution today like it was in Goffman's time (Scott, 2011). Scott (2011) argued that today's psychiatric facilities are not like the asylums of yesterday in the sense that admission is more so voluntary and negotiable (between willing patients who come to the hospital, and administrators who get paid). Chambliss (1996) studied mostly medical hospitals, not psychiatric hospitals. Hence, the environment that he studied was different than mine because of the nature of patients and institutional treatment objectives. Diamond (1992) conducted research in nursing homes (which are long term in care and more so devoted to medical issues and not psychiatric issues), and Rapport's (2009) research was in a medical hospital involving workers who were responsible for delivery, not directly caring or dealing with patients as a primary objective of their job. There are also differences in the types of workers under study. For example, Goffman's (1961) study did not focus on the workers as an objective of study, he focused on patients. My study focused on the workers in a similar institution as the one he studied. Chambliss (1996) observed nurses, my study focused on psychiatric assistants, who work under nurses. Diamond (1992) researched nursing aids, who are a lower status worker than PAs, and also have a different job responsibility than do PAs.

Finally, Rapport (2009) researched hospital porters, a lower status worker than PAs (PAs have at least four year degrees, and some have master degrees, and are paid higher wages). In addition, hospital porters are charged with a different work responsibility, which is to transport materials and not deal with patients primarily.

In a similar light as Chambliss (1996), I sought to understand how the structure/ institution impacted the work of PAs in this study. However, this research differs from his research in several important ways. First, Chambliss (1996) did not become a nurse in order to study them. In this regard he differs from Diamond (1992), Rapport (2009) and my study. I literally worked almost 10 years as a PA. Second, his focus was on a recognized- licensed professional work group (i.e., nurses) and not on non-licensed subordinated workers. In fact Chambliss does not mention in detail the lower status staff working under nurses. He talks about difficult patients, but he does not elaborate on lower status workers who are further down on the hospital hierarchy than nurses. Although PAs share a great deal of similarity in their work with nurses in a psychiatric hospital setting and tend to work alongside them, they are not nurses in very important ways. For example, they do not have the same authority and licensure of practice, and hence status, they are mostly male and black, hence male physicality plays a significant role in their work, nurses are mostly female, and nurses concentrate more on nursing paper work and medication. PAs work the closest with mentally ill patients than any other worker within Mirage. Hence, they are exposed to often times greater levels of violence and harm compared with other workers at Mirage, including nurses who often times are behind nurse's stations. Third, the nurses that Chambliss's (1992) studied were mostly white, middle class women (he makes a point of distinguishing between patients

and the medical staff in terms of race and class), who happen to make up the majority of nurses. PAs consist mostly of black working/ lower class men. Chambliss's focus was not on workers who do not have any legal license or sanctioned skills (as do nurses). There is a deeper level of subordination that PAs experience. There is also an obvious racialized element of being a PAs which Chambliss (1996) does not discuss in terms of the workers (he does discuss this in terms of the patient-worker relationship where the "other" is the patient). This is also another significant difference between his work and Diamond (1992), Rapport (2009) and mine. PAs have no moral oath as nurses do, yet essentially are charged with remarkably similar tasks as monitoring patients' health and behavior, taking vital signs, and caring for patients. This care work at times is highly gendered² in the sense that at times patients need to be controlled physically by men (who are generally stronger than women PAs). Additionally, female and male PAs are expected more so to deal with patients of the same sex. Hence, typically, when a female patient has been admitted to the hospital, she will be checked in by a female PAs who will take care of her needs initially.

My study differed from Diamond's (1992) study in that PAs are not nursing aids. Nursing aides consist mostly of women of color, whereas PAs are mostly men of color. Nurse's aides are mainly women, and are focused on what is called the activities of daily living (ADLs): showering, eating, toileting, etc. Diamond's study focused on this aspect of nursing home work. Although PAs at times need to assist a patient with their ADLs, this is not their primary work, and PAs are dominated by men and primarily function to

²Although this is not the only way that gender plays out in *Mirage*. Gender, like race, is pervasive in my social terms.

control and assist patients within the hospital. Additionally, certified nursing aids usually only have a high school diploma and nursing certificate, PAs on average have bachelor degrees (more often even master's degrees) and earn more money. Many PAs resent being classified as a certified nursing aid or CNA. Many have said, "I did not go to school to wipe butt."

Although there is a great deal of similarity between nursing homes and psychiatric hospitals, there are important differences, as well. The institution is different. Nursing homes are smaller than hospitals and house primarily the elderly and those with medical issues. This means the population of patients at nursing homes is different from today's psychiatric patients. Psychiatric hospitals, on the other hand, today treat people for acute mental health disorders/illnesses and have limited medical accommodations. This study differs from Diamond's (1992) study in terms of institution, the nature of the work, gender, and perhaps class of workers.

In terms of Rapport (2009), PAs share some similar qualities but do differ in important ways. For instance, PAs are made up of mostly black men, people of color, and women; Porters, on the other hand, are mostly white Scottish lower working class men. PAs are different from porters in education and wages as well. Porters make around the minimum wage in Scotland (\$8.75), whereas PAs make between 15.00 to 20.00 dollars an hour. Most PAs have at least a bachelor's degree, and a good amount have master's degrees. Another fundamental difference between porters and PAs is the nature of their work. Porters job is the transport patients (sometimes dead), labs, and other items about the hospital, they are mobile. PAs on the other hand, are experience work directly within

modern day psychiatric settings. This study differs from Rapport (2009) study in regard to actual work, race, and class.

All of these differences suggest there is a gap in the research on PAs, simply because PAs in MPH form a specific work group in which has never or rarely been studied.³ A Psychiatric Assistant is a non-licensed worker who usually has a least a bachelor's degree, and many times higher than a bachelor's degree. This makes PAs different from porters (Rapport, 2009), nursing aids (Diamond, 1992), and even (RNs) registered nurses (Chambliss, 1996) who although are a well-known work group, many have only their associate degree in college (Weitz, 2013). Not only in education levels do PAs differ from nursing aids, porters, or RNs, but in terms of their job expectations as well. She/he has a responsibility to work on the wards and directly service the patients' needs, ward needs, and hospital needs. This makes PAs different from porters (2009) who move around (transport things) in the hospital. She/he differs from social workers, teachers, and other workers in the hospital from the viewpoint that he/she is primarily (but not only) responsible for directly servicing and caring for patients.⁴ PAs wear many work hats; She/he is the orderly, pseudo nurse at times, counselor, nursing aid, youth worker, advocate, and many other things to the patients.

PAs are not attendants or orderlies as Goffman (1961) observed, have higher degrees than nursing aids, orderlies, porters, and even most nurses (Goffman, 1961; Diamond, 1992; Chambliss, 1996; Rapport, 2009; Weitz, 2013). PAs are simply a unique work group. According to the United States Department of Labor (2014), there are over

³PAs, as I have mentioned, are a truly unique work group in their educational backgrounds, if not in their actual work.

⁴This difference between PAs and other hospital workers in Mirage will be studied and documented in this study.

142,000 Psychiatric Aids working in various health care settings, but we know so little about them. Psychiatric Assistants (PAs), the group I researched, fall under the category of psychiatric aids; however tend to be better educated than even this category of workers who are closer to being orderlies. There has not been any direct study of these particular workers. In addition to their numbers, studying PAs is important because their work (psychiatric work done by frontline staff) has been understudied.

In addition to these differences between this study and the previous studies, Psychiatric Assistants (PAs) are expected to give emotional labor. Emotional labor in general involves two forms: 1) The expression of cheerful happy attitudes in spite of customer attitude; 2) The suppression or masking of emotion when dealing with customers (Hochschild 1983; Vallas, Finlay, and Wharton 2009). Emotional labor was not elaborated on in any of the other studies, but was implied. For example, Chambliss (1992) explained how nurses cope with the trauma of frontline emergency room work by it becoming routine. Chambliss (1992) explained that it would be unusual to cry every time someone died. No doubt, PAs are expected to show both forms of emotional labor to treat or serve the mental health customers and administrators. Goffman (1961) suggests a form of emotional labor for attendants who must distance themselves from patients on the ward for fear of not being able to perform their role as disciplinarian. PAs understand this role of providing emotional labor, but in various ways. I will highlight some of the different interpretations of emotional labor by PAs and nurses in the following chapters.

Another point of emphasis for this research which stands out from others is the consequences of frontline psychiatric work. PAs must walk a tight rope, and hence their

emotional labor is more consequential, and this tightrope is noteworthy, and it differs from other service sector jobs in that if this customer (the patient) does not get his/her need met (e.g. Extra food, a room change, a bathroom door opened, or medication given when he/she demands it or behavior dictates it), it might result a psychiatric trauma, physical altercation, or death⁵. Not servicing a need of a mental health patient is different from not servicing a need of a non-psychiatric customer. A non-psychiatric grocery customer who is unhappy about the checker; who did not smile and say thank you at the end of his/her or her grocery store experience typically will not get violent or physically aggressive. The consequences of not servicing a grocery or gas-station customer usually do not cause death on the worker, but maybe a complaint.

Hospitals are the epitome of bureaucratic organizations (they contain hierarchies, rules and regulation, and are supposed to be run rationally). Weber astutely articulated the capitalistic bureaucratic organizations. Loeb (1956) found that psychiatric hospitals, like general hospitals, have a worker hierarchy... He states, "...there is a professional status system which ranges from the physician at the top through social workers, psychologists and nurses to the lowly maintenance and kitchen help" (p. 17). Somewhere in between the "lowly" workers and the nurses, you will find the mental health workers. PAs are a combination of orderlies, nursing aids, and counselors. Based on the social position of PAs, we might ask the question; how are their mental health and general health affected by certain jobs they have? What about their self-esteem? Richard Williams (1990) explains that "Vertical classification implies that moral value and

⁵Emotional tirades, physical restraints, or even death has been an unfortunate attribute of asylums and mental hospitals since their founding.

structural position correlate so that a specific spatial position implies a specific moral position and vice versa” (p. 6). In Rapport’s (2009) study of low-status hospital workers, he found that hospital porters (orderlies) were located within a caste-like structure within the hospital organization. Porters’ bodies were associated with dirtiness, failure, and the lack of medical expertise. Do PAs internalize their moral worth based on their work positions within MPH? Rapport (2009) indicated that porters (the subordinated work group he studied) displayed an existential power to “situate themselves, interpretively, cognitively and emotionally, practically, at the centre of their own working and creational lives” (p. 15). Do PAs do the same? Goffman (1961) indicated there were times when it was impossible to escape one’s mortification within mortifying institutions. Porters (2009) get to move about the hospital, and thus can escape their mortifying situations, PAs on the other hand, must mostly stay on the very wards which mortify them, and thus must use even greater mental power to escape their realities for well-being (Rapport, 2009). This study examined the world of PAs, a work group that has rarely, if ever, been studied. This study showed how today frontline psychiatric work is done in MPH. This study showed how a jack of all trades non-licensed, mostly men of color work group accomplishes work within the structure of a modern day for-profit psychiatric hospital (MPH). None of the studies have articulated the struggles to work and find dignity with this particular work group in such an institutional setting.

CHAPTER FOUR

HOW THE WORK STRUCTURE OF MIRAGE PSYCHIATRIC HOSPITAL
SHAPES THE WORK EXPERIENCES OF PAS

Introduction

“Is efficiency that leads to high profits to be preferred over inefficiency that leads to more jobs; are stockholders more deserving than orderlies, nurses, and patients?” (Fein, 1990, p. 55). Mirage Psychiatric Hospital is a corporately owned bureaucratic organization. This sentence speaks volumes for explaining how the structure of Mirage affects workers, patients, and the general public (Fein, 1990; Roseau and Linder 2004; Berger 2010; Weitz, 2013). When I was hired by Mirage, I remember the human resources recruiter bragging, that Mirage was “doing well” and was on the stock exchange. This is because corporations (including those who own hospitals) have been found to care only about the bottom line (Fein, 1990; Diamond, 1992; Weitz, 2013), which is what he meant by “doing well” According to Berger (2010), the purpose of the corporation was to protect the liability of individuals¹ and allow businesses to grow through private investments. Their worldview, if you will, was to “maximize investors’ financial return” not to “serve the public interest” (Berger, 2010: 2120). Furthermore, according to Fein (1990) the, “commercialization of health care...redefines what health care is about, its purposes and standards of performance, and, thus, our expectations” of

¹Berger did not specify which individuals, but we see that the wealthy individuals are protected more so under capitalism than the average individuals.

what health care is supposed to do (p. 51). Better put, for-profit institutions seek to satisfy bottom line needs over both workers and patients. I found this was also the case in my research. All the workers I interviewed were aware of the shortage of staff on the wards of Mirage. When I asked them in the interviews, most responded as if this was an obvious well-known fact. Many responded to my question about the lack of staff on the wards, “always” it was a problem at Mirage. As the nurse’s aide said in Diamond’s (1992) study, there nothing is wrong with the equipment, but something wrong with the structure or institution. In addition to this, throughout my years at Mirage, inevitably all of the ward meetings between staff and administrators turned into complaints from PAs and frontline nurses about the lack of staff on the wards. This was a consistent finding. The lack of staff on the wards impacts worker stress level, attitudes about their work (or job satisfaction), services they can provide for patients, control and safety of the wards (which means control of patients), and patient satisfaction. The lack of enough staff on the wards was in fact not a mirage at all, it was real.

Work Structure

And it is this requirement of capital—that competition between enterprises forces and thus to increase the rate of exploitation, or, to put it another way, to adjust the wage/effort bargain between management and labour to management’s advantage—that supplies the connection, within Marxist theory, between capitalism and work design and work structures. (Salaman, 1981, pp. 12-13)

How is work structured at Mirage? Does the way that work is structured at Mirage create opportunities for workers or does it impede their ability to perform jobs? When I talk about work structure, I am not talking about how the wards are physically designed; I discuss this in the appendix section. I am referring to how work is organized: what wards workers are assigned to work, who is in charge, the policies, work expectations, the

protocols for each ward (or patient regimen), number of workers on the wards, and types of patients on the wards, and which workers are valued by Mirage, specifically. These structures are dictated by the medical model hierarchy, psychiatric primacy within Mirage, corporate ownership and Mirage hospital administration. According to Salaman (1980), structure “...has been used to refer to the apparent existence of regularities (in societies, organizations and so on) in the behaviours and values of members which can be analyzed without reference to the predispositions and decisions of those individuals” (p. 56). Hence, the structure of Mirage is not dependent on the individual differences of the workers who worked there.

Frontline nurses, particularly the RNs², are the ones in charge on the wards (as stated by Mirage handbook, 2013). This is why the RN, who is in charge that particular shift, is called the charge nurse. When problems arise on the wards, the charge nurse (whichever RN is assigned that shift, no LPN³ can be a charge nurse) has to answer first, and ultimately last, for any problems; it is her/his professional license that is on the line. Although PAs might spend more time with patients compared to nurses, and might have more insight into patients’ problems, ultimately it is the charge nurse who is the person of authority on the ward. MPH employee manual indicates that PAs are assistants of the charge nurses on the wards. Hence, it is their frontline work that is valued more by Mirage. Rapport (2009) iterated that a “orchestrated hierarchy” (p. 7) existed in the hospital he studied where the “porters’ and domestics routine practices [were] regarded as less precious than those of clerks, carpenters,...nurse, doctors...”(p. 7). I found the same

²Registered Nurses who have nursing licenses to practice nursing.

³LPN, licensed practical nurse, often called the med nurse in Mirage.

to be true in my research involving PAs and other workers (particularly nurses, social workers, and doctors), PAs are less valued institutionally as workers although their work forms the backbone of the hospital structure.

PAs, based on their position within the hospital hierarchy have less authority than doctors, administrators, social workers, and nurses. Job “authority is always associated with social positions” and is related to job control, prestige, financial returns, class position, psychological satisfaction, and decision making at work (Smith, 2002, p. 511). The greater job authority, versus lesser authority, translates to greater worker satisfaction and less stress. Smith (2002) found that blacks have less authority than whites, and women less authority than men. Lennon and Limonic (2007) concluded that jobs that are hazardous, high in strain, routine and unchallenging can lead to physical and mental health problems based on the stress produced from these work conditions. These conditions are generally related to lower positions within the work-structure hierarchy. Nurses have more authority than PAs on the wards based on the structure of MPH. Nurses’ actions can put PAs in harm’s way, although PAs may question, inwardly, their actions. Bureaucratic organizations have legitimating mechanisms, as pointed out by Weber (Giddens, 2004; Vallas, Finlay, and Wharton, 2009; Volti, 2012) that justify the line of command. Giddens (2004) explains “The most stable forms of social relationship are those in which the subjective attitudes of the participating individuals are directed toward the belief in a *legitimizing order*” (p. 154). The nurse buys into the physicians’ orders, and the PA and patients who comply do as well. This is not always the case, and at times nurses will not follow an order simply because it is there in the chart, and will consult PAs first. Nonetheless, nurses tend to follow the doctor’s orders first versus

consulting more experienced PAs, especially if the nurse does not have an established relationship with PAs. This field note below accurately captures what I observed over my ten years at Mirage, and what I was told in the interviews by PAs (that is that sometimes nurses do not listen to their input concerning patients on the wards). Social constructions of race and gender play into the structure of work at Mirage as well. PAs are overwhelmingly black men, and the nurses who have more authority on the wards are overwhelming women, and tend to be white. The structure of work on the wards is racialized and gendered, and it could factor into how work is accomplished because these social factors impact social relations at work (Vallas, Finlay, and Wharton, 2009).

Field Notes

At around 7:40 pm, Randy (A 6' 0", 300 lbs.' black male), who earlier, was talking on the phone located near the nurse's station is target of an attempt to give him a thorozone (medication to calm patient down) shot by middle age heavy set white nurse with blond hair and a southern Illinois accent, her name is Country. Randy is in his room, and the nurse, Country, calls from the nurse's station to the day room where I am at, she speaks in a slow, almost uncertain way, "We need... to give Randy a shot..., so I will need your help." I ask, "Will he fight?", and she says, "I don't know." I explain that we might have to call an emergency code for assistance given Randy's size. She explains that she will ask him. She gets the shot ready and walks down to Randy's room holding a needle with green gloves. I alert Rafiq (the other PA assigned to work tonight) and we all go to the patient's room at the end of the hall close to the day room. I feel that first, the patient has not been acting aggressively or strangely, and second of all, he is a big patient so it might be more harm-especially to staff and the atmosphere of the ward to give him a

shot. He might become violent agitated and require restraints. As we enter the room, the patient gets up from his bed. Rafiq and I explain that the nurse wants to give him a shot. Country explains that his doctor has ordered this shot. The patient disagrees and says he does not want to get a shot. Country walks out of the room, and explains that we will need to call a code. However, after some time of waiting, she does not pursue the issue. I ask the other nurse, the medication nurse, Carlotta what was the patient doing, and she states nothing, but because Country saw the order in the chart to give the patient a shot every 4 hours, she decided to follow it. Although the morning nurse did not attempt to follow it, Country does. Country in my opinion has failed to assess the situation; you must always use the proper judgment when dealing with psyche patients, especially big potentially dangerous ones.

Most likely Carlotta convinced Country that she did not have to give the patient the shot simply because the order was in the chart, especially since he was generally calm. This scenario highlights the hospital bureaucracy of Mirage. The doctor has written the order, the nurse has decided to strictly follow it, and the PAs role was simply to assist the nurse in the order without consultation or consideration of their expertise of knowing and working with psyche patients on a daily basis. In addition, there are on a few workers on the floors to deal with these sometimes violent and unpredictable patients.

The ward authority structure privileges those who are farthest away from the wards; this produces frustration amongst PAs who are often closest to the action and everyday psychiatric work. The PA work is the facilitation of ward activities, rules, and climate. The fact that PA authority is lessened by the ward structure means that their work products are less valued by them and the organization.

The bureaucratic order of Mirage hospital not only gives PAs less authority, although they are the most aware of the patients' behavior, and thus potentially his or her intervention, it defines the value of who PAs are as humans. Perrow (2007) states:

Bureaucracy is a tool, a social tool that legitimizes control of the many by the few, despite the formal apparatus of democracy, and this control has generated unregulated and unperceived social power. This power includes much more than just control of employees. As bureaucracies satisfy, delight, pollute, and satiate us with their output of goods and services, they also shape our ideas, our very way of conceiving ourselves, control our life chances, and even define our humanity. As employees, where we see ourselves as exploited or as pursuing "careers," we may dimly perceive this fact... (p. 26).

The PAs, who are mostly men of color, might have the best assessment of the behavior of the patients;⁴ however, they lack the authority which is delegated to nurses who are typically farthest from the patients in terms of physical distance on the wards, and cultural and racial similarity with the patients. There exist patterns in the work force where black men tend to be more concentrated in jobs that call mainly for black men; these jobs are race-typed (Vallas, Finlay, and Wharton, 2009). The black men at Mirage are expected to hold down or physically assist with other black men patients while nurses (mostly women and white) are the ones with the authority in treatment. This bureaucratic process is supposed to be logical and just and thus enable the smooth function of the ward. However, as the above note showed, this can be incorrect, if not dangerous to workers and patients health.

Salaman and Thompson (1973) indicated that the power structure in organizations is no coincidence; it is by design that frontline workers feel a lack of control over their work. Salaman and Thompson state "...the most significant form of power within

⁴Patient populations tend to be heavily gendered and racialized at times being mostly men and men of color.

organizations is the power to limit, guide and restrict the decision-making of organizational personnel, such that even when they are allowed, obliged, to use their own judgment, they do not deviate from official expectations” (p. 5).

Dent Perry, a black PA in his late thirties, who has worked at Mirage for six years, describes the protocol of work on Ward-18, the adolescent boys’ ward. He describes the MPH institutional expectations, in the face of few PAs on the wards. Here are some comments Dent made to me during his interview:

Me: Ok, so then after the briefing and the game plan what happens next?

Dent Perry: We do the ahh we do the protocols, we get everybody situated. You know we do our daily acclamation in terms of their daily hygiene. We start getting their morning ready for breakfast, which they have at 8 o’clock. Ahh you know usually that can be a process in itself. Getting guys up, getting guys in order, organized, somewhat disciplined. If you have guys undisciplined...you have a dismal disorganized situation—Seventeen boys maybe three that don’t get up when they are supposed. They have a problem getting up, whatever, they have an attitude problem. So we are dealing with that situation on a regular basis...getting everybody in tuned. It is not necessarily what we want, but what the ward needs...and that’s to be safe... (4 seconds silence)...so that is the breakdown then we have our goals group. Goals group is meant for everybody to somewhat reflect on things; what they need to do, what they need to think about, how they need to think about going about it. So we have a goals grup...group and we talk about things ahh what happened for them to get here, things they need to deal with, in between talking to parents, things they need to think more of, what they could have done differently, their reactions. You know what was the conflict, think about it. Everything you have done up to this point, things need to change. You know, and it could be just one thing. I need to change you know, maybe the way I talk to people. Maybe I need to change the way I respect people and be more humble. You know, we’ll talk about that and you know and the floor is open to anyone who might have any suggestions. That usually take about 45 minutes out of the time. After that we talk about expressive therapy. Usually their (the expressive therapists) group is about an hour, then after that school (the teachers do this group, but PAs are usually sitting in on these groups to keep the boys in order), after that social worker group. Then around about 2:30 everybody goes to their rooms. Then we get ready for the start of the next shift. That is pretty much how my day goes. Supporting the behavior in the milieu...⁵

⁵From interview with Dent Perry.

These comments by Dent reflect how PAs have been conditioned to do their work. Dent has bought into the safety jargon of MPH, although he explains that there is not enough adequate staffing to provide the safety. This is a form of commodification (Diamond, 1992) and capitalism (Parker et al., 2003) that seeks profit over all else (including enough people on the wards). The charge nurse, social worker, and psychiatrists are nowhere to be found in Dent's comments. PAs are the workers responsible for running the wards' programming; this means also ensuring that patients are following the program as well. Hence, the very protocol of programming on the wards, which are dictated by administration, sets the kind of work experience a PA has at Mirage, and PAs buy into it based on the logic or organizational order (Giddens, 2004; Vallas, Finlay, and Wharton, 2009; Volti, 2012). If a patient is non-compliant, the PA is the worker expected to deal with this difficult patient. Dent says, "It is not necessarily what we want but what the ward needs...and that's to be safe?" Goffman (1961) said that institutions state their mission and vision to the public, but the world of the frontline workers present what really occurs. It is not necessarily that PAs want to make their work experience more stressful dealing with young-angry men who do not want to get up, but Mirage has employed the PA to ensure not only safety, after all a sleeping, difficult to manage⁶ patient is better than an awake difficult to manage patient, but compliance to the structure set up by Mirage. In this sense, as Goffman informed us about the attendants of asylums, the PAs are the governors of the wards at times; they rule the ward. However, the governorship can be taking over at any point by higher-up

⁶A difficult to manage sleeping patient, is a patient with a known history of being a behavioral problem when awake. Patients average two weeks on the ward.

personnel or a difficult patient. Mirage administration feels good when patients are complying with the protocol that they have set. As Goffman (1961) said about total institutions, the appearance is what matters to such places.

Stress Level

“Even before we get to work, we feel the stress of not knowing where we will work or what type of people we will be working with” said Rafiq, Asian⁷ PA who has worked at Mirage for 10 years.

Stress was another identified theme of my interviews and observations. Stress, can be linked to job strain. Schnall et al. (1992) found that job strain (high demand and low control) were associated with high blood pressure, and alcohol use and high job strain were significantly associated with significantly higher blood pressure. Stress at work is created by jobs that have high demand and low control/authority (Schnall et al., 1992; Smith, 2002; Lennon and Limonic 2007). How does the work structure at Mirage create stress for workers? Workers indicated an increase stress level when they did not feel safe or could not provide services and safety to patients on the wards. I identified a theme where lack of staffing on the wards produced greater stress and anxiety for workers.

Field Notes

While sitting in the day room, I am constantly on edge although the patients appear to be calm and appropriate; I need to constantly keep my eyes on them for inappropriate touching or language. Eight pts (patients) in the dayroom, I have to watch them due to the fact that there are young female patients present. Three patients are sitting at a table, one particular patient is a young female SAO (hospital code precaution

⁷His specific nationality is not indicated because it could reveal the identity of this person.

that means Sexually Acting Out), another young male patient is also SAO, and other patient is a male. I note that I am worried and feel tense because I have to keep my eyes on the three patients sitting at the table talking. I watch them from across the day from a table reserved for staff while I am looking down the hall monitoring patients who are going in and out of their rooms and the day room. They are also watching me as I watch them.

The stress that I mention in this field note is the result of the structure of work at Mirage. It can be compared with the stress that Diamond (1992) mentioned when nursing aides had to deal with feeding patients, changing them, or moving them within a short period with limited staffing. The common factors involved are the limited number of staff out on the wards to assist with the needs of the patients (in psychiatric terms, that means monitoring and controlling patients' behavior). I was the only staff in the dayroom on Ward-5. I was responsible for watching the patients in the dayroom, and for watching the hallway because I was the only PA on the floor at that time, and this was not an anomaly, this was the norm. Wharton (1996) found that work structure, not emotional work, was associated with burnout. It is not so much that PAs are exposed to traumatic events in Mirage, but that there simply are not enough PAs on the wards to do the minoring and protecting that they are employed to do.

Dent Perry discusses the stress he feels on an everyday basis on the boys ward:

Dent Perry: Yeah, like that is what I tend to use as a strength. You are not going to always be, it might be one person on that ward, which is not always right with 10 patients, which is probable illegal. How are you supposed to watch 5 people in the dayroom, 2 in the room, maybe two people walking in the hallway and one in the bathroom, and your nurse is sitting down. These are some of things that...that you are going to come across. So what do you do? How do you handle these things? How do you stand up for yourself and say I am in the position I am

supposed to be. I can't help it that so and so are in the hallway. I'm watching boys right here, who is helping me with these guys right here. That is one of the problems we are having with this job right now, they want you to be in places you cannot be. You just can't do it, you couldn't do it, I dare any administration to come down and do what we do, it can't be done.... (Seconds pause)...yeah but we get fired you know. And that is a stressful thing.

Dent's stress is related to the lack of PAs on the floor. He is the only one out on the ward with the boys. This habitually happens at Mirage, and you are told by nursing supervisors "this is all I can give [meaning the number of staff to patients]. Diamond's (1992) indicated that commoditization by profit-care institutions made care difficult for patients and the workers on the frontlines of care. This same analysis can be applied to MPH work structure. Dent Perry is short-staffed intentionally by bottom-line owners of similar for-profit hospitals. I asked Dent about the process of *doing the rounds*. Dent describes the process under the current staffing mandated ratios:

Me: I know a lot about this place so you know the rounds could you give me a description of doing the rounds. How is that done?

Dent Perry: Rounds are about observation and monitoring. Every 15 minutes you have to keep an eye on on the patients and to ahh observe their movements. What are they doing, what they should be doing? You know in your eyesight, you know so 15 minute rounds are to observe patients daily in the milieu, in their room, in the hallway. So that is what the 15 minutes are for, keeping people in a safe situation. We do get people who are in assault situations, so those 15 minutes are important. Some things we look for are precautions. Those things we look for could be sexual, we look for sexual precautions, we look for assault precautions, we look for elopement, we look for depression...2 seconds silence...so these 15 minutes are more than just checking on people. We are doing observations we want to find signs. We are hoping not to find signals of struggle you know, so we definitely keep those monitoring 15 minute rounds up to date.

Diamond (1992) found the same frustrations of frontline nursing aids when he studied nursing homes in Chicago. There is a sense of frustration by these similar subordinated workers due to profit motive by these two institutions (for-profit nursing homes and hospitals). Dent gave me the regular protocol for doing the rounds, however,

I had to push him further to get the context, and remember the stress, of doing rounds under the staffing structure of Mirage:

Me: So but, the adolescent ward is one long hall

Dent Perry: ummhuh.

Me: So the boys in the dayroom, the adolescent ward stretches from you know (the boys ward is at times divided into two with two different round book responsibilities, but at times there is one book for the long stretch of patients rooms), you got that door that is in the middle. So how is the process of doing the rounds from way down there to here (I am using my hand to remind him of the long distance in his mind). In the middle of that, I guess how would you describe that process? You know, certainly what you are saying the observations are the issue, but specifically how do you do it (my voice goes up a tone for emphasis)? How do you do it, you have one PA holding that rounds book, which I already know, describe to me how you are observing 20 something patients (I am chuckling thinking about my own difficult experience). I mean you know what I am saying; this is something that the outsider has no clue. This is difficult to describe.

Dent Perry: well yeah, it's like ahh. Have you ever been in the military bra? You know it's like ah ah MP, military police...

Me: Ahhhuhh (Interjection)

Dent Perry... You are standing you ground...

Me: Ha (I laugh at this excellent analogy he is giving)

Dent Perry:You know, you can't go to sleep. You need to be aware of everything...

Me: Wow

Dent Perry: L...even when you are not in that corner, even when you are not in those places, even when you are not in those day areas. You have to be...(seconds of thinking silence)...absolutely alert to everything, and what I mean by that being absolutely alert is you have to have allies. Even when you are not in the spot you are supposed to be, they are supposed to be. So you are using your allies which would be your social workers, your doctors, your staff, even your janitors. You know we have to work together because we are not always going to be in the same spot in time. And having you believe that is the issue, we cannot be in every spot at one time. This could be one of the issues to why things happen. You know, we are not there to see everything.

Me: Yeah that is true. Like you said we are relying on all the workers to be your allies.

Dent compares watching patients on the ward to being on military guard, and this is significant. At times some patients are constantly walking around posing dangers to the safety of all on the ward. The stress level (the demand of watching these sometimes

violent patients and the lack of control over the number of staff on the wards) for a PA is extremely high at these moments. This stress level that PAs experience on the wards of Mirage is different from the one Diamond (1992), Chambliss (1996), and Rapport (2009) discussed in their studies of related workers. The work of PAs at times closely resembles the work of correctional officers at high security prisons. Ted Conover (2001) documented the high stress levels of guards working in a high security prison in his book, *New Jack: Guarding Sing Sing*. Because Mirage was known to “accept anything” [any type of patient that had insurance], I observed many occasions where workers felt unsafe due to the type of patients that were housed on the wards. What type of patients? The patients who are threatening, intimidating, violent, aggressive, verbally assaultive, and thus difficult manage, are the types of patients workers feel unsafe around.

Attitudes

How does the work structure at Mirage influence the attitudes of PAs concerning their work experience? Workers do not like to be moved to work in unfamiliar wards. Being moved or assigned to work a ward you do not regularly work is called being *floated*. Rafiq, an Asian PA in his early 50s, says one day on the ward as we chit chat, “We know our staff, we know our patients, we have been working here 6, 7 years, we feel comfortable” as we discuss floating to another ward. Rafiq does not like to *float*, and most workers do not, citing some of the same reasons Rafiq mentioned here. Rafiq cited three reasons: familiarity with patients on the wards, familiarity with fellow co-workers, and a general feeling of comfort. PAs stated in their interviews that floating make their jobs more stressful. Attitudes of PAs are shaped by the structure of work at Mirage. Floating, although tolerated, and even denied as an issue by PAs at times, causes workers

to feel uncomfortable because one's governorship of one's work experience is diminished. Catrice, a female PA reacted negatively to being floated several times in a row. I made a note of her reaction to being floated in one of my field notes.

Field Notes

As I make my way into the hospital, in the back of my mind, I know that I might be "floated," which is when a worker, mostly PAs, but nurses as well, are assigned to work another ward than their normal working ward. To no surprised, I see my name on the adolescent boys ward. I am on time though, so I guess that cushions the blow a bit. Catrice (who is a part-time regular on Ward-57), a tall slim white woman with long brown hair and a drowsy facial expression—sleepy eyes, is "punching in" at the same time. She says, "I am being floated" I reply, "Me too." Catrice looks irritated by this and says, "Rosy said she was not going to float anyone today last night." Rosy is the African (from West Africa) nursing supervisor tonight. I respond, raising my eyebrows, but yesterday Keysha, Anthony, and Dave were floated, so it is our turn. Catrice says Yeah, heading into the adolescent girls ward, known as a difficult ward, if not the most difficult. I understand Catrice's frustrations.

I was recently floated to the adolescent girls ward and did not enjoy the experience. Another interaction occurred between Rosy and Catrice again. I met Catrice again at the time clock this past Saturday. "I was floated to the girls adolescent ward last night, it was horrible, I had to grab one girl by myself because she was clobbering another girl," said Catrice. "I was late today because I had to force myself to come in," Catrice continues. "If I am floated again to the girls ward, I am going to walk." As she is heading toward the *boarding ward*, a ward opened due to an overflow of patients, in this

case adolescent girls, she sees Rosy. “If I am floating again to the adolescent girls ward, I am going to leave,” she says to Rosy. Rosy responds, “You have that right to leave if you do not want to work, but I have to take care of the hospital needs.” Because this is the case, I rarely get upset with the nursing supervisors for *floating*, unless I feel that it is not being rotating equally between workers. Rosy ensures me that it is my turn to be floated today, and that the need is on the adolescent girls ward. I work the shift on the ward, it is trying attempting to *redirect* teenage girls with attitude and behavioral problems, especially when no rapport has been established, something that all workers suffer from when they are floated.

PAs have little choice in which wards they might be ordered to work on a daily basis. PAs become frustrated with the lack of reasoning the process of floating. The rational bureaucratic hospital is not functionally rational, this makes PAs have a negative attitude toward the organization and frontline psychiatric work. Nevertheless, at the end of the day, the hospital needs come before the workers, even before the patients. The reason why I say this is that if a worker does not feel comfortable or able to work a ward, he/she will not be able to provide therapeutic or even disciplinarian care to patients. The hospital rarely accounts for this. When I asked Heather, a white female PA regular on ward 5, how she felt about *floating*, she expressed that it has taken some time, but that she has warmed to the idea because it is a forced reality:

Me: Can you tell me about floating

Heather: Well I have come to terms with the fact that it’s going to happen because now we are over-staffed on our ward and so it puts me in a better frame of mind if I go into it with a ok attitude not necessarily positive but at least willing attitude as oppose to how I use to be when I was floated. I don’t want to float I hate going to that ward it sucks, and portray a negative attitude and that did not help me it didn’t make my night go any faster, I think that staff can pick up on

that the patients can pick up on that and so now I look at it is eight hours it's not where I am comfortable at but sometimes it ends up being maybe even better or different and think that hardest thing if we are going to be floated to different spots every day. You know if I am going to be floated and I get to know the patients, then float me there the next time, then I get to know the patients then float me there again the next time, don't blow us (PAs) all around .

As these two examples indicate, PA attitudes are negatively impacted by Mirage *floating* structure which suits its needs instead of workers and patients' needs. Some workers have even "walked" out or quit for their dislike of being floated to difficult wards, especially children and adolescent wards. PAs are "blown around" Mirage according to its needs. Just as the children in a fourth grade class know which teachers are the substitute, patients know non-regular PAs on their wards. This makes it difficult and more stressful to do the frontline work for PAs. The issue is one of control at work. The greater job authority, versus lesser authority, translates to greater worker satisfaction and less stress (Smith, 2002). Goffman (1961) briefly mentioned that attendants preferred to work on wards where patients were less demanding. However, PAs do not have the control over where they are assigned to work. This creates frustration, as Heather expressed, but at the same time PAs have been subordinated to know they have little choice if they will continue to work at Mirage. For this reason, they comply and hope to be assigned to ward they prefer, as Goffman (1961) explained of attendants.

In addition, frontline workers have little control over the types of patients that are hospitalized. What this means is that if there is a difficult to manage/control patient on the ward, the frontline workers must simply endure this. Chambliss (1996) found the same conclusion in his study of frontline nurses in various hospitals. It does not matter if they feel they are actually helping the patient, or if this patient is making life difficult for

other patients on the ward. The current staffing work structure is based on a grid that allows one frontline worker (PA or nurse) for every four patients and this is strictly followed by Mirage.

Attitudes toward work are shaped by nature of work and position one finds his/her self in at work (Smith, 2002). I found that PAs generally had a negative attitude toward the structural policies of Mirage which take away control and add more demands. Work stress affects mental health (attitudes) negatively (Bejean and Sultan-Taieb, 2005). Job stress happens as a result of too many job demands and too less job control (Bejean and Sultan-Taieb, 2005).

Work Experience

I asked workers in their interviews how would they sum up their work experience at Mirage. Most workers indicated that it was a learning experience, “I learned a lot” was a common expression of summing of their experience at Mirage. They learned about how much they could endure as people under stressful work conditions. This particular field note shows, unfortunately, more of a regular occurrence than an anomaly.

Field Notes

I worked with Anna Poles⁸ and Cindy.⁹ Anna is the European migrant female age 39. She has a bit of a heavy accent. She has been working at Mirage for more than five years. Anna recently, within the last month or so, lost her baby to another miscarriage (her second one since she has been at Mirage); I feel sad for her. I worked yesterday and

⁸(Anna Poles), white female in her late 30s with thick polish accent. Anna Poles suffered another miscarriage as of April 2012.

⁹Cindy is an older (around 65 years old) thin Asian nurse who has worked at Mirage for more than 20 years.

today with her. Yesterday we worked on ward 5 (my home ward) and it was basically a pleasant work day (In Mirage psychiatric terms).

However, today was a more stressful day, and as I said to Anna as we left work, “I felt so bad for you...but I am proud of what we did today. This is what I mean by employee of the month, we all deserve it.” Anna has previously won it, I never won it. Anna responded, “You deserve employee of the year” as we both laughed to each other.

Why was it so stressful on ward 6? Ward 6, the ward I originally worked when I started Mirage in 2003, is a much larger ward compared with ward 5. This means there is a lot more space to cover when *doing the rounds*¹⁰ and servicing the patients on the ward. Hence, it is more physically demanding. When things become more physically demanding, they become more stressful. The patients, although as Anna said, are “higher functioning” are basically the same as ward 5. In fact, many of the patients have been on both wards (ward 5 and 6, the primary adult patient wards) during their times of hospitalization at Mirage. The patients tend to go back and forth in terms of psychiatric hospitalization. This also means that the stress is not solely related to the types of patients only, but the physical set up of the wards.

Field Notes

In addition to the physical strain that ward 6 demands, we had some difficult patients and only one nurse today. There were a total of 15 patients and only three staff.

¹⁰The rounds are the documents that indicate the patient’s whereabouts and behavior. They serve as evidence for the hospital of safety and accountability for the patient. The whereabouts and behavior are coded on the round sheet. Doing the rounds consist of continuously walking the halls, at least every 15 minutes, and being the PA responsible for all of the hallway tasks: opening doors to patients bathrooms (which must be locked due to patients having sex with one another or hurting themselves or others), answering phones and making phone calls for patients, and a host of other activities that revolve around patient care and hospital function.

There is a ratio of five patients for every staff. What this ratio does not tell you is that the one nurse must combine charge nurse paperwork duty with medication nurse responsibilities. As Cindy, an Asian nurse who has worked at Mirage for years, maybe more than 20, said, “And this is my first day back!”¹¹ It was ridiculous.

The ratio of 5 to 1 is somewhat manageable if the patients are manageable. All it takes is one out of control patient to make it a difficult shift to work. Today, we had 2. One patient, a young white female who has been hospitalized lots of times before either at Mirage or some other hospital. I will call this patient Curly. Curly has made allegations of abuse toward staff at Mirage. As one staff said, “She tries to get people moved from the ward who she does not like.” Curly, standing in the hallway talking to Anna and myself about her bruised hand, “Kesha¹² beat my ass yesterday. She threw me down hard on my hand and made it worst.” Curly is loud, demanding, emotional, threatening, aggressive, explosive, and more. Curly mainly had a problem with one particular black female patient who I will call Regina. I never observed what sparked them to argue, but they argued and stood face to face several times. This was difficult to deal with because one PA must be in the dayroom while the other must watch the hallway and rooms. I carried the rounds from 7am until 10am, so I was mostly out in the halls. As I am walking in the hallway, I hear yelling coming from the day room. I quickly run to see what is happening and it is Curly and Regina yelling at each other. Curly says to Regina, “You fat bitch” as they walk out of the dayroom toward the medication line. Anna says, “You guys come on!” Curly gets even louder walking toward the back of

¹¹Cindy was hurt when a patient attacked her, and she was given time off from work.

¹²(Kesha) black female in her mid to late 40s.

Regina, and says, “Nigger!!” “They call me white trash.” Curly notices me and tries to justify her language. I respond, “I never called you white trash. Who is calling you white trash?” Curly changes her tone from a racialized one to simply, “I am going to kill that bitch.” Anna walks toward Curly and tries to convince Curly to calm down and walk away from Regina. Regina is a black girl who is at least twice the size of Curly and she remarks in the dayroom when a male black patient says, “Has she looked at the size of your arms?” “She don’t know my background, she does not know,” Regina remarks. Curly goes across the doors on the other side of the ward and yells more threats at Regina. For the rest of the shift, this is a bit part of our concern; we do not want Regina and Curly to fight. We don’t want Curly to become out of control and start upsetting the rest of the patients with her racial slurs, yelling, and banging. We don’t want to be attacked ourselves. Anna has just had a miscarriage. Cindy, the nurse, is a small older lady in her mid to late 60s, so she would not be much of a help. Hence, we are working on the edge at Mirage. The patients need help, but we need help as well. Fifteen patients, two women at each other’s throats, and one black male patient who are starting to “act out” as well. Tim is a black male patient who has been at Mirage multiple times before. Normally, he is a passive patient who just minds his business. He is manageable. However, this time, we got a report that he was acting strangely, shaking his body around as the night shift PA said. As I am in the dayroom now, I hear Anna yelling Tim...Tim! Tim is moving toward a white middle age female who is standing in the medication line outside of the dayroom. I run out of the day room leaving the patients un-monitored, and grab Tim’s arm, Tim does not fight me or Anna, but is not listening to us. He is struggling to get to the patient who “threatened me.” We, Anna and I, are not holding the

patient and trying to talk with him. We are physically separating the two patients from coming to blows. Cindy, hearing this, runs in to the med room to call the emergency code. As we wrestle with the patient, I am concerned for Anna, and I already feel bad for this 40 year old woman who just had a miscarriage, struggling to hold this male patient with me. While we are holding the patient, the ward is out in the open. The other patients could try to attack us, or each other. Who is watching them? There is only 2 PAs on the ward, and we are escorting a patient toward the quiet room. Who is watching the halls or dayroom? The answer is no one. As we are holding the patient, I noticed Anna face, she is in stress and is trying to hold Tim as much as possible. Even during this hold, we must make sure we are using approved crisis techniques of holding because the cameras are on us. I am trying to hold the patient inappropriately. I have my right hand wrapped about this wrist and my left hand on his shoulder. Anna is trying to do the same thing but is struggling. As we walk the patient to the quiet room and hold him, Anna sees the nursing supervisor for that shift, who is also the ward manager of ward 5, and says, "We need some help." The ward manager, Darlene, says, "you have to work with what you have, let us not discuss that now." Anna is right, and probably Darlene knows we are "short-staff" but the staffing comes from above Darlene, maybe even from corporate. It is unsafe for staff. It is physically demanding, but I know not to even complain or ask Darlene why. I just want to make it to end of my shift and go home. Tim eventually started banging his head on the exit steel door and said, "I want to be released now!" Anna and I had to leave only 1 PA on the ward in order to take her break. We would get no help, and we just had to do what we had to do to get the work done and keep our composure. Patients definitely play a role on workplace stress of frontline workers at Mirage. In addition, the

staffing plays a major role as well. We needed more staff, but we knew it was not going to come for whatever reason.

We toughed it out and our reward would be as one worker told me years ago, “is you get to come back to work the next day.” Having a job in this economy with the type of degrees we have is the reward. It is pathetically true. This rather long field note highlights the work experience of PAs that occurred too often at Mirage. It is same work condition that Chambliss (1992) discovered in Chicago nursing homes where there simply were not enough staff.

The First problem Ana and I encountered in our work day, was that PAs do not know what wards they will be assigned, and as Heather and Rafiq indicated, this increases the level of stress because staff has not only failed to build rapport with the patients, and other staff, but generally feel more incompetent on wards they are less familiar. This rapport with staff, which was subtly mentioned by Dent Perry as a way of keeping the ward safe, is critical.

Next, there is the problem of short-staffing. There were only two of PAs assigned to work Ward-6 on this particular day (A routine staffing pattern at Mirage). The nurse was included in the staff ratio, but was physically not helpful. The policy and job protocol demands were barely met due to not having enough staffing. Even when Ana and I managed to leave work safe, including the other patients, I was physically exhausted from the physical and emotional demands of this shift. It takes a lot of stamina to walk long hallways for hours while many other tasks that are patient driven. Chambliss (1996) says of frontline nursing that it is a tireless line of work driven by patient demands. At the end of the day, and at the end of our work experience we were simply

happy to make it through another shift. Too many work days of making it through the shift would sum up many PAs work experience at Mirage. This is by no accident. It is the result of commodification by corporate owned care institutions (Fein, 1990, Diamond, 1992). This field note also shows that ward managers do not want to hear workers voice their legitimate concerns for safety and fair staffing (Diamond, 1992; Rapport, 2009). They are more concerned about making you work harder so that they can continue to make more profit for for-profit organizations (Diamond, 1992). There is not a deeper analysis of this fundamental problem in MPH. The amazing part is that Ana and I survived the shift feeling unsafe and overworked. Over the years of working at Mirage, this was the norm. The other workers and I had so many experiences like the one described above that we viewed this as more normal than abnormal (Diamond, 1992). As Diamond (1992) indicated, there is something wrong with the building, and not just the scale in the institution of MPH.

At the end of the day, it helps the corporate bottom line that there is a paying patient on the ward. Hence, the work structure: number of workers, what is expected of workers, and the types of patients (especially if they are difficult to manage) can cause PA worker experience to be normal (even for a psychiatric facility) or unsafe, chaotic, and stressful (Fein, 1990). In the *structuralist perspective* (Parker et al., 2003), the structure of MPH is conditioning the work experience of PAs.

Conclusion

I found that PAs have high work demands (must physically monitor long hallways doing rounds and other patient driven chores, intervene with angry or misbehaving patients) and low control/authority (do not determine which wards they will work, which

patients they will work with, and the number of staff on the wards) within Mirage Psychiatric Hospital. Within the job strain literature, work stress results when workers have too many demands versus too little control (Smith, 2002).

Short-staffing was the number one structural factor which affected PA work, and is a decision by the corporations of healthcare organizations (Fein, 1990; Diamond, 1992; Chambliss, 1996; Devereaux et al., 2002): It means that staff's work experience is more demanding, and those at the bottom of such organizations (who rationally lack greater authority and control) will experience stress the greatest. All of the interviewees stated that they went into this type of work to help people but find that they are pushed toward more paper work or some other type of administrative hospital goal of Mirage Hospital. I asked PAs and nurses if they were ever short-staffed. This was strange question to most. "All the time" was a common response. I asked workers to describe the impact of being short-staffed due to the corporation's bottom line, and they indicated that they felt "stress, hyper-vigilant, concern about their safety, lack of support, and in general frustration with administration" when they lacked enough staff. As a result of short-staffing, workers felt they could not interact with patients, care for patients, provide safety, control the wards, and provide optimal or even adequate services to patients. Chronic short staffing creates potentially dangerous and stressful situations for staff (Diamond, 1992; Chambliss, 1996).

Heather expresses her frustrations in our interview. I asked her about her thoughts about being short-staffed:

Ahh I think first of all when we are short-staffed, the patients suffer because they are not getting one to one attention. Ahh like where experience that I have had before working as in a psychiatric facility it was part of our goal as a PA, to the

patients we were assigned to you would actually go spend like five minutes doing a one to one with them like you would go up to them like whatever reason they were there for you like if they are there for self-injury would up to them and ask them. You know are you feeling like you wanted to hurt yourself today? Do you have any suicidal ideations? Like that was a part of your one to one and you would sit down you would during our community meeting you would arrange to set up a time to meet that patient and like three o'clock you meet for five minutes and that is the person you are charting on. And I think because we have always been kind of short-staffed I came into this job having that expectation in mind. And I think a lot of times, you don't get to have that one to one time and I think even patients who ask for it. You know if you are the only staff you can't go aside and I can maybe pull them to the side in the hallway but I still have to monitor the everybody else (the other patients), so how much attention am I really giving that patient if I am only half listening to them and half looking around. But, and then it's you know if you've got have the patients in their rooms and half the patients in the day room and you want to run a group but you are the only person you don't have anyone watching the patient's in their rooms. So then the patients who are ready to go to group can't go to the group because you don't have anyone to run the group. Or I mean just basic things like taking a lunch break, if we are short-staffed, you know we can't run down to the cafeteria and get something to eat or take a break until the patients are asleep or something like that (around 10pm). Ahh like for instance tonight when I came on there were thirty patients and there were only three staff of us (PAs) staffed. And I was even looked at it like this isn't right I mean we got a patient who used to be on a one to one I don't think she is discharged so what are they thinking? And then as the night, we ended up getting two more staff, but I mean.¹³

Heather's comments reflect the typical limitations that short staffing has on workers. Not being able to really listen to patients in order to meet their needs, not being able to run a group, or not even being able to keep patients safe by monitoring their whereabouts equal subpar patient care. Devereaux et al. (2002) state:

The private for-profit hospitals employed fewer highly skilled personnel per risk-adjusted bed. The number of highly skilled personnel per hospital bed is strongly associated with hospital mortality rates, and differences in mortality between private for-profit and private not-for-profit institutions predictably decreased when investigators adjusted for staffing levels. Therefore, lower staffing levels of highly skilled personnel are probably one factor responsible for the higher risk-adjusted mortality rates in private for-profit hospitals. (p. 1405)

¹³Direct Quotation from interview with Heather.

If, short staffing is linked to higher mortality rates, then what about quality of patient care rates and worker stress levels. Staffing, accounts for the types of days that PAs have on the ward. If there are enough workers on the ward, groups can be ran, breaks can be taken, patients' needs can be met, and adequate safety can be kept on the ward. However, the hospital *matrix*,¹⁴ a staffing system that allows certain amount of workers for a certain amount of patients. Administrators have never openly discussed the matrix, but it is used as a justification to *float* cancel PAs, thus having enough staff for the patients who are demanding and have various needs are never considered when it comes to staffing. The work structure of Mirage is turned upside down. Like so many work structures in our society, those who are closer to the products of service generally have the least amount of control. PAs embody this notion for they are the closest workers to the patients (the products of service). Not only do PAs have the least amount of authority on the wards (who is admitted, who gets discharge, who gets medication, or who gets certain privileges, what wards PAs will work, and with which patients), they rarely filled adequately staff to control and provide services to the patients.

Is there any beauty in doing work under these conditions? Certainly, I observed PAs keep wards safe and running literally by themselves (one PA on the ward) at times. This, in itself is remarkable. However, the outcome of this workplace structure at Mirage is more stress, negative attitudes, and generally negative work experience.

¹⁴Matrix, or staffing ration, currently one frontline worker to four patients.

CHAPTER FIVE

THE SOCIAL PROCESSES INVOLVED IN ACCOMPLISHING WORK HOW PAs AND OTHERS AT MIRAGE PSYCHIATRIC HOSPITAL ACCOMPLISH WORK

Introduction

This chapter will illuminate the actual work of a PA at Mirage hospital. One of my goals in this research was to describe the process of doing frontline psychiatric work. What is it that PAs do on the wards? Mirage Psychiatric Hospital paints a picture of itself to the public and to its workers (this is a part of a larger *process of subordination* that takes place at Mirage I will describe later). What actually happens on the wards is the real work. I will start this chapter by discussing the image that Mirage wishes to display to the world. Next I will describe how this image does not translate to the reality according to frontline PAs and nurses. I will finally describe the work of PAs.

What Mirage Presents to the Public

In Goffman's (1961) assessment of the world of the staff, he says that institutions present themselves as one thing to the public, but that the real world is composed of what the staff actually does to accomplish the vision and mission of the institution. For this reason, it is necessary that we understand what Mirage portrays to the public, and what actually occurs on its wards. A view of Mirage's vision, mission, and philosophy can be found on its website. Mirage states:

We believe in curing and salvage¹. We believe every person has the right to be treated with esteem and self-worth as they seek help in addressing their mental health necessities. We believe in providing excellent care in a concerned and healing manner. Our devoted team is zealous in treating the whole person. This highly customized treatment includes the individual getting care as well as their family and community. As associates, together we seek groundbreaking paths towards wellness. (Mirage Psychiatric Hospital's website Dec 2012)

Similar to what Fein (1990) found of corporatism and Hodson's (2001) theory of work dignity (in terms of giving workers dignity), I found that corporatism is the number one hurdle to the stated mission of service and care of mental health patients in MPH. This conclusion is based on my more than nine years of working at Mirage, hundreds of conversations with employees, field notes, and 25 formal interviews; short-staffing is the number one hurdle, and for that manner corporatism is one of the major hurdles to representing this vision of concern, healing, safety, and dignity of not only the patients, but the workers as well. Mirage states its vision and mission throughout the hospital and on its website. None of the workers believed this to be true, but all said in their interviews, and informally, "what are we to do?" Mirage states on its website its mission and vision as follows:

We struggle to create an atmosphere that establishes kindness and concern with well-timed and operative communication through complete behavioral health care services of clinical brilliance."²

This mission statement would give the impression of a quiet hospital. One would get the impression from this statement there is tranquility and superb services at Mirage. One might think that the place is modern, clean, and ideal. However, I know this not to

¹I have used synonyms to protect the hospital's identity.

²This statement has been slightly changed to protect the anonymity of Mirage.

be the case. Mirage was established in the 1970s according to Miles Turner and Carlotta.³

It is an old building that has been remodeled internally several times so that when one enters the hospital, it would appear to be new, but if you look closely at the corner of the floors, you would know that this building has been around a long time. One of my first impressions when I first started working at Mirage was the nastiness of its wards, especially the adult patient wards. Human beings are human beings, they will create odors and messes,⁴ and the thing that makes Mirage a dirty place to work at is the sparseness in their janitorial services. All of the housekeepers are eastern Europeans with thick accents⁵ who are paid only 8.25 cents for their services. Many of them complain. In addition, there are no janitorial services between the hours of 7 and 10pm on Saturdays and Sundays. Many other night staff has complained that there are no housekeepers at all overnight. What this means is that if someone vomits, urinates, or defecates in the wrong area, PAs and nurses must try their best to clean it up or cover it. However, the frontline workers lack the cleaning materials to sanitize or properly clean it⁶ up; therefore they must do their best to clean it until a housekeeper arrives to properly clean it. How therapeutic is this for the hospital and wards? I remember on occasion when I noted my interaction with one particular housekeeper who is no longer working at Mirage. Here is my interaction with her.

³I interview both Miles Turner and Carlotta. Miles is 73 and Carlotta is 68. Both workers worked at Mirage for more than 20 years.

⁴What I mean by this statement is that humans natural create waste and might become sick at times, creating sick waste as a normal biological function.

⁵All of the housekeepers spoke broken English and were difficult to understand for most non-European workers. They had limited English skills.

⁶Nor do most see it as their job to clean human waste up.

Field Notes

I continue [walking down the hall way *doing the rounds*,⁷ “You can do your hygiene, and get some towels” I say in a loud voice in the hallway to patients who are listening from their rooms and walking about the hallway. Sam, the housekeeper, is not finished cleaning [the dayroom]. Anna⁸ is down the hall talking with a nightshift staff that is getting ready to leave. It is almost 7:30 am. The house keeper, Sam⁹ is walking toward the back dayroom on ward 5 when she sees an out of order note placed on the outer patient bathroom, she stops and yells in a loud voice “WHAT IS THIS!?” Because I know her temperament and behavior, I quickly shift the focus away from myself toward Anna and the night shift staff about to leave, Teddy Ogomo.¹⁰ I say, “I don’t know, talk to Anna or Teddy.” I turn away and open the back dayroom door to get the coffee water to make the coffee. Although Teddy told Anna and I during the report that the bathroom was out of order and I am the one who told him to put a note on it, I do not know exactly how it became out of order and I do not want to deal with Sam, the irate limited English housekeeper. As I am walking back toward the kitchen, I chuckle to myself because I know she is yelling at Anna or Teddy, “WHAT IS THIS?” in her limited accented English. As I am leaving the dayroom, Sam has come down the hallway and is about to enter the dayroom. She says to me, “Please, this garbage [picking up the small black

⁷This means being responsible for carrying a safety document books that shows where a patient is located and what behavior they are presenting. The rounds are to be done every 15 minutes non-stop around the clock.

⁸Anna is a PA who regularly works on the other adult ward, ward-6. She is 39 years old and has jovial personality. She also has a thick European accent.

⁹Sam has been working at Mirage for about one year. She is very emotional and has a thick accent. She will argue and yell at both patients and frontline workers, especially at PAs. She seems to know who to talk to and who not to yell at. She knows the hierarchy.

¹⁰(Teddy Ogomo), black male in his mid or late 30s with thick African accent.

garbage can in the hallway] not in the hall.” I respond by saying, “I am just starting my shift this morning, you need to talk with nightshift.” She looks indifferent and yells, “I don’t know either, and you talk to my boss.” I reiterate to Sam, “this is not my work [to have a small trash can in the hallway]; you can talk with the night shift if you want.” I say this and walk away from Sam. Sam, no doubt is underpaid and overworked. She is frustrated, and it is easy to tell at times. She is moody as well. On certain days she is smiling walking onto the wards to clean them up. However on other days, she is irritable and short-tempered. She cross-examines PAs about the condition of the ward, about patients making a mess, about things being out of place. What Sam fails to acknowledge is that we (PAs and nurses) can only control patients’ behavior to a certain degree. I often times responded to her complaints about the mess created by patients in the hospital by asking her “what can we do?” She did not respond, so I do not know if she simply did not care about PAs inability to control patients’ behavior on the wards. If the patient is not thinking rationally or simply does not care about cleanliness, it is impossible to make them care. Sam wants someone to vent at, someone on her level of authority and positions. She targets PAs because she can vent to PAs and make us feel somehow responsible for patients’ behavior. Many of times Sam has told me, “It is not my job” to pick up patients towels from bathroom floors. If it is not the housekeeper’s job, whose job is it I wonder to myself. However, my co-workers, especially David sympathizes with her. David considers it a primary responsibility to “keep things clean” because “she has to clean 3 wards and is underpaid” David has said on different occasions. Sam likes David the best out of us three regular morning shift PAs on ward 5. Sam asks “where is David?” when he is not working. Sam talks to David the most out of us three. “I need you

today, to deal with Sam,” I tell Anna. Anna is a native of Sam’s country. Anna responds, “She is rude.” I quickly respond, “Yeah, that is how she is, we try to ignore her.” Anna responds, “I understand the patient, but this is not acceptable. I do not care about her mood or if she is on whatever [her menstrual cycle], this I will talk with her.” I continue, “I thought it was a language issue or something, we (David, Kuzak, and I) sometimes say she acts like a patient.” As I am continuing to really try to make excuses for Sam, Teddy interrupts and says, “What is that housekeeper’s name [in his thick African accent]?” I respond in a subdued voice, “Sam.” I know why he is asking for her name. He is mostly-likely going to talk with the supervisor about her behavior. Just as I figured, she must have scolded both Anna and Teddy over the bathroom being out of order, as if they are supposed to clean it or not allow mental health patients to dirty it. Anna responds to Teddy’s request for Sam’s name, “Yes, she needs to be reported, that is why she feels so comfortable” I again attempt to defend Sam based on my coworkers feelings, “I want say his name, but he feels they are underpaid and over worked.” Anna responds, “Still you are not supposed to act this way that is why I was not saying anything [when Sam drilled them concerning the note of the bathroom door].” I continue, “She says her English is not good, and I do not speak her language.” Anna responds, “Aunt a, no, she is angry, that is the reason.” We end the conversation when we see patients approaching us.

Sam and her husband Alex¹¹ eventually left Mirage hospital and were replaced with other low-paid Eastern Europeans with thicker accents. The lack of cleanliness on the wards is the direct result of the unwillingness of corporate ownership to spend more money on people to clean up. Diamond (1992) concluded the same thing in his study of

¹¹To Eastern European immigrant housekeepers at Mirage with thick accents in English.

nursing homes. The drive to make money by for-profit hijacks its values of deliver excellent care (Diamond, 1992). Frontline workers do not know if it is a problem of English skills or simply disgust on the part of these housekeepers that they are even lower on the totem pole than PAs and cafeteria workers. Why doesn't Mirage pay them more money? Why doesn't Mirage hire people that frontline staff can better communicate with in order to get things done? So, right from the start of entering a ward, a patient or worker has to deal with the cleanliness of the ward. Therapy, and thus the mission, has been compromised from the start. Cleanliness must be provided for both patients and staff to show that the institution is serious about providing superior services and treatment. I do not think this is a bold statement. If you want superior services, workers, even the housekeepers must feel valued. Value is shown in money and in respect at work (Hodson, 2001). Respect means to have conditions that are doable and not extremely difficult. This also means that PA work involves some degree of picking up towels, cleaning dayroom tables, straightening up on the wards, and interacting with housekeepers who feel underpaid and overworked.

Cleaning is an informal part of PA work. However, not all PAs buy into this a part of their work. Because of the chronic staffing problems at MPH, this includes all workers (cafeteria workers, janitors, social workers, nurses, etc.) it impacts PA work as well. PAs must pick towels up, wipe tables, go down to the cafeteria and get coolers of water and Gatorade. If PAs fail to do the dirty work, patients will not get serviced for these needs. The PA is a jack of all trades worker at MPH on the frontlines of care. The governor of the ward (Goffman, 1961) must do the dirty work when there is no one else to do it. He must believe when none else on the ward believes. David says to me about

the dirty work, “I don’t mind, who else is going to do it, administration is not going to.”

As I am standing at the time clock about to punch out from work, I have a brief

conversation with three PAs:

Me: “One day, we’ll get employee of the month.”

Tree: “I don’t care about employee of the month, just give me a raise.”

Me: “But you know they are never going to do that.”

Tree: “Yeah, we will probably never get either.”

Kuzak and Peter, 2 past winners of employee of the month, are punching out at the time clock as well.

Peter: “Just got to have Faith,” the logo on the shirts of nurses and PAs.

Peter: “It does not mean you have to have faith in what they believe in.”

Peter epitomizes the point I am making, the PAs special quality is that they are masters of doing what must be done on the wards. They are first and last to believe in servicing the patients in undignified conditions (Hodson, 2001). Mirage has a vision to be superior in behavioral health services. Their vision is:

We will be a foremost supplier of superior behavioral health services for children, teens, and adults going beyond the anticipation of our patrons” Mirage Hospital website.

The services are not specified in this vision statement. What is interesting is that the workers who spend “100%”¹² of their time with the “children, teens, and adults” are not highlighted. One would think that any philosophy, mission, or vision would mention the important role that frontline workers play in providing such care. This is another way PAs are alienated from their work in a frontline psychiatric sense of Marx conceptualization (Giddens, 2004). Honestly, over the years, it felt like we were barely “*holding it down*.”¹³ It felt like under-staffing was the norm, and it gradually got worse.

¹²One of the administrators of Mirage corrected me when I said that PAs spend 80% of their time with the patients. He said 100%.

¹³Holding it down is a Mirage Hospital term for controlling the ward and its patients.

The current staffing to patient ratio is 1 frontline staff to 4 patients. This means that one staff is there to service four patients who might be very intense patients. In some cases one out of four patients might be considered “intense.” In other cases, there might be four intense patients. An intense patient is a patient who demands a high amount of services. This is something that all of the staff I interviewed confirmed. How can the vision and mission be achieved if there are not enough people or “bodies” to do it? The services or service work directly links the service (activity for another person) with the producer of the service who typically interacts with the customer or consumer. This makes service work primarily a social-relational function. Service work also involves customers or consumers more than in other form of work (Vallas, Finlay, and Wharton 2009). If there are not enough frontline workers to interact with patients, how can Mirage provide “superior behavioral health services for children, teens, and adults going beyond the anticipation” of their patients? When there were not enough workers on the wards, which many times there were not, we simply just watched the halls sitting from day rooms, left day rooms unattended when we needed too, delayed bathroom and food breaks, and did the best we could to make it through the shift without incident. This is what firsthand psychiatric work looked like, “doing what you have to do” as David¹⁴ told me many times. It did not look like that excellence of care that Mirage wants to show to the public.

The Nature of People Work in a Psychiatric Hospital

¹⁴David Lopez, Latino male in his early 50s but looks younger. He has worked as a PA since the 70s. He has been working at Mirage for about 9 years now. He considers himself “hyper” and has encouraged me at one point to “write an article about this, you are a smart guy.” I do not totally know if I can trust him however.

“The chief aim of this attendant culture is to bring about the control of patients—a control which must be maintained irrespective of patient welfare. This aim is sharply illuminated with respect to expressed desires or requests of patients. All such desires and requests, no matter how reasonable, how calmly expressed, or how politely stated, are regarded as evidence of mental disorder. Normality is never recognized by the attendant in a milieu where abnormality is the normal expectancy” (Goffman, 1961, pp. 84-85). A good manager was now one who understands what made others—colleagues, subordinates, and superiors—tick “(Vallas, Finlay, and Wharton, 2009, p. 99).

The number one investment in the work involving people is people. We can look at the human relations theory of work to gain an empirical understanding of this statement (Vallas, Finlay, and Wharton, 2009). What are the conditions of the people hired to work with people? Do they have time? Do they have resources? Are they competent? Cermon Edwards, a 35 year black male PA explains the nature of frontline psychiatric work at Mirage:

Me...ok...ahh in terms of your work with these patients, could you tell me what you are doing with them, and for them, so for the outsider who again, they don't know what we are doing with these patients. What exactly, if you could get more specific are we doing with these patients?

Cermon: It depends on the situation, if you are running groups, if you are running groups or you are giving the patients information. You are answer questions; you are getting the patients input. It just all depends on what type of interaction you are having with the patient. If you are assisting the patient with ADLs [activities of daily living], hygiene products so they can take a shower. It depends on...what type of...what type of interaction you are having with the patient.¹⁵

These comments by Cermon highlight the jack of all trades frontline psychiatric work of which PAs are held responsible. PAs perform multiple tasks of work on the

¹⁵Interview quotes.

wards which are all designed to service and control patients. PA work is service work. Service work involves activities done for others in the broadest sense (Vallas, Finlay, and Wharton, 2009). The production of services can be distinguished from the production of goods in a couple of ways: 1) they are intangible (cannot be picked up) and 2) they are produced and consumed in a short period of time (Vallas, Finlay, and Wharton, 2009). The nature of people work is to interact with people. You must look, not look, listen, not listen, know who you are dealing with, and who you are not dealing with, and in a nut shell interact with a variety of individuals in different situations. You must interact (service and control) with people even when you do not have the desire to interact; the primary job of a PA is interaction (service and control) with difficult people. The theory of interacting positively with others, even when workers may not want to, because it is their job to do it, is called emotional labor (Vallas, Finlay, and Wharton, 2009; Hochschild, 1983). Emotional labor in general involves two forms: 1) The expression of cheerful happy attitudes in spite of customer attitude 2) The suppression or masking of emotion when dealing with customers. There has been a rapid increase of jobs requiring both forms of emotional labor (Vallas, Finlay, and Wharton, 2009). PAs are expected to show both forms of emotional labor to treat or serve the mental health customer and administrator. Many of the service sector jobs require “soft skills” which are based on worker personality, behavior, and attitudes versus production sector jobs, which are based on formal and technical knowledge (Moss and Tilly, 2001; Vallas, Finlay, and Wharton, 2009). The very important fine line between psychiatric frontline people work and other service sector jobs is that PAs and frontline nurses are delivering a *psychiatric emotional*

work.¹⁶ They are dealing with people who might be in “psychosis,”¹⁷ or are acting out of control by screaming, fighting, self-harming, or destroying property. This is a very important difference. My nine years have been full of such moments of frontline psychiatric services. There are intense moments of work, lackluster moments of work, and routine moments of work. I will describe these moments below from my field notes.

The Routine Moments

Me: What do you need Palatine (patient)?

Patient: My meds **Me:** You ask the nurse. What is your name? **Nurse:** Kelly **Me:** You ask Kelly for your meds.

After opening doors and heading back into the dayroom I see the patient standing up

Me: Sit down Palatine.

Patient Palatine: I need my meds! (His voice has stress in it).

Me: She (nurse) is in with another patient. She said she would give it to you.

After about 15 minutes sitting in the day room with patients watching TV (World Series Baseball), Palatine starts up again

Palatine: Do you know when my doctor will be here?

Me: Palatine, you have been asking me the same question since Friday (the last 2 days), and I have been giving you the same answer. I don’t know about your doctor.

Although this is a routine moment, it is nonetheless frustrating to continue to repeat over and over the same thing about things you do not control as a PA. I do not control when his doctor will see him, when or if the nurse will give him medication. On the other side of the token, neither does Palatine. It must be frustrating for him as well. Research on job strain indicates that workers will find these kinds of work experiences stressful (Smith, 2002), and this is what I found. It is a psychological and emotional labor (Hochschild, 1983) rarely illuminated, save in burnout and stress research (Pines,

¹⁶I am claiming here that frontline psychiatric emotional labor is different than mere emotional labor; psychiatric emotional labor is being able to endure psychiatric behavior of patients and the institutions that these workers inhabit.

¹⁷A psychiatric term heard in *Mirage* for a patient experiencing hallucinations (involving any of the 5 senses) and/or acting strangely.

Aronson, and Kafry, 1981; Todaro-Franceschi, Vidette, 2013). What is occurring in the above fieldnote does not feel like art, it feels like torture, and these frontline work conditions leave many PAs to become burnout or reach compassion fatigue (Todaro-Franceschi, Vidette, 2013).

Field Notes

As I look around the ward, I hear a patient ask “could I get the bathroom open,” I turn and look down the hall, which is about 30 yards total estimated, and proceed to walk toward the patient’s room and enter into the room, knock a couple of times, then open the bathroom door. The locks are steel and heavy. Each time you turn the key, you feel it in your fingers. Each time you knock on the heavy wooden door, you feel it on hands and fingers. It is a physical process; walking 30 yards back and forth each time a patient wants his/her bathroom door open, and then turning those hard bathroom door locks each time. As I am walking back down the hall toward the nurse’s station to get the report, another patient complains about the temperature, “its cold man, what happened to the heat?” I respond, “Yeah and tomorrow is supposed to be 80 degrees. It is hard for them (plant operations) to change the temperature when it does this.” I am acting as the middle man.

Frontline PAs are the workers who are the closest to the patients. Hence, we act as middle men to the administrators, doctors, social workers, and even nurses at times. Whatever problem the patient has, we are the first, and maybe the last, to hear about it. PAs are there to meet patients’ needs and hear their problems, from the bathroom doors to the heating issues. This finding is similar to what Goffman (1961) found of attendants (orderlies) on the wards of asylums, that is, PA are the governors of the wards. However,

PAs are not just the governors, they are the service people as well, it is the job of PAs not only to govern between patients, but to service the patients in some of the most mundane ways. For example, nothing is mesmerizing about opening up the same bathroom door several times over a 15 minute span.

Field notes

The patients begin to pile into the dayroom; we now have about 10 patients in the dayroom. Since David is in the dayroom now, I can actually do the walking rounds. I head back into the 30 yard hallway. It is 10 minutes later, and the mentally challenged patient still has not taken her shower and is still asking me for linen to make her bed. She says, "I need a blanket and pillow case." I turn and I reiterate to her, "Housekeeping is going to make your bed; you just need to get into the shower. Take those clothes off, and get into the shower" As I am talking to her, I am also updating the rounds to the next 15 minute interval. I note that this patient is in the dayroom, this patient is still in her room, this patient is in the hallway. I must do this each one of the 19 patients while talking to this mentally challenged patient to attempt to get her to shower. David is in the dayroom with patients and handing out trays as patients are coming to the dayroom. The patient says ok, but is still standing in the middle of the hallway. I have dealt with her before so I know what to expect, but it is still difficult. She is not processing what I am saying. I say to her, "hurry up; someone is going to jump in their shower." There is a brief silence, and then she says, "I need a blanket and a pillow case." I say to her in a slow soft tone, the way I would do a child, "We are going to give you that after you clean yourself up, someone will make your bed, ok?" Seeing that I am not getting very far, I walk toward the linen closet, which is toward the front of the ward, and I open of the closet and give

her a blanket, but there is not pillow case. She says, "I need help." I respond, "Housekeeping will clean your bed and make it up." "Here is a blanket, but we do not have any pillow cases." She takes the blanket and heads toward her room. I tell her, "You can take off the dirty sheets." She says, "I need help." I return I respond in a agitate voice, "No you do not, you can take the sheets off the bed, you can do that." She repeats, "I need help!" "No you don't need help to take off those sheets," I respond. She is able to do it, but for some reason she just refuses. She refuses to listen to me. Or she cannot understand. I do not really know which it is. I do know that it is frustrating to deal with her every day. She typically gets very upset, then she needs to have shots to help her calm down, then she cannot wake up to use the bathroom. It happens every day, and sometimes twice a shift. She says again, "I need help." I say to her, "Ok, we'll do it, just go take your shower." I walk down the hallway to go into staff's lounge to pour myself a cup of coffee. After walking up and down the 30 yard hallway, I find myself interacting with another patient, Michele, who is anxious and wants to go home. She is pacing around the nurse's station. I ask her, "What's wrong?" She says, "I want to go home." I respond, "I know, but you need to focus on the reason why you came here, and work on that problem." She replies, "I just want to be with my boyfriend." I respond, "I know, he is going to be there, if he is a good man." She says, I know, I just get bored up in here. There is nothing to do." I respond back, "Why did you come in here?" She responds, "I was cutting myself." I say, "This is what you want to focus on, getting the help you need." As I am saying this, one male patient asks, "Can I use the phone?" Another patient immediately asks, "Can I get my bathroom open." I respond, "It's not phone time yet," and I head down the 30 yard hallway to open up the patient's bathroom.

The above field note highlights how PAs must do rounds (account for patients whereabouts) while opening bathroom doors, redirecting patients to shower or follow regimen, and even counsel patients. I am doing these thing because they are part of my job responsibilities and because I am the only PA out in halls on this particular day. The only other PA is in the dayroom with patients. The nurse is in the medication room getting the medications ready for patients. Hence, the social process of doing PA work involves doing multiple tasks at the same time. I am holding the rounds, which should be my only job (this is articulated by Mirage whenever an incident happens on the wards), and I am interacting with patients to meet their needs all at the same time. This multitasking, which according Mirage should not happen, but habitually does, is a direct result of not having enough staff on the wards, there is no other explanation for multitasking. How does it occur, it occurs because it has to occur. Does it make workers feel more dignified? No. PAs felt more frustration and stress as a result of multitasking everyday on the wards with limited staffing.

These routine moments of frontline psychiatric work at Mirage, and from what many PAs have said, at other hospitals, consist of interacting with patients in order to address their routine needs and wants. The wards are *labile*¹⁸. The wards can go from routine, to lackluster, to intense. All of these conditions or climates of the wards are impacted by the patients (the people) and the frontline PAs and nurses on the wards. I note that the patients are more important than the frontline workers in determining the stability of a ward. I talk about the type of patients in another chapter. However,

¹⁸Another Mirage Psychiatric term for patients who have mood swings from high to low, from passive to aggressive.

“normal” patients are generally routinely managed. Difficult patients make the work intense and really require competent staff and staffing ratios.

The Intense Moments

Field Notes

I walked on the ward to see Rafiq dragging the patient, a 57 white male who has dementia to his room. The man reeks of urine. The nurses are following Rafiq. The nurses are two older African American women in their 60s. One nurse brings the scissors and cuts the paper pants of this patient to discover that he has feces on him and will need to be cleaned. I join the crew after putting on gloves to hold this patient’s hands. This patient is highly aggressive and confused. He screams “Momma, Momma.” He tries to reach out and hit one of the nurses as we all four struggle to wipe his butt with towels and face cloths. The patient has been put on “unofficial 1:1”¹⁹ in order to discharge him to a nursing home. Reportedly nursing home will not take patients who are on 1:1 care. The patient is a huge man who is around 230lbs. He really requires a 2:1, two staffs to take care of him due to his non-compliance, aggressiveness, and confusion.

This particular moment was more stressful than usual. The patient was in immediate need of help because he was soiled. He was also a large patient, which posed a physical threat for all the staff attempting to help him. This note also highlights how frontline nurses and PA work together on the same frontlines to help when they are willing to do so. This field note also sheds light on the nature of emotional labor (Hochschild, 1983) in a psychiatric setting. Vallas, Finlay, and Wharton (2009) indicated

¹⁹A 1:1 is a patient who must be watched at all times by a PA or other worker due to them being a danger to self or others. One worker is assigned to shadow or follow this patient.

that police officers and social workers perform a different type of emotional labor than the one that Hochschild (1983) refers to in her study. Officers are expected to be stern emotionally and act as authority figures. Likewise, I found that PAs need to act unafraid in moments where they might normally be. This is the nature of this frontline work where the PA finds himself dealing with sex offenders, murders, and urbanized people who might be rather intimidating. Nonetheless, the remarkable aspect of the work of PAs is that they are able to push themselves and overcome annoying, mundane, or intense moments through sheer human will.

Field Notes

I have just entered the ward; put away my things and I hear “Auh... Auh... Auh,” in a loud tone. A lady is screaming and yelling. AuhAuh, Auhh. Her screams and yells are getting louder and louder. It is just two of us (psychiatric assistants) out on the floor (Samantha²⁰ and myself). The lady has just used both of her hands and nails to scratch her face to the point of bleeding. She is a white lady in early 50s and is MR (mentally retarded) or, to use the latest terminology, mentally challenged. “Oh my God” I say to myself. I am horrified by what I just witnessed. The nurse coming down the hall slowly into her room reaches her and says, “You’re ok.” This is Steve Glenn, a white male nurse in his late 20s to 30s. The lady is weeping, nervous, saying things that are difficult to make out, “Wee... wee...” I feel bad for her and at the same time concerned for my safety, because she could attack one of us out of fear. We urge the lady back into her room, “come on Diane,” we say. In the middle of this we are also watching other patients, making sure that they stay in their rooms. Some mental health patients can at times

²⁰A black female PA around 35 years of age.

intervene thinking they are helping the patient (or causing problems for you). We hear more yelling... AuhAuhAun. Another nurse, Lana²¹ says, "Call an emergency code." Samantha, who is irate that a code has not already occurred, responds, "When are you going to call it." Nurse, Lana responds, "I am calling it now." Although the charge nurse is "in charge," Mirage lets us know that anyone can call a code. I run down the hallway open up the door of the nurses' station, grab the phone, dial the emergency number for the hospital 1111, and tell the opera, "code orange Adult 5." Seconds later, I hear the announcement over the loudspeaker, "Code orange!, Ward 5!, Code Orange! Ward 5!" I say out loud to myself, "the main thing is that we need everybody in their rooms."

"Everybody in their rooms, we need everybody in their rooms" I say as I walk back down the hallway toward the room of the irate mentally challenged patient. Some patients are peeking out of the rooms to see what is going on. I redirect them by saying "All the way in your room please." "In your rooms" Stephanie says. "You're ok" I tell Diane (patient), "What?" she says. I repeat "You're ok" making eye contact with her. She seems to slightly understand, but I am not sure. "Diane," why are you angry? Why are you hitting yourself? She says "what, what?" She is standing in the hallway now, looking at the workers who have responded to the code. The charge nurse Lana, tries to intervene and reason with Diane. Diane starts to yelling and screaming again. "Maawama, Maawama," she yells. Two PAs grab Diane and walk her in her room and place her on her stomach in preparation for a shot. "Relax Diane, you are ok," I say. We hold down Diane while Lana gives the shot. "Ok Diane, ok Diane, all done," Lana says. Lana, addressing the

²¹The charge nurse on the shift at the time. She is a black middle age woman who had been working at Mirage around 5 months.

nursing supervisor for the shift (Serge, middle age, white female who usually dresses in a blazer and slacks), she hit John, and [she hit] me in the breast. You ok? Serge asks. “I’m fine,” Lana responds. “Auh,” Diane says, “You’re ok Diane,” Lana says. We are holding Diane while the nursing supervisor Serge is preparing the peroxide to clean Diane’s bloody hands. Serge says, “We’ll just going to clean you up with some peroxide. “It’s just peroxide, it’s not going to sting, it’s not going to hurt.” As Serge applies the peroxide she says, “Does that hurt?” “Hurt?” “It does not sting, it’s just cold,” Serge says. “Cold,” Diane says, “You’re going to be ok,” Serge tries to reassure Diane. We are still holding Diane down. “What time was the hold about?” one of the nurses asks. “About 5 minutes” “Dadop, dadop,” Diane says. Lana responds. “Is she coming from the group home?” I muster enough courage to ask the nurses [asking nurses questions sometimes is viewed as a challenge to their authority or overstepping one’s job position as a PA]. “Yeah, group home” Lana and Steve Glenn reply. “Last night,” Steve Glenn²² responds. “If we had someone who knew how to communicate with her that would help, we can barely understand what she is saying. “Yeah,” Serge says. Diane has calmed down. She is making softer sounds. “Come on Diane, sit up.” It’s ok.” We need Diane to sit up in order to clean the blood from her face. We have just finished cleaning the hands. “Can I clean your face Diane?” Serge asks. “Face?” Diane responds. Serge examining Diane’s face says, “That’s raw.” Lana responds, “She came in like that.” Serge, although she was aware of the condition of Diane, she came with scars on her face, MR, irate, she says, “I better call Kuzak back, I cancelled him. Serge realizes that Diane will need a 1 to 1.”

²²Steve Glenn, white male in his late 20s to early 30s. (He did not stay at Mirage very long; he left about four months ago, 3-13-2012).

Kuzak is a PA on 2 West.” I am thinking to myself, he was cancelled, and we are dealing with all of these traumas. Indeed this was very traumatic to watch. A hysterical patient yelling incomprehensible things while scratching skin off her face until it was bleeding.

This note shows how frontline work can be stressful and emotionally difficult at times. The mentally challenged patient Diane scratching her skin off shocked me and was difficult to witness. However, frontline nurses and PAs came together to assist Diane in her trauma. This note also highlights how PAs might take the lead in calling an emergency code for help. Samantha does not just wait on the nurse to call the emergency code; she takes charge in demanding that one be called. Although charge nurses are in charge, at times PAs are in the lead of controlling situations on the ward. Clear lines of industrial bureaucracy (Grint, 2005) can be overthrown in this sense. The order of command at times between the charge nurse and PA changed based on the type of PA (assertive versus non-assertive) and nurse (newly employed at MPH versus not newly employed).

Me: You want eat, you want attend groups. You do not want to me here. I can see why your mother sent you here. I am very frustrated with this patient who is on the 1 to 1 and will not sit still, and he focuses only on being discharged. He is a huge, 6’0” 289lbs mentally challenged young black male. I am 5’ 7” 168lbs.

Patient: mumbles, you are going to threaten me?

Me: No, I did not threatening you. I am telling you why your mother sends you here.

Field Notes

The patient’s eyes are barely open, and before I can finish lecturing him, he walks back down the hallway toward the nurse’s station. He does this repeatedly and is prone to touch others and become physically aggressive. I must follow him and keep trying

to convince him to behave. This is also called re-directing in Mirage Psychiatric terminology.

The non-compliant patient, difficult to communicate with, is the difficult patient for the PA. In the above note, I am struggling to get the patient to comply with my verbal directions. This work is frustrating. Chambliss (1996) found that frontline medical nurses experienced a similar, but different type of frustration with non-compliant medical patients on medical wards.

Field Notes

June 7, My Birth Day at Work. I was cancelled yesterday. Maybe this was to my advantage because today was an understaffed and busy shift. It hurts even more when the staff who one is working with, are not totally regulars. I worked with Corletta Lewis²³ and Ray Rogers.²⁴ I had a feeling today would be kind of rough when I saw the patient population. One patient, who has been coming back and forth to the hospital since she was an adolescent girl, is on the ward. This patient, who I will call Posey, is mentally challenged. She is loud, impulsive like a three year old, and hyper. Her hand now shakes from all of the heavy psychotropic medication she has taken to control her behavior. It is a shame and I and Corletta discuss this amongst us in the day room. I want to feel sad, but this is interrupted by Posey's behavior. She is difficult to deal with. She starts licking a dayroom table she is sitting at trying to get up some water she has spilled. She grabs Gatorade and spills it all over the place. She pees a huge puddle of urine in her room and says it was an accident. She throws sugar at a patient who demands that we make her

²³(Carlotta Lewis) (LPN), black female in her mid to late 60s but has youthful personality. She has worked at Mirage for more than 20 years. I interviewed her.

²⁴A black male PA in his middle thirties; he is a part-time worker.

clean up. She screams in Corletta's face "you don't tell me what to do!" She is difficult to manage. Managing patients is our jobs. If we do not at least attempt to manage patients then other patients will get upset. "Why aren't you making her do this or that?" If we do not manage patients, then nurses will get upset. In the middle of dealing with these mental health patients, we got three admissions. The charge nurse had two discharges, three admissions, and had to pass meds (hospital terminology, meaning to give patients medication). One staff with the patients, the other staff doing the rounds, and nurse down the hall dealing with paperwork, phones, and patients who roam down there on their own or directed by PAs when we can't solve the patients' problems. It is a hard job working frontline in psychiatric care. Today was hard. But I said to myself out loud many times, "I am not going to complain, I am going to stay positive." I said this so that others could hear. I said it in a less not genuine manner. I wanted to complain, but I know that this is like it is at Mirage. The census of patients drops and the staffing jobs. Why does it happen I will never know. What happens to our patients from time to time? I can see that many do not want to be "locked up" as they say, but where do they go? Unfortunately the Posey of the world do not get better. Posey has been like this since she was a teen coming to Mirage, and maybe longer than that. She is an "adult" now. At least age wise. It is sad, but as I ask Carlotta, who has been working at Mirage for more than 20 years, "What should we do?" We do not want to over medicate a patient until they reach the "Tardive dyskinesia" phase that Carlotta said Posey had after many years of psychotropic medication to help sedate Posey, but what is the system supposed to do. Carlotta said that Posey never knew her real parents and was the "product of mental health patients I

think.” Carlotta also said that Posey’s foster mom had died and “she has a bleak future.”

It is sad, very sad to make one cry, but what is the solution?

The intense moments desperately point on the emotional labor or strain that PAs endure during the course of a shift. In this note, I do not have time to feel too sorry for Posey (who has been coming in and out of hospitals since she was a child) because I am too overwhelmed and consumed by my other frontline PA responsibilities. My work demands and my own emotional state make it difficult to feel. This state that I found myself in was result of prolong experiences of this sort at Mirage, and is confirmed by scholars of work as burnout or compassion fatigue (Pines, Aronson, and Kafry, 1981; Vallas, Finlay, and Wharton, 2009; Todaro-Franceschi, Vidette. 2013)

In addition to theories of burnout due to stressful prolong work conditions, human relations as source of support and dignity (2001) are worth noting. In the above field note, I attempt and succeed many times during the course of this shift to get moral support from Carlotta, and person I have known during the duration of my employment at Mirage. How do workers cope during intense moments in Mirage? I found that I gain the greatest support from my fellow co-workers that were in the trenches of frontline work with me. Diamond (1996) and Rapport (2009) showed how the workers not only showed them how to do frontline healthcare work, but also the importance of their work groups as sources of support (venting about work conditions, and identifying each other common work struggles due to their work positions). In addition, human relations have been found as more important than money in explaining workers’ job performance (Rose, 1988). Similarly, I found that human relations at Mirage were important to PAs accomplishing work in intense moments or difficult shifts. These are some of the intense/difficult

moments that are a part of frontline psychiatric work. You try to service patients who might be self-harming, violent, or difficult to control. You also might be working with difficult staffs who do not respect your expertise or your turf in the hospital. These moments make the job of frontline work very difficult and somewhat irritating and intolerable. Some moments are lackluster in nature. These moments are personally difficult because they slow time down. These times make the day go by slow.

The Lackluster Moments

Field Notes

I am sitting in the dayroom with only a few patients. The nurse is 30 yards down the hallway sitting at the nurse's station. One male patient, a white male patient in his late 40s, is sitting at another table in the day room staring without emotion at the TV. Another patient, a black male in his 50s, is sitting in the corner of the dayroom smiling looking at his fingers. The third patient, a 50 year old white woman, is making herself some coffee. The rest of the patients are in their rooms sleeping or laying down. It is 1:35pm. I have one and half hours left. I am not content just sitting here waiting for the clock to move. It is a slow day.

There are many small moments where the ward is calm and the patients are under control. This might sound good, but it is always that way to workers. The PA frontline work consists of following the protocol set up by administration. The PA is in charge of implementing the program of the wards which slightly differ.

The Protocol of Work on the Wards

I asked PAs to describe their work in the formal interviews. Many of them started with a protocol of their work schedule. The protocol consists of entering the hallway to

get *the report* first. The PA then proceeds to start the “dirty work.” PAs start picking up towels, checking bathrooms, walking the halls with the rounds book, *doing the rounds*, opening the dayroom, interacting with patients (intense or routine), doing groups, making phone calls, opening bathroom doors, charting, and in general servicing patients, nurses, administrators, visitors, etc. The work of a frontline PA (Psychiatric Assistant) and nurse is a jack of all trades type of work on the wards. I will describe some of the main work in detail below.

The Report

The report is a process by which important or routine information is passed from the leaving shift (or preceding shift) of workers to the oncoming shift (proceeding shift) of workers. What Mirage emphasizes is that this report is necessary for the safety and continuity of care of patients. PAs and nurses give separate reports to their respective work groups: PAs to PAs, and nurses to nurses. Reports typically occur when all proceeding workers have shown up, typically this is around 10 minutes after the shift has started. If a PA is not there, preceding PAs might start the report without him/her. One preceding shift PA²⁵ is responsible for giving the report to all of the proceeding PAs. The PA holding the rounds book last is the PA responsible for giving the report. Typically this is a walking report for PAs, although it could be done sitting or standing around the nurse’s station. While walking and holding the rounds²⁶, the preceding PA allows proceeding PAs to look at each patient’s picture. He/she gives information concerning the patient’s behavior during the proceed shift. The preceding PA highlights if the patient

²⁵Typically each shift has 2 to maybe 3 PAs. The other PAs might stay in the dayroom with the patients and tend to their needs while the one PA giving the report walks the halls with the proceeding PAs.

²⁶This process is documented in a separate writing.

was a problem especially on the shift. The preceding PA tells the group of PAs if any patient is set to be discharged from the hospital, or has any serious issues. Usually the preceding PA will especially alert proceeding PAs about any patients who are HIV positive or Hepatitis C infected, because these are serious diseases that no worker wants to contract.

Report qualities vary in length and quality depending on how the preceding shift went, and on the energy and ability of the worker giving the report. All proceeding PAs are expected to listen to the report. Sometimes this does not happen if a PA is late or feels they do not need to hear the report because they have been regularly working the ward, this is especially true if there have been no new admissions and patients are the same. Typically, patient behaviors tend to remain the same. If a patient is classified as agitated, depressed, isolative, manic, manipulative, cunning, etc., this will remain the same throughout their stay in the hospital.

Nurses typically give their reports behind closed doors or nurses' stations. Nurses and PAs used to get their report together from the preceding nurse, this process stopped over four years ago. Now, nurses give each other reports. The charge nurse, and not the medication nurse, is the nurse who gives the report to all proceeding nurses. The nurses' report emphasizes more of the medical and medication issues of the patient. Nurses' report seems to take a lot longer than the PA reports. This is one reason why PAs often times negotiate who will start doing what on the ward. PAs take around 10 to 15 minutes to give and receive report. However, nurses on the other hand take 25 to 35 minutes for report. This creates more problems for PAs because patients usually are already

requesting something from the nurse (usually medication) even though the nurse has not finished with her report or set up medication to be dispensed to patients.

This is the general way the report is done. The report's purpose is share information (important or routine) about patients' behaviors, and to give any other important information about the ward. Typically, a lot more happens during the report, workers make jokes, spread gossip, express disdain for the hospital or patients, console one another, and generally bond with each other. This could be one reason why the nurse's report takes so long behind closed doors.

Charting consists of writing a note of the patient's behavior, the staff's intervention, the patient's response to this intervention, and the expected plan for the patient. The charting on the patient is connected to how the hospital bills and is thus paid. Hence, charting is a very important activity for the hospital. The bulk of the charting comes from PAs who must document something on the patient each shift. Typically, PAs are given five to six charts to do each shift. Charting occurs no matter what. Even if the ward is chaotic, a worker has not had their break, the ward is understaffed, etc., charting must occur.

A typical chart would begin by stating the general reason why the patient is hospitalized, something like Harm to Self/Others. Up under this general heading would be the behavior of the patient. For example, "Patient was agitated, restless, and failed to eat his breakfast." Next, the PA would write what he/she did to address this negative behavior. He would write, "PA encouraged patient to take his medication, use his coping skills, and eat." Next, the PA would write the outcome of this intervention. For example, "Patient was able to use coping skills and take medication that allowed him to calm

down.” And finally the PA would write about the plan for action of the patient. For instance, “Patient should continue to use coping skills and talk to staff about his problems.”

Charting is customarily done at least midway through the shift and workers are encouraged to write an addendum note if anything new and significant happens. The reality is not patients tend to exhibit the same behavior. A PA would blind write the progress note if he wanted. Mirage is terribly wrong with the state of most mental health patients, especially the chronically ill patients who seem to have lost the inspiration for real change. Charting is viewed as a mundane thing which is simply mandated by the hospital for its purposes (which does not necessarily involve the animate object of care, the patient). A significant part of the PA and frontline work is physical. There is a lot of walking in the work. For this reason I now turn toward completing the description of PA and frontline work at Mirage by describing the physical process of the work.

Let's Get Physical

Being a PA requires a lot of physical work. They open doors, walking up and down long hallways, holding and restraining “out of control patients,” handing out trays, get coolers of water, walk up and down long stairs for various needs of the hospital and nurses, and they talk, and talk, and talk to the “needy” or mentally challenged patients who often fail to cognitive understand rules, policies, information related to their discharges, or directives by staff. PAs work not necessarily with our minds alone, but with our bodies. However, do not confuse this statement to mean that there is no mental work involved in being a PA, there is.

Being Mentally Alert to Know When Things are Getting Out of Control

PAs, similar to security guards or correctional officers in prisons, must be mentally sharp to deal with patients that are often times physically aggressive. PAs must be on constant mental alertness when they watch patients down long halls in Mirage, and when patients interact with each other. The safety of the patient is the number one objective of any psychiatric hospital and frontline worker

The Physical Work

By far, the most physically exhausting work today for PAs at Mirage involves “doing the rounds,” opening bathroom doors, and getting supplies for patients. This was not always the case, but certainly is true today. Many PAs have internalized these physical activities as meaning they are “just bodies” and nothing more. However, walking down long hallways to open up someone’s restroom is priceless to them and to the cleanliness of the ward (some patients will urinate or defecate in their rooms if they bathroom door is locked). The bathroom doors are justifiable locked due to patients using them to shield eyes from inappropriate behaviors such as smoking, having sex, using drugs, or hurting self. Bathrooms are hiding points for some patients. PAs often times have to stop whatever they are going, usually heading toward the opposite direction during rounds, charts, or supplies, and head in the opposite direction to open bathroom doors. The opening of bathroom doors never stops during the course of a shift on the wards, especially on the adult wards. Patients, perhaps due to their medications, medical issues, or just plain boredom, will ask “could you open up my bathroom on average of at least 12 times a shift. Now, must staff might go to the bathroom two to three times a shift. Opening the bathroom doors also goes beyond the physical walking to the turning

of hard metal locks which often hurt your fingers. Each time a PA turns the bathroom door lock, or nurse's station's door to get supplies, he/she feels it on their hands and fingers. These physical acts are continuous throughout the shift.

Servicing the Needs of Patients

In addition to the requests to use the bathroom, patients often ask for hygiene related supplies, books, journals, socks, pants, etc. The PA is the one expected to hold off on doing the rounds, and get these supplies, although the supplies are located behind nursing stations where nurses are physically sitting. The nurses are bombarded by paper work and other issues concerning the patient (e.g., discharges, admissions, communicating with doctors and other nurses), so they often feel overwhelmed. PAs must walk down hallways to make coffee, get refreshments, and sometimes meal trays because the cafeteria workers are not available to do it themselves. A PA must hand out trays and make phone calls for patients as well. These are all largely physical tasks not requiring a high level of thought or education.

Doing the Rounds

The number one physical act that the PA must perform is the rounds. The process of doing the rounds is physically holding a three ring binder with the pictures and coding documents inside that code for the patient whereabouts and his/her behavior. The PA, or whoever is holding the rounds book, is supposed to locate each patient visually every 15 minutes. The documentation within the rounds book must reflect what the PA has seen of the patient. Because many patients move around the ward, it makes keeping up with moving targets every 15 minutes quite difficult at times; the more the patients, the harder the task. The restless and active the patient is, the harder the task. There is usually one

PA assigned to “do the rounds” every two hours. The PA assigned the rounds book or holding the rounds book is the one responsible for the busy hallway work. The PA holding the rounds opens bathroom doors, gets supplies from behind nursing stations (position far from where most patients are located in dayrooms), answers phone calls, and at times is bombarded by patients who simply want to talk. The PA holding the rounds book, one could say the hallway guard, is responsible also for keeping patients away from nursing stations because nurses are busy with paperwork at Mirage. The hallway PA is supposed to “redirect patients” or as some nurses demand, “get this patient away from the nurse’s station.

Usually, Mirage allows only a maximum of two PAs per eight hour shift. This means that one PA is responsible for doing the hallway work at least four hours a shift. That means four hours of walking around. I recall at times my feet aching and wondering what would be the toll of years of waking around on sore feet.

Physically Holding or Wrestling down a Patient

Although it happens less now at Mirage than it did in the past, holding patients down for shots or to calm them down is a part of PA physical work. When patients become out of control, they often need to have emergency medications called PRNs (as needed medication). Patients at times rarely willingly take their medications, so they need to be held down by PAs. PAs also put patients in restraints or simply holds to call them down as well. There were times when I held onto patients for close to hours. PAs must also lift heavy patients up off of floors to be removed from dayrooms or inappropriate places for patients to lie. Patients also needed to be lifted up to be changed or clothed.

This is especially true of the geriatric ward of the hospital. There is nothing technical about it; just physically holding on to a patient is what PAs have done.

Field Notes

It's 12:55. As I sit here head down wondering why do I feel emotionally drained? Why is it that I hate the patients? Two black male are walking up and down the hallway. One of them says, "What time is it?" I am sitting in the hallway watching the patient I just held and prevented from throwing a chair at the nurse. I am emotionally strained from grabbing her. I was on full alert standing up watching the female 1 to 1 patient when she was in the dayroom. My senses and energy level had to be on full alert, ready for anything. She is sleeping now.

The above field note shows how the work of a PA is a physical work, especially at traumatic moments. These traumatic comments can come at any time during the course of a shift.

The Role of Physical Power and Presence

As one of the PAs, David remarked, "size does matter." A PAs mere physical presence at times can do work on the wards. Many patients, far from being the stereotypical irrational, do respond differently to physical presences. Big PAs, and there are some big ones, command more respect from your more physically aggressive patients. Smaller PAs, as Jonathan remarked, "They figure they can try me" are often times viewed as less of a physical presence by patients. Gender often works in a similar way with female PAs less likely to engage in holds or to be sent as a physical presence (a show of PA numbers to patients) to quell certain volatile wards. Many times in the hospital PAs have been switched to different wards because "there is only one male staff

on the ward.” Even female PAs have pointed out that there is only “one male” on the ward. Indeed, size and masculinity do matter at Mirage for PAs.

Conclusion

In summary, PAs must walk back and forth down long hallways during the course of their shift. They must physical open hard to turn doors with their hands. They must physically walk around wards to continuous locate patients. They must service the needs of patients by walking various places to bring items to patients. This is a standard part of the job for PAs, and does not include running groups, talking to patients, and writing progress notes noting patients’ behaviors. PAs did not go to school for any of these physical activities. PAs have bachelor degrees in psychology, social work, sociology, teaching, medicine, economics, etc. Many of these physical acts were done my workers who had mere high school diplomas or nursing assistants. However, at Mirage, the PA is a jack of all physical trades on the ward. He/she is a hall monitor, janitorial worker, secretary, security guard, butler, and club-bouncer all in one. Psychiatric Assistants and frontline nurses do the mundane, routine, and intense psychiatric service work. This work by default deals with emotions; this work involves the emotions of the patients and the workers. It is ironic that the emotions of the patients are acknowledged, but the emotions caused by the structure of Mirage are not. Goffman’s (1961) work did not focus on emotional labor, or even specifically how the institution affected the emotions of the patients. Goffman’s (1961) focused on how total institutions were mortifying agents, and this analysis could potentially stand as a framework for understanding more details about patients’ emotions in such institutions. I have had the opportunity for more than 9 years to do emotional work. However this is not the same emotional work that Hochschild

(1983) talked about, although PAs do this work as well. I have been doing work that involves self-esteem and human value. I have had to become aware of and try to resist my own subordination and mortification. This forces some workers like Cermon to become angry, angry at Mirage, angry at the needy patient, angry at this perceived devaluing. This can only result in Mirage being just that, a mirage for the public to see, but in reality nothing more than mortifying place Goffman (1961) told us about years ago. The mortification though Goffman was not only on the patients, but the career of the attendants, orderlies, and PAs that spend years of their lives in such work place positions. The social processes involved in doing frontline psychiatric work involve using all of the PA skills to quell situations, watch patients for safety, meet patients' needs, and do the protocols laid down by Mirage (charting, groups, and doing rounds). The frontline emotional work of the PA involves servicing patients, administration, other workers, and others through masking their emotions of disgust and subordination. Over the long-term, I observed burnout in the faces and verbal expressions of PAs and frontline nurses. The work is accomplished because workers need jobs and will themselves to do it. I asked Jonathan, a black male PA how he continued to perform his work after four years of employment as a PA and indicated it was the combination of the job market and his need to provide for his family:

Jonathan: One major factor is me, but another factor would be...actually the job market. I have not been getting the calls back. I have been seeking employment. Actually, the main motivation to help keep Mirage is my family. If it were not for my family, I would drop Mirage. Dig deep into what I want to do, and what I know, which is to own my own business.²⁷

²⁷Quotation from interview with Jonathan.

CHAPTER SIX

WORKPLACE RELATIONS

HOW WORKPLACE RELATIONSHIPS AT MIRAGE AFFECT THE ATTITUDES
AND PRODUCTIVITY OF PAS AT MIRAGE

Introduction

The Hawthorne studies were a series of experiments conducted in the great depression era (late 1920s and 1930s) originally designed to study how work could be improved in terms of worker fatigue, monotony, and discomfort. However, the focus of the studies shifted to feelings of workers about their work and their relationships between themselves and their supervisors (Thompson, 1983; Hodson, 2001; Vallas, Finlay, and Wharton, 2009). The Hawthorne studies confirmed the importance that relationships have in the workplace. This further highlights the importance of using ethnography, which focuses on the day to day interactions in life, as a tool to learn about workplace environments. The human relations paradigm, most closely associated with Elton Mayo and the Hawthorne studies, indicated, in contradiction with Taylorism, that workers' social needs were the most important factor in motivating them to work. Given the importance in examining how workplace relations impact work, it is important to understand how they affected frontline work at Mirage Psychiatric Hospital. The question that this chapter answers is: How does work-place relationships at Mirage affect the attitudes and productivity of PAs (and other workers that come into contact with PAs) at Mirage?

Workplace Relations at Mirage

Who you work with, means everything to frontline workers at Mirage. This would certainly be true if PAs were on the real frontlines of war. I have often told Kuzak¹ and before him Rafiq,² that I would work with any population or any shift if I knew they were working with me. This is because I know, like, and trust them as human beings and as workers. Moreover, as Hodson (2001) found, coworker relations give workers dignity. He states, “Coworker relations are fundamental to the “social climate” at the workplace, which is often as important to the daily experience of work as are relations with management” (Moos, 1986, p. 47).

Typically this closeness happens as a result of working together and liking each other as workers. PAs and frontline nurses work together. That does not always mean that they get along or even like each other (within these groups and without). Nonetheless, their workplace relationship is a necessity.

Heather³ talks about her interaction with a nurse who is hesitant to respond to her needs as a PA:

Yeah it's more, it's all the consistency between you might see something in a patient and ask the nurse to check it out they'll be like, you know you really got to push them to come and check it out. Like, I don't know if it is a medical emergency that's why you (voice is animated) are here (laughs) (meaning the

¹Kuzak Shan, Indian male is 58 years old. He has been working at Mirage for almost 10 years (Dec 2002). He used to be a medical doctor in his native Indian country. He is a cordial man and generally follows the rules and does not argue with administrators. He was chosen as an employee of the month. He started working as a PA when he failed to pass his board examination. There have been more than a few workers from various Indian countries like him who were medical doctors in their countries but could not get their licenses in this country.

²Rafiq is a 52 year old South Asian male. He is former doctor in his country, used to be regular on adult ward when I started. He started at Mirage when he was 40 years old. He said, “I never thought I would not get my license.” He said to me on 11-10-12 Saturday I am depressed mostly because of the type of work I do. His elder son is in medical school. His younger son is in college.

³Heather is a white female, former PA, in her late 30s. No longer works at Mirage since five months ago (July or so 2012).

nurse) (slight chuckle) that's why I am telling you (voice is animated), cause our job is to report to the nurse and then you want them to do something.⁴

Heather is frustrated with the lack of response by the frontline nurse. However, what Heather did not realize then, and she does today because she is a nurse⁵, nurses are overwhelm with paperwork. Nonetheless, this slow reaction from the nurse in charge creates a tension between the PA and the nurse, and makes the PA feel not respected by her co-worker. However, in order to have the patient's needs met (which in this case might be medication), the nurse and the PA must communicate, hence, they must have some sort of relationship in order for the frontline work to get done. I have had countless similar interactions with nurses over my years at Mirage. I document one such incident here that highlights workplace relations at Mirage and how that impacts work.

Field Notes

Yolanda, the other person I am working with, is an Asian lady in her early to mid-40s I would assume. She is the charge nurse this morning. I do not particularly like the way she responds to me when I inform of what is going on with patients or in general. She acts like she is overwhelm and hates to respond. After a psychotic patient who is 6' 3" 340lbs has explained to me that "God and Satan" will punish me, I report this to Yolanda, the charge/medication nurse. "Roland is very psychotic, he is saying strange things." She is preparing the meds and barely raises her head to say to me, "I, Is that news to you?" "No, it's not" I reply, but her response irks me, and I continue "I am just reporting, stop over reacting Yolanda." "Yolanda explains, "I heard him." "No, every

⁴Quotation from interview with Heather.

⁵Through my analysis of the work of PAs and nurses, I learned that PAs and nurses have different work agendas and perspectives about accomplishing the same frontline work on the same wards. Hence, it is a matter of workplace perspective which creates the tension that sometimes exists between PAs and frontline nurses on the wards.

time I talk with you have this funny reaction, I am not out to get you,” I explain. She replies, “I have nothing against you either, I heard you.”

Many times nurses are frustrated, PAs are frustrated and overwhelmed with patients who are difficult to manage or remain psychotic in spite of all the medication they are given. These types of psychotic patients present as potential dangers at all times because no one ever knows if they will act out the psychotic thoughts they continuously display. Because our workplace relationship is not very good, I was told by an informant that Yolanda did not like me, it makes our communication tense, and our work place experience less desirable (Hodson, 2001).

The conflict in this interaction is also rooted in this problem of professional hierarchy, because PAs (being nonprofessionals) are supposed to report behaviors to nurses (more so professionals) (Vallas, Finlay, and Wharton, 2009; Weitz, 2013) in order for nurses to give medications, call doctors, or come up with plans for dealing with potentially dangerous patients. If no preventive measures were documented, the PA and nurse could be easily blamed as to why they did not attempt to recognize problems with patients and use some type of intervention. Had I not mentioned anything about this patient’s behavior to the charge nurse, I might have been asked why I did not. Therefore, although Yolanda says, “I heard him,” I was in the right to report it because I cannot assume that she did hear the patient rambling on and becoming accusatory.

Field Notes

For the remainder of the shift, I would try to have as little interaction with Yolanda as possible. Certainly I would not open up any personal conversations with her. This is why PAs and other staff take a keen interest with who they are working with on

the various units. It matters to staff, worker cohesion. Now, what this interaction does not tell the reader is the context. Yolanda is acting not only as the charge nurse (nurse who deals primarily with the paper work, she is also acting as the medication nurse). She is already stressed out because she has to do both jobs which are the result of company staffing ratios. The ratio calls for 1 frontline staff to 4 patients. On that particular day, we had 13 patients (three staff). We were three patients short of getting another staff. This additional staff could have been another nurse who would have helped the single nurse on the ward today. Nonetheless, I or Yolanda, were not willing to put for any extra work together to ensure that the work was done in a supremely excellent manner, we were simply going to do the minimum that our job demanded to accomplish our work. I have seen these workplace dynamics countless amounts of times influence the running of the wards. Nurses and workers also spoke about workplace relations in their interviews confirming that they do matter in shaping frontline work experiences at Mirage.

Workplace relations, if not positive, can even get a PA fired. I had one particular incident with a nurse that got me into trouble⁶. I show in this field note below:

Field Notes

Right after punching in at the time clock, I was summoned by the DON (The Director of Nursing) (Stacey – Dark skinned African American Women in her middle to late 40s who wears business dresses and has short hair), “Terrence, can I speak with you,” she said. Right then, one of an employee’s “worst nightmares” came true. As I waited for Stacey to come out of the Nursing office (book bag, polo uniform shirt, and

⁶I would eventually resolve this issue with this particular nurse. She is one of the nurses I interviewed.

lunch bag in hand), I noticed that the human resources director was in the nursing office with Stacey (I knew this had to be serious). He, Ronald, opened the door to his human resources office (leading the way without saying hi or anything, the “silence before the slaughter.”) where the three of us set down. Stacey and Ronald looking seriously at me, Stacey asks, “There was an incident that happened on Friday...No, Sunday involving you and the nurse” “Tell me what happened.” As I am trying to compose myself and think, I ask Stacey, “Specifically what do you mean?” What do you want to know? Stacey indicates that I refused to do an assignment. I explain that I never refused to do the assignment, but I “questioned the assignment.” I proceed to explain that I was with a difficult 1:1 autistic patient (Stacey interrupts to say that there are three autistic patients on the ward now) and was given the first round with him and the last walking rounds, which is very difficult. I explained that despite the fact that I was not pleased with the assignment, “I did my job professionally.” I explained that other PAs got their pick of assignments and left me with the worst one. Stacey proceeds to explain that the “entire team” wrote me up and that is “what concerns me.” I am very shocked that the entire team, PAs included would write me up. I explain that “No one ever came to me.” The argument that I had with the nurse lasted a minute or two ended and I carried out my assignment without incident. Stacey explains that it was indicated that I was very disruptive in the milieu. This is something that is not tolerated, but it happens on occasion. Administration wants workers not to “talk in the front of the patients,” or show any real emotion. I explained that the “nurse was working a double and seemed frustrated.” I explain that “she asked the other workers what they wanted to do, and gave me what was left over to do.” I indicated that the nurse said I needed to be more

“assertive” on an autistic patient who has slept for two days, and that “asked for medication for this patient. The medication did not come until 6 pm, when another PA was assigned to him. Stacey never acknowledges the difficult situation that we were in. We were short-staffed, the nurse was on the phone trying to get more help, and I was working with a difficult autistic patient who was psychotic and anxious. Stacey says, “You can go to the nursing supervisor.” I respond by saying that “I normally try to handle things internally.” I indicate that this was “a mistake on my part.” “However, I was not disruptive, no patients were around, and no one was affected by my conversation with the nurse.” Stacey says Ronald, looking at him, as I now turn to look at him, “do you have anything to add?” Ronald proceeds to back this statement up saying that he has heard others complain about me. I ask him specifically what the complaints are, because I have “never been written up before.” Ronald says, “You are not team player.” I am flabbergasted, and I say “Wow!” “There are a lot of things that I see, I tell them that I do not run down and tell you about, perhaps I should be doing this,” I state. Ronald says that my demeanor and tone are good in this meeting and says, “I wonder if you come across differently on the wards?” I agree to rectify my behavior and just “Do what the assignment says without questioning it.” In my mind, I know what is at stake, my dissertation, my career interests, and my livelihood. Ronald says, “Remember this is confidential” so “we do not want you to talk with others or confront others.” I make a silent vow to change how I carry myself at work, to not question assignments or speak out about any issues publically. Stacey says, “Could you give us a few minutes and wait outside.” I attempt to pick up my bags, she says, “You can leave them here.” I sit right outside the office not sure what is going to happen. Ronald prints something out and

opens the door to go and pick it up. He returns and closes the door to his office while he and Stacey continue their discussion. Stacy opens the door and summons me in. I sit next to Ronald who is now sitting beside me. Stacey says I will read it, and proceeds to read the document indicated that I was insubordinate (by refusing the assignment) and disruptive throughout the entire shift. The document says that if another incident happens, it could result in termination. I reiterate, "I never refused the assignment, just questioned it." Stacey says, you can write your comments in the space provided. "There is no gradual process?" (Where one is issued a warning, then written up, then suspended, then fired), I ask. "No," responds Ronald. Stacey indicates that it is almost "four o' clock any way," so we'll send you home." "Do I talk with the staffing coordinator to take me off the schedule?" I asked. "No, we'll do it." As I take the paper, read it, and write my comments, Stacey and Ronald joke that "The doctor got involved in a code green," laughing, "We need get more doctors like this." After I sign it, Stacey says, "When is your next day," I say, "Friday." She says we will see you on Friday and you have to meet with one of the behavior specialists for personal development. Despite the fact that I have never been written up before, I was suspended for this day, Wednesday May 13, 2009. I felt horrible. I did not know if I was going to get fired. I have a mandatory employee performance training to complete. If I am written up again, I might result in termination. I am shocked that the "entire team wrote me up." I wonder who did it. No one ever spoke to me and tried to resolve the situation with me. I feel betrayed by the entire team. However, the team was not the normal team. I was working with a nurse who I have known for a while but not really worked with (the nurse was working a double and frustrated), a PA who had been moved (floated) from the boys ward to the adult ward, a

new medication nurse, an orientate nurse, and two regular PAs, Denise and Dupree. I question if Dupree was “in on it.” I do not think that Denise would do it. However, Dupree is quiet, he said during the shift that he supports his nurse, and has at times mocked me in terms of my education. There is a perception that I am the” smart one.” Ray is another PA who I question if he was a part of writing me up. I have to be careful now, because if I am going to complete this, I cannot be fired. I want to be mindful of who are my enemies; I want to bring them close. I want to be aware of who are my friends; I want to use them as allies and informants. I make a mental note to attempt to “get to know the nursing administrators a little better, and to be more strategic in my dealings with others in this organization.

This detailed long fieldnote highlights how PAs and nurses can come together against other PAs or nurses. It also shows the whimsical nature of frontline work at Mirage. For example, the charge nurse gave the other workers that picks of assignments and I was left with short-end of the stick, the worse assignment. Workplace relations shape work experiences, and impact dignity and respect (Hodson, 2001). Maybe she gave the other workers the first pick because she associated and joked with the PAs more than she did with me. I attempted to stand up for my dignity but it ultimately backfired. Also, this shows that nurses’ words are taken more seriously than are PAs. The note also shows how PAs are not united in their stand with other PAs. This could have happened to any of the other PAs, instead of supporting me, they went against me. From that moment on, I never forcefully questioned an assignment made by a charge nurse. If charge nurses know you, like you, and are not intimidated by other PAs, they generally will give you the better assignment. I had the opportunity to speak with Nurse who wrote me up over

the incident, and she indicated that “I was stress out at that time, and just did not want to hear it.” Later she would say, ‘it is hard to realize how we are divided on the wards by those downstairs [in administration do to their staffing patterns].

How Workplace Relations impact Frontline Psychiatric Work:

Attitudes and Production

PAs and nurses voiced their dislike of floating mainly as a lack of competence on different wards. However, when asked about the role of their core staff, most acknowledged the importance of “my team” in doing rounds and achieving their socialized objective, keeping patients safe. Diamond (1992) and Rapport (2009) showed how negative brushes with fellow nursing aids and porters respectively influenced their emotional state. Rapport (2009) showed how one porter never stopped teasing and given him a hard time throughout the duration of his time working as a porter. Diamond (1992) also talked about a nursing aid that disliked him for being nursing aid. The fact that there can be workers who simply might not like other workers is not groundbreaking, but how it impacts frontline workers from an emotional standpoint is interesting, and we know so little about it. However, what we do know, and what I felt and observed, is that negative or positive workplace relations do impact the production of work and worker emotions. Hochschild (1983) illuminated the impact of service work on workers behavior coining the term emotional labor to describe the forced emotions that workers display to customers. However, I found that there is an under-researched form of emotional of labor that occurred not due to forced smiles, but due to poor workplace relations. I concurred with many other workers do find that what impacted me emotionally the worse was having a bad day with my fellow co-worker or administration, not with the patients. This

is ironic because many might guess that after being yelled at, curse out, or attacked by patients, this would be more-likely to spill over into one's work life. Some indicated that their co-workers were the main reasons why they did not want to leave Mirage Hospital. I asked Kuzak what he would do if I or David did not work at MPH. He said, "I would not work at Mirage anymore." Working with people who workers know and like meant that work would run smoother for PAs and nurses because they would know that the work would be shared and not need to be articulated. Assumptions about who takes patients down to the cafeteria, who makes the coffee, who talks to the young patients, who does the groups are not always stated but mostly implied. When workplace relations at Mirage are positive, work runs more smoothly, and workers work harder and are less stressed out. However, when workers do not particularly like one another, you can sense the difference in productivity and worker stress level. I take note of this doing one work day at Mirage in a field note. I note the positive human relations that I have with my two regular co-workers on Ward-5 in this note:

Field Notes

David and I have been working together on the morning shift for about two years and knowing each other for about nine years since we both have been employed at Mirage. Because we have been working with each other for a significant amount of time, we have built a working relationship where we reasonably know what to expect from one another. I know that he typically does the "dirty work," and he does not mind, and describes himself as "hyper." He feels that the housekeeping must be done. He said one

time, “Sam⁷ has to clean 3 wards. They⁸ work hard for minimum wage. So I try to help them when I can.” The cleanliness of the dayroom (especially the dayroom), water and Gatorade coolers, and patients’ garbage and towels inside their rooms must be taken care of by PAs. Usually, before I arrive on the ward, David or Kuzak⁹ have already started to make the coffee and gather the coolers for the water and Gatorade. In David’s case, he typically will start straightening up the dayroom as well. Today is no exception; David has already started the coffee and carried the twenty-pound coolers to the front of the hallway. After listening to the report, David says to me, “I have already started with the other stuff, so you start off with the rounds.” This is all David and Kuzak have to say to me. I already know that this is a part of their routine and the ward’s routine. This stuff, especially getting water and Gatorade, is not a part of the job description, nor was it mentioned in training when we first started working at Mirage. However, it is now a “commonsense” expectation of the ward, at least by us (regular PAs). The general philosophy behind this is that the ward should be as clean as possible, remember the expression “Cleanliness is next to Godliness;” and that patients should be serviced at the minimum with something to drink (coffee, water, and Gatorade). The cleanliness is for all in the hospital. Administrators like to visit wards knowing that there is an appearance of cleanliness, cleanliness might represent order, and it certainly something that corporate administrators demand. Many workers feel disgusted or irritated by filth, and many

⁷Sam is a European immigrant housekeeper. She is the regular housekeeper on Ward 5.

⁸All of the housekeepers are white European immigrants who speak very broken English.

⁹Kuzak Shan, Indian male in his early to mid-50s. He used to be a medical doctor in his native Indian country. He is a cordial man and generally follows the rules and does not argue with administrators. He was chosen as an employee of the month. He started working as a PA when he failed to pass his board examination. There have been more than a few workers from various Indian countries like him who were medical doctors in their countries but could not get their licenses in this country.

patients will voice their discomfort and distaste for the mess that their fellow patients typically create. Many times patients will clean after other patients by wiping tables, picking up trash, cleaning up spills, and even washing down trash cans. This is not a job that I particularly like, and when I first started working at Mirage, I felt it was not a part of my job description. However, a lot has changed over the years concerning my attitude toward this work. First, it is indeed needed at times. The housekeeper simply cannot be summoned every time is a spill. Second, administrators have not so subtly suggested that the expectation is that the wards be clean. About two years ago, Mirage made all workers agreed to pick up any trash they might see on the floor throughout the hospital, and to speak to all workers or non-workers they might see throughout the building. Both mandates have failed. Workers, especially administrators do not speak directly speak to workers by their names, or even make eye contact. Communication is still generally with a work-class-race structure. PAs typically socialize and speak with other PAs. The same can be said about social workers, therapists, administrators, nurses, and other groups of workers.

The third thing that has changed is that the group I work with, David and Kuzak, heavily emphasize keeping the ward relatively clean of towels on the floor, food in the dayroom, and tables clean and clear. David, speaking one day to me about this said, “You are doing a good job. I don’t want you to take this the wrong way. This is sort of a constructive criticism, but we need to make sure the dayroom is clean. Just throw away the garbage in the trays [he demonstrates for me in the day room grabbing trays and pushing in chairs under tables].” Three or two years ago, I probably would have said to David that this is not our job as PAs. We are here to keep the patients safe. However

today, I understand his reasoning and do not want to create a work relationship based on animosity. I want peace. I want to “do my eight hours and get out of here” with less friction as possible. The tough part at times about being a PA, as the Hawthorne experiments discovered forty years ago, is work relations. If you are working with a PA and a nurse that you can get along with, this is half the battle. The other half is the physical and emotional nature of the job of a PA.

The Hawthorne studies concluded that workers have a positive influence on work productivity (Hodson, 2001; Vallas, Finlay, and Wharton, 2009; Volti, 2012). Clearly from this field note, I have grown to appreciate the “dirty” work in which David and Kuzak emphasize, this was not always the case. I grew to appreciate this work from it being emphasized by both workers, especially David. My value in my being a regular shift worker with David and Kuzak was reflected in my willingness to confide to their way of doing things. This finding confirms the findings of the importance of workplace relations as first discovered by Hawthorne studies (Vallas, Finlay, Wharton, 2009). As I started to pick up more of their identity as workers, our relationship improved, especially with David.

None the less, David or Kuzak do not like all PAs. I note this interaction between David and James Williams.¹⁰

¹⁰James Williams is black male in his mi- 30s. I tried two times to interview him, and he failed to show up. He was commonly referred to as a difficult PA to work with on the wards.

Working with Difficult PAs

Field Notes

David was visibly upset with patients, at one point reprimanding a patient to stop it “because we were too busy for this.” I could tell, and I know that David was not too happy working with the other two PAs, Cindy C and James Williams. David tends to be very territorial and I could see that he was quieter than usual. James is a particularly loud and upfront PA. Some have said he is “ghetto.” At one point he intentionally mispronounce David’s and Kuzak’s name. He has a bad history with both workers. They do not like him and he does not like them. He knows it and I think they know it. Nonetheless, this is one of the challenges that PAs endure. They have to work with workers they do not necessarily like. Although they (Cindy C and James) were floated to our ward, it felt more like we were floated to their ward. It is the controlling nature of James which accounts for this. James talks to patients and staff in a very urban way using slang and humor to get his point across. He says “listen up everybody. This is Terrence” and introduces me to go the goals and community group. Although I am the regular on ward 5 and he is not, he has assumed control based on the difficulty of working with him. I inform him that we usually do the group after meds. He yells more commands for David, but David subtly brushes them off. We know James, and he knows us. We all coexist because we have learned to tolerate each other. James not only teased me and David, he also intimidated the charge nurse to give him a more favorable assignment, although David and I were the regulars on the ward. Not only do bad human relations with fellow PAs make the work more difficult to bear, but negative interactions with ward managers have potentially an even worse impact on worker morale and

productivity at Mirage. David and I suffered during the course of our shift with the ward manger. I demonstrate this in this particular field note below.

Field Notes

I worked with David and Ward Manager Darlene. Many of us shake our heads in disgust. Although Posey is difficult to control, we see the effects of her medication on her body. She at one point was yelling, looking up at the ceiling camera on the wall saying, “STOP LOOKING AT ME!” The Ward manager, Ms. Darlene, a white woman who looks around 62 years old, but as one black nurse recently told me, she is only 55, my age, says, “Just tell her I am going to take her over there soon.” I was frustrated at the start of the shift seeing that Darlene was the nurse. This is a major factor in PAs and others not liking their work, i.e., the interactions with one another. Darlene can be this way as well. Darlene has really earned a unanimous sentiment among PAs and nurses. They don’t like her. David tells me “what is going to happen is that we are going to have a clash, and I am going to put my reputation up against hers. I have 10 years of work here and everyone knows me. You can ask the social workers, AR (assessment and referral), nurses, HR, they all know me and that I work.” He says latter when I complain to him that Darlene “tells me obvious things although I have been working here for 9 years,” “I do even say anything. I just keep doing my job.” Darlene is controlling, rude, demanding, and feels she knows the best and PAs and younger nurses know the least. Hence, she feels it is her job to tell you what to do. This erodes PAs knowledge and expertise. She overrides our knowledge and tells us what to do like children or inferiors. She especially does this when she is feeling stressed out. For example, when she yells out, “I need to have these patients for medication Terrence.” I respond after walking to patients’ rooms

and asking one to take her medication, “She wants her blood pressure taken before she takes her medication.” Darlene replies, “Take her vitals! We have four patients that did not have their vitals taken.” I am already opening doors, getting patients supplies, redirecting Posey (tall biracial mentally challenged patient who has been coming to the hospital ever since she was a child), attempting to get patients to take their medication, and *doing the rounds*. I attempt to hold my frustration inside but I say, “The rounds are not caught up. I will get the vitals.” She responds, “I know,” walking toward the nurse’s station. Later she says to me, “I did not mean for you to get the vitals now.” I really believe that Darlene does not mean any harm but because she is not physically fit for this job, I think she wants to push everyone physically to do more and more. She wants to get the most of PAs and others and she lacks professional tolerance to skillfully get PAs to do the job. Her style, which is very common among nurses (especially female nurses) at Mirage, is to demand and yell when all becomes stressful on the ward.

David and I make it through the shift without any major explosions with Ms. Darlene. What we have to look forward to tomorrow is another shift with Darlene. I tell David that I really do not blame Darlene, “I blame the administration for hiring someone who is not qualified.” David says, “It is making my job hard.” I reply, “yes, but they don’t care about our happiness or well-being at work.” I think that this is the bottom line. The hospital simply just does not invest in workers. It could be that because they know most workers do not invest in it. Or it could be because they do not treat workers with the consideration to say “David, Terrence, Kuzak, since you all have been working here more than nine years, let me see what you think of this person as ward manager.” They do not consult us. They really just barely give us a rub on the back and say nice job of managing

an understaffed ward today. Our source of frustration is sometimes not the patients, but your fellow coworkers, frontline nurses, and administrators. PAs have subordinating relationships with nurse managers who are quickly hire, promoted, and sometimes fired. However, because of their professional title of being a nurse, they command more authority within this medical psychiatric setting than do PAs. Nurses are more so the professionals and are entitled to greater authority than PAs (the non-professionals), according to Vallas, Hodson, and Wharton (2009). More than the nurse manager official authority, it is the way she talks to us that makes our jobs miserable. She intrudes on our dignity by not respecting our workplace expertise and experience at Mirage; Hodson (2001) calls this behavior by the ward manager a challenge to working with dignity in the form of mismanagement and abuse. Hodson (2001) elaborates:

Even supervisors who are not inherently ill-mannered, arrogant, or domineering sometimes take unfair advantage of their power and abuse employees... Mismanagement and managerial incompetence can also be chronic problems for the workers. (p. 19)

This field note highlights the difficulty of working with the newly promoted ward manager Darlene. She commands PAs to do work although they know their work and are busy doing other work. Rapport (2009) attributed this behavior to the hospital hierarchy or cast system which entitles higher up workers to command lower status hospital workers. Darlene has poor people skills; nonetheless she is in a position that requires people skills if you are going to keep the morale up, and thus productivity. Had I liked Darlene, I probably would have compromised my rounds and got her the vital signs on the patients. However, because she is rude and brash, I certainly was not motivated to do anything other than my assignment, which was to do the rounds. Workers can slack off

intentionally; this phenomenon has consistently been documented from the factor studies (Rose, 1988; Thompson, 1989; Grint, 2005; Vallas, Findlay, and Wharton, 2009; Volti, 2012) until today (Hodson, 2001; Rapport, 2009). Workers do this when they feel disrespected (Hodson, 2001).

Conclusion

Workplace relations impact work (Rose, 1988; Thompson, 1989; Hodson, 2001; Grint, 2005; Vallas, Finlay, and Wharton, 2009; Volti, 2012). I found that workplace relations, not just among fellow PAs, but among all workers who PAs encountered at Mirage (especially those directly above them in the hierarchy) impact job performance and satisfaction. Workplace relations within the hospital shape if workers are floated, cancelled, promoted, or chosen for employee of the month. However, on the frontlines of psychiatric work, they can account for if a worker is hurt or not, if a worker is more stressed out or not, and if services and control of patients occur or not. As many PAs have said, “Do you got my back?” Workplace relations at Mirage involve PAs with PAs, PAs with nurses, Nurses with Nurses, and even all frontline with housekeepers.

I found that staffing ratios to patients impact frontline workplace relations. How? When frontline staffs are short of workers, they become more stressed out. When workers are more stressed out, just like in our homes, nurses yell, nurses write up PAs, PAs argue, and often relations are tense (Rapport, 2009). Workplace relations at Mirage were found to also impact the emotional level of workers more so that their interactions with patients, it was their co-workers or nursing managers that irritated or pleased them the most. This further confirms the human relations theory and its importance work life (Thompson, 1983; Vallas, Finlay, Wharton, 2009). The connection with human beings socially at

work impacts work and workers, hence the investment in good managers, PAs, nurses, housekeepers, and others who work in Mirage cannot be understated if the aim is to provide a good work environment for dignity (Hodson, 2001).

CHAPTER SEVEN

ATTITUDES AT WORK

THE INFLUENCE OF MIRAGE'S STRUCTURE ON THE ATTITUDES AND BEHAVIOR OF PAS TOWARD THE CARE OF PATIENTS

Introduction

“Job satisfaction can be defined simply as “how people feel about their jobs and different aspects of their job” (Vallas, Finlay, and Wharton, 2009, p. 53). Doing frontline psychiatric work in itself is a challenge, patients are “here for a reason” is something that most will say in Mirage. However, when workers sense that administrators do not care enough to provide appropriate staffing and resources, this sends a message that it is alright not to care about people the hospital is designed to care for, the patients. Many frontline workers and non-frontline workers at MPH have said, “We are here because of them [the patients].” It is true that the hospital only exists to help its patients. If there were no patients, there would be no hospital, and thus no workers. However, the common saying that “we are here for the patients” is more than simply a reality check, it is *a way of conditioning workers* to accept their status as frontline workers. Certainly when Goffman (1961) explained that the work of attendants is different from the work of those in manufacturing jobs in that the former is dealing with human beings and the latter is working with inanimate objects, he was making an important, although obvious, point. I believe it is clear that human beings are different than inanimate objects. We cannot treat

a chair the same way we would treat a human being, this is obvious. In this chapter I will answer the research question concerning the impact of Mirage's structure on the treatment of patients at Mirage.

They [administration] don't give a fuck about us; I don't give a fuck about them [patients]—Cermon, PA at Mirage.

Cermon's¹ comments are blunt. However, they convey the impact of Mirage's organization structure on PAs' view and sometimes treatment of patients at Mirage.

When frontline workers do not feel valued, how can they value what they are doing?

How can they work effectively on the inanimate or animate products they are charged to service? Dent Perry² voices his view on how administration impacts his work with patients.

Me: What do you like least about your job as a PA?

Dent Perry: ...When you really think about it we should be helping people, we should be very supportive. But from an administrative ahh professional look at things, just ahh... (2 seconds silence)...I don't like the way administration... I mean I don't think they look, I can't say what they don't like, I don't think they look at the whole picture of things most times. In my head I don't think they do the briefings the way we do briefings. I don't think they recognize things quickly the way we have been chosen to recognize things, and that just because I guess we are on the frontlines, we see things we attack it, we don't just counter act it, so it is there we just nah, we know exactly what that person may need because that person has been here quick a few times, we have developed that rapport. We done been in the battle, we have been physically hurt; we have been in altercations, so we sort of know what we are supposed to see, so if that is not a situation we need to be in, we react to it really quickly. Whereas with administration man, it could be a couple of things involved in this thing, insurance money, my say so aint really...what I think may not be warranted at that time. I feel like man when you

¹Cermon is a Black male, ex college football player studying to be a social worker in his early to mid-30s. He was known for his frank talk and also physical tactics of controlling patients.

²(Dent Perry) is a 39 year old black male. He is a darker skin black male with a wide nose. He definitely has African blood in him. He says he is married to a black/Italian woman. He and I have been talking about self-preservation of our race. At first, I did not really talk to him, but over the years, especially in the last year we have talked more, and I have come see he is an intelligent man. How has he coped with working on the adolescent boys ward is quite interesting. I conducted first part of interview on June 27, 2012.

say something to administration that it is not really taken to heart. That is one of the things man that we really have a problem with that when you talk about certain issues on the ward, when you talk about problems that could be solved, we do not feel like administration really listens, or they do listen but they do not act on our words. So you know, I think that, I feel like some of things like 9 times of 10 can be you know, not warranted, you know.

Me: I don't think you are alone....

Dent Perry: ...I feel like man if they listened, we could solve a lot of our issues, having staff you know, being you know yeah, not always going by, yeah I mean you got to go by the grid, you got to go by that. Do you know what you put us through when you go by a grid? Do you know exactly what, I see the numbers you are talking about, but what you don't see is the personalities behind these numbers, what you don't see are the dangerous people you done grouped together, it might be 10 people to one person, and here we is, we got 2 people who is sexual, we got 3 people who want to assault each other, we got 3 people who just do outlandish stuff, very impulsive, but you got one staff. That's a problem, I don't know, I aint never fought 10 people before, I believe I can, but you know but if 10 people decided they want to go off on me, man I would be in trouble, So having people with you and its safe, we talk about safe, welfare, care, it is not just for patients it is for staff as well.³

Dent is expressing a common view among PAs concerning adequate staffing to keep not only patients from hurting each other, but patients from hurting staff and in return staff hurting patients. All staff expressed a common desire to “go home safe.” PAs want to help patients, but are pragmatic in wanting to go home safe as well. This creates somewhat of a moral dilemma that Chambliss (1996) showed in his study of frontline nurses. It really is not much of a dilemma, because most PAs would choose their safety over safety of patients. It becomes a reality shaped by the institution, and its chronic short-staffing and disregard for PA input on the wards. PAs and other similar frontline workers blame the institution as a justification for their attitudes and actions (Chambliss, 1996). PA input is not sought after; Diamond (1992) found the same thing regarding

³Quotation from Interview with Dent Perry.

nursing aides in nursing homes, where their input on the staffing ratios to patients is not desired.

The nature of this bureaucratic organization (Mirage) would suggest that this is the rational way it is supposed operate, letting authority come from those higher in the hierarchy (Hodson, 2001; Giddens, 2004; Vallas, Finlay, and Wharton, 2009). However, what this constitutes to Dent, and many other PAs, is a denial of his dignity and expertise at work. The PA position is a subordinating one by definition and symbol. The symbols of subordination are uniforms, lack of authority, and physical positions in workplaces (Vallas, Finlay, and Wharton, 2009).

The Patients

Erving Goffman (1961) says,

Within this context [between what the total institution says it does, and what it does] the first thing to say about the staff is that their work, and hence their world, have uniquely to do with people. This *people-work* [emphasis his] is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people. (p. 74)

Goffman continues in the section to tell us about how staff (i.e., attendants) who can be considered today's PAs (Psychiatric Assistants), have fears of being physically attacked or contracting a disease from patients⁴. In addition, PAs and frontline nurses have a problem of governing the wards they work on; they must implement safety and extend individual privileges to patients. The patients are sometimes made out to be customers by administrators in the business of mental health care. This point is implicitly known and at times explicitly stated by "higher ups." The patients have various mental illnesses

⁴Goffman (1961) uses the same point to discuss how patients are mortified by other infectious patients.

such as schizophrenia, bi-polar mood disorders, mania, major depression, and others. Any of these mental illnesses can be combined with mental retardation, substance abuse, dementia, physical disabilities or limitations, autism, anger problems, or a number of other issues. Often times these patients are lumped on the same ward although they may have specialized issues. Goffman (1961) argued that psychiatric patients are human beings who have the ability to behave in human ways to get their needs met. The patients want and need human interaction. The patients want and need services. When I first started at MPH, many frontline PAs (many I have forgotten) would say, “all they [the patients] want is attention” or in the more negative psychiatric sense “they are attention seeking.” I initially thought this was staff simply reacting to the patient demand negatively. Being a new PA, I thought PAs simply lacked insight into the psychiatric needs of patients. I no longer feel quite this way today. Quite a few of patients have admitted that the reason “I came back” to the hospital was because “I liked staff” and received the most attention in this hospital [Mirage] compared with other hospitals. One such patient, I will name Tiana, said to me, “I come here because I do not have any support out there.” Tiana has been hospitalized dozens of times. She typically will throw objects around and cry but never usually hurts herself or other patients. I have seen her with bed sheets tied over her head or objects in her hand. However, she never seems to hurt herself while she is in the hospital. It is like a game that she and the psychiatrist are in on, and only the most uninformed workers are not. It used to be an open joke that she was Samantha’s⁵ personal one to one.⁶ Patients have agency, they are not all are merely

⁵Samantha is a 37 black woman who is full medium size. She is currently finishing up her nursing education. Samantha has always displayed great confidence. However, she does walk the talk. I observed

mortified by MPH as Goffman (1961) described (Scott, 2011). Scott (2011) argued that total institutions have changed into what she described as reinvented institutions where actors actively seek to enter institutions for their own re-socialization purposes. Scott (2011) states:

A central argument of this book is that a new form of institutional has emerged since Goffman's time which implies subtler mechanism of power and social control. Whereas traditional TI inmates were committed against their will, and new identities imposed upon them, now we find people choosing voluntarily to enter institutions, believing that they need to change, and that it is their own responsibility to do so. (p. 2)

Patients Today

MPH is more specialized today with separate wards for different patient populations based on age, behavior, and diagnosis. However, diagnosis has always been subject to reliability and validity questions (Weitz, 2013; Bentall, 2009). When I first started at MPH, I sensed that there were many types of patients on Ward-6. Back in 2003, on one ward there were multiple types of patients ranging in age and diagnosis. Ward-6 had always had at least one or two elderly patients, about 13 higher functioning “bi-polar” patients,⁷ and about 10 lower-functioning “schizophrenic” patients,⁸ and about

her march down to the nursing station and proceed to call the doctor and have him give the order to transfer a black male patient who was acting sexually inappropriate. I will never forget the nurse's expression when Samantha said that the order had been given by the doctor to transfer the patient to another ward. The particular moment let me know that

⁶Tiana customarily would check herself into the hospital and request that Samantha be her one to one. A one to one is a patient who is deemed to unsafe by the doctor to not be monitored personally by a PA or nurse. A patient who is given the precaution of one to one must be within arm's reach of a staff at all times. Whichever worker who is assigned to be the one to one staff must devote their work (attention, intervention, redirection, etc.) to this particular patient.

⁷Those patients who have been diagnosed with a bi-polar mood disorder by a psychiatrist. Usually drug abusing patients had this disorder I noticed.

⁸Those patients diagnosed by a psychiatrist to have some form of schizophrenia. These patients typically had various forms of hallucinations (auditory, visual, or hearing) and delusions (false perceptions of reality). They were impaired from normal functioning, and typically needed more intervention from staff. For this reason, schizophrenia patients were viewed as lower functioning. They needed more

three “autistic or mentally challenged” lowest-functioning patients.⁹ Bi-polar disorder and schizophrenia, the two most common types of diagnosis for the adult wards at MPH, have been shown to have tremendous overlap in their behaviors. Typically from the frontline perspective, “bi-polar” patients are looked at as higher functioning than are the rest of the types of patients at MPH. I will discuss the different types of patients most commonly encountered on the frontlines of psychiatric care at MPH.

Proper staffing is one of the more critical components that impacts PA work with patients. Whether the patients are admitted on their free will or not, properly diagnosed or not, truly in need of services or not, they all require attention and services. Attention and the services provided to patients are dependent on the human power to provide these needs to patients. Some patients are more difficult to provide services and attention to than others. These types of patients can be categorized as difficult patients.

The Difficult Patients

The difficult patients are the ones that are non-compliant, difficult to communicate with,¹⁰ attention seeking,¹¹ needy,¹² disruptive, agitated, and aggressive. Difficult patients make it hard for PAs and nurses to do their job, which is mainly to keep

assistance to function without problems on the ward. This assistance could come in many forms: dressing, reasoning, intervention, redirecting, etc.

⁹Those patients who were diagnosed with mental retardation or autism were often in need of total care or intervention. These patients were labeled as the low functioning patients. These patients typically needed assistance toileting, shaving, showering, eating, and not bothering other patients on the wards.

¹⁰This includes those who are autistic and mentally challenged.

¹¹Frontline staff documented patients as attention seeking when patients intentionally or unintentionally did things to demand the attention of staff. Attention seeking patients would do things such as: pull fire alarms, attack other patients, cut themselves with objects, take off their clothes, etc.

¹²A needy patient according to the frontline staff at MPH is a patient who constantly is in need of some type of interaction (the patient asks a lot of questions or talks a lot) or service (the patient asks more than other patients for his/her bathroom door to be opened, and/or more food, toiletries, etc.).

order on the wards and implement the hospital's protocol of activities, as Victor Sam¹³ said in his interview, "our job is to normalize their behavior." It is quite interesting that the mission statement of Mirage Hospital of providing sympathetic care is often times at odds with its need to fulfill the documentation quota (Weitz, 2013; Diamond, 1992). The objective of hospital heads seems to be to get paid, and many PAs and nurses indicated this in interviews. At the end of the day, it appears that this is more valued, book-keeping, versus sympathetic care. However, I will deliberate this in another chapter. Difficult patients are those that stop PAs from running the program and having a degree of peace and space from them personally. Difficult patients are not easily directed, controlled, redirected, or managed. They require extra attention. Extra attention requires time and energy. Time is something that PAs (and other similar frontline workers) do not have (Diamond, 1992). My findings on the time constraint that PAs have in during their work is similar to what Diamond (1992) found. Diamond's conclusion is the same one I found, there simply is not enough staff on the floors to do the patient demanded work. The reason is economic, private hospitals, like Mirage, and the nursing homes run their facilities to make profit, this often leaves frontline staff short in worker numbers. PAs must chart, write group notes, do rounds, open bathroom doors, hand out trays, make phone calls, get supplies, you name it, and the PA must do it. She/she is a "jack of all trades" in Mirage. Difficult patients increase the level of stress for PAs who already must deal with an overwhelming amount of issues. Not only do difficult patients require more time, they also pose serious threats to the personal safety of workers. Difficult patients

¹³Victor Sam is a young white male nurse who I interviewed. He was promoted to a part-time nursing supervisor.

can be physically and emotionally threatening toward PAs. PAs are the ones who stand in between patients' freedom and control of the wards. If no PAs were around, the most aggressive and dominant patients would run the wards. Working on the wards is like the animal world in this regard; the strongest and most aggressive rules. In this regard, being a PA is like being a CO (correctional officer) in a prison (Conover, 2001). Ted Conover (2001) book, *New Jack: Guarding Sing Sing*, showed how frontline correctional officers maintained order in a maximum security prison. It is an intense process of learning about the prisoners (or patients), what to do, how far to push, what you cannot do, and what you can do. These things are learned on the job in the interaction with patients. This intensity level I found similar at times working frontline at Mirage. The difficult patients, just like the difficult student in class, are the ones that command most of your attention and work. Here is one such patient that I encountered on the ward one day. My field notes are below.

Field Notes

The 1:1¹⁴ was difficult. She threw her sanitary napkin on Dawn and kicked her for coming near me. The one to one is a mentally challenged one to one patient. For the two hours that I had her, she laid complaining and puking on the floor complaining that "I want to go to the [medical] hospital." She would not sit or lay still. She pretended to have a seizure by shaking her body and moaning on the ground. She even started acting as if she was biting her lip, a sign of a person having a seizure. Additionally, a patient started scratching herself with a fork, seeking attention from us. Other patients were

¹⁴A 1:1 patient is:

asking for bathrooms to be opened, a chore¹⁵ when PAs are already exhausted. Other patients were yelling and screaming at patients and at staff for attempting to redirect them. David was visibly upset with patients, at one point reprimanding a patient to stop it “because we are too busy for this.”

Now this was a difficult patient, and we see how David reacted to her pretending to have a seizure explaining, “We are too busy for this.” Too busy also means not enough staff to deal with the ones who behave in ways that demand your attention. This behavior can be appreciated by teachers who feel classrooms are overcrowded and they simply do not have the time to deal with the problem student. PAs often feel the same way as a result of having too few staff on the wards. Staffing is a component of the organizational structure of Mirage. The lack of control over patient ratios and high demands equate to greater stress (Smith, 2002) on the wards for PAs and frontline nurses. David’s screaming at the patient, “We do not have time for this” is ironic in the sense that PAs are supposed to be there to work with patients who have these behavioral problems. The longer PAs stay in these positions where they feel even helpless to help those who they are supposed to help, the more they might fall victim to emotional burnout, which might have consequences for their personal lives outside of work (Vallas, Finlay, and Wharton, 2009)

Another major problem that impacts how PAs treat patients is the suitability of the patients for mental health hospitalization. Not all patients benefit from psychiatric hospitalization. Some patients never change in their mentality or behavior while hospitalized. For this reason some patients simply do not belong in the hospital, they are

¹⁵PAs sometimes need to walk up to 50 yards down long hallways to open one bathroom door.

those who are considered inappropriate admissions by staff. However, frontline workers do not have the power (Chambliss, 1996) to control whether patients come or leave the hospital. Samford,¹⁶ a PA migrant from Africa explained to me in his interview, “If there was anything I would change, it would be the admitting process, some of these people should not be admitted.” One such individual I documented in my field note below.

Field Notes

1:1 patient is street-like.¹⁷ He yells and curses “Fuck You!” He starts singing loudly in the hallway although the other patients are perhaps sleeping in their room. He turns the music up loudly and sings the latest rap song talking about street life. I agree to let him early into the dayroom to stop him from yelling at the nurses behind the nurse’s station. While in the back radio room of the day room, he says looking at me in eyes, “I’m going to start throwing chairs if I’m not discharged Monday, you can write that down.” He is loud, threatening, and somewhat intimidating. I don’t feel I can control him. Because of his verbal threats and profanity, I feel somewhat threatened and more alert. I feel a certain degree of fight/flight mentality. I am uncomfortable. What is the best way to deal with this type of patient? He seems like a guy off the street. He has this street manner of curses and talking loud. He rolls up his sleeves so that everyone will see his tattoos. I ask him what does his middle initial A stand for, and he says, “Asshole.” I am thinking to myself, “yeah this is the way you are acting.” The nurse, Bernice,¹⁸ attempts to try to talk with in to establish some rapport. She says, “Would you like some

¹⁶Samford, black male with thick African accent in his early 50s but physically fit. He lost a son to a car accident a couple of years ago. He has been working at Mirage for about 10 years also.

¹⁷By street-like, I mean he is urbanized in his behavior and language using common language and behavior like those who hang out or live in urban communities.

¹⁸Bernice is a 68 year old black woman.

medication?” He stares at her. He takes off his shirt and walks up to her face. I step in between them and I say, “this is a woman, why are you walking up on her like that?” He says, “A woman raped me, I don’t care!” Bernice responds, “You’re not going to hit me” as if to convince herself and him that he is not going to hit her. It is patients like this, loud, vulgar, disrespectful, verbally assaultive and aggressive, that makes staff alert and ready to respond. I believe that it is patients like this that make staff become physically and verbally aggressive toward them. No one throws an elderly grandma into the wall, but patients like this have been in Mirage. They almost control the ward if they are not “put in check.” As I said to Kuzak, how can we provide safety when we do not feel safe? Patients expect for us to handle to these kinds of loud and intimidating patients, however, what they do not understand is that these days that culture of Mirage no longer exists¹⁹.

There might be a few individuals, especially off camera in a patient’s room, who would still use physical aggression to put these types of patients in line, but that is the exception to the rule today. There is a context of fear, which the outsider cannot fully appreciate, that contributes to staff or PAs using force to quail the patient. The objective is control. PAs are expected to control the ward and the patients inside of them, as Goffman (1961) found of attendants, PAs are the governors of the wards. PAs feel personally responsible, as the frontline workers to deal with patients, and want to implement safety (or their version of it). PAs want to be the ones who are in control. It is patients like this 1 to 1 that make it hard to accomplish. Patients like this 1 to 1 essentially dictate what they are done: screaming, cursing, and intimidating. As he said,

¹⁹Back when I started in 2003, PAs at Mirage would physically control the patients by tackling them to the ground, putting them in locked quiet rooms, holding them down for shots, putting them in physical restraints, and at times responding to the patients’ physical aggression with like physical aggression.

“You don’t tell me to stay in my room!” PAs, as I did today, stand around and feel helpless to the nurse, the other patients, and the ward. A PA has to then use soft methods not hard methods to calm the patient. I opened the dayroom early for him. I gave him extra snacks. I followed him up and down the hallway. I let him do what he was going to do, and I minimally redirected him to “stop, come on, I gave you this, work with me.” There was a time when a patient like this would have been controlled by a shot and a take down to the floor if not put in restraints to let him know who is the boss. Those days are gone to a significant degree because of the monitoring cameras installed in Mirage since 2009. The Installation of the cameras throughout Mirage also further limit the control over the wards that the PAs once enjoyed, and suggests that PAs would have less job pleasure (Hodson, 2001; Smith, 2002).

Who wins? Maybe the patient wins, but the frontline staff and other patients who have to endure the wrath of patients like this, lose. Maybe even the hostile patient loses as well, because he/she does not learn to control themselves. Perhaps the real winner is the corporation that profits from his tormenting stay in the psychiatric hospital. The above fieldnote highlights how PAs become frustrated and fearful with patients they cannot control on the wards. At this point, it would be in the best interest of patient and PA if the man was released. However, PAs cannot discharge this patient. This means that because of the admission process, PAs are in a flight or fight mode where they feel that they are no longer servicing or addressing a need by the patient, but simply trying not to be hurt

by the patient or keep a reputation.²⁰ A PA cannot help but feel negative toward such patients. Chambliss (1996) found the same frustration that frontline nurses felt when dealing with medical patients they felt they no longer could help. Frustration sets in with such frontline workers of care who do not control the admission or discharge process. This process is control by higher up administrative and medical staff (mostly medical doctors).

Mirage Structure

Two of the main structural policies and practices are short-staffing, which for-profit institutions are known to do (Devereaux et al., 2002) and inappropriate admissions. Chambliss (1996) documented these common concerns in his study on frontline nurses in hospitals. Diamond (1992) also found common complains among nursing aids of short-staffing and inappropriate admissions. The short-staffing and inappropriate admissions cannot be explained for any other better reason than the corporation that owns Mirage quest to please shareholders by making more and more profit. It appears that the profit motive to come out on the plus side effects proper staffing of hospitals (Devereaux et al., 2002). According to Devereaux et al. (2002), private for-profit hospitals were associated with lower numbers of qualified staff. Private For-profit Hospitals were associated with higher payments for care compared with private not-for-profit hospitals (Devereaux et al., 2004).

²⁰The Mirage cultural term “holding it down” is a street-like terminology linked to being tough enough to handle difficult patients. If a PA could not “hold it down” they might be teased by other fellow PAs. Reputations do matter in this line of tough controlling work.

Short-Staffing

Chronic short staffing creates potentially dangerous and stressful situations for staff and patients (Devereaux et al., 2002). It appears that the profit motive to come out on the plus side effects proper staffing of hospitals (Devereaux et al., 2002). According to Devereaux et al. (2002), private for-profit hospitals were associated with lower numbers of qualified staff. Heather,²¹ a white female PA from a middle class background, expresses her frustrations in our interview. I asked her about her thoughts about being short-staffed:

Ahh I think first of all when we are short-staffed, the patients suffer because they are not getting one to one attention. Ahh like where experience that I have had before working as in a psychiatric facility it was part of our goal as a PA, to the patients we were assigned to you would actually go spend like five minutes doing a one to one with them like you would go up to them like whatever reason they were there for you like if they are there for self-injury you would go up to them and ask them. You know “are you feeling like you want to hurt yourself today?” “Do you have any suicidal ideations?” Like that was a part of your one to one and you would sit down you would during our community meeting you would arrange to set up a time to meet that patient and like three o’clock you meet for five minutes and that is the person you are charting on. And I think because we have always been kind of short-staffed I came into this job having that expectation in mind. And I think a lot of times, you don’t get to have that one to one time and I think even patients who ask for it. You know if you are the only staff you can’t go aside and I can maybe pull them to the side in the hallway but I still have to monitor everybody else (the other patients), so how much attention am I really giving that patient if I am only half listening to them and half looking around. But, and then it’s you know if you’ve got have the patients in their rooms and half the patients in the day room and you want to run a group but you are the only person you don’t have anyone watching the patient’s in their rooms. So then the patients who are ready to go to group can’t go to the group because you don’t have anyone to run the group. Or I mean just basic things like taking a lunch break, if we are short-staffed, you know we can’t run down to the cafeteria and get something to eat or take a break until the patients are asleep or something like that (around 10pm). Ahh like for instance tonight when I came on there were thirty patients and there were only three staff of us (PAs) staffed. And I was even looked at it like this isn’t right I mean we got a patient who used to be on a 1 to 1,

²¹Heather became a frontline nurse.

I don't think she is discharged so what are they thinking? And then as the night, we ended up getting two more staff, but I mean.

Heather's comments reflect the typical limitations that short staffing has on workers. All of the interviewees mentioned that short-staffing impacted the time they were able to give attention to the patients on the ward. Not being able to really listen to patients in order to meet their needs, not being able to run a group, or not even being able to keep patients safe by monitoring their whereabouts were all attributed to short-staffing.

Devereaux et al. (2002) state:

The private for-profit hospitals employed fewer highly skilled personnel per risk-adjusted bed. The number of highly skilled personnel per hospital bed is strongly associated with hospital mortality rates, and differences in mortality between private for-profit and private not-for-profit institutions predictably decreased when investigators adjusted for staffing levels. Therefore, lower staffing levels of highly skilled personnel are probably one factor responsible for the higher risk-adjusted mortality rates in private for-profit hospitals. (p. 1399)

If, short staffing is linked to higher mortality rates, then what about quality of patient care rates and worker stress levels. Staffing, accounts for the types of days that PAs have on the ward. If there are enough workers on the ward, groups can be ran, breaks can be taken, patients' needs can be met, and adequate safety can be kept on the ward. However, the hospital *matrix*, a staffing system that allows certain amount of workers for a certain amount of patients. Administrators have never openly discussed the matrix, but it is used as a justification to *float* cancel PAs, thus having enough staff for the patients who are demanding and have various needs are never considered when it comes to staffing. The other major theme I identified was the lack of control over work. One way that PAs fail to have control over their work is manifested in patients being admitted to

wards where PAs do not seem to be able to control or stabilize mental health patient's behavior.

Inappropriate Admissions

From time to time, it happens, a totally inappropriate admission comes to the hospital, an inappropriate admission is a patient deemed by staff to be untreatable or more in need of other services than psychiatric services. Of course, the front-line direct staff has no say in the process of admission.

Field Notes

On a busy Friday evening, one such case is reported to be coming in for admission. The patient is a 28-year-old African American patient who has been admitted before. He is wheeled onto the ward and directly into his room. I am working with Dave, an African American PA in his early 30s, on Ward-6. Dave is caring for an elderly bed ridden man on the one to one, thus I am the only PA free to do the admission. Chipper, an African American male nurse in his 50s is working tonight as the charge nurse. Me and Chipper hustle into the room as the ambulance workers wheel the patient in on a stretcher. According the ambulance worker, he has been "in the ER for the last 10 hours." The patient's face appears to be burned, I am horrified by what I see, and he is in restraints, his arms tied up from apparently hurting his own self. His arms are burned with scars all over them. Chipper, wearing gloves unties the patient in order to transfer him to his bed, says, "Oh God," as he momentarily walks away from the patient in shock, "No, No," he says as he sees an IV still in the patient. "They are supposed to remove these." "I'm going to call the DON." I caught an admission worker standing by the door and ask her about the patient, she says, "I tried not to let this patient come here, but Dr.

Fine said, “Admit the patient, this is a psychiatric hospital, we have to admit everyone.”

The patient’s arms are tied to the bed, where they would remain like this for the next 24 hours until the order is given by the DON to untie the patient. Once the patient was untied, he picked at the back of his ears, and turned over on his stomach to reveal blood ears and pieces of skin falling off of him. For the next few days we would change this patient’ diaper, feed him, and monitor him on the *one to one*. I bet someone poured something on him,” says Carlotta²² as we all scratch our heads to figure out how he got in this state. According to nurses, “Dr Fine²³ does not want us to take report, so we don’t know how the patient got in this state.” It is reported later that Dr. Fine said, “I did not know anything about how this patient got admitted to the hospital.”

The patient would end up leaving the hospital after 5 days. Carlotta, a medication nurse (LPN) has worked at Mirage for more than 20 years (now she says she is interested only in collecting her pension), says, “They’ll take anything.” From my years of working at Mirage, this is indeed the case. Patients are simply commodities to be admitted in order to make money. All the workers, save administrators of course, say this from time to time. Similar to what Chambliss (1996) found of medical nurses within medical hospitals, I found that PAs and frontline nurses ability to control the admission process negatively impacted that sentiments about their jobs and about patients. Chipper and I were in shock by what we observed, and we did not he belonged in a psychiatric hospital, but it was not our decision to make, that decision belonged to the medical director Dr. Fine.

²²(Carlotta Lewis) (LPN), black female in her mid to late 60s but has youthful personality. She has worked at Mirage for more than 20 years. I interviewed her.

²³The Medical Director of Mirage at that time. The Medical director approves pending admissions to the hospital.

Lisa, a female African American worker who is working *registry*,²⁴ a position where a worker signs up to work different days, and if he/she are not cancelled, they show up to work anywhere the hospital needs them now says in our interview, “I think as soon as their Medicaid runs out, they have a miraculous recovery.” Staff often times feel that Mirage is simply a business, as the comments above by Lisa indicate, it is not about truly healing the patients, it is about warehousing them until their insurance runs out. Another such inappropriate admission occurred involving a mentally challenged young black woman. She stayed on Ward-6 for three long months. Her behavior never changed. She continued to ask over and over the same things, “When am I going home?” and “I miss my mamma.” I capture her behavior below in another field note that shows how certain admissions serve to frustrate PAs and shape their views of the business of mental health and its patients.

Field Notes

I notice David picking up towels, redirecting patients, opening bathroom doors, and doing other things while I am sitting in the day room. I alert the patients, “It is now phone time, you can go down there and David will make your phone calls.” Diana,²⁵ the mentally challenged 27 year of patient, was not able to get through to her mother during phone time. She walks into the day room and says “I miss my auntie.” I tell her, “We know, come on into the dayroom and sit down.” She says, again, “I miss my auntie.” She

²⁴Registry is a term used for registry workers who register their availability to work. These workers often have other jobs. However, it appears that Mirage’s new policy is that all new employees start on a registry basis then earn their regular position. Mirage depends on these non-benefit part-time workers to run the hospital because the full time and part time regulars are kept at a bare minimum. All most every day every shift there will be a registry nurse or PA working in the hospital.

²⁵Diana would end of staying on ward 5 for more than three months. Her behavior, with all of the psychiatric medication that we gave her, never changed.

begins to lightly tap another patient who is sitting in the day room. I jump up and shout, "Diana what are you doing? You are going to get a shot." She continues, "I miss my auntie." You are not my auntie." She raises her hands to grab me. I respond, "I know, have a seat please." She refuses to sit, and continues to say the same thing over and over. I tell her to "go tell the nurse." I threaten her, "Do you want a shot." David comes back into the dayroom and threatens to "change your room." He says "stop" as she follows him around and begins to attempt to hit him. He tussles with her and frees himself from getting hit. He grabs her arms and says, "Stop, you need to get some medication." She follows him out of the dayroom. There are around 8 patents watching Diana and us. They are mostly calm. I do not see Noreen the nurse. Mables has left. I decide to help David by grabbing the other arm of Diana and walking her toward her room. There is no one to watch the patients in the dayroom. David heads back down to the dayroom, and closes the door. Diana says, "I want to go to the day room." I respond, "You can't attack David. What is wrong with you?" She now begins to attempt to hit me. I dodge her and say, "Stop Diana." Noreen walks up to her and tells her, "find something to do; the doctor is not going to discharge you like this." After I have taken down the phones and placed them in their draws behind the nursing station, I head back down toward the nurse's station. Diana has followed and says, "I miss my auntie, I miss my auntie." We attempt to ignore her, but she walks up toward David and lightly taps him on the shoulder. He says, "I don't like to be touched." She continues tapping him on the shoulder and saying, "I miss my mother." I plea to her, "Diana stop or you are going to get another shot." I say to David, "if you are going to do group, I will head back down in the hallway."

These notes highlight PA and frontline nurse frustration with this patient. The patient continues to repeat over and over the same thing. One who has never experienced this work might say, “She is a patient, that is our job.” However, to experience this work gives one a different view. We were only three workers on the ward doing various other jobs; we simply did not have the time to deal with Diana. In addition, maybe we lacked the skills to deal with mentally challenged populations. Mirage does not train for this population. I later spoke to a specialized ward worker (SWW), a promoted PA, and he told me that Diana “should not be here, but they cannot find anyone to take her.” The result of frustration by PAs is that negative thoughts and impatient behavior sets in toward patients. This is a natural result of being overwhelmed by short-staffing and patients who you simply cannot service or give attention.

The Stress Process Model explains that the “...emergence, severity, and duration of emotional distress are all functions of social arrangements acting in tandem with common genetic inheritance, not of individual pathology” (Horwitz, 2007, p. 213). Stressors (i.e., circumstances that produce stress) have generally been divided into two categories: acute life-events (e.g., divorce, death, health problems, etc., which also maybe recent or in the past) and chronic strains—e.g., living in poverty, working in undesirable jobs, living in high crime neighborhoods, etc. (Pearlin, 1989; McLean and Link, 1994; Aneshensel, 1999; Pearlin, 1999a; Lantz et al., 2005). Chronic stress is stress that occurs overtime throughout life and is related to social locations within society. After working more than 9 years (will be 10 years in July) at Mirage, I have mentioned many times to fellow PAs, “I have a lot of battle wounds.” I find it difficult to believe at times that the longer I work at Mirage, the worst I feel about my job position and the organization as a

whole. Why? I believe that the chronic stress theory and burnout phenomenon (Todaro-Franceschi, 2013) explain not only my feeling at the end of 10 years of frontline work, but the sentiments of many workers at Mirage. Is it the lack of respect for the work that we PAs and frontline nurses do? Is it the lack of control of our work? Is it the lack of human consciousness that Marx talked about when workers lose connection with what they produce? Is it that we see so much chaos, nastiness, irrationality, psychosis, negative attitudes and behavior, apathetic administrators, that we begin to feel nothing inside? Is it that we take on cynical apathetic personalities as a form of dealing with chronic work stress? It is a feeling/emotion, attitude, and behavioral phenomenon. Burnout, or what Todaro-Franceschi (2013) calls *compassion fatigue* happens as a result of continued discontent with one's workplace condition, Todaro-Franceschi states:

People who are burned out and work in health care are frequently seen as *dispassionate* [her emphasis] because their apathy appears to indicate a lack of caring. In other words, they appear *heartless* (or *empty hearted*) [her emphasis] and usually feel quite hopeless (*disheartened*!) [her emphasis] to make things better in their work lives. The feelings of discontent that may arise from one's work and which leads to development of burnout can, and frequently do, spill over into our personal lives. If we are not mindful, it can even snuff the enjoyment out of our daily living (and can also remove the joy from loved ones' lives in the process!). So when I refer to the good, the bad, and the ugly of professional quality of life, I am referring to *compassion contentment*—heartfelt (the good); *compassion fatigue*—heavy hearted (the bad) and the *burnout*—seemingly heartless or empty hearted (the ugly). (p. 5)

I started to notice the burnout phenomenon in others and myself as I continued to work frontline at MPH. Rapport (2009) only spent a year doing the work of porters, and not a decade as I did. Hence, the discussion of burnout and chronic stress as it relates to this grueling frontline psychiatric work is important. Coping with a chronic institutional problem seems to take something away from the spirit of frontline work (Todaro-

Franceschi, 2013). The feeling of despair was embodied in subtle and not so subtle statements and actions of PAs and other frontline workers who indicated that they did not feel Mirage would ever stop its structural practices and that the only way was to simply leave the institution, as soon as they could.

Seeing Through the Structure to See the Ones Who Need Help

I think that reason I go to work is cause there are patients there; so it's a patient driven job, and I'm just there to provide, I think it comes from having a long history of customer service too... — Heather former PA.

I remember a young autistic black male named Kenny who used to frequent Mirage years ago when I first started. He would make sounds like a pig squealing, “uurk, uurk.” He would look off to the side and in all sorts of directions, but rarely at you. Occasionally he would get out of control, and need to have a shot (a PRN). When I say get out of control I mean he would become too animated in his sounds, run down the halls (sometimes naked), and might scratch someone. Basically, he was a harmless kid in a man's body. Kenny does not come to Mirage any more. I never see him. I asked his doctor recently, and his doctor said, “I don't remember, I have seen so many patients.” I felt devastated when I heard that an adult male sex predator had raped Kenny. This rumor surfaced around the major time up upheaval at Mirage, 2008-2009. Reportedly, due to their not being enough staff on the overnight shift, a much older man had forced Kenny to do sex acts and had penetrated Kenny. I never heard it officially addressed by nursing administration, but I never saw Kenny again in Mirage. There was a similar event that was confirmed by nursing administration recently of a child patient forcing another child patient to give him oral sex in the day room of the children's ward. Apparently, there was a nurse who should have been watching the perpetrator, but had left him. The nurse was

assigned to be the boy's one to one, and had failed in this assignment. It was reported that this nurse was fired. Still, these incidents are painful because they happened to children or child-like individuals who were at Mirage to be kept safe from such acts. The innocent victims of Mirage Corporation profiteering hurt frontline workers the most because they are on the wards interacting and living with these victims.

It is often hard to see through the structure of society and its organizations to the ones who really need help. Similarly it is hard to see through the many types of mental health patients those patients who really need your help. Because there are so many social breakdowns that can lead people to hospitals (Liska et al., 1999), it is sometimes hard to see it as more than a business or job. Even when you see them, it is hard to provide the care and attention that they need to help them get through life. Chambliss (1996) and Diamond (1992) found that frontline nurses do manage to compassionately do their work in spite of similar institutional constraints that I found exist at Mirage. Similarly, many PAs and frontline nurses at Mirage manage to complete the day's work with professional excellence. This is another reason why I view them as unsung heroes. At the end of the mental health worker's day, and despite sincere attempts otherwise, it is my opinion that all he/she has done was to "get through the shift" without really addressing the root causes of why patients behave the way that they do. I recently spoke to a psychologist that works for the hospital, doing mostly diagnostic testing, and he stated that the patients' social, economic, and work problems were not being addressed by the mental health system. Patients and workers at the end of the day are commodities for the owners of hospitals to make a buck. Private for-profit hospitals have a notorious record of looking after their pockets versus their patients. In fact, more people die in private for-

profit hospitals than any other hospitals (Devereaux et al., 2002) which despite claims of superiority over non for profit hospitals, provide inferior care and higher prices ((Rosenau, 2003; Rosenau and Linder, 2003). Overall, the studies revealed that contrary to the logic of capitalists, for-profits do not provide superior care as the money drive would lead us to believe (Rosenau and Linder, 2004). Nonetheless, for profits are expected to increase to 20% of the hospital share (Galloro 2003). Mirage is owned and run on the basis of profit, and this fact shapes the structure and culture of work for frontline psychiatric workers.

Conclusion

What is the impact of the structure of Mirage on PA attitude toward patients? As Diamond (1992) and Chambliss (1996) found of similar frontline workers, I found that it makes workers certainly tired, frustrated, angry, and reactive toward patients. The reason for the inadequate staff patterns is linked to the thirst for profit by the corporation that owns Mirage, and many other psychiatric hospitals. For-profit hospitals are viewed as money driven “cash cows” of the rich. Woolhandler and Himmelstein (2004) state:

Privatization results in a large net loss to society in terms of higher costs and lower quality, but some stand to gain. Privatization creates vast opportunities for powerful firms, and also redistributes income among health workers. Pay scales are relatively flat in government and not-for-profit health institutions; pay differences between the CEO and a housekeeper are perhaps 20:1. In US corporations, a ratio of 180:1 is average. (22) In effect, privatization takes money from the pockets of low-wage, mostly female health workers and gives it to investors and highly paid managers. (p. 1815)

I found that in spite of the chronic short-staffing that occurred at Mirage, workers do care about patients in spite of that feeling not care for by Mirage Psychiatric Hospital. Yes, there are patients who are simply not your in need psychiatric patient, however, I

would say they are the minority. Most PAs indicated in their interviews and in the behavior I have been privileged to observe, a deep care for, an even an identification with most patients. Mirage makes care difficult, but PAs manage to service and care for patients in spite of Mirage, not because of Mirage. I asked Cermon, as well as all the other PAs I interviewed what they like the most and least about their work as PAs.

Cermon indicated he liked helping people the most, but felt little support in doing it:

Me:What do you like most about being a PA?

Cermon: I mean ideally you want to have the opportunity to help individuals, get them in a better situation, that is what I like the most, the opportunity to do that.

Me...helping people, what do you like least about being a PA?

Cermon: No support. No support from the administration.

Me... what do you mean by support? Like somebody to come and hold your hand. What do you mean?

Cermon: Support is basically when something is spoke upon where you need help on the ward, you are lacking something on the ward, that we need. It could be short of staff, it could be ahh, it could be transferring of a patient, it could be a lot of different things, so the administration do not support the counselors that are there. Our word, I mean, what we need is not valued.²⁶

Cermon's comments beautifully summarize this chapter.

PAs came to Mirage for no other reason than to help (and earn a livelihood), but are turned off by the lack of support and eventually take a survivor's mentality toward their work. Marx theorized that capitalism would alienate workers from their products, they would feel a lack of ownership toward it (Vallas, Finlay, and Wharton, 2009).

Cermon's comments reflect the alienation from his product of frontline psychiatric work. Without his and many of PA work, Mirage could not function, but he feels disconnected from this work because the structure and culture of Mirage has devalued his work. PAs do not own the means of production and are lower on the bureaucratic line as Weber

²⁶Quotation from interview with Cermon.

explained (Giddens, 2004). As a coping mechanism, PAs tell themselves they do not care, or perceive things as it is me versus the patient. However, when PAs have sobered up, they overcome this frustration and put forth tremendous efforts to their jobs. This is because dignity in work (Hodson, 2001) is a necessity, and we strive to take pride in our work even if we have been less connected to the means of production.

CHAPTER EIGHT
DIGNITY AT WORK
HOW PAS STRUGGLE FOR THEIR DIGNITY IN THE FACE OF THEIR
SUBORDINATION

Introduction

How do workers get dignity at Mirage? This question can be applied to many similar subordinated workers (Diamond, 1992; Chambliss, 1996; Rapport, 2009) who find themselves working in other institutions as well. We might apply this question to security guards, nursing aids, correctional officers, janitors, housekeepers, and many other displaced workers as a result of the economy. Many fight back aggressively with absenteeism, voices, and even by leaving their jobs (Hodson, 2001). However, I think many workers fight back in a passive-aggressive way. For example, looking busy so that “no one will say anything to me,” is one way PAs get their dignity or escape the pain¹. Laughing at higher up workers (Doctors and social workers) getting attacked or hassled by patients is another, going slowly to assigned wards or not going at all, and refusing to give 100% of their effort in the work with patients and other workers is another way PAs take back their control and dignity. Giving patients back what they dish out (cursing, throwing objects, fighting) is another way PAs earn their dignity. For example, the

¹David, a fellow Latino PA regular who worked the same ward and shift with me, and Kuzak, an Asian PA who also worked the same ward and shift with me strongly indicated after a humbling experience I had with the ward manager, that I should “look busy” to avoid the eyes of the manager.

mentality that “If you put your hands on me, I’ll fuck you up” is a common saying and mentality by many PAs.

It is unfortunate, that many PAs do not get dignity by simply professionally doing their job over many years of work. Mirage mortifies and subordinates these workers even more so than frontline nurses (many only have an associate degree). PAs are more qualified to know about running the wards and dealing with the patients than are nurses. As Goffman (1961) explained of attendants, PAs are the governors of the wards. PAs main form of expertise is running the wards and interacting with the patients on a common every day level. In spite of this, nurses usually have the right to question and cross examine more experienced PAs, as the below field note will detail. The net result of this interaction between higher up frontline nurse and experienced PA is indignity. How do PAs overcome this? Can they always overcome this? Goffman (1961) provided little analysis of how mental health patients resist their mortification. Goffman’s (1961) focus was on the power of the institution to mortify human beings, not on human beings ability to overcome this mortification. However, Rapport (2009) showed how similar types of workers transcended their low-status identifies by what he called an “existential power” (p. 15). It is important to note that the porters Rapport (2009) studied are different from PAs in that they are moving throughout the hospital constantly using their movement to transcend their institutional statuses.

Dignity in Work

Before I discuss how Mirage infringes on Psychiatric Assistants dignity and if and how they resist these infringements, I need to define what dignity within work is. Hodson (2001) defined dignity as “the ability to establish a sense of self-worth and self-respect

and to appreciate the respect of others” (Hudson 2001:3). Dignity, according to Hodson (2001) is a human fundamental need. “Life demands dignity, and meaningful work is essential for dignity” (Hodson, 2001:3). PAs need dignity and respect in their work as frontline psychiatric workers, and it does not matter their position within the hierarchy, all workers seek it out. PAs need to feel valued as workers within the hospital organization in order to feel good about themselves not only as workers, but as human beings. People define themselves in relation to the work that they do (Vallas, Finlay, and Wharton, 2009).

Given the importance of having human dignity, it is easy to see how workers will ultimately seek ways of obtaining it at work. Hodson (2001) found four major areas that workers gain dignity at work: resistance, citizenship, the creation of independent meaning systems, and social relationships at work. Briefly, resistance involves individual or small worker groups resisting claims by employers or advocating their claims. Citizenship involves taking pride in one’s work accomplishments independent of the actually official job demands. The creation of independent meanings involves workers gaining dignity within the meanings they place on their particular work (Rapport (2009) existentialism). And finally, as the Hawthorne Studies showed, positive worker relationships is key to workers having dignity at work, and thus being more productive.

What are some of the challenges to dignity that PAs face at Mirage and how do they respond to win their dignity? In this interview with Cermon, a black male PA at Mirage, he tells me about this worth as a PA at Mirage:

Me: How important do you feel your work as a PA is to the hospital’s overall objective, mission statement, you know purpose? So your work as a PA, how important is it to the hospital?

Cermon: I don't think it is important. We think that we are ahh interchangeable. We are just bodies. Ahh, I don't think we are important at all.

Me: To the mission statement objective of the hospital?

Cermon: Naw, naw I think we are just glorified baby-sitters.... (3 seconds silence, my face is probably indicating displeasure or disbelief with his answer)...I'm just being honest.

Me:... (4 seconds of silence)... So, given that, given what you are saying could you imagine... (slight pause) the hospital... (slight pause)... Functioning without PAs?

Cermon: Ahh... (2 seconds thinking silence)...no I don't see it functioning without PAs...ahh no; I do not see it functioning without PAs. I think that PAs do, some PAs do keep control and ah help the ward run correctly but... (2 seconds silence thinking)... I don't think the hospital values us at all. That's just my opinion.

Me: I see what you are saying, but at the same time you are saying it could not function really without PAs.

Cermon: No, no, It couldn't.²

Cermon's words seem contradictory. How can PAs be not valued by Mirage, while at the same time the hospital could not function with PAs? Cermon was answering my question based on how he, and many other workers, felt administration treats him. He does not feel like he or any of the other PAs are valued or respected by Mirage administration. He does however know that PAs are in fact the most important workers to the day to day functioning of Mirage. Cermon has been alienated from his work do to the fact that he has rationalized the hospital hierarchy and knows his position as a PA. It is merely rational as Weber (Giddens, 2004) explained. This rationality turns out to be not so rational and is one of the contradictions of modern day bureaucracies (Vallas, Finlay, Wharton, 2009; Volti, 2012).

Challenges to Dignity at Mirage: Subordination/Mortification

Throughout the day, the hospital expect for groups to be ran. They have increased the scrutiny over groups actually being done of the years. Initially, groups were supposed

²Quotation from Interview with Cermon.

to occur, but if they did not it was not look upon as negligence on the part of the worker. Now, if a group is not documented (not necessarily done) a worker is threatened to be “written up” as a disciplinarian problem. Similar to what Diamond (1992), I found and extreme interest by Mirage in ensuring that service was documented versus actually occurring. PAs, nurses, social workers, and therapists are the main groups of workers expected to conduct groups. Nurses, usually swamped with paperwork, rarely get a chance to actually conduct groups. Nonetheless, they must document that a group has actually occurred. PAs do groups the most, although technically, they have the least credentials but the most expertise. So not only do PAs do the most amounts of groups but their other frontline work as well. The flow of documents that say something is going on positive in Mirage is consistent with Goffman (1961) analysis of asylums. Goffman (1961) explained that asylums painted an image to the outsider which was different than what actually occurred, the world of the staff. I used to hear frequently from administrative personnel “do a group” to calm patients down. When patients become bored (which is often) on the wards, pacing, fighting, medication seeking, and general requests and acting out behavior can occur. For this reason, it is often times good to have something to keep patients in control. Having groups (sometimes patients complain they have had too much) is one way to keep patients from being bored and out of control. Controlling the patients through forced groups also keeps the corporation from spending on more entertaining services that are relic of the past according to Carlotta and Miles Davis (two PAs who worked at Mirage more than 20 years). According to Carlotta and Miles Davis, each time Mirage was sold to a corporation, the services were cut. The

thirst to make more and more profit is common practice among corporations which buy profitable businesses (Fein, 1990; Rosenthal, 1998).

Groups are important to Mirage for reasons of control and appearance (the symbol that mental health treatment is occurring by non-licensed or trained workers). However, do other workers view the groups of PAs as important? Are PA groups respected, and for that matter, their work within a psychiatric (medical and credentialed) setting?

Field Notes

I hear Michael's voice coming from the day room. He is really into it³. Two social workers are standing outside of the dayroom waiting for Michael to finish group (sometimes social workers will walk in and interrupt group without even speaking to PAs). They are both white-male social workers. One of them, Peter, recently completed his doctoral degree in clinical psychology, he insists now on being called Dr. Peter by PAs and patients especially. The other one, Nick, is working on master's degree in social work. Nick says to Dr. Peter, "Michael ...haha...he really gets them warmed up." Dr. Peter smiles and directs a new black female social worker who has now joined them, "this is what we have been talking about, you are going to run group."

Michael is merely the warm-up, the opening act to the main presentation which is going to occur. Social workers, therapists, and nurses are the ones who do the real groups, at least in their eyes. They are the real professionals and believe they are entitled to deference (Vallas, Finlay, and Wharton, 2009). "Deference—or the capacity to place oneself in a "one down' position vis a-vis others—is a characteristic demanded of all

³PAs run their groups usually in a lively and down to earth manner, usually street language, profanity, and real life examples that patients can relate to. For this reasons, most patients will state they enjoy the groups of PAs.

those in disadvantaged structural positions, including women, racial-ethnic minorities, and others in subordinate statuses” (Vallas, Finlay, and Wharton, 2009, p. 177).

PAs are just the side show, the warm up. This further shows the subordination of PAs at Mirage. PAs conduct passionate groups and usually relate themselves to the subject matter. They get into it. One social worker said to me one day, “It’s tough to follow your groups.” PAs usually discuss the reasons why patients have come to the hospital and how life circumstances relate to patients’ lives. Usually PAs talk about themselves in relation to patients. This is unique to PAs who often do relate to the communities and circumstances that patients endure. Jonathan and Dent indicated that they live in the same communities that most of the adolescent boys who are on the wards live. Social workers/therapists cannot make the same claims, but make claims of clinical knowledge which positions them in their minds to be the authorities and therefore are the “main events.”

Dent Perry, who has a bachelor’s degree in social work, discusses his experience with non-PAs:

Me: What other people besides PAs do you work with? Could you describe your relationship with them? Doctors, social workers, nurses, janitors, etc.

Dent Perry: Well... (Slight sign)...I am one of those people I deal with everybody, so I really have conversations and have relationships with the janitors on up. Cause the janitors are on the wards as well...Ah...Ah we have the social workers, we have the doctors that are on the wards on the wards, as far as I’m concerned some people don’t feel like they have any contribute... ah contribution ta ta to the patients, you know, some people might walk by and be ignoring you know those people, those patients rather and some people actually generally, you know, try to work together, try to communicate. Yeah, you know, I work with the social workers, the social workers on a close basis, the doctors as well. I have well, some communication with doctors. That’s something... that is something that is sort of strange too cause you have to try to get their attention in order to try to talk about patients. They usually just walk around as if... (1 second silence)... I had a, I had a doctor who I was standing in line, I was standing in line to get

some lunch anndd... he totally ignored me and went in front of me, and ah ah, I thought that was kinda of..kind of, well I knew it was rude. I knew it was rude, but I wanted to be professional as well, and I wanted to somewhat keep grounded. You know what I am saying, it wouldn't be no cool situation I was in somewhat awe he would do something like that, but it didn't care to him that it happened. And that's why I think some of the doctors get hurt on the wards you know cause they don't care, you know it is not them, it is not them going through stuff, they're there to prescribe you know, and move on, as far as they're concerned, they do what they do and move on...⁴

It could be that the doctor expected Dent to know the rule of deference to him as the higher up, and true professional, nonetheless, Dent Perry's comments during our interview highlight several key infringements on PA dignity, and they also suggest ways PAs get back their respect. First, Dent talks about how some higher-up workers (e.g., Doctors, social workers, and administrators) ignore PAs who are easily identified by their purple polo shirts throughout the hospital. Those purple polo shirts serve the purpose of letting the other staff know which staff are the subordinates (Vallas, Finlay, and Wharton, 2009). The doctor simply walks in front of him to get his lunch without saying anything. This is a systemic practice at Mirage. Dent does not know how to deal with this infringement on his dignity. However, he does explain why "some people get hurt" on the wards. Many PAs do not feel remorse when doctors or certain social workers are attacked by patients because of poor human relations with PAs. PAs are also prone to slowly respond, if at all, to cries for help if such doctors or other workers are perceived to be arrogant toward them. Thus, similar to what the Hawthorne studies found (Vallas, Finlay, and Wharton, 2009) human relations can determine if workers hold back in doing their work. When a PA, who feels undignified by a doctor, holds back, it can result not merely in the lack of production, but in a doctor becoming severely injured or killed. As

⁴Quotation from interview with Dent Perry.

Goffman (1961) explained, we are not merely discussing inanimate objects, as the early scholars of work did (Vallas, Finlay, Wharton, 2009), but my findings demonstrate how those early studies of production restriction or alienation toward one's product manifest on the front lines of psychiatric care with low-status workers.

Early on, I learned my place in relation to other workers in Mirage by their interactions or non-interactions with me. I highlight my experiences with the medical director in this field note.

Field Notes

I notice the medical director, Dr. Fine, the "big shot," walking down the hall toward the nurse's station. Most likely, he is going to get a patient's chart and see him/her. He fits the image of a Peter Jennings type news reporter or a politician. He is a tall white male in his middle 50s I would guess. He has finely trimmed pepper hair with a well-groomed mustache. He never really engages staff, especially PAs in any real conversation. He gives superficial smiles that would have you think that everything is just fine. I have never seen him angry or express much emotion. He often will pass you in the hall without acknowledging you. He commands respect because of his title, not for his connection with workers. I have overheard nurses saying that Dr. Fine "did not want be to get the report on a pending admission." Based on what I know, he is the one responsible for giving the ok for patients to be admitted to the hospital, which generates revenue for the hospital. The only real address that I have seen out of him came doing orientation, over two and half years ago. Throughout my observations, this remained the case. He never made eye contact with me or called me by my name. He walked up to me

several times, despite the fact that I have been seeing him in the hospital for three years, and just asked, “Can I see this patient.”

This common interaction, where the doctor asks for a patient and never says anything that would show interest in the subordinate worker, is consistent save in a few cases. Similar to what Diamond (1992) found with nursing aids in nursing homes, the administrators rarely visit the wards, only when the annual checks come do PAs really see them. Thus, the administrators are perceived as distant, uncaring, and above your average workers. PAs, nurses, social workers, doctors, administrators, and others are socialized at Mirage to know who to talk and socialize with (usually their own work group), and who not. In addition to this work class stratification, it is deeply racialized, with post PAs being black men, social workers being white women, and other workers being non-black. In this regard, as Rapport (2009) found of the hospital he studied in Scotland, mirage is reflecting the larger society’s racial and class order.

PAs Struggle for Dignity

Sometimes, workers do resist. Dupree, a black male in his middle to late 40s who has been employed at Mirage for more than seven years tells me about a situation that just occurred with the nursing supervisor:

Dupree coming back over from another ward after speaking to the night supervisor:

Me: What’s going on Du?

Dupree: Nothing, Sarge⁵ had called us over here, me over, and I answered the phone, and she was like who brought the patients over here? I was like I brought them over here. She was like get over here, they’re not being monitored, they’re over here playing around. I was like first of all you don’t talk to me in that

⁵A white female nursing supervisor.

manner. “You want something done, then you ask me, you don’t tell me anything. I am a grown ass man” Dupree talking about a confrontation he had with a middle age white female nursing supervisor.

This particular reaction by Dupree is an act of resistance (Hodson, 2001). Dupree is informing the night supervisor Sarge, that he will not be talked to any way she pleases. He is demanding dignity. At times I have not always resisted in this way because the consequences can be a write up for insubordination because you were challenging the order of a nurse or nurse supervisor.

Field Notes

Without failure it happened again to me. The new MSW/therapist, Brenda Kennedy, a white female in her early thirties, whom I had already been self-introduced by her less than a week ago, walked onto ward-5. She walked to the day room and asked Kuzak something. He said, “Hi Brenda.” She struggle and mispronounced Kuzak’s name saying, “Ku-Kuzi,” hi. Kuzak is used to others struggling with his name, so she usually does not attempt to correct them. She walks out of the dayroom and meets meet holding the rounds. Without saying hi or good morning Terrence, said “Could you tell me where John Doe’s room is.” I knew she would do this. Without saying, “Hi or better Hi Terrence” first, and then asking for help to find a patient’s room, she simply asked a question that I was supposed to jump to. Here I am, a PA for almost 10 years. I said to Brenda Kennedy, “Good morning, your name is Brenda right?!” She looked slightly caught off guard, and replied “Yes.” “Do you remember my name?” I asked. She said, “Ter-Terrell?” with a strange smile. “No, my name is Terrence. I don’t know his room number, you can go to the board [behind the nurse’s station] and find it there.” “Ok,” she said looking somewhat stunned and walking away.

“To defend one’s dignity means to resist infringements on dignity and to insist on being treated with respect” (Freeman and Rogers 1999; Hodson 2001:4). One example of interactions that build positive relations in society is saying hello, how are you: Schwalbe (2008) calls this the greeting ritual and says:

The greeting ritual is a way for people to acknowledge each other’s presence. We do this because we know it feels better to have one’s existence affirmed than to be ignored. We do it, in other words, because we respect other people’s feelings, and they ours. It is a little ritual that uplifts and stabilizes us emotionally as we go through our days. (p. 89)

This was not easy for me to speak up and resist my mortification/subordination. It never is. Sometimes you do it, and sometimes you don’t. I am highly conscious of my work position status, but it is so systemic within Mirage that it would be hard to constantly challenge it as Kuzak does not challenge those who mispronounce his name. Brenda is new, so one might be tempted to say, “Give her a break.” However, what is not new is the pattern and my predictability of her interaction with me. I have had almost 10 years of these interactions and at first I never paid it much attention, particularly when this behavior has been mirrored all my life in the American society. Maybe this is why I can connect to Goffman’s (1961) concept of mortification of the patient. Brenda is denying my humanity, my individuality, whether she knows it or not, when she does not address me as she would a fellow therapists, doctor, administrator, and even nurse. I take the time to ask Kuzak what he thinks. “Kuzak, you know I predicted that Brenda would not call me by my name. They are newly employed and we have been here for 10 years,” I say. Kuzak responds, “We are nobodies. We are the pawn, that’s why.” I am getting support from Kuzak, as I got it from him, David, Samford, Kimberly, and Michael Simwingo after a particularly difficult day for me recently. Hence, PAs also cope

mentally with their subordination/mortification through the support that they give each other. It is within this position, a college required position, that the subordination process occurs. The polo shirts that the PAs wear are key identifiers. I talked briefly to a white male social worker who has worked at Mirage for more than 20 years, and he said, “You are going to need a lot more than that” as I told him about my theory of the shirts as “equipments of mortification” as Goffman (1961) put it. Certainly, there is a lot more than the shirts. This interaction with Brenda highlights this. However, the shirts, which came about in 2009, readily give the green light to the rest of the “professionals” who is a professional and who is not. Who is deserving of a greeting and interaction as any human being would demand, and who is not. It tells Brenda, they are doing the dirty work, finding the patients, holding the patients, opening up bathroom doors, etc. As Brenda was leaving the ward she did it again. I am sitting in the dayroom with the patients. I am the only staff in the dayroom, so I cannot leave the patients unattended. A patient asks Brenda, “Could you open up my bathroom?” Brenda pauses, and says, “Ask him...my key doesn’t work.” I respond, “Yes your key does, we all have the same keys.” Brenda then turns around and opens up the patient’s door. Maybe she did not know, but why assume first instead of trying to open the patient’s bathroom door?

This is a pattern. This is a pattern of being an *ignorant agent of mortification* and *subordination*. Goffman (1961) elegantly described how the total institution mortified the patient. There is no doubt in my mind that I have played, and have to play a role in the institutionalizing of mental health patients. It is important to consider that the same institutions mortify the less privileged workers who are the closest to those mental health

patients. It is important to note that these workers have medical and college degrees and did not dream of the American dream this way.

Existential Power

Rapport (2009) illuminated humankind's ability to transcend total institutions through their existential power, or alternatively what he calls, *machtgefühl*, which translates as to feel power. Rapport (2003) explains that existential power, *machtgefühl*, is the ability of individuals to get strength from elsewhere (i.e., other than within their mortifying institutions/situations/confinements) through one's thoughts. Existential power is a "...means of removing themselves cognitively from the world, the total institution..." (Rapport, 2003, p. 248). Rapport (2003) conceptualizes existential power as a projective force which pushes one through their mortifying environments, and is product of one's own internalization of their circumstances. Existentialism is one's ingenuity, which all human beings have potential for, to find a purpose or goal to keep moving past external circumstances. It is the very dehumanizing environment, the slave boat, the Nazi concentration camp, and the asylum, that individuals are forced to use their existential power, "their secret," (Rapport, 2003, p. 260) in order to form their identity from elsewhere. Individuals do this in an active forceful process.

How do PAs overcome their subordinating statuses in *Mirage*? David, a Latino male I interviewed and worked closely with, did emphasize "staying busy" as a way of coping with mortifying environment. David stayed busy by constantly picking up towels on the wards, cleaning up after patients, running up and down the hallway in spite of his age, in his middle 50s. PAs, as one administrator recently said are "with the patient 100% of the time" to challenge me when I said PAs are with the patients 90% of the time,

in a recent meeting. The point here is that the PAs are not able to physically move about the hospital (leave the wards) enabling them to leave their statuses temporarily behind as porters do (Rapport, 2009). At times, if the PA is left alone he/she can enjoy humor, talk about sports, and run groups the way they like⁶. However, in the face of their interaction with other institutional workers, this fades away. All it takes is for PAs to be commanded to do something by frontline charge nurses, or written up. All it takes is for a therapist to pretend that they cannot open bathroom doors for patients, and thus PAs must drop what they are doing and fetch the door open for a patient 30 yards down the hallway. All it takes is walk to the cafeteria and see that other workers are not wearing those polo shirts (uniforms are a symbol of subordinate status) (Vallas, Finlay, and Wharton, 2009) to be reminded of one's work status. Rapport (2009) mentioned porters how transcended their positions by not analyzing their work deeply; porters were aloof in their mentalities toward work. Porters joked and pranked each other and embraced a working class culture of freedom.⁷ PAs are very similar in that they do not fully embrace their identities as PAs; none went to school to become PAs. It is a job or a "hustle" as many black men say. However, after the years keep going by, is this mentality possible to maintain? How can workers continue to tell themselves they are temporarily doing a job (it's a hustle) for decades? I wonder if workers ability to transcend their institutional statuses (existentialism) has longevity? My former wife recently finished all her hurdles to becoming a licensed and employed psychologist. She told me that "everyone was so nice [at her new professional job], I couldn't believe it." PAs battle long term with their

⁶The PA ran groups are mostly left up to PAs how they want to conduct it. It is one of the last aspects of PA work that they control almost exclusively.

⁷Rapport (2009) showed how porters drank and partied in a free way without concern about the next day's work or loss of valuable income on drinking and partying.

mortification can only come in two ways. One is that the institution changes, not likely, and all of the workers interviewed agreed, and the other is for them to leave their work statuses. After the awareness that asylums were mortifying, many were closed down with the aim of reducing such phenomenon (Weitz, 2013). Can we learn something about the nature of institutions, or even the larger society, that give some mortifying statuses versus others? Can we find a way to acknowledge the production of workers, even at lower levels of the hierarchy, that gives them pride and meaning? Hospitals are hierarchical in nature, and they divide labor, supposedly justly and rationally according to Weber (Giddens, 2004; Vallas, Finlay, and Wharton, 2009) in particular areas that are logical. What is troubling is that the workers, who spend the most amount of time with the patients, are the ones who are maybe mortified the most in Mirage. Is this rational? Is this logical? Additionally, when these workers went to our universities, they dreamed that the product of their many years of labor (and debt) would take them further than yesterday's orderlies (who only had a high school diploma). They certainly did not know it would mean having to deal with their own self-esteem and identity constructs as men of color in America. This mortifying feeling that comes from work positions similar to the ones PAs find themselves in, is not something simply sustained by research (Diamond, 1992; Rapport, 2009), but it something that I, and many other PAs felt.

PAs believe that they have more to offer to Mirage and in society. However, does the American society have something to offer them for the skills they acquired but are somehow stuck in their transitional moments? Should workplace resistance, which has its tolls on the individual, be always up to the individual? I know that the problem lies within the institution as Goffman (1961), Rapport (2009) and others showed.

Additionally, we need to look into the larger society to see how it already shapes the individuals who enter into such institutions to naturally accept their assumed statuses. This is where a study of class, race, gender and nation comes into vision as Rapport (2009) mentioned: “If culture is founded upon symbolic classification, then held together by the symbolic web are the institutions of everyday social life (p. 39)...Wellness is individually and collaboratively effected, in alignment with institutional norms and in subversion of them” (p. 59).

Are some people mortified within our larger society relative to others? Is the only way to overcome our mortification gained through leaving the structure (existentially or better yet physically) or destroying (de-institutionalization of all of the oppressive institutions) it? If we do, what better structures will come? I do worry about the existential power to engage in play (Hodson, 2001) or distraction as a remedy for the long term situation. I end this chapter with a field note written up rather recently to ponder the above point. Goffman (1961) states; “...protective response to an assault upon self is collapsed...he cannot defend himself in the usual way by establishing distance between the mortifying situation and himself” (pp. 35-36).

In the below concluding field note, I was simply unable to escape existentially from my mortifying feeling. Perhaps at times it is easier to overcome one's mortifying situation and escape with dignity through direct confrontation with agent of indignity, but perhaps at times as Dent Perry's encounter with the doctor in the lunch room and my encounter with the nurse manager on the ward, it is not possible to escape. At the moment, workers have to simply bare it the hard way until the moment has drifted away with time. Time heals the present wounds to live to fight another day.

Field Notes

It is Tuesday afternoon at work; Kuzak was switched over or “pulled over” to ward 6 because Michael Simwingo,⁸ a regular PA, had a problem with a patient over on ward 6. Michael said to me, “it is unfair how a patient has a problem with us and they pull us.” I am sitting on the plastic blue chair in the hallway of ward 5. Hazy White,⁹ white nurse in her late 20s, who only has her associate degree, is orienting a new nurse, who looks to be a white Latina in her late 20s. Hazy White yells out at me about 10 yards away, “Terrence are you doing the rounds?” Hazy is sitting behind the nurse’s station with the new orientée and the ward Manager, Darlene Smith¹⁰ (Nurse D). I respond, “Yes I am doing the rounds.” Hazy says, “they are supposed to be done walking.” I am irritated by this response, and I say, “Don’t I always do the rounds.” Nurse Manager Darlene and the new nurse trainee are listening. Darlene says, “You cannot sit in the chair in the hallway.” It is around 2pm, and I am somewhat tired from working since 7am. I challenge her response, getting up to walk toward the desk to try to have a private conversation not in from of Hazy or the new trainee. I say, “Michael is in the day room [with the patients and therapist]. Am I supposed to keep walking around?” Darlene replies, “patients might throw the chairs and you need to be up at the desk assisting the nurses.” Most of the patients are in the dayroom or in their rooms. The rounds are supposed to be done in 15 minute intervals. I attempt to justify why I am sitting in the chair, but Darlene does not let me. She says, “Did you understand me, you cannot have the chair in the hallway, and you need to be up standing.” I attempt to say explain, but

⁸Michael Simwongi, Black male with a slight African accent. He is of West African descent. He is in his late 20s to early 30s.

⁹Hazy had only been employed at Mirage less than four months.

¹⁰Darlene had only been employed at Mirage less than six months.

she cuts me off again and reiterates her point, "Did you understand me." I respond, "I understand.' The Latina nurse and Hazy are sitting listening but not making eye contact. I feel humiliated, subordinated, mortified by Mirage and its agent, the nursing manager. I am trying to console myself. I start to walk the halls and try to hold in my facial expression of sadness. I feel furious. I am thinking, should I go to human resources, what should I do? I am thinking that I have worked in this place for almost 10 years and have no voice, and little respect. I look around and all I see are social workers, therapists, and nurses. All are white women. I wonder to myself about race and gender. I feel powerless. I go to the day room and tell Michael Simwingo, and he attempts to console me by telling me his stories. He says, "Darlene once told me I could not have the table in the hall, and I told her that the CEO did not say anything. She went back and told the CEO and before I knew it, I was in the nurse manager's office and then the CEO's office. The CEO told me I could not have the table in the hallway." Michael asks, "T are you ok?" I tell him, "Yeah I'm ok." I am attempting my best to hold it inside. This is personal now. It is beyond merely listening to data and analyzing, I feel it. I feel belittled and demeaned because my actions can be dictated by others who I feel sometimes not well suited to tell PAs what to do. However, it's an institutional thing, and I understand that, but it is difficult not to be frustrated by it. Michael offers to take the rounds for a while, but I declined saying, "I need to move around. I got it." Michael tells me a saying in his native African country how one must do what they need to do to provide for their sustenance. He says, "Don't feel bad T." I continue to walk the halls trying to interact with patients and hold it together. I notice how at this moment, I feel closer to the patients than I do the nurses, social workers, therapists, and others. They are all non-black, and are all dressed

in their nice clothes save the frontline nurses and PAs at this point. The social workers are waking about the halls freely. Hazy attempts to come to me and talk, but I am not in the mood, so I say, “Hazy, not right now, not right now.” I am upset with Hazy for simply following nurse manger Darlene’s command to question me in front of the new nurse orientée. I know what has occurred was part of the education of the nurse to put “your staff” as Hazy said to her, in check. Nurses are socialized to manage and watch the PAs, and if necessary write them up for being insubordinate. I say to Samford and Kimberly who have just walked on for the second shift, “I just had my existential experience,” I repeat my interpretation of what has just occurred to me. I am getting support from my fellow PAs, and I feel the closest to them right now. I feel close to them and *the patients* who are mortified and told what to do and when to do it. A number of workers told me in their interviews that the “patients” help me deal with difficult times on the ward.” I see Kuzak come over from working ward 6, and I repeat what has just occurred. He says, “I know.” I give the report to Samford and Kimberly and then I head to staff’s lounge. I see David coming over from ward 57. I say, “David, let me tell you what happened to me.” He says, “What.” I explain again, and he says, “That sounds like Darlene.” He tells me, “You have to be more like us, “you have to appear to be busy. You can’t give them any reason to say anything.” For some reason, I start to break down in the staff’s lounge. I am trying to stop what I feel inside from happening, but I cannot. I feel the tears come out of my eyes. It has been a long time since this has happened, and it has never happened at work and in front of others. David notices me, but keeps talking. “You have to decide if you can handle this or not. You have to decide when you can no longer take it. I need my job, that is why I do it. You cannot change things. I know what

you want to do, but you cannot change things inside, maybe one day from the outside you will be.” I am trying to compose myself. Kuzak is looking away, and I am glad. It is still hard for a man to cry in front of others. If I were in my car, I would start whaling, but I am not. I light wipe the tears in my eyes, hoping that no one walks inside the break room. A minute later, Hazy walks in with evening shift worker to give her the report. I do not say anything. I walk out with Kuzak. Kuzak, David and I meet at the elevator and walk out together. David and Kuzak continued to tell me, “You have to look busy.” David says, “Darlene left me along when I started doing what I have to do, so she does not need to say anything to me.” Some other workers from Mirage walk out, and we joke around, “Is this a huddle?” one Asian male nurse asks. Kuzak walks me to my car and counsels some more. He says, “I know how you feel.” I ask him, “How can you do it being a medical doctor?” Kuzak says, “What can we do, being a Muslim, who will hire me?” He continues on, “I don’t want to work at KFC or anything like this. “ I get into my car and drive off and tear up some more at the light. I do not know why this particular incident affected me like this. I know that PAs are subordinated staff. I am writing about this, but I guess it personally impacted me. As I said to Kimberly and Samford, “I guess I had to be brought back to reality. Even as I type these words they are painful. I am ready to leave Mirage, but I really want more. I really want PAs to be dignified. I really want to earn my dignity. I really do not want incidents like this to occur again, but as David said, “You cannot change it while you are here, you are educated I know it’s difficult. I use to know guys like you. It was difficult for them.” To top all of this off, I know in the back of my mind that come my next day at work, I could be pulled in to HR and suspended if not fired for even trying to question the nurse manger. It is amazing how positional status

with certain organization count for everything. One patient tells me, “You are probably the smartest person here outside of Kuzak.” Nonetheless, being in this position minimizes all the intelligence one might have. We open bathroom doors, run errands for nurses and patients, and “are like this” Michael Simwingo says, holding his hand low to the ground. Indeed PAs are, and there are moments like this when we existentially feel it. My existential power has been temporarily closed by the material reality.

Conclusion

Workers need and demand dignity (Hodson, 2001). However, institutions, and those in charge of them, often pose challenges to their dignity (Hodson, 2001). PAs face infringes on their dignity through impolite demands for them to do things, being ignored, their work being minimized and viewed as the side show to the real work, being yelled at, being understaffed (and thus overworked), and not given proper resources to deal with their needs. Diamond (1992), Chambliss (1996), and Rapport (2009) found similar challenges to dignity involving nursing aids, nurses, and porters. It is often times difficult to existentially escape their mortification (Rapport, 2003, 2009). Goffman (1961) elaborates on his conception of mortification in his book *Asylums*, he states: “I would now like to consider a source of mortification that is less direct in its effect, with a significance for the individual that is less easy to assess: a disruption of the usual relationship between the individual actor and his acts. The first disruption to consider here is “looping”: an agency that creates a defensive response on the part of inmate takes this very response as the target of its next attack. The individual finds that his protective response to an assault upon self is collapsed into the situation; he cannot defend himself

in the usual way by establishing distance between the mortifying situation and himself (pp. 35-36).

However, just as many workers and peoples in difficult situations and environments have done, PAs escape through focusing on their work (David), looking busy (David and Kuzak), dreaming of finishing their school (Me) or being in a better place of employment.

CHAPTER NINE

CONCLUSION

I had five research questions I was interested in answering. First, in chapter 4 I addressed my first research question: How does the work structure of Mirage Psychiatric Hospital shape the work experiences of PAs? I found short-staffing to be the number one organizational pattern that impacted work at Mirage. Short-staffing is a structural decision by the corporate ownership; it meant that PA work experience was more stressful and less effective. The fewer workers on the wards, the more profit Mirage generates for its shareholders. Parker et al. (2003) iterated that capitalism is an organizational structure that seeks to maximize profit for owners. MPH is a for-profit owned hospital.

All of the interviewees stated that they went into this type of work to help people but find that they are pushed toward more paper work or some type of administrative hospital goal of Mirage Hospital. As Diamond (1992) found, documentation is at the heart of for-profit care institutions, even at the expense of actual care, the same is true of MPH where PAs and nurses cut corners to do work. I asked PAs and nurses if they were every short-staffed. This was strange question to most. “All the time” was a common response to this question of short staffing. I asked workers to describe the impact of being short-staffed due to the corporation’s bottom line (Fein, 1990). Workers indicated that they felt more “stress, hyper-vigilant, concern about their safety, lack of support, and in general greater frustration with administration” as a result of short-staffing. As a result

of short-staffing, workers felt they could not interact with patients, care for patients, provide safety, control the wards, and provide optimal or even adequate services to patients. Not only was the short-staffing a problem for workers, the lack of transparency and perceived care by administration negatively impacted the sentiment of workers about Mirage. Many workers said “they would never get employee of the month to me” or even if they had won this major award in the hospital, they indicated “I do not know how I was selected” or even that it was a true sign of appreciation by Mirage.

Floating is another institutional issue that impacted workers negatively. PAs like to work on wards they feel comfortable with and with people they like, which is usually the people from which they work every day. In summary, a financially driven structure that rarely provides enough support (staff and resources) and is perceived to be “clickish” and un-caring, negatively impacted the workers morale, services, perception of safety, and stress level at work. The job strain explanation of job satisfaction explains that the greater work demand and lesser work authority/control will lead to less satisfaction at work. This summarizes the overall experience of PAs due to the structure of Mirage.

In Chapter Five, I addressed my second research question: What are the social processes involved in accomplishing work for PAs and others at Mirage Psychiatric Hospital? The PA work is a patient driven service type of work. PAs are your jack of all trades type of frontline worker. They do many small tasks to service the patients on the wards. They tend to the daily needs and wants of the patients on the wards. In addition, PAs and nurses (Victor Sam¹ talks about giving medications before he gets the

¹Victor Sam, white male nurse in his mid 20s. He minored in sociology and majored in molecular biology as an undergraduate. He recently switched to the first shift. He now works registry as of 2012. He

order from doctors) cut corners to get work done. They fail to watch dayrooms, leave dayrooms, cheat on the rounds, and give medication before orders are given. These are all serious infractions which could result in lives being lost or the hospital being shut down due to its stated objective of keeping people safe. In fact when Mirage made the newspapers due to patients dying or being sexually assaulted you can link it to very structure of profit and chaos that exist at Mirage. PAs perform their work in less than ideal ways, which forces them to work together to accomplish the overall objective of safety. They use coffee and other soft tactics, a PA expertise. They make judgments about patient care that is suited for the various situations they find themselves on the wards, in short, PAs are governors of the wards (Goffman, 1961). They are the “expert practitioners of its everyday life” (Diamond, 1992, p. 222). If there is any art to be found in the work of PAs, it is in their ability to manage the wards (and the patients that come there) under less than ideal situations, and to do it well. Frontline-psychiatric work is accomplished through the will of the workers (the nurses and PAs) in spite of the structure of Mirage Psychiatric Hospital, as Diamond (1992) found of nursing aids working in a similar for-profit institution. Many frontline nurses indicated this much in their interviews. They indicated that PAs were part of a team in which they had to work together to accomplish their goals. A wise nurse or PA realizes that they have to work together for safety. Teddy Ogomo² mentioned how a nurse saved him from retaliating on a patient who had just threw water on him. Not only in helping each other remain in relative control, but PAs and nurses are the ones who must cooperate if services and

also works as a nursing supervisor. He has undergone a shift in perspective about nursing and Mirage. He is going back to school to be a chiropractor.

²Teddy Ogomo, black African migrant male in his mid or late 30s. He works the night shift and has been employed more than six years at Mirage.

control of patients are going to occur. Informal rules are the result of the lack of staffing at Mirage. PAs and nurses simply must cut corners as a result. PAs and nurses must cut corners when there is not enough staff on the floors. Sometimes, usually too often, dayrooms are left unguarded or PAs do not watch closely as patients are attacked or fall. The work is accomplished because PAs believe when no one else on the ward does, because they have to in order to do the work need to service patients.

In Chapter Six, I addressed my third research question: How do workplace relationships at Mirage affect the attitudes and productivity of PAs (and other workers that come into contact with PAs) at Mirage? PAs and nurses voiced their dislike of floating mainly as a lack of competence on different wards. However, when asked about the role of their core staff, most acknowledged the importance of “my team” in doing rounds and achieving their socialized objective, keeping patients safe. Some indicated that their co-workers were the main reasons why they did not want to leave Mirage Hospital. Working with people who workers know and like meant that work would run smoother for PAs and nurses because they would know that the work would be shared and not need to be articulated. The work would run smoother. The Hawthorne studies concluded this as well (Vallas, Finlay, and Wharton 2009). Assumptions about who takes patients down to the cafeteria, who makes the coffee, who talks to the young patients, who does the groups are not always stated but mostly implied. If PAs had negative work relations with fellow PAs or nurses, they generally had poorer communication. Poor communication means that wards do not run smoothly, and also workers are more stressed out. This hurts productivity, which in psychiatric terms means psychiatric patients are not serviced as well as they could be.

In Chapter Seven, I answered the question: What is the influence of Mirage's structure on the attitudes and behavior of PAs toward the care of patients? Gradually, PAs and nurses expressed an idea of just doing their jobs. Most PAs and nurses remained committed to servicing patients but subtly or not so subtly expressed a focus on simply doing their job and waiting for the shift to end. Burnout, alternatively called compassion fatigue by Todaro-Franceschi (2013) is according to Pines, Aronson, and Kafry (1981):

...a state of mind that frequently afflicts individuals who work with other people (especially but not exclusively in the helping professions) and who pour in much more than they get back from their clients, supervisors, and colleagues. It is accompanied by an array of symptoms that include a general malaise; emotional, physical, and psychological fatigue; feelings of helplessness, hopelessness, and a lack of enthusiasm about work and even about life in general. (p. 3)

I found no better explanation for what I observed on the faces and expression of many PAs (mine included) other than an expression of burnout or compassion fatigue.

Mirage's organizational structure was the agent of subordination, mortification (Goffman, 1961), alienation, and ultimately burnout or compassion fatigue (Pines, Aronson, and Kafry, 1981; Todaro-Franceschi, 2013). Cermon Edwards, a 35-year old black male who is an ex-college football player who majored in sociology as an undergraduate, and is currently going back to school to get his master's degree commented on the staffing situation at Mirage and how that affects his work, and level of stress. Cermon Edwards has worked at Mirage for more than five years:

Cermon: Ahh, a lot of times when you are short-staffed, you have to be hyper vigilant about. You have to be very alert, you have to be very conscious about the wards, a lot of times patients suffer due to the fact that we don't have enough staff. Sometimes patients have to go to the cafeteria to the gym, but if we do not have enough staff. [How structure impacts staff and patients]. That can't happen

because we have to keep the actual ward safe. The patients are deprived of some things due to the lack of staffing.³

I believe Marx's theory of alienation caused by the ownership of the means of production, in this case, ownership of the hospital, and Weber's conceptualization of bureaucracy (PAs internalization of their order in the hierarchy) explains the sentiments of PAs. For example, Cermon Edwards not only expressed the sentiment of many of the frontline workers, nurses and PAs included, but he always expressed how valued he felt as a worker. This is important in that how can frontline workers provide a service philosophy of "every person has the right to be treated with esteem and self-worth" when the workers who are directly and prominently charged to do so do not feel respected at all? Cermon on numerous occasions as said, "I don't give a fuck about them [patients]. They [Mirage Administration] don't give a fuck about us [PAs and frontline nurses] or them. He expressed the same sentiments and words in our formal interview. Some might feel dismayed by such comments. However, when workers feel habitually understaff and under supported, resentment, much like an overworked and underappreciated spouse, creeps inside such workers. Cermon indicated that

Support is basically when something is spoke upon where you need help on the ward, you are lacking something on the ward, that we need. It could be short of staff, it could be ahh, it could be transferring of a patient, it could be a lot of different things, so the administration do not support the counselors that are there. Our word, I mean, what we need is not valued.

I argue here that there is no way superior, therapeutic, and dignified services can be translated to patients if the workers do not feel supported and respected by administration. This applies to all service work involving frontline workers who are

³Quotation from interview with Cermon.

charged to provide an interaction with another human being. This is something that Goffman (1961) did not focus upon when he saw the mortification of patients. What caused the workers to be active participants in such processes when the patients and frontline workers spoke each other's language (Goffman, 1961), and thus were socially more connected to each other. Cermon's sentiments are an example, not an anomaly, of the frontline PA and nurse workplace circumstances at Mirage, and I am sure a lot of other places as well. Granted that most workers described their workplace condition as "short-staffed or understaffed," less than ideal for providing the image that Mirage struggles to maintain in the public, what is the nature of frontline psychiatric work, and does it get done? PAs battle their own mortification and burnout (Pines, Aronson, and Kafry, 1981; Rapport, 2009; Todaro-Franceschi, 2013) to service and provide safety patients. The longer the workers stayed at MPH, I observed an attitude shift in the PAs over time toward one of less-caring or burnout (Todaro-Franceschi, 2013).

In Chapter Eight, I dealt with the fifth and final research question: How do PAs struggle for their dignity in the face of their subordination? PAs and nurses have "an inner line drawn" to when it is time to speak up, leave the ward, or quit. Some nurses and PAs, who came to Mirage with their inner line very clear, did not stay very long at Mirage. Madonna,⁴ a Latina nurse was an example of this. Her ultimate stance for dignity resulted in her quitting a few months into her employment. For PAs, their stance for dignity is more subtle. At times, certain PAs did not wear the mandated polo shirts. At other times PAs "only focus on doing the rounds." At times, PAs yell back at nurses. At

⁴Madonna, Latina female in her early to mid-40s. She has been working at Mirage for about 4 months now (as of 3-13-2012). She has been categorized as "tough" by Kuzak Shan and David Lopez. She quit on 3-30-12 (Friday).

times PAs stand up to nursing managers and are supported by HR. At times PAs go to human resources and complain, this is a form of resistance (Hodson, 2001). At times PAs and nurses call off from work (absenteeism), as Hodson (2001) documented. PAs at times work so hard (or appear to be busy) so that no one can “say a word to me” David.⁵ Other PAs stated that they dignify their polo shirts due to their inner confidence and self-affirmation (Kenny⁶ and Samantha⁷). At times in the face of demands, PAs simply swallow their pride and work the years, as I have done.

How does the Structure impact the total work experiences of PAs?

Being a frontline PA means being a worker who is subordinated and/or mortified (Goffman, 1961; Rapport, 2009) and treated as a commodity (Diamond, 1992) by the institutional structure. Goffman (1961) spoke of the patient; here I speak of the frontline worker who is positioned the closest to the patient in the hospital hierarchy, the PA. To be a PA in Mirage means to be a worker without a professional title. To not have a professional title is to be invisible to others (Vallas, Finlay, and Wharton, 2009); it is to be a nobody, a body, an expendable (Rapport, 2009). This phenomenon is structural. In fact, when Mirage instituted the purple shirts, all workers began to notice who wore those shirts. Wearing such uniforms represents a badge of subordination (Vallas, Finlay, and Wharton 2009). PAs seek to earn their dignity by being professional in an organization

⁵David Lopez, Latino male in his early 50s but looks younger. He has worked as a PA since the 70s. He has been working at Mirage for about nine years now. He considers himself “hyper” and has encouraged me at one point to “write an article about this, you are a smart guy.” I do not totally know if I can trust him however.

⁶Kenny is a black male in his middle to late 30s. He has worked at Mirage for more than 10 years. He currently works the night shift. He declined to be interviewed officially, but unofficially I had many conversations with him about the nature of work at Mirage.

⁷Samantha Simms (black female in her late 30s who is in nursing school). She worked the lower functioning mentally challenged ward on the first shift.

that labels them, and treats them as a non-professional. In addition to this company based professional value, Mirage contradicts professionalism by not providing enough wages and conditions (Diamond, 1992) that would show it is a professional company. The structure of MPH makes the work experience of doing frontline work quite difficult. They say only the strong survives. Out of the 14 workers that started in my cohort, only two remain today, barely.⁸

Is their work important? Yes. Many PAs and frontline nurses acknowledge that without PAs, the hospital could not be run. However, do PAs feel that they are valued by Mirage as they should be? No. Do they overcome their subordination and work with dignity? Many do, and this varies according to the individual agency that they bring to Mirage hospital. However, there are times when even PAs cannot be elsewhere psychologically [Rapport (2009) existentialism], and must endure their mortification as Goffman (1961) showed in the career of mental health patients in asylums. I got a huge laugh out of my class when I said that frontline psychiatric work was like “being in a relationship,” it is fun in the beginning, and then it starts to change. Additionally, I have often thought, never read, that what we do as PAs and nurses is a lot like *rearing children*. You scream, yell, control, bribe, coerce, teach, look after, care for, and everything for patients as well as for children. Although, treating adults and even children as one of your own would be perceived as being less than professional, this is what we often needed to do because nothing else works. Our job, as articulated by many PAs and nurses is to “keep patients and the wards safe.” This is our entire objective as articulated to us in our training by Mirage. It is an important objective accomplished by

⁸Myself and another black female.

PAs on an everyday basis. However, the institution of Mirage makes workers feel as Cermon said, “glorified baby-sitters.”

The position of a PA at Mirage is shaped by a feeling of being incomplete. It means to be a worker at a dead end position, they do not see room for advancement, not supported by administration (by genuinely showing appreciation after many years on the job and/or providing the resources that show respect and support). It means inhabiting a position/status is practically and symbolically lower than social workers, administrators, doctors, and according to PAs (nurses). Some resist this positional status based on qualifies they had before they came to Mirage. Jimmy Smith, a longtime PA in his mid-50s said to me, “You had to have it become you came here.” Samantha prides her upbringing as to how she is able to resist her subordinated status in Mirage. Others feel their positional work status, but view it has temporary. They deal or ignore their workplace statuses by focusing in on the chore work, as David does, viewing this as the last stop on the work place journey, as Rafiq, Kuzak, David, Bernice, Miles Turner, and Carlotta do (all 50 years and older), as a part-time work (Cindy C, Oliver Smith, Dawn Mills, Rafiq, all registry staff), or as a transition (Me, Jonathan, Marshal Cromwell, Cermon, Jada Sett, Kimberly, Peter Sam). If we keep telling ourselves that we are better than these devalued jobs, it serves as a distractor from our current reality. David says, “I just focus on the work.” If we focus on the patients and our positive interactions with them on the frontlines, it does serve to lessen the blow. I started to gain a greater appreciation for this process. I started to feel like I was in it with patients. If we, the frontline workers could tell the chronically ill patients not to give up, who were we to not take our own advice? I started to notice the connection between the statuses of patients,

and that of staff. We inhabit the same areas. Hence, we smell the same smells, sometimes eat the same foods,⁹ we are irritated by the same patients, and we seem to have a greater connection with each other versus the doctors, social workers, administrators, and sometimes nurses. I even wonder if the purple polo shirts were placed on workers, especially the black ones, to distinguish them from the patients. If we were to pull off our shirts, how would others (social workers, doctors, and administrators) know if they were letting a patient off the ward or a staff? In the beginning of my employment at Mirage, I did not feel my subordinated status as much. There were no shirts or cameras; two main factors that changed the nature of being a PA. However, as my prolonged graduate experience endured, financial situation worsened, and reality of me being in a dead end position, struck, so did my morale and subsequent mortification. I had to find my way out. Some factors that I believe helped me were my co-workers (my sense of connection with them struggling like me) and the work (doing a respectable job and most importantly wanting to help or needing to help. Dent Perry said it well, “You are helping yourself by helping them.” It feels good to encourage someone not to give up. It feels good that you can say I am a practical example of not giving up (and you know it). It feels good to know that you have kept people safe and done the dirty work. Oliver Smith and Janet Exit clearly articulated their religious values in helping others. If you focus on “the help,” it is a way of escaping the other side of the coin, your positional status. A PA has no title. A PA embodies his attributes as a worker. The way he communicates to the patient. His/her dealing with people who might be psychotic, out of

⁹ I have certainly eaten trays that patients did not want or that were extra. When you are stuck on a ward for eight hours and cannot leave due to short-staffing, or do not have money, these trays are a God-send.

control, angry, confused, or sad, in a human way is the gift that PAs possess. Yes, we ask doctors and nurses for medications when needed; however, we first, and sometimes last, deal with patients using human skills. We use our presence as men. We use our physicality as men. We use our street smarts, intelligence, and tacit tactics (sometimes letting a patient beat us in chess or giving extra snacks) to deal with patients. These skills were acquired and required because of our frontline work. Indeed, many of the PAs had these skills of street smarts and speaking patients' language when they came through the door, but as a matter of survival these person skills became a necessity. What does it mean to be a PA in mirage? I think it means to be able to push one's self past what one thought or was willing to do. It means being flexible. As Jonathan said, "I'm no longer the new cop, I'm the old cop." No one set out to be a PA. The PA position became a default position as a result of education or non-psychiatric credentials. The meaning of being a PA is being a position where only laymen skills are appreciated. As Janet Exit said, "We bring something to this position." If one has little to bring, then the position itself brings the status of an attendant or orderly (who might only have had a high school diploma) to the individual. As Jonathan said in his interview, "we are at the bottom of the totem pole." PAs are very aware of this fact. Kuzak said "we are ward boys." It is ironic that the workers most close to the patients, thus perhaps, in the best position to know what the patient is experiencing, have the least authority and status in the hospital outside of janitorial and kitchen workers.

It must be pointed out that PAs are not nurses aids, correctional officers, security guards, or even orderlies or attendants (although this could be argued). Kuzak says "we are ward boys," something I sure some PAs would initially have a problem accepting.

The main reason I say that PAs are none of the above mentioned workers is based on the required bachelor degree for employment and hour rate of pay (15.00 and hour average pay). Additionally, and I hope to describe later in detail, PA is different from the work of nursing aids, security guards, or even correctional officers. The orderly question does beg further conversation. I discuss it here one of my field notes:

Recently, while sitting around in the day room with Sandy, a white female PA¹⁰ in her mid to late 30s, who holds a master's degree in counseling psychology, I asked her “what job titles historically, would you say that we fit into?” Her response after pausing and thinking, “orderly... yes, we are in charge of keeping order on the units.” This blew my mind. After pausing and thinking a second, I said, “I guess you are right. We are highly educated orderlies.” She later said to me while we were seated in the dayroom watching patients and the hallway, “a bachelor’s degree is like a high school diploma today, many people are working at Subway and McDonalds with bachelor’s degrees.” I said, “but there are many people that don’t even get their high school diplomas (thinking to myself of the black male high school graduation rate of around 43%), what happens to them?” My face was expressing display, I would assume. She said, “Look around” (meaning look at the patients sitting in the day room we were caring or working for). Sandy continued, “We are paying for these people...we pay in order to have a job to take care of these people...I just hate when they make mess, why can’t they pick up the packs of sugar and clean after themselves.”

Samantha Simms, a black female in her late 30s who is in nursing school currently, says about the title of a PA: “There is nothing technical about what I do, I get

¹⁰I have not seen Sandy in a while. She is/was a registry PA.

offended” when people refer to PAs as “techs.” “The title used to be Psychiatric counselor, but they changed it.” “We have bachelor degrees, we are professionals.” “I came up here and they saw me with my civilian clothes on and they were like, Uuhh,” Samantha says. “The patients or staff,” I ask. “Both,” Samantha replies. PAs are automotive specialists, medical doctors, accountants, and nursing assistants. It is quite impressive to talk with PAs and learn that many are unassuming individuals with loads of what I call untapped talent.

I will ask this question again, and answer it for the final time. How does the structure Mirage shape the work experience of PAs? The position is clear, a subordinated devalued worker. This is institutional. If we focus on the significance of the work, in the spirit of a Florence Nightingale, who want to assist the troops of the front lines of war, the PA position is the most noble in light of Mirage’s objectives. If you were to ask workers, they know they are important, but do not feel important and only look toward some type of transition. This status is overcome by some not as a result of their position, but in spite of their position. As I asked Nigel Rapport about Bob-the bodybuilder, in his study of another subordinated hospital work group, porters, “How long will Bob the bodybuilder be able to escape his work-place status through his body building identity?” I do not believe that this is a static situation. I think realism occurs, as what happened to me when Sandy said I was nothing but an orderly. Perhaps, focusing on nothing but the chore/service and helping others will suffice, but I have my doubts. The only way out of this status as a PA, a layman in psychiatric work, is to get out.

Existential Power (Rapport, 2009; 2004) is a cognitive ability to overcome difficult circumstances by being elsewhere mentally by internalizing different meanings

than the material situation would indicate. PAs exercise this power because they need to in order to deal with their subordinated statuses within Mirage. The meaning of being a PA is in being a frontline-psychiatric worker who is not specialized or credentialed in the higher fields within Mirage (i.e., nurses, social worker/therapists, or medical doctors). Even if one has these credentials, when one puts on that purple -polar shirt and works as a PA, they are by default only responsible for the “dirty work.” They are responsible for dealing with patients’ needs and behaviors on the wards. They are subordinate to nurse, social worker, and doctor on the ward. They are the bodies. Because PAs are physically in these positions, they are symbolically in these positions as well. They are often ignored or treated as “staff” instead of treated as individuals. Many PAs mentioned that being ignored or wearing those purple uniforms as being demoralizing. The same colored shirts indicate this symbolically as well. As some workers said, uniformity was needed as a justification for the implementation of this shirt as a uniform in Mirage in 2009. Many workers indicated that they felt they were “bodies, expendables, demoralized, or not important” despite the fact that they also said, “we are the glue, information conveyors for patients, the foundation, *“hold it down,”* and the hospital could not function without us.” In the superman analogy, PAs would be Clark Kent and the Psychiatrists would be Superman. Clark Kent indeed is superman, but he never gets the credit, he just stays in the background and plays his role.

In spite of their subordination/mortification, PAs are excellent conveyors of patients’ behaviors in laymen terms, not necessarily experts in psychiatric terminology. As Rapport (2009) mentioned about porters being experts in hospital information, PAs are expert in knowledge of patients’ actual behavior, not in psychiatric terminology. They

know the patient well because they are mostly around the patients. This also means that PAs are potentially experts in dealing with the patients' needs and problem behavior. The work of a PA, a jack-of-all-trades psychiatric frontline worker, is multifaceted. It can be said that the history of nursing shows that nurses were historically in a similar position until their specific nursing knowledge was instituted (Weitz, 2013). PAs are members of a subordinated work group within Mirage. What makes this unique is that their educational levels and experience would suggest that they would enjoy higher statuses than other similar workers (nursing aids, hospital porters, and even nurses who in most cases only have an associate degree). However, it is the lack of credentials, which serve to solidify.

PAs and the frontline nurses of Mirage are the unsung heroes of society. I say this not because I am one of them, which I am, but because they really risk much for unequal return from Mirage Psychiatric Hospital, and from society. Social services don't pay relative to other job sectors. Society seems not to value the human being the way it should. PAs have a lowly status relative to other workers, and especially non-frontline workers within Mirage. This is clear, and all PAs have a sense of their statuses relative to others. Yet, many PAs work hard doing the so-called dirty work of psychiatric care. PAs bathe patients, change diapers, pick up towels, change beds, clean up waste, wipe tables, dress patients, open bathroom doors, hold patients, watch patients, chase patients, teach patients, encourage patients, listen to patients, and try to believe in patients, even when they do not believe in themselves. They do this for human beings because they feel they need and deserved to be helped and cared for. They are the heroes. This is not to say that there are no bad PAs or nurses, there certainly are bad apples. Similarly, the same could

be said of any line of work. There are bad doctors, police officers, judges, teachers, politicians, you name it. However, the rule is that PAs, although many times by default, are the actual people that help mental health patients with the needs that are essential. As many PAs said, they could not imagine Mirage running without their services. More than just the services that PAs provide to patients, the context in which they provide the services and care, and from which they come from is truly remarkable. PAs are the expert practitioners (Diamond, 1992) of frontline everyday psychiatric care at Mirage Psychiatric Hospital. However, at the end of the day, MPH mortifies, disrespects, and makes frontline work more difficult than it should be due to the organizing structure of capitalism (Parker et al., 2003). MPH does not provide adequate staffing. Inadequate staffing means workers must be floated, undermined, and put under stress. Diamond (1992) observed the same phenomenon giving the same explanation. This institutional practice contributes to negative attitudes toward MPH, other workers, patients, and self (Goffman, 1961; Diamond, 1992; Chambliss, 1996; Rapport, 2009; Todaro-Franceschi, 2013).

CHAPTER TEN

FUTURE RESEARCH

MY SUGGESTIONS FOR FUTURE RESEARCH AREAS

Vallas, Finlay, and Wharton (2009) indicated that the long-term impact on frontline workers who experience burnout is incomplete. Future research needs to look into the long-term impact that frontline stressful psychiatric work has on its workers. What is the impact on the self-esteem and identity of workers who carry subordinated workplace statuses over their work careers? What is impact on the personal lives of such workers? In addition, future research needs to explore more thoroughly the role of race, class, and gender in bureaucratic organizations.

Many PAs and nurses remarked that they “learned a lot” about themselves and about frontline psychiatric work as a result or benefit of working at Mirage Psychiatric Hospital. As I spoke with Victor Sam, a young white male nurse currently in medical school, I revealed that “I am cable of doing things that I would not have been able to do’ if I would have never worked frontline psychiatric work, “I can go to another level.”¹ He agreed, saying he felt this kind of work does that to a person. It is something about holding a person down for hours because you know if they are released, they will attack you are someone else that pushes you to have the ability to do things you never would have conceived of doing, or you would deem them as immoral. It is a matter of self-preservation at times working frontline with psychiatric patients who can and do attack.

¹By this I mean do things I would never had done had I not worked many years as a PA.

For example, Ina Jaffe's (2011) NPR article, "At California Mental Hospitals, Fear Is Part of the Job," it brought to light patient violence toward mental health workers. This is something that most, if not all mental health workers, (PAs included) can say is something that potentially can happen and does happen in psychiatric settings.

I remember Cermon remarking that this impacted his treatment of not only patients, but "human beings" in general. I call this the desensitizing effect of working as a frontline worker with Mirage Psychiatric Hospital. Future research should seek to explore when frontline workers can no longer use their existential power that Rapport (2009) cited as a tool for similarly subordinated workers. I wrote to Dr. Rapport, and he wrote back. In one of my emails I used the porter Bob-the bodybuilder as an example of a person who should be researched to find out if after years on the job, when the realization as set in, he is not a body builder, what will he use as his existential power to escape the reality? I wrote:

No doubt, Bob and the other porters struggle to escape their workplace identities by gaining their dignity through body-building and other identities. However, who or what is the ultimate victor? After working ten years on the job, I wonder how would Bob cope with his identity after such a long period of telling himself he was not a porter? I can say that it has been a struggle for me. My identity has been that of PhD. student. At least I have tried to escape mentally in this construction. For the established researcher this is not a problem. He knows he will leave the field. For the graduate student who has not yet obtained ABD status, it was not easy. At times, I have struggled with this. At one point, I said to a co-worker who said, "We always saw you as a student," "No this has been my work life, like you, for 9 years." When does the concrete reality set in for workers at the bottom? When does the subordinated worker wake up and see that he/she earns his living through being a PA, porter, nurse's aide, security guard, or some other lower caste? The hospital shapes his identity in the long run and at the end of the day? I have a question. Should the goal as ethnographers be to show how such workers as porters/PAs negotiate their status in the workplace hierarchy? Or, should the goal be to explain as you said, "employees of total institutions find themselves mortified and alienated"? I can highlight the unique expertise that PAs have and their importance to the everyday function of the

hospital. However, at the end of the day, their expertise has to be recognized as a fundamental moral function as the profession of nursing has to a degree. (Scott, 2006)

In addition to examining the long-term impact of being a PA, future studies need to examine the role of race, gender, and class on frontline work. Many of the PAs are black men. I think future quantitative studies and qualitative studies need to find out why? I did interview these workers to get their life histories of why they chose the educational and career routes. I also did not examine quantitatively why most PAs are black men.

Additionally, gender plays a role in how work is organized at Mirage, most PAs are men. Future research needs to examine this dynamic in psychiatric hospitals. Last, but certainly not least, we should not forget the patients. The focus of this study was not on patients, but patients are still very much mortified in today's mental hospital. Although some are willing to come, and are not simply shipped to places like Mirage, places like Mirage are still mortifying. In many ways, they have to be this way due to the lack of control mechanism to prevent some patients from abusing others.

APPENDIX A
METHODOLOGY

Every one of us has had the experience of being a stranger in the midst of a new crowd. We walk into a room or join a large cluster of people all of whom seem to know and understand one another. As we nervously approach some part of the chattering crowd, we look at individuals to make eye contact or to shift their position to allow us to join the group. Our senses are on full alert. We observe the people present, how they are dressed, their relative age, who seems to be doing the most talking, and how each individual responds to what others are saying. We listen to conversations taking place to try to gauge the pace of the conversation, the degree of formality or informality of the language being used, and what it is that is being discussed. We look for ways in which we might begin to contribute to the dialogue. In such situations, each of us is engaging in something akin to ethnographic fieldwork, and using the method that anthropologists call participant observation. (DeWalt and DeWalt, 2011, p. 1)

Introduction

The purpose of this chapter is to discuss the methods I applied to complete this study of frontline psychiatric workers at Mirage Psychiatric Hospital. I feel I could write a small book (Instead how about a medium chapter?) on the methods I took to do this research. What is a method? A method is a way something is done to achieve an objective.¹ Methods are also a part of our epistemology (Madison (2005)). Although years would pass with me battling finishing my classes, qualifying exams, and finally defending my proposal with IRB approval, I always kept my eye on studying the work of frontline workers at Mirage. I really had little choice in the matter because I had to work to sustain myself and family.² I had limited financial resources as a working class³ (whatever that is) black male. I was raised essentially by a single poor black woman. Workers have eyes and ears; hence, workers see and hear other workers during the course of their work. Informally, I have been observing workers and developing my thoughts about the processes involved in frontline psychiatric work for years. If it is necessary to

¹Sometimes objectives are known, sometimes not.

²A method of necessity perhaps.

³Living check to check is working class or the poor working?

make a formal distinction between naturally observing and actually jotting down observations and writing them up as field notes, this is my attempt to do so in this chapter.

Distinguishing between merely observing and writing up and analyzing what one has observed is in fact a critical one according to Emerson, Fretz, and Shaw (1995). Silverman (2008) states, “Ethnography puts together two different words: ‘ethno’ means ‘folk’ while ‘graph’ derives from ‘writing’” (p. 67).

Learning how to do ethnography

Ethnographic research involves the study of people “as go about their everyday lives” (Emerson, Fretz, and Shaw, 1995, p. 1). The first process is to get to know people in the setting one chooses to study. You join the community or group and do what they do and observe. Next, you write down in a systematic way what you are observing.

Emerson, Fretz, and Shaw (1995) state:

These two interconnected activities comprise the core of ethnographic research. First-hand participation in some initially unfamiliar social world and the production of written accounts of that world by drawing upon such participation. (p. 1)

In fact, I believe had entered the field of study in 2003 when I got hired as a PA, although I did not realize it⁴. If this is true, my level of participation was on the level of what researchers say is *complete participation* (DeWalt and DeWalt, 2011, p.1). Had I “gone native?” No, I do not think so because it was not initially my intent to study what I was doing. I was a full member unaware (or uninterested) of the rich traditions of sociologists studying health care institutions (e.g., Schwartz, 1954; Belknap, 1956;

⁴Although I did not intend to study this work, I have always been interested in studying structure and agency.

Dunham and Weinberg, 1960; Goffman, 1961; Strauss et al., 1964; and Scheff, 1966; Diamond, 1992; Chambliss, 1996). This is not even to mention those who studied work or how structure influences work (which can be linked to the founding architects of sociology as a discipline). Additionally, I did little writing in the beginning.

In 2004, I took a qualitative course at DePaul University and was given the assignment of studying a site which was most convenient.” What was convenient was the work I had already been doing for one year.⁵ Since this was a class study only, I did not need to bother myself with any formal disclosure, nor did I try. My assignment was simply to note what I and others were doing in the environment. I certainly did not feel that I would still be working at “the practice site” nine years later.⁶ I have mixed emotions about this until this very moment. I cannot say that it has been the most pleasurable experience, but I, like many other PAs,⁷ have learned a lot (I guess about myself too). I completed a few practice assignments writing up field notes. I do not remember much feedback from the instructor in regards to turning this into a real project. I thought little of the experience after it was over. However, when I review the field notes from back in 2004, it really is amazing how much I captured that is still basically the same. The hospital is still a locked facility with the various doors workers open every day. Workers are still trying to keep order on the wards, and personal work relations (a theory I was not aware of based on the Hawthorne Studies of the 1930s) still influence the type of information workers get, and potentially the type of day a worker will have.

⁵My first “class project” in qualitative studies at DePaul University occurred in 2004. I started work at Mirage in 2003.

⁶I think that this is a very important point. If I would have known this, I would never have stayed employed at Mirage. It was too difficult at times emotionally.

⁷When I asked PAs and nurses in their interview how they would sum of their experience, many said “I learned a lot.” Indeed, very few work environments are like psychiatric wards.

Many of the workers from back in 2004 are no longer at Mirage; however, the structure remains the same.

My next learning moment came in 2006, when I took qualitative methods at Loyola University with Dr. Judith Wittner. I was encouraged to do basically the same thing I had always done, i.e., as what Lofland and Lofland (1995) recommend, “starting where one is socially located and most interested” (p. 3). I naturally started again at my work. I was not “most interested,” in studying work again. At this point (three years into the work) I wanted to finish my schooling and leave Mirage Psychiatric Hospital. I was not totally aware of the mortification process, or what I call, the subordination process, I was going through. Learning to do ethnography this time around in qualitative methods was more intense and involved. I wrote more field notes which were analyzed by Dr. Wittner in detail (unlike in my first experience⁸) over a full semester. I coded my field notes for themes, interviewed two PAs (transcribed the interviews), and wrote up what I felt was the story of Mirage at that time. I informed the PAs I came into contact of my study objectives for my class. I got consent from the workers to do this class project. I called the final project “Between Services and Expectations.” I identified the tightrope that PAs walk between servicing patients and enforcing the rules of Mirage.” I look at this in somewhat amazement because I had not read much empirical studies of work. Now, after having read a great deal of empirical studies of work today, it appears that I was on to something (I did not realize this). I got an A out of the course and much encouragement from Dr. Wittner. It was an excellent learning experience. Nonetheless, I

⁸This is not to be negative of my first graduate school qualitative professor. Her focus was to give an introduction into qualitative methods and not have us focus on doing an ethnographic project.

had to complete the rest of my studies. Still, at this point, I was not passionate about studying what I was trying to leave (the job of a PA). From 2006 until 2009 I took courses, and I started to focus on my scholarly interests at that time. I was interested in studying race and structure connected to my experiences as a “New African”⁹ as one of my close associates has coined for African Americans or blacks in America.

I wanted to study something involving race, and this view was heavily influenced by my new advisor, Dr. David Embrick. I listed as my interest back in 2007 or 2008: race, socialization, structure, social psychology. My master’s thesis was called “The Success and Failure of African American Young Men in High School.” It was a quantitative project involving the NELS data set. I was still not clear on what I would study for my dissertation. It is important to note that during these years of “figuring out things,” I had to go to work. I built relationships among the workers. I wanted the interactions between various groups (or classes) of workers. I experienced when work at Mirage was better than it is today. I find it worth pondering how my experiences of studying PAs would have been different if I would have showed up the first day introducing myself to PAs as a graduate student interested in studying what work is like for them. Would they have given me their time, as many did, for the interviews (And it was still difficult at times to arrange meetings)? Would they have been as candid in their interviews (one worker even admitting that he became physical with a female patient). Would I have been as convincing as a graduate student attempting to study their work? I think it would have been more difficult for me to complete this study had I shown up my

⁹Black people are no longer culturally (or even racially) the same as they were before slavery. However, blacks in American carry a unique culture that bonds and separates them from others.

first day looking to study PAs. Would I even have felt trusting enough to put my job on the line by informing workers of my research intentions? One nurse right before I interviewed her said, “They [administration] would never give **you** [my emphasis] approval because they don’t trust you.” My point here is that the time I spent at this site, although I was not officially studying it, has helped me enter into studying the work as a PA. From this perspective, my time was not wasted, although at times I surely felt this way.

Focusing and Committing

It really did not crystalize for me to study the work of frontline workers until Mirage started to make the news, and the hospital started to change. I felt like, if the things that were going on in Mirage were news worthy, and they were. I thought to myself, “Why am I not studying how work is carried in this hospital?” Madison (2005) states:

It is important to honor your own personal history and the knowledge you have accumulated up to this point, as well as the intuition or instincts that draw you toward a particular direction, question, problem, or topic...Ask yourself questions that only you can answer: “What truly interests me?” What do I really want to know more about?” What is most disturbing to me about society?”... “What is the work my soul must have?” (p. 19)

These last two questions “What is most disturbing to me about society” and “What is the work my soul must have?” tremendously motivated me to arrange a meeting with Dr. Wittner to discuss the potential of studying work within Mirage Hospital. It had been three years since I had taken her course and studied Mirage as a way of learning ethnographic methods. I did not know if she would remember or be willing to work with me. I went to Dr. Wittner with the idea of studying my work. She supported me and we

went to IRB. We tensely met with IRB. Doctor Wittner admitted that she did not know if they would approve the project. To our delight, IRB indicated the study would be approved without the need of formal consent from the hospital. That was in 2009. I however, was still not done with my comprehensive examinations. I recall IRB explaining that as long as my consent from the workers and field notes occurred outside of the hospital, I was find to write field notes.

From 2009 to 2012, I have kept an eye on the nature of work in Mirage. I have kept a close eye on how the social structure has shaped work life (Bonilla-Silva, 1997). I have seen workers come and go. I have felt frustrated, subordinated, depressed, horrified or mortified, and in this process, have become more committed to studying the work of psychiatric frontline workers (nurses and PAs). From 2009 until 2012, I completed my qualifying examinations, dissertation proposal, and got IRB approval. During this period, it was very difficult to stay motivated. I read books and articles on work, mental health, and race theory. These readings helped me to see the sociological significance of what I was intending to study. One of my main concerns during this period was not getting fired. I could not get fired before I officially engaged in studying the work. I remember being called into human resources one day and suspended. I thought I was going to get fired. I was charged with insubordination (for arguing with a nurse over the assignment she had given). One of the main incentives that I believe enabled me to continue in this work for nine years as that fact that this is want I was committed to studying. However, at times, as I said, it was the last thing I wanted to entertain in my thoughts. What this means to me, or others who might want to learn from my methods, out of extreme desire

to move on past what I was studying, I had to remain committed to remaining there to study it. That sounds strange, but it was part of my unorthodox method.

As I am learning, doing

At times, I have focused on merely doing my work, and at other times I have attempted to pay attention to my work. This is a difficult line to draw in honesty. Was I working merely? Was I observing mostly? Is it possible to merely observe even if Mirage gave me approval to observe and work at the same time? First and foremost I believe I have been a PA, and then a researcher, if it is again necessary to make this distinction. Gold (1958) categorized four types of field workers: the complete observer, the participant-as-observer, the observer-as participant and the complete participant. I was not a complete observer because I was a worker. I was not hired or allowed to be an observer and then a participant. Hence, I was more so in the role of a participant as observer because I was in this setting to carry out the work with the personal intention to observe (when I had the opportunity to do so). I continued to work and observe PAs and nurses, administrators, patients, and others. At times, I intended to pay attention to what workers did and said. At times I honestly was disinterested because I was at times emotionally numb. I did not want to think or observe because I was burnout emotionally and physically. From 2003 to 2010 (seven years), I worked the second shift (3-11:30pm) while my wife attended classes and cared for our children in the evening. The second shift is a difficult shift. For example, I was home by 1145pm, but I was so wired up from the work, that I usually did not get to sleep until 3am. This is very common with PAs and nurses that work this shift. At 6am, sometimes earlier, I was greeted by my sons and tired wife. A lot of times honestly, I did not want to write or think about work because I was

simply irritated by the day to day process of being a PA in Mirage. Chambliss (1996), Hodson (2001), Rapport (2009) show how workers cope with their difficult work realities in a number of ways: by conceiving of it as a routine or viewing themselves beyond their realities (existentialism), or creating games of horseplay. I mentally, as much as possible, thought of myself as passing through Mirage on the way to becoming a professor or academic. This allowed me to absorb or ignore my reality on the ward up until a certain point. I think a critical point occurred during the subordinating period that made me question my reality and identity. After the polo shirts were implemented (I really felt that this smelled of classism and racism but I could not openly exclaim this to administration despite evidence saying that uniforms represent subordinate workers), after the staff was cut, after the cameras were implemented, after the 3% pay raises were frozen, after workers were constantly reminded that the economy was bad, I started to look at my current reality of being an PA who happened to be an “over-glorified PhD student” or “doctor” as some workers called me.

Telling PAs and Interviewing

After finally defending my proposal and getting IRB approval in June of 2012, I started revealing to the majority of the PAs my intentions of studying the work of frontline workers. Not only did I start telling PAs and nurses about my intentions to study and interview them about their work, I began to involve them in the process. I asked PAs “do you think I should ask this PA or nurse to be interviewed?” PAs gave their opinions about who was a suitable candidate to be interviewed. “Why don’t you ask Christian (A social worker at Mirage)?” Kuzak (An Asian middle age regular PA on my ward) would explain. After my interview with Miles in his house, he said, “I told Nancy (A black

female nurse)” about what you were doing, and she would be willing to be interviewed.”

One PA, who I never got a chance to formally interview, even offered to call the former director of nursing (DON) of Mirage to arrange an interview with me. Hence, many PAs wanted to “help me,” and many saw it as important.

Many have said that this work is very important. It is, but nonetheless I found myself needing to tell workers that this is “between us” because I do not want this to make it “to human resources and administration.” All of the workers I spoke to about the study agreed it was important not to let administration know what I was doing. I first naturally, asked workers who I felt the closest to. This would naturally mean the workers who I work with the most, and who I trust. I would explain to workers that I had to “talk to you about something.” I looked them in the eyes with a serious face when I told them I wanted to study the work of PAs and frontline workers (nurses). I made it a point not to ask workers for an interview over the phone. I wanted to look people in the eyes and let them know this was serious—at least to me.

This made my study sort of clandestine in nature. I was studying work, but mainly at one point outside of the hospital. This process occurred when I interviewed workers outside of the hospital. At the same time, I was (and am) a worker at MPH and regularly observed what they and others do. I know what the workers are, and are not, telling me on audio tape. This is intriguing to see how participants might say one thing on tape that seems contradictory. Dent Perry’s interview is a clear example of someone seeming not to connect the dots on his own subjugation although at times he said, “we are mostly black males” but does not indicate that he would change the uniforms (which mostly black males wear) or anything about Mirage. This made me consider if asking

workers direct questions is good methodologically. Indirectly he indicated clear subjugation in the first interview, but in the second one he was less revealing? It had been a week that passed since our first interview. He could have been concerned about his confidentiality. Did he trust me? Was he trying to keep some control? When one reveals all to someone, it does open them up to the devices of others. I was not sure. Most of the interviewees (the remaining 24) were very straight forward and candid in their responses to my last to final question about “What can we do as PAs to change our and our patients’ conditions at Mirage?” This process of what interviewees said and what they say and do off of tape have been debated and talked about by researchers. Chambliss (1996) indicated in his ethnographic studies of nurses, many workers do not notice what is occurring during the routine course of their work, hence they then to recreate events in interviews that reflect their interests. This is putting it nicely. Some workers are very calculating. They considered the ramifications of being interviewed on tape discussing their feelings about MPH. Some I believe were indeed concerned about their job security. This indicates the importance of methodology. I do not believe simply interviewing workers would have gotten to the meanings of work for frontline workers at MPH. I believe one had to be there amongst them to understand.

The majority of the frontline workers I asked for an interview seemed willing. One particular person politely declined saying “They will know it’s me” although they remained candid in conversation about their frustration unofficially. Some people, agreed to be interviewed, but never returned texts or phone calls to arrange dates for the interviews. With others, something seemed to always come up at the last moment. In fact, even with those I eventually interviewed, I had to bear with last minute

cancellations. I was frustrated at times with this. I wondered how could we agree one day, and then the next day a hair appointment or something else materialize. I did wonder at times were they simply not willing to tell me they did not want to be interviewed. One particular PA twice stood me up at Burger King after I had confirmed with them¹⁰ the same day. They told me, “Yeah, punch out at 315pm (early)...at BK [Burger King].” I punched out early and race to BK and waited for 30 minutes. I called and called the person and did not get an answer. This was the second time the person had stood me up. I decided I would not attempt to interview them again. What was somewhat strange about this is that when I told the PA about what I was doing they said, “Yeah, that sounds good, I have lot I want to say!” When I asked the PA about “what happened,” they said, “When I leave here, my mind goes somewhere else.” This particular person had a bit of a reputation for being somewhat of an intriguingly interesting character who in my initial judgment was not a person I should have tried to interview simply because I had doubts of whether I could trust them. I decided to tell them because although they are known to be a bit of a character, and maybe even difficult to work with, I felt they exemplified a certain swagger or “street mentality” that characterized certain PAs who “held it down” back in the day. I once observed this PA leave the dayroom open on ward 5, and none of the patients even dared to move from their doorways toward the dayroom. This is a presence, a swagger which worked to the advantage of nurses, PAs, and Mirage to control the wards. This person is candid with me on his terms, not on mine. What did I learn? Perhaps those fieldworkers have to trust their instincts about who they can trust and there are varying levels of what participants might be willing to do.

¹⁰I use the plural pronoun here to try to protect their identity.

I started interviewing Psychiatric Assistants (PAs) and frontline nurses as soon as I got the approval from IRB. I started in June first sending texts to certain PAs and nurses I had known for a while. I conclude my official taped interviews at the end of August. I made sure I told workers that I wanted to be done by August so that they would feel a sense of urgency as well. One PA, Jonathan, said to me just recently, “what you are doing is important work, with the investigation, this has never been done here.” I met with a total of 25 PAs and nurses. I interviewed 4 RNs, 1 LPN, and 20 PAs. I met with frontline workers mostly at fast food and coffee houses. I met with frontline workers mostly at fast food and coffee houses. However, I met with a few people in their homes. One person, I even met with in their back alley as they washed their car. That was an interesting experience moving out of the way of his hose and other cars in an urban street alley. I traveled to the Southside and other suburbs to meet with workers. Quite a few of the workers I interviewed for more than three hours in one sitting. Most of the workers I conducted two 1 hour interviews on separate occasions. I had to be understanding, flexible, and persistent to get several people for the interviews. One RN, Christina said “I think you would get more people if the interviews were not so long.” Some people wanted to be interviewed on break time or in the facility, which would not have been appropriate. They devoted hours patiently answering my questions, waiting on me to arrive when I was either late or lost. They got very little compensation if any in return for their time. Many of them declined coffee or any food. This helped me because many times I had no money. I believed that my choice of interviewing PAs and nurses was the right one. I got to better understand how workers came to Mirage Psychiatric Hospital, why they stay or how they have managed to stay. I got to hear their major dislikes and

likes about their jobs. I got to better know and respect them. I started to hear the same frustrations about staffing, recognition of their work by administration, and feelings of subordination. Many PAs and nurses are aware of their statuses within Mirage.

The Known Researcher

After I “came out” and told many of the PAs and nurses my intentions on studying the work of frontline workers and actually interviewed them, workers seemed interested in knowing the progress of my work. Many workers, even those who declined to be interviewed asked me, “How is the paper coming along?” Before I interviewed Christina, a RN, I asked her had anyone spoke of the interviews. She said “people said you were writing a book,” with a smirk. Months have passed now, so people do give me as many eye winks or sly smiles. It is certainly known by those who I interviewed that my intentions are to study work of frontline workers. David at times seems to be intentionally trying to teach me things about his profession. When I ask him questions, he talks in details knowing what I am after. I am not sure if more PAs, nurses, or even administrators know my intentions. I am not as worried about it either for I have collected the data I set out to collect. I continue to observe, as I am paid to do, but with a critical eye. I am in the phase of analysis at this point. I continue to read, write, think, and analyze. I have started to give opening chapters to workers for their feedback. That is very exciting for me to do. I have told those I gave chapters that “we will write” what we feel is the story of frontline workers and Mirage Hospital.

The Role of Race and Culture

I believe the role of race played a significant role in gaining the trust of workers to open up to me and in understanding the perspective of some PAs. Why do say this? The

majority of the PAs are black men like me. When I say like me, I also am talking about social class. Many of the men and women I interviewed were born and raised in urban black neighborhoods, similar to me. I noticed how blacks say things around each other, in a certain way, that they do not say around others. Many PAs speak in codes and in slang to each other. Moreover, who has “street credit” is important because gossip is a huge part of communication at MPH. PAs tend not to be from uppity backgrounds. More than this, as I indicated in this chapter, I was more than a fly on the wall in this setting. I lived and breathed as a PA. I heard conversations about “beating his ass,” or “fucking him up” if a patient tried to attack a PA. I heard the small talk about race, “All of them Terrence, all of them.”¹¹ Are their white PAs? Yes they are. I interviewed one white PA and two white nurses. Do black PAs and nurses talk and act the same way around white PAs and nurses? I am not so sure. Many of black workers have said, “They don’t stay here long [the white PAs] or “they make a way for them [the white nurses]. I noticed, and I have noticed in many different conversations how conversation often times is coded. This is not simply a matter of race; it is also a matter of clicks. Many workers I interviewed spoke of a click which is an interworking group where support happens and private local gossip occurs. In doing this study, many times I coded my language and others did too. “How is that paper coming along?” is a prime example. I also talked about race with PAs, especially those on the adolescent boys ward. Was being black and male (in other words, one of them) a plus? I think so. Was race the only factor in getting close to the research subjects to learn their culture? No. It is interesting to note that many blacks feel that they cannot even trust fellow blacks. As Jonathan told me, “You know

¹¹Samantha talking about white women administrators.

how it is, maybe some don't want you to get yours if they do not have theirs." Within the black community, it is a well establish notion that blacks will not work together, don't trust one another, and tend to destroy one another. If you look at the statistics on black on black crime, there is great evidence that supports this notion, although socioeconomic hardship is at play. I had my share of problems with some black workers. I already described how one worker, who was black stood me up twice with very little explanation as to why. I had problems with certain black nurses and black PAs. There were certain black administrators who black PAs regarded as "uncle toms" or sellouts to blacks. Additionally, perhaps I was perceived differently around certain blacks. One worker, a female black PA, told me one time, "You are different; people [other blacks] are intimidated to talk with you." One white nurse indicated that "Terrence you are not your average PA" when referring to PAs who do not work or understand the need put the patient first over their needs. I never tried to talk in a slang way. I never tried to use sociological language, but I am sure I did. I was myself. I felt the subordination of wearing those polo purple shirts. I looked around and saw that most of us were black men. I also respected to prowess of these black men (many of who I have forgotten by name) to control difficult to control patient populations with Mirage. I remember one time during an emergency code, seeing a sea of much bigger black men than I in their purple shirts. They were ready to go to action and stop any altercations that would have occurred. In general I would describe my relationship with most PAs as being positive and friendly. The easiest type of conversation to get into with black men will be involving sports or racism. If I wanted to ask a worker how he felt that most of the PAs were black, he would most-likely immediately concluded this opening statement

indicating some form of racism (which keeps most PAs down within Mirage). If I were to talk with black nurses or black female PAs about white women, nine out of 10, or even 10 out of 10 would say, “She’s racist.” There is a general perception that most blacks continue to have toward whites. The perception is that most whites have some benefit because they are white and one should be weary of trusting them. For these reasons, being “one of them” one of those close to the bottom of Mirage’s hierarchy not only aided me in my collection of data, it enriched my ethnographical objectives to understand what it is like to be a PA.

Conclusion

My methods were somewhat unorthodox in the sense that I “worked my way” into studying frontline workers at Mirage. I had in fact entered the field when I started back in 2003 because it is impossible to separate one’s work observations (or life observations) from one’s research observations. The critical distinction is when one turns toward writing field notes and analyzing the field notes in a systemic way (Emerson, Fretz, and Shaw, 1995). Can practice class field work be separated from official field work? Can work place observations be separated from research observations in reality? Is there something special or exemplary in my long-term methods? I am not sure. However, I know that it took endurance and carefulness to complete. I have seen many workers come and go (many have been fired for losing their cool). What is remarkable I feel is that employee at Mirage has always felt insecure. I had very often the feeling that when I walked in to work, or when I saw Mirage’s number on my caller ID, I would be or could be fired. I am not alone, and this has nothing to do with doing something intentionally wrong, but it has everything to do with being as one worker described, “the

expendables.” Did I forget to document a round sheet? Did I question my assignment? Was I simply not liked (as many workers indicated was a factor to why they were not given employee of the month or other accolades). I felt this uncertainly as I worked fulltime over the last nine years. This is the tremendous part about the methods I took. I truly was and am a PA first, and then a researcher learning his craft. I was less than perfect. I got mad at fellow PAs, administrators, and at patients just as regular PAs might do. One might ask about objectivity. I would answer that this story is the story of PAs from the frontline perspective. I do not claim to understand the viewpoint of administration or corporate ownership. Additionally, there are many commonalities between frontline workers, but also important differences as well. I think the most interesting aspects of my methods lie within the length of time I had to maintain them and the natural way I was truly close to what I was studying. Additionally, I sincerely wanted to analyze the meaning of frontline psychiatric work to understand it better, and what workers go through in process of doing this work. This was my morale compass to listen and observe the work as best as I could. It is my hope that these methods do justice to this objective.

APPENDIX B
PSYCHIATRIC ASSISTANTS

Introduction

The purpose of this chapter is to describe the workers known as Psychiatric Assistants (PAs) in Mirage Psychiatric Hospital. I will use their words along with what I have observed to depict them. I will discuss why and how they became a PA. I also will discuss what we all seem to have in common, “our failure “or destiny depending on how you want to view it.¹ I will finally discuss the nature of being a PA, i.e., a jack of all trades type of worker. The purpose of this chapter is not to discuss “what it means to be a PA”² or even the actual work of PAs. These subject areas are set aside for other chapters in this book. I simply want to give portrait of PAs, however incomplete that portrait is.

The Demographics

Psychiatric Assistants (PAs),³ the group I have been studying, and to which I belong, are predominantly black men in their middle to late thirties. As of today,⁴ I count a total of 87 PAs (give or take a few who may have been recently hired or recently fired). Out of the 87 PAs, 68 are black⁵ (78%) (45 black males and 23 black females), 12 are white (7 white females and 5 white males), 5 are Latino (3 Latino males and 2 Latina females), and 2 Asians (all males). There are 55 male PAs and 32 female PAs (63%).

Sixty-seven PAs are regular workers; they regularly work in the hospital and have rights to health insurance and other benefits. The rest (20) are registry staff. Registry

¹PAs differ and struggle with their meanings.

²There is a degree of overlap in simply describing PAs and analyzing the deeper meaning of what it means to be a PA.

³Psychiatric Assistant (PA) is the pseudonym of the hospital title that Mirage gave to these workers.

⁴April 11th, 2013 was my last day at Mirage.

⁵ Black and White are racial social constructions based on phenotypes and American racial politics. Some PAs might reject these labels for other categories such as Polish, Nigerian, bi-racial, African, etc. I am using these racial categories because this is how many in our society would commonly categorize these people based on their phenotype and the historical one drop rule or race (Davis, 1991).

employees (PAs and other workers) do not receive benefits and are not regularly guaranteed to be on the work schedule. Registry employees sign up to work, and if there is a need, which often there is, they are called in to work. They sign up by filling out a sheet that asks them to write down the dates and shift they are available to work. They leave this slip with the nursing supervisor in the nursing office. They will work the hours they signed up to work based on their availability. Many of these registry workers have second jobs. Mirage is just “some extra change” I have heard many say. Nonetheless, it is an important source of “extra change” when you consider Americans spending habits the cost of rent, and other economic factors. They work at Mirage in order to supplement their income. Many of them are college educated. I do not have an exact number because I had never asked a PA if he/she graduated from college (although this is the requirement today, some workers may have been grandfathered into the field when this was not a requirement. Others may have been nurses’ assistants without a BA). Out of the 25 I interviewed, all had their bachelor’s degree or higher (92%) save two people, one had her associate degree in science and the other had her education as a nurse’s assistant.

From the above demographics, we learn that most PAs are black, and most-likely male, in his middle 30s, who have bachelor’s degree in a social science field (psychology, sociology, social work) or some other liberal arts. Now that we have a general sense of who Psychiatric Assistants are, we can discuss how they became PAs.

Why They Became Psychiatric Assistants

There is no direct education or classes one takes to be a PA. No one goes to school to become a PA. The requirement to become a PA is at least one year of psychiatric work, and a bachelor’s degree in social science (in reality any degree).

Therefore, it is very important to learn how and why people became PAs. After I asked workers the opening question, how *old are you?: this was somewhat awkward at times*, because some were much older than I thought, and as they say, you never ask a woman's her age, I asked PAs; *Could you tell me about how you became a PA?; Your educational background; your interest in the field: Qualifications for the job; How specifically did you become a MHA at this hospital?* I was looking to know the context to how people venture into working in a psychiatric hospital. To use Goffman (1961) words, what about the "worlds of the staff?" I was also curious why so many PAs were black (78% by my estimate), and if their background had been similar to mine. I came to work at Mirage mainly because this is what my education and work experience deemed me most appropriate to obtain. Did they come to Mirage simply because this is what they were qualified to get? I came away with somewhat of a surprise. This also made me reflect differently on why I initially chose sociology, and hence, why I came to Mirage.

Dent Perry, a 39 year old black male, and the first PA I interviewed, talked about how he got into the field⁶ and what has helped him stay in the field for as long as he has (six years at Mirage). I have seen Dent be present at many emergency calls for staff assistance. I have never seen him shy away from physical work or intervention. Dent tells me how and why he became a PA. We sat down at Dent Perry and I agreed to meet for the interview at Dunkin Donuts after work on Wednesday June 27, 2012. I explained to Dent that I did not even want to be seen leaving with him after work because this would tip others who know about the study that I was interviewing him. He agreed. At

⁶Many PAs considered their previous jobs as being similar to their current work, although their titles changed. They indicated that they have been in the field for a lot longer than their time at Mirage hospital.

about 345pm, I noticed Dent's car in the parking lot of Dunkin Donuts. He said that He was waiting on me and did not recognize my car, which is why he did not come inside. He came inside shortly after I informed him I was already inside. No one else but the workers was initially inside. I offered him something to eat or drink but he initially declined, "Naw bra, I'm good" he said. I insisted and he agreed to have tea. We started the interview. He was sitting at a bit of an angle from me, not directly in front of me as I turned on the tape recorders. I noticed that he looked at them:

Me: Ah. Could you tell me ahh about how you became a psychiatric assistant?

Dent Perry: Ah, I should say well, ahh well how I became ah in that field in the first place. Ah went to school ah..went to No-Name university majoring in ahh bachelor.. I have a bachelor's in social work. Ah from that point on I have ah my experience as ah..within the field of social...social work or the behavioral system City, State...(2 seconds)..asylum.

Me: Ahh wow

Dent Perry: So when I involved, when I got involved in that dealing with people's understanding and their nature about certain things....

Me: Humm (interchanging while he is talking)

Dent Perry:...I started to get more interested in behaviors.

Me:...How have you managed to work here as soon as you have...here at?

Dent Perry: Hmmm...that is a very good question...one never really get used to the work...being a PA...and if it were not for me needing income...I would probably be doing something else.

Me: ha ha huh (I laugh in support because I know what he means here, many PAs feel this way)

Dent Perry: But because of the profession of dealing with people, it sort of draws you in, you want to help...you want to help...so that was a part of me being here as long as I did...being able to want to help...and and it has helped me. You know..

Dent, mentioned several times in his interview his sense of connection and moral responsibility to the adolescents he works with. His work goes beyond being a PA. He wants to help.

Me: We take away the PAs

Dent Perry: We are taking away the PAs ...well first of all, like I say that question goes so deep because we are talking about a system...

Me: Ok (interchanging ok)

Dent Perry: ...ahh community of people who have to be policed (boys and other patients on the wards). And we have rules and regulations, so within this community it is very important that...and I want to be real careful how I say this, ahh..(2 seconds silence)..that's a difficult part of this job...Just feeling like you got to police people in this system..that is a difficult part about this situation...these are human beings. [I sense some real emotion I did not anticipate from Dent concerning the ward of adolescent boy patients. He seems to really identify with these patients who are mostly black inner city boys, he goes on later in the interview to tell why]. We know better than them, we are capable of being in this situation like them. You know it is a borderline. That is the difficult thing about this job man is that...It is very important. It is very important that we you know...(seconds silence)I always get kinda stressed out when people ask me that question...you know it is like you against them...you know the attitude...at least what they built to me. It is like you know, and I don't want to get to durist [I could not understand what he said here]. It is like you against yourself. You know it is like your attitude against...(3 seconds thinking silence) what you could be

Me: I see what you are saying

Dent Perry: And you have to fight it everyday

Cindy, a 33 year old black woman, who has been working at Mirage since 2007, as a registry PA tells me during our interview at Burger King, "I really like working with the kids, I have always wanted to work with the kids, that's my reward." Cindy, a darker skinned beautiful black woman who is sort of tom boyish, indicated that she "needed the extra money" and when she heard about Mirage, it was the "perfect opportunity" because of her desire to work with boys. She has master's degree in criminal psychology, and had wanted to be a profiler for the FBI. I saw Cindy lots of times over the years working with enthusiasm and spirit on the boys' ward. Hence, when she says that this is something she has always wanted to do, I believe her.

Tammy is a 39 year old black female. She started working in social services in 1994. She was working at another hospital, and was told Mirage was hiring by a friend and was paying more money. She says I was "hired on the spot" by a lady whose last day

would be the next day. She started off part time. She says as an explanation for why she chose this field, “I have a passion for working with the geriatrics. From 1994 to 2001 she worked in a correctional facility through “my dad.” She cites “the patients” as a reason why she has been able to work so long at Mirage. “They adore me, and I adore them.” “Also, my co-workers,” she adds.

Patrick Jole, a 33 white male PA. His father is/was a professor at a local college. He has been working at Mirage since 2005, 7 years. I interviewed him at a local coffee shop:

Patrick Jole: I have always worked in this field, I like to help people. I saw in the paper, a job opportunity and I applied, it took them over a year to contact me and at the time I was in between jobs, so that worked out perfectly.

Pamela Smith, is a 50 years old black woman However, she does not look like it. She looks around 39 years old. She worked eight years at Mirage. She liked working with the mentally ill patients in the nursing home and realized that it was less back breaking compared with the nursing assistant work. A co-worker at her former job at a long term facility, introduced her to Mirage hospital:

Pamela Smith: I got a CNA certificate in 1984... I started early, I had had my daughter when I was 24 years old. I was in school for nursing at You know University. I always wanted to have a job so I could help somebody, that is how I got interested in nursing... I worked in the nursing field for over 24 years. ..My goal is to help somebody. If I can help someone within these eight hours I am fine you know, because you are dealing with so many behaviors. So it makes you feel good when you work with individuals and their situation come out A plus. They see the difference and they act accordingly. These patients desire someone to care for them, they just want to spend a little time.

Miles Turner, 73 year old black male PA. If this does not make you admire him from the start, I don’t know what would. He is a tireless worker, walking up and down ward 6, smiling at staff and patients. He explains the context to why he chose to work as

a PA. He worked for a record company before joining Mirage, but it went out of business.

Miles Turner: I started working November of 1995 at Mirage. I went to the University of U to get my degree in social work (master's degree). I had a lot of deaths in the family and did not complete my first year... All of this time I wanted to help people. A simple answer (he laughs)... I just felt that was my need. I have the patience of Job⁷...[After the record company job ended he thought].. You are good at dealing with people. What do you know how to do.

He filled out two applications for employment and was eventually hired. He got his bachelor's degree in social science. 1964 he got his BA. She worked in pharmaceutical sells, case worker, and record salesman.

Michael Simwingo is a 31 year old black male with a BA in sociology. He can be loud and humorous but is a very straightforward dedicated worker. I have had many opportunities to watch him work tirelessly. He has been working at Mirage for two years. He tells me about how he became interested in PA work. Residential treatment center is where he started off working. After the residential agency, he went to another social service center, and then another place. One of his co-workers told him about Mirage I met Michael in the back alley of his home in an inner city neighborhood near the Indian and Chicago border. He washed his car while I interview him dodging the water from the hose, cars driving by, and the hot burning sun. It certainly had an urban feel to the interview:

Michael Simwingo: I really like working with kids. That generated my interest in finding out what happens. They [his former co-workers] gave me the idea of Mirage hospital... I saw one of my kids go to Mirage. I knew about Mirage...I knew someone who worked there, they got a lot of overtime. I decided to check it out... I enjoy doing what I do. I do not enjoy what I do with administration. I enjoy my PAs what we do.

⁷From the book of Job in the bible.

Janet Exit is a 55 year old black woman, she looks around 40. She is a soft spoken woman who is easy to talk to because of her good listening skills. She has a degree in social work and human services. She has worked 6 years as a PA. She started working real estate, but then the economy took a turn for the worse and she started working full time a Mirage. Janet Exit and I met both times at Burger King down the street from Mirage. She declined my offer to buy her a beverage each time. She was very calm and interested in the talking during the interviews. The first interview lasted about one hour as she had to meet someone afterwards. The second interview was longer. It took around two hours the second time. For the first interview, I disguised my voice and called Mirage to confirm our meeting, as she asked me to do. My wife called the second time to confirm the interview with her. For the second interview, we simply met at BK after work. She is deeply motivated, as Oliver Smith, by her church and religious ideology. These attributes are clear to see during the interviews. This is why she cares for patients and bares with administration's infringements on her dignity. She said that "we make the polo shirts dignified by the way we carry ourselves." This was an interesting way to look at wearing the shirts. The PAs bring honor to the shirts. I never thought about it like that before I interviewed her:

Janet Exit:...I have been involved with working with people for years, with my church, and with younger people...I came on as registry...I knew somebody, I wanted to see what it was like, and more money...We were always involved in working with people...I like this versus working with paper...I was going to be a music major, then the children started coming...It was not about the money... I just work better with people...There are rewards when you see people who really want to be helped. That is part of the reward when you see people smile. You see people's confidence change.

Oliver Smith is a 45 year old black male PA. He looks a lot younger than his age, and to be in good shape. He used to be a regular PA, but he went registry⁸ about two years old. He, very much like Janet Exit, is motivated by his religious worldview to help people. Oliver Smith and I met for the first interview at the small diner first recommended by David Lopez. Again, the waitresses were invasive. He was candid, and I really enjoyed the interview. It last slightly over an hour. For the second interview I convinced Oliver I would travel to where he was because he was giving me his time, why should he travel as well. We met at a larger diner. He was eating when I got there. During the interview when asked about floating, Oliver broke down and cried about his experience working with adolescent girls. He said that the girl had been raped and reminded him of his daughter. Oliver indicated that he had always hated to work with this population until this experience made him realize that “they needed help too.” He had to go to the bathroom and compose himself. Oliver is deeply motivated by his church work. He is a compassionate jovial man. I left the interview, as many of the others thinking that these PAs are the unsung heroes. They want to help people sincerely. This is truly remarkable.

Oliver Smith: Well, the interesting thing is not a thing of my interest in the field. Ahh It’s ahh I guess trial and error thing cause I like helping people and by me being in the social service industry I was introduced to Mirage by a friend, or should I say I was introduced...I wasn’t supposed to say...

Me: Don’t worry about it, it will be edited

Oliver Smith:... I was introduced to this field by a friend and I saw how it was closely related to what I had been doing ahh since getting out of school and working in a type of help....capacity. Ah I did City board of education...felt

⁸Registry is a term used for registry workers who register their availability to work. These workers often have other jobs. However, it appears that Mirage’s new policy is that all new employees start on a registry basis then earn their regular position. Mirage depends on these non-benefit part-time workers to run the hospital because the full time and part time regulars are kept at a bare minimum. Almost every day every shift there will be a registry nurse or PA working in the hospital.

I was not getting the support I needed from administration dealing with our youth today. Like I said I got turnover to to this particular field mental health by a friend. So my education has nothing to do with what I do cause I have a bachelor in science in economics.

Me: Ok so, Ahh, when get more specific so ok, ahh, a friend had said, hey here is this place you want to help people? So specifically I'm saying how did it come about?

Oliver Smith: It came about cause I was already helping people cause I was in the...I transitioned from the board of education to the social services. So I was working in the group home setting Ahh you advocate setting working with youth. So ahh, he just said they hiring at this particular place I went and checked it out. And he said it was basically the same thing you had been doing, and I was like ok. Then in terms of following up on what he suggested, I saw that it was similar.

A Turning Point or Stumbling Block?

A common characteristic I began to notice about PAs (and for myself) is that most are in some type of transition (even if this is mentally only) and have stumbled into being a PA. No one goes to school to be a PA. There is no direct training to be a PA like it is for nursing, nurses' aides, phlebotomists, or other subordinate health care workers. PAs are your jack or all trades type of workers.

David has been working at Mirage for about nine years now. He considers himself "hyper" and has encouraged me at one point to "write an article about this, you are a smart guy." David Lopez was unemployed and was referred by the unemployment office to an asylum in 1977. He came to this country to make a better way from his self, but became captivated by the American music and way of life. David and I met for the first part of the interview at a small diner down the street from Mirage. The place was moderately busy. There were more interruptions from the waitresses trying to get us to buy something or asking us if we wanted more coffee or water. David was candid and enjoyable to talk with. He left the interview seeming pleased. The interview lasted slightly over an hour. We shook hands at the end and agreed to meet again soon. The

second part of the interview took place at Burger King. It took around an hour and a half to complete. He was again very relaxed and candid. He was the second person I interviewed. I have learned tremendously from David in doing front line work:

David: Ahh basically I... ahh... I was sent to the hospital, a psychiatric facility...by the unemployment office. Ahh... I was unemployed at that time but I was going to school. So I am actually ahh...I have a ahh bachelor's degree in physical education, teaching, in others words, but there was no jobs available at that time, but they had a special program available for people who were unemployment [unemployed] for more than 6 to 8 weeks. So, they had this position and I was barely knew about it and they needed someone who speaks Spanish, which I do. You know fluently, so. I started my career in the psychiatric field by going there. It started my learning actually, getting to know most of the psychiatrists, doctors, nurses, counselors, and they took me under the wings and felt basically taught me what to do, there was a lot of orientation, ahh a lot of in services that I attended and became familiar with the field and kinda liked it, and basically I stayed there. And that is how I got started.

Me: It was totally random

David: It was random pretty much

Kuzak has been working at Mirage for almost 10 years (Dec 2002). He is a cordial man and generally follows the rules and does not argue with administrators. He started working as a PA when he failed to pass his board examination and "had to do something." Kuzak Shan and I met for the first interview at his home. Kuzak was very hospitable offering tea, pop, water, and fruit. He was candid and very relaxed, perhaps being in his home helped. Our interview lasted around one and half hours. For the second interview, we met at Burger King after work. We met that following Wednesday. He was relaxed, candid, and cordial. The second interview lasted slightly over an hour.

Kuzak: Basically I was a physician in my country. I am not going to tell you which country, but the country is Un-named. Don't write it down. I graduated in 1980. I was a medical officer in a medical hospital some 18 years...

Me: Wow

Kuzak: I have been migrated over here, I first, initially I tried to pass the board exam. The board exam, board exam, but I could not make it. Step one or two, then after that...ahh I had to do something to stay over here... so I join this doctor,

JimonBey.. He is president of the religious institution...Rafiq was...I don't know Rafiq... but ahh he told me that Rafiq was working over there if you want in a psychiatric hospital you can join us, I said ok I will go and check with Rafiq, Rafiq said oh yeah you can work with me. You can come, it is not a big job, you can work with me. So I join Skinny center, a psychiatric facility. So I stayed there for two years, and then that hospital has been shut down. And then Jimon told me, JimonBey told oh me another hospital it is for a half of hour drive. So you can go and fill out the application. So I join the Mirage hospital in 2001. December 2001. Now I have been working 10 years over there...

It would be hard for me to find a PA who is a PA not out of some lack of opportunity or failure. Janet Exit started working fulltime as a PA because of the failing real estate market. Marshal Cromwell, a 32 years old black male, who "heard about the job through my father," wanted to become a lawyer. He got his BA degree in May of 2003. He says, "I got very comfortable" at his former place. He took his LSAT in October 2003, but did not apply to Law school because "I did not like my score." He has been working in this field ever since trying to prepare to take the LSAT gain.

Jonathan, a 31 year old black man who studied automotive technology in school expressed disappointment about not being able to pass his automotive examination and "do what I love, work on cars." Jonathan and I met at his home on the Southside of Chicago. He said as long as his name was not going to be used, he was cool with telling it like it was. As I drove up to his car after he arrived from obviously picking up his children, I notice that his small two year old son had fallen asleep. He has two beautiful children. A girl age 7 and a son age 2. As he said, our children are the same ages apart (mine are 4 and 9). After he put the children inside his home, we started the interview on his porch. He lit up a cigarette in the beginning of the interview. He was candid and very animated. He decided to move the interview inside his home because it was too hot. We sat in his living room being playfully interrupted several times by the needs of his

children. During the interview in describing the situations, he got up out of his chair and acted out several descriptions about dealing with adolescent boys. He turned on the TV during the interview and faced it and talked to me the same time. I found that interesting. We met for several hours and completed the interview in one meeting because he wanted to keep going. Anytime that is the case, I am not going to stop the participants because it is not always easy to set up and date and commit to it. He indicated that despite winning employee of the month, administration really did not care about him or us. He indicated that PAs were at the “bottom of the totem pole.” He indicated that he remains at Mirage because he has not finished his automotive certification. He said, “I like working on cars.” He also indicated that he likes helping people and does not mind opening doors or servicing patients. I really appreciated him meeting with me for the length of time he did, and him being totally candid with me. He met with me and instructed his children to give us space several times although I did not mind. It was another good interview. He has been working four years as a PA. He answers my question of how have you manage to work four years as a PA. He says:

Jonathan: “One major factor is me, but another factor would be...actually the job market. I have not been getting the calls back. I have been seeking employment. “Actually, the main motivation to help keep Mirage is my family. If it were not for my family, I would drop Mirage. Dig deep into what I want to do, and what I know, which is to own my own business.

I really felt Jonathan’s pain and sentiments. Sure, Jonathan stated, like many of the other PAs and nurses, that “I don’t mind helping people,” but this was not his dream or goal in life. This was not a self-actualization needed for happiness for many PAs. Timothy Long, a white male in his mid-40s or older talks about his days at the University of Chicago, and how he still keeps up with some of the guys. His eyes seemed to be

watering. I know he has battled some type of drug/alcohol addiction. Patients usually say how much they like him and many have said “the best drug counselor is someone who does what it is like to use drugs.” Timothy is an intellectual, and I enjoy our conversations on the ward. I wonder how he ended up here. I was not able to interview him however. He seems very cynical and talks about his 30,000 dollars in student loans from the University of Chicago and says, “I was a smart kid.” Timothy got hurt on the job. I was not around when it happened, but they say a patient picked him up, slammed him to the ground, and stomped him saying, “I could have killed you!” I spoke with Timothy afterward on the phone and he said he was during therapy and was not sure if he would ever return to Mirage. One other worker I would like to mention, and there are too many to mention, is Samford. Samford is a black male with thick African accent. He is 45, he says. He is physically fit. He lost a son to a car accident about two years ago. He previously worked at a “facility working with disabled people.” He has a bachelor of arts in general psychology. He says “I went into general psychology to understand people. The aim was, at that time, to get into the professional level, like PhD in that...entire but because of family and other issues...I was not able to pursue my professional interests. I have been working as a PA for almost 10 years.”

The political economic system (i.e., capitalism) claims to be rational (Fein, 1990), and thus orderly. Somehow what I felt is that what it was telling us PAs is this is how we are materially valued by society. Somehow, our initial aspirations fell through. I failed to get into pharmacy school, what I initially studied as an undergraduate. Kuzak failed to get his medical license in America to become a doctor, David failed to become a professional athlete, Marshall failed to pass his LSAT, Pamela had a child “too soon” and

dropped out of nursing to be a RN. These were life changing events, and paved the way for many PAs to bounce around in entry level positions or in positions dead end or unfulfilling. We have discussed how and why these workers became PAs, but what about the nature of what type of workers are PAs?

A Jack of All Trades

In terms of the position in which PAs exist in Mirage hospital, I see it this way:

Hierarchy

- Corporate headquarters 500 Fortune Member
- CEO of hospital
- Medical Director
- Doctors
- DON (Director of Nursing)
- Human resources
- Administrator positions
- Department managers
- Social workers and therapists
- Nurses
- PAs (Psychiatric Assistants)
- Cafeteria workers 92% are black
- Janitorial workers 100% are European immigrants
- Patients at times

From this listing, it is clear that PAs are at the bottom of the hierarchy in terms of their positions relative to others. As Jonathan said in his interview, “we are at the bottom of the totem pole.” PAs are very aware of this fact. Kuzak said “we are ward boys.” It is ironic that the workers most close to the patients, thus perhaps, in the best position to know what the patient is experiencing, have the least authority and status in the hospital outside of janitorial and kitchen workers.

It must be pointed out that PAs are not nurses aids, correctional officers, security guards, or even orderlies or attendants (although this could be argued). Kuzak says “we

are ward boys,” something I sure some PAs would initially have a problem accepting.

The main reason I say that PAs are none of the above mentioned workers is based on the required bachelor degree for employment and hour rate of pay (15.00 and hour average pay). Additionally, and I hope to describe later in detail, PA is different from the work of nursing aids, security guards, or even correctional officers. The orderly question does beg further conversation. I discuss it here one of my field notes:

Recently, while sitting around in the day room with Sandy, a white female PA⁹ in her mid to late 30s, who holds a master's degree in counseling psychology, I asked her “what job titles historically, would you say that we fit into?” Her response after pausing and thinking, “orderly... yes, we are in charge of keeping order on the units.” This blew my mind. After pausing and thinking a second, I said, “I guess you are right. We are highly educated orderlies.” She later said to me while we were seated in the dayroom watching patients and the hallway, “a bachelor’s degree is like a high school diploma today, many people are working at Subway and McDonalds with bachelor’s degrees.” I said, “but there are many people that don’t even get their high school diplomas (thinking to myself of the black male high school graduation rate of around 43%), what happens to them?” My face was expressing display, I would assume. She said, “Look around” (meaning look at the patients sitting in the day room we were caring or working for).

Sandy continued, “We are paying for these people...we pay in order to have a job to take care of these people...I just hate when they make mess, why can’t they pick up the packs of sugar and clean after themselves.”

⁹I have not seen Sandy in a while. She is/was a registry PA.

I decided to check the facts. I first searched in academic data bases for studies done on orderlies. I found remarkably little, and the studies that I did find mentioned race and low status workers. I next turned toward Wikipedia and found the job description of orderlies. Some of the other titles given for the type of work PAs do are medical orderly, ward assistant, nurse assistant, psychiatric aid, nursing auxiliary, or the informative Unlicensed assistive personnel (UAP). Sure enough, after studying the job descriptions of these various unlicensed hospital workers, PAs are filling the roles of yesterday's orderlies, and perhaps more. The title orderly has been or is in the process of being phased out.

The somewhat revolting feeling that I have is that I have accumulated so much education, and debt for that matter, to be today's orderly? I often feel I have many excellent sociological skills to offer people. Orderlies, in the past, and still true today only needed a high school diploma and on the job training. Why am I in this position? Is it to do with the economy? Is it the type of education that I have? Or is it my place within the capitalist market? Does it have something to do with today's social science degree not carrying much weight? These are not questions for investigation. Nonetheless, how can they be removed from theoretical analysis?

According to U.S. Department of Labor, Bureau of Labor Statistics:

Nursing aides, also known as nurse aides, nursing assistants, certified nursing assistants, geriatric aides, unlicensed assistive personnel, orderlies, or hospital attendants, provide hands-on care and perform routine tasks under the supervision of nursing and medical staff. Specific tasks vary, with aides handling many aspects of a patient's care. They often help patients to eat, dress, and bathe. They also answer calls for help, deliver messages, serve meals, make beds, and tidy up rooms. Aides sometimes are responsible for taking a patient's temperature, pulse rate, respiration rate, or blood pressure. They also may help provide care to patients by helping them get out of bed and walk, escorting them to operating and

examining rooms, or providing skin care. Some aides help other medical staff by setting up equipment, storing and moving supplies, and assisting with some procedures. Aides also observe patients' physical, mental, and emotional conditions and report any change to the nursing or medical staff. (Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2010-11 Edition, Nursing and Psychiatric Aides, on the Internet at <http://www.bls.gov/oco/ocos327.htm>, visited February 20, 2012)

I followed up with the question to other PAs. Rafiq, in his mid-50s, works at Mirage as registry now, was a medical doctor in his native South Asian country, responded “We have education.” I heard him answer a patient before I asked him my question of interest, “Yes I am a doctor. I dress like a doctor. [he laughs out loud as Samford and I look on]” Many patients have always confused Rafiq for a doctor over the years, and he clearly takes pride in telling patients that he was a doctor in his native country. Samantha, a female black PA, remarked to my question, “Are we just orderlies? You and I are educated, I offer a lot to this job.” Stephanie is currently going to school for nursing and her husband is a pharmacist. She begins telling me a story of her interaction with a middle age white female nursing supervisor. “Dean (the supervisor) came onto the ward and said hello you guys, Dean should not have done that, I said who you guys are? I don’t think that you guys are in the human resources manual. She knows my name”

On the other hand, when I asked David if he thought we were orderlies, he said, “pretty much, yes, we keep the unit clean and patients in line, ...I do not mind this much, but the assholes (patients) who are demanding and are only coming here for a place to stay, I hate this.” Perhaps, educational level and life aspirations play a role in job satisfaction at Mirage.

Samford, a black male PA with thick African accent in his early 50s, but physically fit, remarks (grinning and shaking his head) to my question, “yeap TA, we open doors (bathroom doors for patients).” He continues “we have to get out of this; this is not what we wanted to do with our lives.” Rafiq and I agree. My way out is to finish my education I believe. Rafiq’s way out is to retire, he is interested in his son finishing medical school. David’s way out is to retire as a PA. Samford always talks about going back to his native, African country. Samantha is working on being a nurse. I have known these particular workers for years, and we are all survivors as PAs or highly educated orderlies.

Psychiatric Assistants do frontline psychiatric work. They do “the dirty work.” Dirty work it may be, but without it, the hospital would not function. What is the “dirty work?” The dirty work is that work which most would rather not do. It is the small work as well as the difficult work. Controlling the ward, “holding it down,” grabbing or holding people, smelling people, dealing with people most probably would rather not. Psychiatric Assistants are a jack of all trades type of worker who works directly with psychiatric patients within this bureaucratic organization. To know what it is like to work as a psychiatric assistant is to know what it is like to service psychiatric patients under a hierarchical work structure (e.g., a hospital). PAs are at the lower end of hierarchy in the hospital in that they have to wear hospital shirts (purple shirts that state faith along the company’s emblem). Social workers, teachers, doctors, and others do not. In fact, only housekeeping personnel, cafeteria personnel, and nurses have uniforms. And only nurses and PAs have BA/BS degrees. PAs do not have authority to discharge a patient (only doctors). PAs do not officially meet with doctors in order to discuss patients’ statuses,

treatment plans, or discharges (usually only social workers do this). PAs do not have specialized meetings with food organized by the hospital (Doctors, social workers, administrators, and other employees are usually the workers that enjoy this privilege). PAs do not determine their schedule, what ward they will work, or even at times their lunch break (this is negotiated with the charge nurse, who is in charge of the assignment of work for the shift she/he is working). The only control that PAs have over their work is how hard they will work (e.g., how many times he will make patient coffee or walk the hall to check on patients, or respond/address patients' requests for service). She/he does not walk around in their street clothes (e.g., the purple shirt that PAs must wear) as do social workers, doctors, and administrators. He/she does not directly affect patient admission or discharge. This is important in that if there is a difficult, violent patient on the unit PAs have no choice but to deal continually with the patient. PAs can only leave the unit during their break or when it is time to leave for home; the purple shirt that PAs are forced to wear signals to all people that she/he is a PA. Uniforms are markers of subordinate worker statuses (Vallas, Findlay, Wharton, 2009; Volti, 2012). These things categorize PAs as direct care workers who have no specialized licensing or degree (e.g., LSW (licensed social worker), RN (registered nurse), or a licensed psychologists/therapist). A PA is just a worker. PAs work directly with patients (thus may have the most rapport and impact on the patient) in servicing their needs (e.g., Making coffee for patients, opening bathroom doors, handing out supplies or food, talking with patients for support, conducting groups, writing progress notes based on the behavior of patients and treatment plan, or using emergency interventions (techniques to calm or control out of control patients). PAs must remain on sometimes chaotic wards with difficult people,

such people whom society does not want or cannot deal with effectively. PAs are not recognized as specialized degreed workers or at times degreed at all. If the patient is eager to go home, he is told “talk with our doctor or social worker about discharged.” This is because all PAs primarily responsible for dealing with patients (their needs and problems) while they are hospitalized on the units. PAs are segregated mostly with sometimes violent, socially inappropriate, and psychotic patients. PAs have little control, authority, or opportunity for advancing within the organization.

PAs form a specialized group; this group has to wear uniforms, does not control where they will work, cannot leave the wards they are assigned, or determine what types of patients they will work with (disorderly, difficult, nice, manageable, etc.). PAs do not work with doctors in treatment planning for patients, directly are responsible for dealing with and servicing patients, and are not recognized as a specialized group of workers (have licenses). This not to say that some workers are not highly educated (e.g. some have master degrees in social work, psychology, sociology) or other professional programs for graduate degrees (e.g., Psychology, sociology, or nursing). However, this is all intermediate and not used as criteria for their work as a PA.

Some attributes that I have learned about PAs over the years are:

Toughness or roughness. PAs were known for their toughness or roughness. This was especially the case when I first started before the cameras and the subordination.

One of the PAs and I were sitting around one day talking in the dayroom. Here is an excerpt:

August 5, 2012. I showed him the book and section on attendants in Goffman's Asylum book. This seemed to spark him into conversation. As we sat around the table in the dayroom designated for staff, he had the rounds book on the table facing the hallway and I sat perpendicular to him facing him and looking out the room toward the hallway as well. He said that "Runner or Ron used to be very violent. He would throw patients up against the walls." I explained, "I know." He continued "Especially if you called him nigger, you would get an extra shove or push when he had you down." He continues, "I was scared at times because what if something happened." I interjected, "But who benefits from this? The hospital benefits, the nurses benefit." Runner no longer works at Mirage. He and a lot of other workers like him are relics of the past to a degree.

In another one of my earlier field notes, I elaborate on this attribute of PAs:

I begin to put away my lunch and coat and head back out of the unit. I already know from looking at the schedule downstairs who I will be E-Ghee¹⁰ is a muscular black man from Nigeria in his mid-thirties I assume. He keeps his head shaven and appears to be in good physical shape, so I really cannot tell exactly how old he is. Numerous times while holding down patients for shots, he has said "I working today, we are not going to have that," referring to a patient's actions and his presence today at work. On other times he has said, "This is Ward-5, we don't play that over here." He seems to take pride in the fact that is responsible for controlling mentally-ill patients. He takes it personally if patients are disrespecting staff or ward rules while he is there. This type of competitive sentiment from the various PAs on the different wards about "their wards" being the best to work on is prevalent in Mirage.¹¹

Street smarts. Many PAs have lived and do live in urban areas. Additionally, PAs have observed and learned patient behavior very well. We often act patients out.

Six sense. At times I have observed PAs act very quickly, and many have said they have a six sense, and are able to anticipate patient's behaviors.

The common communicator. As I was explaining to a nurse very recently, PAs have an uncanny ability to speak the patient's language. PAs can communicate with almost anyone; from the CEO or corporate administrators to the autistic patient who can barely articulate a sentence.

¹⁰He no longer works at Mirage. He obtained his degree master's degree and left years ago.

¹¹This is less so today, I will discuss this in the chapter on the subordination process.

Comedians. PAs can be very rough, depending on the patient, or very kind and humorous. Allowing one to be loose, I saw Kuzak dancing to himself imitating a patient several times on different shifts. This is a very unique quality of PAs. We can be “crazy” in a crazy environment. We can let our hair down although this could be viewed as unprofessional and is less likely to occur when bigwigs are around.

Conclusion

Psychiatric Assistants have so much untapped talent. They are much more than what their shirts and positions indicate. Samantha Simms, a black female in her late 30s who is in nursing school currently, says about the title of a PA: “There is nothing technical about what I do, I get offended” when people refer to PAs as “techs.” “The title used to be Psychiatric counselor, but they changed it.” “We have bachelor degrees, we are professionals.” “I came up here and they saw me with my civilian clothes on and they were like, Uuhh,” Samantha says. “The patients or staff,” I ask. “Both,” Samantha replies. PAs are automotive specialists, medical doctors, accountants, and nursing assistants. It is quite impressive to talk with PAs and learn that many are unassuming individuals with loads of what I call untapped talent.

The majority of the PAs stated in their interviews that they were motivated to help others as a reason why they chose to get into the field of social services/mental health and thus to work at Mirage. It was not simply for a check or a “hustle” as many said in the presence of others during the course of my nine years at Mirage. I thought I would hear that workers were simply doing work for a check¹², or because this was all they could

¹²This is what was drilled into our heads by administration. They told us up until the last year, “you are here for a check” during our course of being trained for emergency training.

find. It was something more pushing PAs to do this frontline work. Other PAs said that they were curious about behavior. Many PAs and nurses indicated that they enjoyed seeing patients “get better” as one of the main reasons why they enjoyed their work. The administration was one of the things they least liked about their work. This curiosity led them to take up fields in psychology or sociology. This led them to jobs in the social services, which led to them becoming PAs. Hence, the root of how/why they became PAs was their collective interest in the human being and human behavior. What better place to study human behavior than at a psychiatric/behavioral hospital. I chose to study sociology as an undergraduate because I was interested in society, the world, and the groups that lived in it. Hence, when I reflect on the interviews and the work I had been doing, it was to help people in my own way. I have an interest in humans, and seeing that humans live together in a more peaceful way. I was bothered by racism, classism, and sexism, and always hated to see or hear about some type of misbehavior involving my fellow human beings. Yet and still, like many PAs, working as a subordinated frontline psychiatric worker was never my dream. This is especially true after enduring a place such as Mirage which does not go out of its way to make PAs feel differently about their work—the dirty work. PAs do the dirty work, but with the patient in mind. They want to help, even if that means controlling a patient physically. Does that mean that there are no rotten apples in the basket? Most certainly there are, but those are the outliers, most, especially the ones still around to tell the stories of old, truly want to help. In my view, this makes PAs, as well as frontline nurses, the true heroes of society, even if it is just a stepping stone in their lives to something hopefully better. The minute workers put on

those purple polo shirts; it becomes clear that he/she is a frontline worker subordinated within the work structure of Mirage Psychiatric Hospital, for better or worse.

APPENDIX C
NURSES AT MIRAGE

Introduction

Although this dissertation focused on PAs (Psychiatric Assistants), a group rarely, if ever, studied, the frontline nurses (not all nurses are frontline, some are administrative or work on things not directly dealing with patient care) are an important ingredient in accomplishing psychiatric care at Mirage Psychiatric Hospital (MPH). The nurses at Mirage Psychiatric Hospital often stand on the same frontlines as the PAs.¹ I have seen nurses habitually neglect their lunch breaks, become overwhelmed with emotion, stand up to belligerent and threatening patients, challenge difficult to manage PAs, and work as hard if not harder than some PAs. This does not mean some are not lazy, aloof, incompetent, abusive, and disrespectful to PAs, patients, and other nurses. It does not mean that some nurses simply lack the makeup to do frontline psychiatric nursing. Indeed, some nurses are all of the above mentioned qualities, maybe more. However, among the nurses I observed and interviewed on a whole, they were very much like PAs, they wanted to help others, and voiced a deep respect for PAs as *team members*.² They mentioned that they could not accomplish their work without PAs. This is not simply something nurses said in their interviews, this is something that I observed countless amounts of times on the ward. I will discuss how nurses came to work at Mirage, who they are, and their work with PAs at Mirage Psychiatric Hospital.

The Nature of Nursing

“She spit in my face because I would not call her doctor for medication,” the male nurse tells me as I respond to an emergency code on the girls’ ward.—From a recent fieldnote.

¹Psychiatric Assistant (PA) is the pseudonym of the hospital title that Mirage gave to these workers.

²Team members means more than simply members of a team but a mindset that PAs and nurses are working together to do the work.

Nursing is a female dominated profession which is subjugated to medical doctors who are mostly male (Street, 1992; Chambliss, 1996; Weitz, 2013). Through the works of people like Florence Nightingale, who demanded that nurses not act without the authorization of doctors, nursing both legitimated and subjugated itself with the medical profession (Street, 1992; Weitz, 2013). Still today, there is debate on if nursing has reached a professional status because professional statuses are typically male dominated (Street, 1992; Illich, 2010; Weitz, 2013). So, although nurses definitely have a greater status relative to non-licensed frontline workers such as psychiatric aids, nursing aids, or PAs at Mirage, they still are subordinate to doctors (Chambliss, 1996) and maybe even therapists at Mirage.

According to Chambliss (1996), the hospital nurse must be three things: *a caring individual for patients, a professional (most be considerate and do her/his job in a professional way), and a subordinate to higher up medical personal such as doctors.*

Scott (2006) indicated that nursing care is multifaceted and consists of being professional (e.g., interacting with patients), relating and communicating (e.g., treating people with dignity), skilled nursing (e.g., intuition of care), doing the job (e.g., planning, reflecting), and managing and facilitating (e.g., making sure things get done). All of this work cannot and does not get done on the wards of Mirage by one nurse (often times there is only one nurse on the ward). As Christina, one of the nurses I interviewed indicated it is a team effort with the PAs who are doing or assisting with this care work.

A Moral Element and Goal

Scott (2006) indicated scholars have conceived of nursing as moral and caring profession. Scott (2006) says that nursing has a moral element and objective. The

evidence is that nursing has a direct impact on people/patients which yields benefit or detriment. Because it yields benefit or detriment as a result of nursing's work, it is moral in nature. Scott (2006) states:

In the second place...the activity of nursing is directed at an aim. I would argue that this aim or goal, patient comfort or well being, is clearly a moral aim or goal, having as it does the essential element of some notion of the good for a person/patient as human being. (p. 182)

Scott (2006) essentially concludes that a philosophy of care (where patients are treated as humans and individuals) is needed to understand nursing work instead of a purely science-based evidence of care. Nurses, and other subordinates, do not exercise morality or ethics because they do not have power to according to Chambliss (1996). Chambliss (1996) states, "Ethics aims to answer the question "What should be done?" Hence, in its practical applications, it is witting for powerful people who make decisions, not the powerless who carry them out" (P. 5). The moral question according to Chambliss (1996) is beyond nurses and other frontline staff. The moral responsibility rests with the institution. Chambliss (1996) states in his conclusion on page 183, "To pretend that someone is good or bad apart from settings which allow or prevent their acting is abstraction in the worst sense and pragmatically foolish." One such event I recorded in my field notes below.

Field Notes

I am working with an autistic mentally challenged 1:1 patient³. He keeps putting his finger into his mouth saying "ouah, it hurt." The nurse, Heather, says "a hole in his tooth," and that the doctor is aware of it. The big 20 year of autistic 1:1 patient goes to

³A 1:1 is a patient who must be watched and shadowed by a frontline staff, usually the PA, for safety reasons. This patient is considered an imminent danger.

the medication room to see Nurse Heather but says “No” and backs away when she attempts to stick a cotton swab into his mouth. The patient, who is clearly limited in his communicational skills, refuses the very medication that will relieve the pain that he is going through. This makes me feel very frustrated. I say to nurse Heather and other PAs who are working, one African male and a white female tonight (white female is registry worker who is new and African male has worked at the hospital six years like myself), “Why is he not sent out to the hospital or dentist if he is in pain but does not have the mental insight to take his medication.” At one point I proclaim, “I am going to talk to the supervisor, this is immoral.” Heather gives the patient more psyche meds versus dental medication. We somehow get through the shift.

The Demographics

There are around 43 nurses at Mirage Psychiatric hospital.⁴ This includes the collection of registry nurses. Your typical nurse at Mirage Hospital would be middle-aged (in her early to late 40s) and female. Ironically, this description would fit the nursing administration. Thirty-four of the 43 nurses are female (79%). Racially speaking, 13 are black (30%), 14 are Asian (33%), and 16 are white (37%). It is noteworthy that most of the nurses are female, and most of the PAs are male. Thirty percent are black, so the racial conflict among frontline nurses and PAs is not as much of a source of conflict, but gender issues are subtly at play in the interaction between PAs and nurses. I note in a recent field note my interaction with one of the nurses.

⁴It is somewhat hard to get an exact number because nurses are constantly coming and going at Mirage.

Field Notes

I walked onto Ward-57 to see Jackie Brown holding the rounds in the hallway. I forced a “hello Jackie” and she forced a “Hello” to me. It was a dry hello barely showing any emotion to my hello. I have been wondering why she turned this way on me, but she has. Even one point during the day I intentionally tried to flatter her. I said, “I enjoy working with you so much Jackie.” She replied, “Terrence, I’m not trying to get into an analysis.” I said, “I don’t know about you, but I truly like working with you.” Jackie somewhat blushes and told the patients, “You guys go in there [the day room].” She is very guarded and intentionally tries to avoid conversations with me, for some reason.

During this interaction, I am trying to appeal to her emotions as a woman. I have noticed many PAs comfort and interact with nurses in a way that is very different with each other. Like any relationship, when this interaction is not demanding, it is fine, but when stress comes into the picture, the subtle dynamics can be clear. Jackie Brown’s attitude seemed to change toward me after this particular interaction with Hazy White, a newer white female nurse in her late 20s.

Field Notes

September 18, 2012 Tuesday: The day started out where patients were in the halls, I was handed the rounds by Kuzak, the two female PAs went to the rooms of the female one to ones. We had two female one to one’s on ward 5. As I am holding the rounds book, signing each page of the patient’s rounds, the phlebotomist Grace holds up the lap sheets letting me know she would like for me to get the patients for their lab blood work, I hold up one finger saying wait, and then I tell her, “I’ll help you, but I need to sign on to my rounds first.” I continue signing the rounds and casually looking for

patients, and redirecting patients to go back into their rooms. Within a few moments, the charge nurse, Hazy White yells down the hallway, “Terrence, I need for you to get these patients for their lab work.” This infuriates me. I respond, “I will get the patients, but I am trying to sign on to the rounds and locate the patients.” Hazy White insists, “I need for you to get the patients,” I yell back, “Are you going to do these rounds?!” I continued, “I always get the patients, I know how it works.” I have been doing this job for nine years. She is a few months out of nursing school. She backs off, and one the night shift workers begin to collect the patients for the phlebotomist. This was a public display of frustration on the part of the nurse, and by me, the PA. We, PAs are not children or ignorant of how things work. Often times the charge nurses feel a need to command PAs base on their perception, or stress level, that PAs do not do their jobs. I consider myself a “worker” in the since that I run around the ward, I do my groups, I do the rounds, I redirect patients, and I generally do whatever I am asked to do by nurse. However, there comes a time when we, not on the nurses, are overwhelmed my patients in the hall, non-compliant patients, patients that need to be lifted and taken to the toilet, we have one such patient. I am all overwhelming. Moreover, the PA’s job is to keep people safe, how I can watch the hallway, do the rounds, redirect patients, assist the man who is lying in his wet diaper, and get the patients for lab work. I have no one to turn to, because if you complain to the nursing manager, she only wants to see how she can temporarily fix the issue with solving the deep rooted issue of staffing according to the need of the ward and its particular patients, which fluctuates. I understand Hazy White’s stress of all of the nursing paperwork and her dilemma in figuring on the staffing breaks and assignments, but I do not accept being yelled at in an already stressful situation. I know as well that I

could be written up for “yelling in front of patients,” although the nurse yelled at me first. It is unfair, and it is situations like this that make the position of a PA somewhat horrible. It is not right, and not always possible to accept one’s subordination. I am sure HR would say that she should not have yelled at me in this way, but at the same time they would write me up for being insubordinate. This sounds strange, but it reflects the power which PAs have within Mirage Hospital. Kuzak was off the ward, the other female PAs were hidden in patients’ rooms, and I was the only one out in the hallway with 23 patients while the other staff was either leaving or in the nurse’s case trying to collect her thoughts and emotions to begin her shift. Something is wrong here. Later in the shift Kuzak would tell me that one of the nurse managers complained to Hazy White about giving charts to one of her PAs who was doing the one on one. For the PA assigned to exclusively do the one to one, they are not supposed to have any other charts because they have technically not interacted or observed others. However, in practice, anything goes that suits the nurse’s shift and Mirage Psychiatric hospital needs. Hazy White eventually changed the assignment incorporating Kuzak and I on the female one to ones and thus dividing the work. I appreciated the fact that I could sit on my butt and do some charts a little as well. This is typically what the one to one staff will do if they have a “good” or compliant one to one patient. For the rest of the shift, Hazy and I had limited interaction. I thought about smoothing things over with her, but Kuzak said that this would be “admitting guilt,” which in this case I do not believe I am guilty, however I hate that I got upset and responded the way I did. However, maybe this is one way in which PAs and other workers reclaim their dignity. This was not something that I thought

about; it was something that I just could help. I had to respond to her in equal force. I had to stand up.

The Nurses at Mirage

In order to find out how nurses came to work at Mirage Psychiatric Hospital (MPH), I asked them early in the interviews, *Could you tell me how you became a nurse*⁵? One of the nurses I interviewed was Dawn Mills. Dawn Mills is a white female in her mid to late 30s. She has a nice smile and is usually friendly with all workers at Mirage. She worked full time on Ward 5 dayshift for about 4 years. She recently resigned on 3-6-12 and is now registry. Dawn Mills and I met at Starbucks in a suburb close to her new full-time nursing job. Dawn was sitting down when I finally made it to Starbucks late. She got up, and awkwardly hugged me. I naturally almost kissed her on the cheek, but it turned into an awkward air peck. That was strange, I felt. Dawn really misses the core staff, me, Kuzak, and David at Mirage. She asked about Kuzak. I can't imagine what she was thinking...here I am being late for my interview. Once we got past the awkwardness of my lateness and the air peck and hug, we had a very good interview. I found myself laughing out loud several times at her descriptions of patients cursing her out over small things, such as no phones being available to make phone calls. She was candid and very motivated to tell all and everything. I reminded her that I am interested in learning about the *process of during work in a psychiatric hospital* and not necessarily the dirt that happens in Mirage. She is a very caring person, despite our once conflict, we have moved on from it. She indicated that they [administration] are the root cause of our conflicts on the floor. She said, "I did not always realize that." She wants to become an

⁵The same question I asked Pas.

advanced nurse one day. She admits that she is a very caring person and has a desire to please others. This leads to her being taken advantage of in her work experiences and personal life. She says she was traumatized when a patient attacked her pulling her hair and biting her. She indicated this example as showing how short-staffing affects safety of staff. She has a great appreciation for PAs saying they are a comfort to her and without them “I could not do it.” Her last straw that made her go to registry was when the patients did not have a bed and the populations were inappropriately mixed. I worked that shift with her and David, and it was a very rough shift. She admits that she got away with a “lot of things at Mirage.” She cited examples such as not wearing the mandatory light purple polo shirts. She explained that she knew she could get away with it because she was “needed.” As she said, no one could run that ward, ward 5. She said that if they ever pulled her downstairs [to HR] she would complain about all the other issues the hospital was not addressing, like short-staffing. She also indicated that employee of the month award is either for those in in the click or those who administration feel need a morale boost to stay working at Mirage. Hers, as I figured, was a very candid interview. Some of it appears below:

Me: How did you become a nurse at Mirage?

Dawn Mills: I first never wanted to become a nurse because my mother always wanted me to come one, so I was against it, completely. Ahh...When I was junior in high school I took a psychology class. And that all began my whole psyche ahh wanting to be in psychology of some \sorts. When I went into college, and I just took psychology classes, I wanted to be a therapist, and then I realized I have my own stuff, so I tried sociology.. Or..social work, I should say. There was a time I was in the hospital, and the nurse was really rude to me, and that was the day I decided if I could make one change in someone’s life, or be a good nurse, one nurse out of the whole unit, that I could make a difference, that is really how I became a nurse, was because of this mean horrible nurse. So I did, I went into CNA [certified nursing assistant] school. I was in it for a couple of years, So then

I got into nursing school, got my phlebotomy certification, psyche rehab tech certification...but that is really why I am nurse, to help others.

Me: Very interesting...so from that one bad experience with a nurse you decided to follow up..

Dawn Mills: Yes, and it wasn't just me, it was other patients I observed her being really ignorant, and it hurt me to see that.

Me: Ok so Ahh, what lead you to Mirage hospital?

Dawn Mills: I started off in ICU (Intensive Care Unit)..ahh I stayed there for a year...and when I left there cause when they getting rid of their... worked in open heart surgery, and they were opening up a new wing, I wasn't getting . A lot of changes were going on, and I decided to move on. I found myself just applying for psyche positions. I family kept saying I was crazy. But that is what I wanted to do.

Me: Changes were happening at this place [her first place out of school],and so you decided...you knew you wanted to move on so you decided I'm going to move on to psyche...so how did you get interested in psyche.

Dawn Mills: Prior to me being in the nursing program, I went to a psychiatric program at the University of Chicago for psychiatric rehabilitation technician, and I had over 500 hours of experience at Tinley park, and I always enjoyed psyche. My nursing clinicals I hated it. I'll be honest I hated it. Ahh...but I always wanted to do psyche, but my plan was to medical because that was always the thing, "Oh you need medical before you go" and I would do psyche later in my life, but it was just a calling that I wanted.

Me: So that would explain why you started off in ICU

Dawn Mills: yes

Me: and you eventually decided that I can't

Dawn Mills: Yes

Me: Cause when you look at it you studied psychology all throughout college..

Dawn Mills: Pretty much all through college.

Me: Ok, so you decided to get into psyche, how did you hear about this place? So it was just random?

Dawn Mills: Actually I have a friend who I went to nursing school with that was hospitalized as a teenager...but I was just looking up different facilities and I saw they were hiring and I applied.

Me: So it was random, it could have been anywhere

Dawn Mills: Yes

Me: Oh, so how long have you been working at Mirage?

Dawn Mills: I started there in 2008.

Me: So 4 years during those 4 years what kept you afloat? We talked about this before but you came in during a transition period cause I think a lot of stuff started to happen around 2009.

Dawn Mills: hummhum

Me: So what kept you there for as long as you did? How did you manage to stay?

Dawn Mills: In the beginning I stayed because I noticed some patients weren't being taking care of like they should. So I thought in my head that at least if I

stayed, at least at my shift I would make sure they would care for...ahh and...the staff. And I love the patients...so I think that was the bigger reason why I stayed honestly.

Me: so when you say the patients, I know that sometimes you will have patients that will come in and out, are you talking about those, or the psyche patients in general?

Dawn was drawn into working with patients who had mental health issues because of her interest in psychology and probably her own issues, as she says, I had my own issues. The one bad hospital experience motivated her to be “part of the solution instead of the part of the problem.”

Christina and I met for both interviews at a local fast food restaurant. Christina actually bought me coffee for our first interview instead of me buying her coffee. I felt this was very nice of her to do. Christina worked the night shift before we interviewed. Christina is an Asian female who looks younger than her age (it seems that everyone at Mirage looks younger than their actual ages). Christina is joyful and humorous most of the times. She has a cynical sense of humor and rarely seems outright angry. This is could be cultural. She told me on the second interview that if “the interviews were shorter;” you could get more people for the interview. She was candid in the interviews. She mentioned in her second interview when I followed up on why she decided to study nursing in the beginning that she wanted to be a doctor or nurse from a young age, and could only afford to study nursing. She indicated that it was not a religious impulse as much as it was a humanitarian calling. Christina discussed how she became a nurse below:

Christina: I started a bachelor’s of science in nursing in the Philippines for four years, and then I got my license there, and then I came here, and ahh took the board exam.

Christina: I first job I worked ahh...in home health agency

Me: Humm

Christina: Doing chart audit..that was for 6 months

Me: Similar to what you are doing now, chart audits...ahh...and so after that 6 month period what did you do?

Christina: After that I worked at a nursing home and I was a unit nurse for about..ahh.. I would say 3 years and then after that at the same nursing home I was a MDS coordinator. MDS is involved with ahh reimbursement. So ahh I do the nursing part, and once in a while I have to do the care plan meetings as well.

Me: Hmm hmm, ok, ahh does that bring us up to this particular hospital? So how did become a RN at this hospital Mirage?

Christina: ...Ha ha [laughs at the pseudonym]...[3 seconds pause]...ok well...it was something personal that had happened to me [I never asked because it seemed she wanted to keep it personal] that's why I ended up here. Cause after the nursing home experience...I was...a mother and baby unit nurse... for a year...and then I decided to move here[the neighborhood] and then I ended up applying at...at this hospital...and ah I have been working for about 8 years now. In a psychiatric hospital.

Me: Ok, so how did you hear about this hospital?

Christina: I just know that it is close to our house. Where I am staying at, so nothing in particular that I want to work in a psychiatric setting. It was just one of the hospitals that is close to the house and at that time I wasn't not driving. It would be better for me just, you know get a job somewhere close by, that way it is not going to be hard for me.

Me: So that was about distance, it could have been any hospital, it is just close by.

Christina: Right

Me: So, ok I know because I have been here 9 plus years it can be trying place many ups and downs. What factors do you think have helped you work here 8 years?

Christina: Well I had some psychiatric experience anyway from working at the nursing home because ahh 70 percent of our clients were mentally ill, and then 30 percent geriatric so I am used to ahh really dealing with them, talking to them. I am familiar with the medications [the work of nurses at Mirage]. So you know it helped me...to really...ahh...actually like it.

Christina: The thing is that I am familiar with psyche patients, I know the medications, I know the cases, and I know how to take care of them, and it helps. The only thing that probably helped me to stay 8 years is that I work the night shift. It is not about really dealing with the patients that make you ahh...last...It's not about the...actually...the patients... that ahh help you stay. Some of the things I would think that make a nurse quit, not because of the patients, but the administrative policies, how they run the hospital. It is not dealing with the patients that make you want to quit, it is what goes around it.

Me: And that is specific to this hospital, so more nurses leave than PAs. Granted that you have been dealing with administration for 8 years...so the question is in a sense...why didn't you leave? You kept dealing with the dynamics of the

administration even though you know. So it is kind like strange relationship or something, I do not know.

Christina: It is better that you work night shift cause you do not deal with administration that much [I think so]. You deal with the supervisor, so that helps when you don't deal with people telling you you didn't do this, you didn't do that. Cause when you work day shift you have too many bosses; ward manger, supervisors, director of nursing, ADON [Assistant Director of Nursing] and they are all telling you what you didn't do

Me: Ok, so really night shift gives you a bit of cover...

Christina: right

Victor Sam, white male nurse in his mid-20s. He minored in sociology and majored in biology as an undergraduate. He now works registry as of 2012. He has undergone a shift in perspective about nursing and Mirage. He is going back to school to be a chiropractor. When Victor first started at Mirage, he was a lot more enthusiastic about his work as a nurse. He went through a "burnout" process that he once described to me. Victor describes how he became a nurse below:

Victor Sam: For nursing, ahh honestly I had a program that was available to me near where I went to college, and I took it. I was in a grad program actually at the time studying molecular biology, graduate studies, and I ahh... passed it up actually cause I was seeing a girl who explained to me that we were too far from each other and the closest and the only way come closer near was to make our relationship grow was to go into this nursing program a year and 3 months program, and it was the only program near my college, so I could actually get something out of it. Mom was a nurse, dad was a doctor, I felt I could fit in. I thought it through and thought it was possible I could come... get my master's in nursing afterwards. The totally program was like 5 thousand dollars which was in expensive, I thought out all this stuff before I started, I thought I would go ahead and try it. So it was kinda a complete accident as to why I became a nurse. I thought about going back to school to become a MD, unfortunately I became a nurse. I am quite happy with what I do now, but was a roundabout path for me to get there.

Me: It seems like it was an opportunity because again because you wanted to be close to this girl and she told you about this program and financially and it was also quick. A year in 3 months..

Victor Sam: yeah very quick

Me: Ok, so let me go back...as an undergrad were your interests in studying?

Victor Sam: I loved chemistry, biochemistry, I loved science a lot.

Me: Wow⁶

Victor Sam: I was really big into sciences. I do very well physiology bio-chemistry, my dad has a PhD in physiology. Those were the only classes I liked.

Me: Wow...

Victor Sam: So nursing kinda made sense this was close to what I like. Being a bedside nurse is really draining... I can't do it much longer, that is why I am going back to school now.⁷ It just takes a lot out of me. I honestly did not expect to become a nurse. I had no idea what a nurse would do, I thought they sat around all day just working. In the OR [operating room] setting was where I was at--working.

Me: Even though your mom, she did really?

Victor Sam: My mom was stay at home mom. She worked for 15 years, then stopped working when she had me. So she hadn't worked in years. She had no idea, she hadn't been a nurse in a while. So she really did not guide me. She said you would like it, I think the thing was I was guaranteed to have a job when I got out of school. When I finished molecular biology I was not sure my program I would get me a job. I thought when I get a master's degree in this, what can I do other than to go further in school. I thought it was an opportunity to money while I was still trying to figure out what to do, and only a year would be quick. And then I could have a decent paying job. So it was about several things, monetary, inexpensive, and I could make money, and plus I could be close to the girl I thought I wanted to marry, so it all seemed to work out in this pattern so..

Me: So what I get though, did you want to become micro-biologist?

Victor Sam: I wanted to be a doctor.

Bernice is a black registered nurse. She carries herself in a very dignified manner.

She speaks slowly and professionally. We met for one interview at Burger King. She is in her mid-sixties:

Bernice: All my life, ever since I was a little girl, I always wanted to be a nurse

Me: Umm hum

Bernice: ..So, this is something I have fulfilled my dreams.

Me: ok, so your education in nursing. When did you take up that, and what did you take up in school?

Bernice: First of all, when I finished high school I was going to go to Provident [hospital]...for their nursing program. And what happened was I became pregnant and got married, so I took, later on I took practical nursing. I went into practical nursing.

⁶This surprised me because I thought he was a sociology major. It turns out he minored in sociology.

⁷He is going back to school to be a chiropractor.

Carlotta interview took place in BK. We met twice in BK. This is the first interview. Carlotta is a black woman in her late 60s (68). She works as a LPN, or medication nurse in Mirage Hospital.

Me: Ok, so I am looking at the time now, and it is like 3:22, we will stop at 4:22. Ok, so the first question is: How old are you?

Carlotta: I am 68 years old

Me: Ok, could you tell me about how you became a LPN and exactly what is a LPN?

Carlotta: A LPN is a Licensed Practical Nurse, who with special training is allowed to give medications to patients. Ahh to administer support Ahh give medical, some medical advice. Ahh Just taking care of patients basically, Ahh doing things that..assignments that are given to people at the hospital basically.

Me: How did you become a LPN?

Carlotta: Well I started off actually as a nursing assistant. Ahh, I went to ah inner city school for nursing. Well really, ah a hospital run program for nursing. Then after that I was trained for a medical nurse. Then it was history after that.

The Nurses Work with Pas

As Ronda, a black nurse in her early to mid-30s, said more than once on the wards, “You guys [PAs] are my eyes and the floor.” Bernice, another black nurse said the same. Dawn Mills, Christina, Victor Sam, and Carlotta, all acknowledged the same thing. Frontline nurses and PAs work together at Mirage. Indeed, there is little choice in the matter and it is both work group’s benefit (and objectives) that they do so. Christina voices her work with PAs on the night shift below during our interview:

Christina: Usually I am done around 130 or 2 am. If you are working with one person [PA] you are going to split up the charting, and you are going to help with the rounds. That depends on how many people you are working with.

Me: So you help with the rounds?

Christina: If you are only working with one person, of course, you are going to try to help that person. At least with the charting, if you cannot help with the rounds. You are going to help with the charting. That is why you have to work together to make it work. You are only two people working.

Me: Some people might say, let it be the PAs responsibility. Some nurses to say they want to be fair. Some say they want to be a team. So you take that approach too?

Christina: It has to be team because if, ultimately whatever happens is on the ward, it is going to be on the nurse. Even if it is going to be the PAs fault. They’re going to make the nurse responsible for anything that is going to happen. So why

not try to make it work with your, whoever is with you because you have to work as a team because you are responsible for everybody. So why saying you know I'm going to be, I'm the charge nurse I need you to do your job, and I'm going to do my job only. So it has to be a team work, team effort to make it work.

The nurses simply could not do their jobs without the PAs. Nurses must first listen to report, make out assignments, check medical boards and doctor orders, do paper work, and many times set up and administer medications. The one main impediment to this work are the patients. The PAs must keep the patients in relative order and convey information between patients and nurses in order for nurses to accomplish their work. In order to accomplish work, PAs and nurses must interact and do interact on the wards indirectly and directly sharing their feelings about their work to each other. One such example I documented in my field notes below highlights the nature of this interaction between nurses and PAs.

Field Notes

Around this time, Noreen⁸ comes on the ward. I tell her, "David has made the schedule and we will help you out. She says, "Usually I am extending my hours and registry does not show up." I can tell she is upset by her tone and facial expression, and continues, "I tired of this bullshit." Noreen was kind of close to Dawn⁹ (who left), and is no doubt feeling even more frustrated that nurses have recently quit. When other workers leave or quit, it makes some remaining workers feel like they are the fools for continuing to stick around. I know I have experience this feeling. Additionally, workers hate to

⁸See footnote 23.

⁹See footnote 13.

float,¹⁰ and Noreen has to float from her ward to ward 6. David, who has left the dayrooms overhears Noreen complaining and says, “They know that [administration].” Noreen replies, “That’s why nurses are leaving, they are tired of that.” David responds, “What are you waiting for?” Noreen, in her Asian accent, responds, “I have my other job!” She asks out loud as Mables, who has stayed from the night shift to help out, walks by, and “Are there any discharges?” Mables does not respond and acts as if she does not hear her. I overhear this and proceed to leave from behind the nurse’s station. I can sense that Noreen is upset. The way she is talking. Nonetheless, workers need to control themselves and be professional. Unfortunately, all too often, they fail to do this. Perhaps if Noreen would have first said hello to Mables, maybe Mables would have responded. It’s around 9:03am, the mentally challenged patient, Diana has come out of the shower. She asks, “I need a pillow case.” I respond, “we do not have any now.” Mables yells down the hall, “Send them for their medication.” I respond by shouted so that patients on the ward can hear me, “go get your meds!”¹¹ Mables is looking down the hallway in the small medication room which is toward the front of the ward. In the dayroom, David and I talk briefly about Noreen. “Noreen seems upset,” I say to David. He responds, “I’m staying away from her.” I attempt to explain Noreen’s behavior, “She is alone and has to pass the medication.” David replies, “Mables is passing the medication. She only has four charts.” I say, “Yeah.”

¹⁰Float is a hospital term for when workers are assigned or asked to work another ward that is not their regular ward. Workers are less familiar with the patients, staff, and arrangement of the ward they are floated to.

¹¹Meds is short for medication.

The Report

Most of the workers answered my question to tell me about a typical shift at Mirage by telling me the protocol of work at Mirage. The first thing that a nurse must do is get the report. Nurses and PAs at Mirage used to listen to the report together when I first started working a Mirage in 2003. Nowadays, nurses give report to each other only, and PAs do the same. Hence, the segregation of nurse work and PA starts at the start of the frontline workers shifts. Nurses go into a separate meeting room, usually behind the nurse's station, and PAs get report out in the hall way while interacting, servicing, and *redirecting*¹² patients. PAs are the workers who are keeping the patients at bay from the nurses. Nurses meet behind closed doors and for longer periods of time than do PAs. Many times PAs are frustrated by this fact because the patients are constantly trying to get to the nurses or doctors for medications or to be discharged. The PAs are the foot soldiers keeping the patients away from the nurses. When I would listen to the report, when PAs and nurses meet together, there was nothing particularly special about the medical part of the report that necessitated the nurses meeting any longer than do PAs. The nursing side of the report would consist of the physical or biochemical problems patients might have. Mirage only deals with psychiatric patients, so the medical issues which patients might have would naturally be at a minimum. So what makes the nursing report longer, much longer than the PA report? I believe the answer is the space that PAs allow for nurses to have, that PAs do not have because they are out on the wards constantly dealing with patients. Many times I observed nurses simply not wanting to “go out there” on the wards at the start of their shifts. This “not wanting to go out there”

¹²A Mirage psychiatric term for verbally attempting to set limits on patients' actions.

is a product of employee morale. When nurses are faced with being the “only nurse,” they react in passive-aggressive ways such as taking a long time to listen to report. Only those nurses who are meeting sometimes up to 30 minutes can answer this question. I did not ask nurses this direct question, but based on my past experience of listening to the same report, knowing how nurses look and speak during the course of their work at Mirage, the nursing report involves more than merely listening to the run-down of typical behavior from patients. I might add that patients’ behavior is fairly typical and mundane. The behavior of psychotics typically does not change, he/she is psychotic today and psychotic tomorrow. Of course, I might be wrong. It could be that the nurse’s report has become so technical now and so overwhelming that nurses need to meet for more than 30 minutes in excess. This is my view as a frontline PA, and not one of a frontline nurse. In summary, the PA-nurse work together during the start of a shift for a nurse involves PAs dealing with patients, so that nurses can meet for their report.

Setting up Meds

Frontline nurses, LPNs (Licensed Practical Nurses) and RNs (Registered Nurses) set up the medications to be administered or given to nurses. Nurses, like PAs, start at 7am. Nurses, LPNs and RNs, listen to the report together. If there is a LPN scheduled, then she will set up and administer the medications. It typically takes a LPN about one hour to get the medications (meds) ready and then start to give them to patients. If there is no LPN scheduled to work the shift, then the RN will be both charge nurse and *medication nurse*.¹³ Because psychiatric patients at Mirage are so *needy*,¹⁴ PAs are

¹³The medication nurse is the nurse giving the medication to the patients.

needed if nothing else, to fend them off of the nurses. Many nurses I have observed say to patients, “I’m not ready yet.” This means that they are not ready to give medications to patients who will ask for medications throughout the night, afternoon, and day. Some patients constantly ask for meds. They constantly are after the nurse for this purpose. Hence, PAs must attempt to *redirect*¹⁵ patients in order for the nurse simply to set up medications.

Out on the Floor or Behind the Nurse’s Station: Paper Work

In my earlier years, I wondered why nurses were not out on floors with patients, especially when patients mostly wanted to interact with higher-up workers such as nurses, social workers, therapists, and doctors. However, as the years have gone by the paper work, to protect and help Mirage get paid, has increased, I no longer wonder why. Most nurses would prefer to be out on the floors with the patients. Dawn Mills, Bernice, Christina, Victor Sam, Carlotta, and many others I did not interview expressed this fact. However, it is the paper work and other bureaucratic demands of Mirage which prevent them from doing so. However, it is this very paper work which allows the hospital to get paid. Weitz (2013) indicated that health care organizations are focused on documenting instead of actually providing the care work. Below is an interaction I had with a former nurse at Mirage Heather.

Field Notes

To my surprise I worked with Heather (RN) who I interviewed over five years ago when she was a PA (she has been working at Mirage for about eight years now).

¹⁴Needy is a Mirage term for someone, could even be staff, which needs something a lot of something. The patient could be seeking to constantly to interact with staff, make demands, need services, etc.

¹⁵See footnote 6.

David was the other PA I worked with today. Kelly has not changed much. I asked her how she felt as a nurse. She said "I don't like it. There was less responsibility as a PA." Heather never liked having so much responsibility. K-Dog indicated that if something goes wrong, she has to answer to it. Heather is still not married and views marriage as too much of a responsibility too. K-Dog still criticizes Mirage for short-staffing and says, "There is so much fraudulent things going on around here." I asked Heather why she has stayed so long at Mirage. She explains that "I thought you got your bonus at five years. But I found out it was after four years but in increments." She states, "I have a plan" as a reason for why she stays on at Mirage. Heather is a good nurse. She talks with patients. She is active on the milieu. She does not call down to the dayroom overly asking PAs to make phone calls or do this or do that. The way the current manger, Ms. Darlene of Ward-5 does. Heather states "I ought to learn how to delegate." I reply, "Then no one would like you." Heather is competent. Maybe it is because she used to be a PA? She knows how to do her job. She knows how to deal with patients. She dealt effectively with them and did not ask us once to get a patient from the desk so that she could do her paper work. We, David, Heather, and I worked well together. Additionally, the patients were half way decent and each one of us supported one another. Heather was happy that we basically ran the ward without needing us. She jokingly said to the oncoming shift of PAs, "I might go to first shift because these guys kept everything running smooth." Heather recently left Mirage by moving to another state with her boyfriend. It felt good seeing Heather because as I told her it means "I am not the only one still here." I guess misery loves company. I warm face and smile; someone who knows a little about you. I really miss her in a way. She reminds me of a high school friend.

Heather would rather be out on the floor working together with PAs, and did do this fairly often. However, over the long term, there are consequences in morale and in physical wear on the body and mind.

Passing Meds

*Passing Meds*¹⁶ is a routine part of a nurse's job at Mirage. It is one of the more important duties, and as Victor Sam describes in his interview, the most important aspect of his job.

Victor Sam: Well, when I first walk in I get a report, honestly may not even listen to. The only thing I want to know is which patients I need to medicate. I tell them [the nurses leaving and giving the report] tell me about the major stuff. Don't tell me about the patients who are quiet, honestly I could care less. They don't do anything to affect me. I go right into the med room and start setting up meds. I don't do anything until meds are set up. Then after I get my meds set up, it does not matter whether it was first shift or second shift, I start giving my medications out. Then after that I do my assessments. I get my assessments out of the way, then I do my assignment sheet. That is like the last thing I think about because feel the PAs know how to handle themselves. There is no need to write down an assignment sheet. You all [PAs] are adults, you know how to handle yourselves. I get so frustrated when administration asks me. Then after that my shift is really over. I can get done with my shift in really 3 to 4 hours.

Me: What would you see as your main responsibilities as a RN in the hospital?

Victor Sam: Medication, medication is my main responsibility. Making sure these patients have their meds on time. That is my 100% point of being there.

Some nurses like creativity and tact when working with PAs. They see it not as working with PAs, but PAs working for them in accomplishing their objectives. One such interaction is recorded in this field note below.

Field Notes

June 9, 2012 Saturday. I worked with David and Ward Manager Darlene. Many of us shake our heads in disgust. Although Posey is difficult to control, we see the effects

¹⁶Passing meds is nursing terminology for setting up and administering medication to patients by nurses.

of her medication on her body. She at one point was yelling, looking up at the ceiling camera on the wall saying, “STOP LOOKING AT ME!” The Ward manager, Ms. Darlene, a white woman who looks around 62 years old, but as one black nurse recently told me, she is only 55, my age, says, “Just tell her I am going to take her over there soon.” I was frustrated at the start of the shift seeing that Darlene was the nurse. The hospital staffing has never been the same). This is a major factor in PAs and others not liking their work, i.e., the interactions with one another. Darlene can be this way as well. Darlene has really earned a unanimous sentiment among PAs and nurses. They don’t like her. David tells me “what is going to happen is that we are going to have a clash, and I am going to put my reputation up against hers. I have 10 years of work here and everyone knows me. You can ask the social workers, AR (assessment and referral), nurses, HR, they all know me and that I work.” He says latter when I complain to him that Darlene “tells me obvious things although I have been working here for nine years,” “I do even say anything. I just keep doing my job.” Darlene is controlling, rude, demanding, and feels she knows the best and PAs and younger nurses know the least. Hence, she feels it is her job to tell you what to do. This erodes PAs knowledge and expertise. She overrides our knowledge and tells us what to do like children or inferiors. She especially does this when she is feeling stressed out. For example, when she yells out, “I need to have these patients for medication Terrence.” I respond after walking to patients’ rooms and asking one to take her medication, “She wants her blood pressure taken before she takes her medication.” Darlene replies, “Take her vitals! We have 4 patients that did not have their vitals taken.” I am already opening doors, getting patients supplies, redirecting Posey (tall biracial mentally challenged patient who has been coming to the hospital ever since she

was a child), attempting to get patients to take their medication, and *doing the rounds*. I attempt to hold my frustration inside but I say, “The rounds are not caught up. I will get the vitals.” She responds, “I know,” walking toward the nurse’s station. Later she says to me, “I did not mean for you to get the vitals now.” I really believe that Darlene does not mean any harm but because she is not physically fit for this job, I think she wants to push everyone physically to do more and more. She wants to get the most of PAs and others and she lacks professional tolerance to skillfully get PAs to do the job. Her style, which is very common among nurses (especially female nurses) at Mirage, is to demand and yell when all becomes stressful on the ward.

David and I make it through the shift without any major explosions with Ms. Darlene. What we have to look forward to tomorrow is another shift with Darlene. I tell David that I really do not blame Darlene, “I blame the administration for hiring someone who is not qualified.” David says, “It is making my job hard.” I reply, “yes, but they don’t care about our happiness or well-being at work.” I think that this is the bottom line. The hospital simply just does not invest in workers. It could be that because they know most workers do not invest in it. Or it could be because they do not treat workers with the consideration to say “David, Terrence, Kuzak, since you all have been working here more than 9 years, let me see what you think of this person as ward manager.” They do not consult us. They really just barely give us a rub on the back and say nice job of managing an understaffed ward today. Our source of frustration is sometimes not the patients, but your fellow coworkers, frontline nurses, and administrators.

Darlene truly lacks creativity. It might be a product of her deteriorating health. Darlene is somewhat obese and is a heavy smoker. However, some nurses are more

creative and allow PAs to accomplish their work goals (controlling patients and having less hard work and more enjoyable work) The creativity in giving medications to psychotic patients is a learned art. Jackie Brown is very effective in giving meds to patients for two reasons: she walks down the hallway to give patients their medication, and she uses humor and psychiatric emotional labor, or psychology, to get patients to take their medications. Here is one example from a recent field note:

Field Notes

LPN using her skills to give Darcy Medication at 847am, Jackie Brown, a LPN (licensed practical nurse), casually approaches Darcy for medication. She walks up to his doorway, right in front of me, without talking with me, and says, “can I come in?” Darcy says, “Yeah.” “I have your meds¹⁷ ready, can I give them to you?” Jackie Brown says. She continues, “earlier you asked me, but I did not have them ready. Darcy responds, “Yeah.” Within three minutes Jackie Brown comes back into his room. Again, she does not say anything to me¹⁸ I get up and come over to Jackie and Darcy. I know that if he were to hit her, I would be blamed because I am his 1:1 staff. She hands Darcy a small cup of pills while she is holding the larger cup of water. He takes the small cup and turns in up to his mouth. She hands him the water cup. He drinks it. Jackie says in an enthusiastic voice, “I have one more for you.” I notice she has a needle in her hand. I guess he does too, because he lifts his gown sleeve to accept the shot in his right arm. I am standing right next to him and Jackie Brown. Jackie says, “Can I get on this side?” She moves to his other left arm. Darcy is looking directly into Jackie’s eyes and at

¹⁷Meds means medication.

¹⁸Typically nurses will ask PAs to come be there as a show of presence.

nothing else. They are very close. Jackie grabs his arm, feels around, and inserts the needle. I am watching closely. Darcy says, “I can control peoples’ bodies.” Jackie says “Keep smiling” as she is pushing in the thick clear liquid medication. Darcy’s eyes open up wider. I assume because of the increasing pain as Jackie is injecting the medication. Jackie starts to sing a Motown song, “I guesssss, whatttt they say, nothing can make me feel this way, my girl” Jackie continues, “You like when I sing don’t you?” Darcy grimaces but does not resist. Jackie Brown finishes and walks out of the room. Darcy is sitting up on the furniture shelf with his headphones on. He has not moved from this spot. I hear Jackie Brown proudly saying to Hazy White, “I got him to take his dec¹⁹ and everything. This medication does end of slowing Darcy down. It took an hour and half but he is not pacing any longer nor is he speaking to a non-immediate reality. I tell Jackie, “Good job.” She smiles and pats her own self on the back. At 9am, I switch with Kuzak and got into the dayroom to do group. Lena Horn still has the rounds, and Hazy White is still behind the desk.

Typically, RNs are on the wards with no other nurse (e.g., a LPN). Therefore, the RN must do the paper work of frontline nursing at Mirage, and overwhelming amount due to the other responsibilities nurses must manage, and pass medications. This often times makes them feel overwhelmed which makes their interaction with PAs (the main information conveyers and “eyes and ears” on the ward as Rhonda says) poor. My interaction with a nurse attempting to get the patient medication produced this result one day. Here is a field note of such an interaction.

¹⁹Haloperidol Decanoate is medication given my injection to calm agitated patients down.

Field Notes

Yolanda, the other person I am working with, is an Asian lady in her early to mid-40s I would assume. She is the charge nurse this morning. I do not particularly like the way she responds to me when I inform of what is going on with patients or in general. She acts like she is overwhelmed and hates to respond. After a psychotic patient who is 6' 3" 340 lbs has explained to me that "God and Satan" will punish me, I report this to Yolanda, the charge/medication nurse. "Roland is very psychotic, he is saying strange things." She is preparing the meds and barely raises her head to say to me, "I, Is that news to you?" "No, it's not" I reply, but her response irks me, and I continue "I am just reporting, stop over reacting Yolanda." "Yolanda explains, "I heard him." "No, every time I talk with you have this funny reaction, I am not out to get you," I explain. She replies, "I have nothing against you either, I heard you."

Many times nurses are frustrated, PAs are frustrated and overwhelmed with patients who are difficult to manage or remained psychotic in spite of all the medication they are given. These types of psychotic patients present as potential dangers at all times because no one ever knows if they will act out the psychotic confused thought processes they continuously display.

The conflict in this interaction is rooted in this problem, because PAs are supposed to report behaviors to nurses in order for nurses to give medications, call doctors, or come up with plans for dealing with potentially dangerous patients. If no preventive measures were documented, the PA and nurse could be easily blamed as to why they did not attempt to recognize problems with patients and use some type of intervention. Had I not mentioned anything about this patient's behavior to the charge

nurse, I might have been asked why I did not. Therefore, although Yolanda says, “I heard him,” I was in the right to report it because I cannot assume that she did hear the patient rambling on and becoming accusatory.

For the remainder of the shift, I would try to have as little interaction with Yolanda as possible. Certainly I would not open up any personal conversations with her. This is why PAs and other staff take a keen interest with who they are working with on the various units. It matters to staff, worker cohesion.

Giving Shots

PAs are the ones holding patients or being present for support, and nurses the ones giving the shots. Nurses depend on PAs for their physical expertise. This is one important way the work of both PAs and nurses are accomplished. The PAs do the holding and the nurses do the injecting. One such event I documented in one of my field notes below.

Field Notes

While standing around the nurse’s station, I am alerted by Nica, a nurse, who is putting on green plastic disposable gloves, “We are going to give Jane a PRN!” Nica has a stressed serious look on her face. The patient is an elderly African American woman. Nica gets on the telephone and calls over to other wards for “male assistance.” At first I take this call a bit personal, it is a reflection that I am not man enough to handle holding down an elderly woman while she gets a shot. Nica tells me however, that this patient is strong and fights back. When more males arrive, we put on our gloves while the nurse, a middle age white woman readies the shot. Once the nurse is ready, we proceed to head into the elderly woman’s room on Ward-57. Keysha is down in the day room on Ward-5

with the male pts. As Nica approaches the elderly woman's room, she jumps up and throws her arms forward to push back Veronica. At this point, a huge (6' 0" 280 lbs) white male PA who has come to the call for male assistance grabs the patients arms and we all grab some body part. I grab the woman's thigh area; another male PA grabs the legs while the nurse struggles to get inside of us to administer the shot. The nurse squeezes in as I lift the woman's gown. The nurse comments, "She got tough skill," as she pushes the needle into the woman's buttocks. The elderly woman is cursing and screaming as if we are beating her up. She shouts, "Oooucchhhh, You are killing me." I am smiling because the woman is excessively dramatic or psychotic. Once the shot has been given, we all let go of the woman one by one, so that no one is hit. We turn off the woman's light and tell her to stay in her room until she comes down. Tonight was a typical night of re-directing patients and assisting in giving PRN shots to pts.

PAs Cannot Replace Nurses but Must Work Together for their Objectives

It is sometimes easy for PAs to take nurses for granted and nurses to take PAs for granted. However, both frontline workers are dependent on each other. They work together. Although out of frustration, many PAs have said that nurses "stay behind the nurses stations, only do paper work, and have lower degrees than us, but tell us what to do," PAs cannot replace nurses. The reasons why PAs cannot replace nurses are for several reasons: Nurses have specialized knowledge of psychiatric medications and biochemistry, nurses are the direct lines to doctors in conveying messages from patients, and nurses are the sole ones authorized to give medications to patients. What this means is that at a certain point when a PA is dealing with a difficult non-compliant patient, he/she must get the help of the nurse to intervene in some capacity. The PA does not call

the doctor for medication to control a patient. The PA does not prepare and give the patient the medication, and the PA is not a position to be as neutral as nurses can pretend to be in order to achieve their nursing objectives of controlling patients, decreasing paper work, and having patients leave them alone so they can have peace and do their work with as less stress as possible. PAs have similar objectives of having as less stress from patients and administration as possible, controlling patients, and getting their work done. Patients, especially the difficult ones, are the impediments in achieving these objectives. Therefore, nurses and PAs depend on one another for getting their work done on the wards. The PA attempts to control the patients as much as possible. When the PAs cannot control the patients, nurses must step in to give patients answers to their questions, warn patients of potential consequences (medications being a primary one), call doctors, listen as peacemakers, and prepare and administer medications. The PAs cannot replace nurses although many wish they could. [Maybe provide examples of PAs complaining about nurses not give medications] Victor Sam talks about the importance of nurses versus PAs in his interview below.

Me: How important do you feel your job as a nurse is to Mirage Psychiatric Hospital?

Victor Sam: We are the frontline workers that they have to have on every single ward. We have this thing in nursing that if you leave the ward without a nurse to relieve you, you could be thrown in jail. That's pretty serious. In fact, one nurse told me she was held hostage for 20 hours. She had worked the double and there was no one to relieve her, so she had to stay until the house supervisor came in at 4am to relieve her. Until someone replaces you, you cannot leave. As a nurse we are the bread and butter, we are ones that keep this place running. Not that the PAs aren't necessary, but they could run with the PAs and be short, but not with a nurse showing up to the ward, it can't function. But what do I actually do there? Pass meds. Do I help the bottom line? The only thing I do to help their mission statement is that I provide meds on time. All I can do is give meds to keep my staff and patients safe. Am I helping with therapy? No. Am I helping them get better? I feel like the best treatment possible is giving mediation with therapy. At

least from the nurse's point of view, I feel like the nurses are not providing therapy. I don't feel so much like I am helping toward the mission, obviously I am needed there, but I am needed like as a state requirement not like we really need you to be here to help with the patients.

Do they actually need PAs? They could run the whole place with nurses. Not that they don't need you guys but you are I feel more undervalued than nurses. They are desperate for us. They have to have us to function. Sandra [a former nursing manager] said it best when she spoke to Wendy [a PA]. Wendy said Sandra you guys aren't treating me fairly, I am going to quit. Sandra said goodbye, you are replaceable. That's what she said to her, you can go, you are replaceable, we will replace every one of you. And I heard that and I was like wow.

Me: Yes, a lot of PAs perceive this.

Victor Sam: You guys can feel it. They could care less about you. They could care less about us, but especially you guys. You guys are like the bottom feeders. That is what they treat you like. The very very bottom. Does it also have to do with, and we can get into this later, does it also have to deal with stereotyping from a racial standpoint? You know most PAs coming in her African American and most nurses are white. There is a whole other power struggle going on here.

Victor Sam highlights some important points in this portion of his interview. PAs are mostly black men and nurses are mostly white women. Additionally, it is very important I feel that Victor, a young white man in his middle 20s senses the low status of PAs relative to nurses who have a low status as well in the hospital but not as low as PAs. PAs sense the differences between nurses and PAs as well.

Christina certainly must sense this but understands that she must work with PAs to accomplish her work and remain safe.

The Work Conditions for Nurses: The Impact of Structure on Nurses and PAs

Christina voices a common sentiment about short-staffing among nurses in her interview below.

Me: Do you feel there are times when there are not enough workers on the ward?

Christina: Yeah you always feel that way. There are times when I feel I need another staff with me and they do not give me enough staff. There is not enough consistency. I have talked with the DON [Director of nursing]. I have already complained about it numerous times, so it is beyond my control. So the way I deal with it, you know whatever is being provided I deal with it. If I can ask the

supervisor for some help and she is receptive to that, then I appreciate it, otherwise you know you just have to do your job, try to do the best you can with whatever resources you have. Cause ultimately it's your responsibility. Instead of complaining about it all night, being on the phone all night [with the supervisor for that shift], that's wasting your time. So you might as well just do your job, because no one else is going to do your job anyway.

Me: Does it make you feel any more unsafe?

Christina: There are times when you feel unsafe, that's why you have to learn to work with the person that you have.

Me: So when the PA takes his break, and you are the only one out there on the ward...

Christina: It feels unsafe when patients are up and you know you've got SAO²⁰ patients. You know when we have males and females. It does make you feel unsafe, but you have to deal with the situation.

As a petite woman, Christina's willingness to work with a PAs as team also reflects an understanding that PAs, especially the male PAs act as protectors for Christina. Hence it is in her interest to work with them by sharing the rounds and charts when needed. Dawn recalls the last straw that made her quit full time at Mirage.

Me: How did you come to work registry?

Dawn Mills: My final decision?

Me: Or the process, cause it happens, why if you will how did come registry?

Dawn: I have a particular scenario why I think my last straw.. I mean it built up. But my last straw was the day I came in and on the schedule there were 25 beds, and it said I had 26 patients, and I thought this was impossible because we had a lot of *blocked rooms*,²¹ *MRDD*²² patients, *SAO*.²³ So when I got upstairs I realized we had 7 *boarders*.²⁴ And all of the boarders were MRDD patients. So you have MRDD patients mixed with psychosis, psychotic patients. Bad mix, so patients had no beds to rest or to sleep. I didn't want to mix to psychotic with them, so I opened up the front day room. And their medications make them real tired, so I

²⁰ AO means sexually acting out patients who have or have had sexual issues.

²¹ There are usually two patients to a room. However, if one patient is mentally challenged or retarded, or is sexually compromised, his/her room will be blocked, i.e., they will be only one in that room.

²² The Mentally Retarded Dual Diagnosed. The patient is mentally retarded and has a mental illness.

²³ SAO stands for Sexually Acting Out. This means the patient is likely to become sexually inappropriate around others or has sexual problems due to being abused sexually by others. This person is put a room by themselves (it is a blocked room).

²⁴ A boarder is a patient who does not have a room on the ward is assigned. He/she will sleep on another ward. This is a problem if the patient wants to sleep before he is allowed to go to the boarding ward at bed time.

ended up putting mattresses in the front day room. HR happened to walk through that day.

Me: I remember that²⁵ Yeah

Dawn: He didn't say a word to me. I stayed in that dayroom and did my paper work. And that particular day they even sent the nurse who was with me downstairs cause another nurse got hurt and had to go home and change her clothes because she got blood on them. So it was just me another counselor, who was down the hall²⁶ and one of the patients hit a MRDD patient in the mouth and ran back down the hall. It was just hurtful to see that I could not offer a bed or safety for people who need it. And that was my last straw. And when I said something to the CEO about it, her response to me was oh we have tried our best. And I said how did you try your best when, and then she told me she was not aware there were no beds, I said how could you not be aware of something for 3 days? You let it go on for three days.

Me: Right

Dawn: So she just looked at me and wouldn't say anything. And that was just, a lot of not answers to questions the patients and staff deserve. It was a very unsafe environment.

Me: So that was the last straw?

Dawn: Yeah.

Me: So when you were regularly working, when you do work, how important to you feel your work as a RN is to the hospital's mission and objectives? [I chuckle and laugh as she looks at me in disbelief that I would ask such an obvious question].

Dawn: I think that without...without the staff on the floor, the hospital would not function because the administration does not know how to function the hospital. But it is kind astounding ..Did I answer that?

Conclusion

The frontline nurses of Mirage are an important part of the frontline psychiatric work at Mirage. They are, most of times, on the same firing lines as the nurses of Florence Nightingale were during the Crimean War when the profession was first created. Some nurses are not as active as others, and this could be a learned behavior of being burned out as Victor Sam talks about in his interview. In other cases, nurses might

²⁵I worked that day, and it was one of the worse days at Mirage. David was the other PA who worked with me.

²⁶It is a 30 yard hallway from the dayroom where I was to the nurse's station where the patient was attacked.

not be physically capable of doing the active frontline work of opening doors, redirecting patients, or grabbing and holding patients, as perhaps nurse manager Darlene is.

However, the nurses I interviewed and a good amount I have seen are right there with PAs as unsung heroes. Madonna, a Latina nurse once told me, “I don’t want anything to happen to you out there,” despite our differences at one point. Victor Sam indicated that he medicates patients so that “patients and staff” can be safe.

The nursing profession historically has been a subordinated female profession relative to white male doctors (Weitz, 2013). Hence, frontline nurses at Mirage are trained in a culture of subordination that teaches them to follow the command of the superiors in light of caring and knowing one’s role. Nurses are less subordinated than PAs are, but because they share the same spaces and places (the wards) they are impacted in a similar way as PAs. It is quite interesting how gender is at play in the work that PAs and nurses share. PAs often are the physical protectors of female nurses on the wards. However, at the same time the mostly black male PAs are the subordinates of white female nurses. When PAs are yelled at by female nurses what is the impact on their minds and emotions? Often times, as I have showed in this study, it causes a negative reaction by PAs toward nurses.

Frontline nurses are stationed on the wards, although usually behind nursing stations. Hence, nurses deal with the same conditions as PAs and are impacted negatively by the structural practices of short-staffing and lack of resources that makes the job of frontline workers more stressful, less satisfying, and potentially dangerous.

APPENDIX D

MIRAGE PSYCHIATRIC HOSPITAL AND ITS WARDS

Introduction

The purpose of this chapter is to describe the setting where PAs work. Mirage Psychiatric Hospital (MPH)¹ is a privately-owned psychiatric hospital located about an hour and a half outside of the city of Chicago in the southeast suburbs toward the Illinois and Indiana border. According to long time workers at the hospital, it has been sold and bought by at least five corporate entities. In 2009, the hospital made the local news with public charges and documentation of failing to keep patients safe. In addition, in the same year one of its main doctors of Ward 5 made the local papers for overmedicating (patients complained of side effects) and overbilling for services. The hospital responded by saying that it had cleaned up its act and that no further incidents had occurred. Behind the scenes, however, changes ensued internally. People were fired, and new managers were hired. According to many workers, this was in order to “house clean.” One infamous day, 23 people were fired or let go. There had been brief talk by some PAs to form a union, but after this, this type of talk diminished. Uniforms were implemented on frontline workers (nurses and PAs), time clocks were instituted, cameras were installed all over the building, the number of full time employees was reduced, staff was put on notice that “the boat was moving, with or without you.”² The place received a beautification physically and was eventually sold to a new 500 fortune corporate entity in 2010.

¹Mirage Psychiatric Hospital is the pseudonym that I use for the hospital.

²This whole process I call the “Subordinating Process” will be fully described in another chapter.

The Physical Surroundings

Physically, Mirage is a large pink building with small trees surrounding it. MPH has four floors with a basement and cafeteria that contain eight open wards³ with different patient populations. There are two adult wards that house men and women (Wards 5 and 6), a children's ward (Ward 11), which treats girls and boys, a teenage girls' ward (Ward 17), an adolescent boys' ward (Ward 18), a geriatric ward (Ward 57), which treats the elderly and those unable to care for themselves mentally or physically), a mentally challenged ward (Ward 12), that treats autistic and mentally challenged patients, and finally, a ward that treats teenage sex offenders (Ward 24) who are non-transient or a permanent residents until they reach adulthood. All of the wards, save Ward 24, are supposed to be short-term treatment wards that average 11 days of stay for the patient. This a rough average, I have seen certain "disposed" patients stay for more than three months. MPH also has a daytime hospitalization program which treats children whose parents feel they do not need full hospitalization but some mental health care during the day school times. We will call this program the Day Hospitalization Platform (DHP). With eight wards and one daytime program, the total capacity at any given time (a happy time for administration and corporate) could be around 185 patients. When I first stated back in 2003, the patient population could max out at 230 to 240 patients.⁴ I used to sort of get lost in the building. I was recently reminded by a new PA (easily identified these days with the purple polo shirt) have confusing it can be. The new PA asked, "How do

³I have changed the names of the wards to guard confidentially

⁴A series of public events hit MRP about four years ago that triggered the change in culture and patient bed numbers.

you get to Ward 6” as he walked inside Ward 5. I said, “You go straight north and you will run right into it.”

The wards and their patient capacity as of 2012:

1. Ward 5 Adult Patients	Capacity 27
2. Ward 57 l Geriatric Ward	Capacity 12
3. Ward 6 Adult Patients	Capacity 27
4. Ward 12 Mentally Challenged/ Autistic Adult Population	Capacity 15
5. Ward 17 Adolescent Girls’ ward	Capacity 27
6. Ward 18 Adolescent Boys’ ward	Capacity 27
7. Ward 24 Long Term Sex Offenders teenagers ward	Capacity 15
8. Ward 11 Children’s ward	Capacity 20
9. Daytime Hospitalization Platform	Capacity 15
10. Total _____	185

MPH is a locked facility. Workers have to use their key to come in and out of the building. There are several entrances and exits to and from the building; however, most PAs and nurses use the side backdoor entrance by the time clock. MPH is a total institution in that it provides 24 hour housing for patients who are locked away from society. It totally regiments its inhabitant lives. For example, at MPH, patients cannot smoke on the wards, they have little choice of which ward they reside in, when they eat, what type of food they are served, when they leave the hospital, visiting times and days, and even where they may sit in the day room (usually not where staff is sitting). The institution makes patients confirm to it in the name of accomplishing its missions and goals. Goffman (1961) states, “...they [the total institution] usually present themselves to the public as rational organizations designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends” (p. 76).

MPH has undergone major structural changes since 2003. It no longer has carpeting (which smelled of urine) throughout the hallways (which I first experience when I walked on the ward). The carpeting was mainly on Ward 6 (the ward I first worked). Small trees were put up around the building to make it more scenic. Portraits and painting were put throughout the hospital including within the wards. The dayrooms were remodeled to include larger digital TVs. New couches were placed inside dayrooms throughout the hospital. The entrance area where the receptionist sits was totally remodeled. An overhead TV was placed up on the wall. New black leather couches were placed inside the waiting front area. Compared to when I first started in 2003, MPH has much improved on first appearance. Still if you look close enough, especially on the wards, you will see cracks along the edges of floors. The heating and cooling system leave much to be desired as well. Many patients complain about these issues. MPH is still a very old building. It is believed to have been established in the late 60s.

MPH exists to house and treat patients. Patients live, eat, fight, get restrained, even die, and sometimes have gotten raped, molested, or hurt on wards as the news reports verified. PAs spend most of their time on the wards attempting to keep patients safe and establish order. For these reasons, I will describe the wards. I have worked most of my time on ward 5 (my ward, as PAs and nurses call them), hence I will begin my description here with the greatest amount of detail.

The Wards

Ward 5 (Adult Population). Ward 5 used to be combined with ward 57 (The geriatric ward) when I first started back in 2003. Heather, who became a nurse and recently left MPH worked primarily on that ward back then. I can still remember sweetly

remember working with Heather back then. On ward 5 were the male patients, and ward 57 had the female patients. There is one solid steel door dividing the wards. A lot has changed since then, and the hospital seems to constantly change in some small fashion. Now, Ward 5 stands alone and ward 57 is exclusively for the geriatric population. Ward 5 has 12 rooms. One particular room has three beds, the rest have two. This makes for a total capacity of 25 patients on the ward. Ward 5 has one long hallway with seven rooms on one side of the hallway and five rooms on the other side. Toward the entrance of the ward (facing east) at the beginning of the long hallway is the nurse's station. On the opposite side of the hall way at the end is the day room (facing west). One must travel an estimated 30 yards to get from the day room (on the west end) to the nurse's station (on the east end). One worker, Kuzak, estimated that we travel at least a mile a day walking back and forth down the hallway to do rounds, open bathrooms, get supplies, communicate with nurses, doctors, and others, open up doors for visitors, go off the ward for various needs including going to the cafeteria for patients or for one's self on break. It is a physically exhausting process just to walk the halls as a PA.

Inside the rooms patients have at least two beds (solidified in the ground) in each room, two desks solidified into the walls, and some wall shelves to hold their clothes and other belongings. There are a total of seven bathrooms on the ward. Four bathrooms are connected to the rooms. The other three bathrooms are not. This is important in that the bathrooms which are shared connect rooms together. For example, one bathroom is shared by four patients because one bathroom is in between two rooms which house four patients. A patient could pass from his room through the bathroom to another patient's room. This could be potentially unsafe, and a lot of times it is. This is one reason why

males and females are not given rooms in which they share bathrooms. This is one reason why the hospital demands that rounds be done and bathrooms be locked. Three of the rooms on the left side have connecting bathrooms. The last room on the left side, the biggest room, is not connected with another room. The last room on the right side of the hallway facing the dayroom is not connected to a bathroom either. And finally, the first room on the right side is not connected to another room; its bathroom is located outside of its room and is shared with the room next to it.

The dayroom, located at the back of the ward, has four wooden tables with plastic chairs. One table is unofficially reserved for staff only. The dayroom also has a small table against the wall for coffee and other beverages. There is a large TV that sits inside a wooden entertainment center that is built inside the wall in the far side of the dayroom. There are small cushion seats that form a couch along the wall making an L shape surrounding the room. The dayroom also has a smaller connected room which serves as the music room for patients. In this back area is a small kitchen with refrigerator, sink, and cabinets. There is also a staff's bathroom in this back area. The structure of ward 5 is new. There used to be a PA room in the back area and a smoking room for patients. When Illinois became a smoke-free State in 2007, and when the hospital closed down this ward after serious charges were brought against it, ward 5 was remodeled. Supposedly, this new corporate entity emphasizes the appearance of their hospital more than the actual substance of the hospital. Not much has really changed in terms of the way Mirage is operated.

The back end of Ward 5 has windows which allows for you to see from the front of the hospital entrance to the back part of the entrance. Toward the front of the ward,

there is a small front area that contains a small quiet room (there used to be two quiet rooms), storage room for patient's belongings, and another staff's bathroom. Toward the front end also, there is a small staff lounge, a closet for line, and a small laundry room. The nurse's station, at the front of the ward has a small room for interviewing and other purposes such as nurses giving each other reports or doctors/ social workers meeting with their patients. Right when one enters the ward, there is also a small room which is called the front day room but is not used as such. Doctors use this room at times to meet with patients, nurses use this room for their reports, and typically patients just admitted on the ward use this room. It has two small tables, chairs, a scale, and one desk inside with a glass window for view.

On the walls of the ward, and really throughout the hospital, there are inspirational pictures, photos, and words encouraging positivity. There are beautiful pictures of nature and quotations about "believe" and "determination." In general, although Mirage is a pretty old facility [at least built around the 60s], Mirage renovated the building making it appears more pleasant outwardly.

This basic description of ward 6 can be more or less used for all of the wards in Mirage Psychiatric Hospital. However, there are some important differences which I want to point out about the various wards. Therefore, I will describe the other wards as much as necessary to accomplish this goal.

Ward 57 (Geriatric ward). Ward 57, the Geriatric patient ward is located right to the north of Ward 6 separated by a door only. As I said, it used to be a part of ward 6. It is about half the size of Ward 6. It has six rooms with two beds in each one. In the middle of the hallway there is a small nurse's station. In the back of the ward going

eastward is a medium size dayroom. There is an office right in back of the nurse's station and a few other small rooms for storage, food, medication, and other supplies. The major dynamics voiced by staff about this ward is that one PA is not enough to help clean up and move the elderly patients who are often times in need of total care.

Ward 6 (Adult patients' ward). Ward 6, the other Adult ward is located north of Ward 6 going past Ward 57 and pharmacy department. It is larger than ward 6. It has two dayrooms and one steel door separating the rooms of the female patients from the male patients. It has a maximum capacity of 36 patients at two people per room. From the entrance of the ward (the south end) to the back of the long hallway (the north end) it could fit around eight full size cars inside. The nurse's station is located in the middle of the hall way going inward to the west. In the middle of the all way is another short hallway leading to the main day room, the medication room, two supply rooms (one used to be the old smoke room for patients), a bathroom, and an exit. Right past the steel door in the long hallway going north is a smaller dayroom, which can be used for visiting time or to separate males and females if needed. Ward 6 is more difficult to work than ward 5 because it is larger, and there are more areas were patients can hide. Additionally, when the steel door is closed (or not propped open by a towel, workers have to open the steel door every time they passed through to get to the nurse's station which as patient supplies, office supplies, and charts. Ward 6 is a busy ward and tends to care for the more "aggressive" types of adult patients relative to other wards. Its size along creates problems for frontline staff. In addition, the structure of the nurse's station allows nurses to hide front patients. This creates problems for PAs, who are often times the gatekeepers to nurses on ward 6.

Ward 17 (Adolescent girls' ward). Ward 17, the adolescent girls' ward is located on a lower floor than Ward 5. It parallels Ward 6 in its dimensions. There is one long hallway with a short one in the middle leading toward an exit, and toward two more patient rooms. Ward 17 runs north to south with the entrance being on the south end. Toward the back, or north end is another small hallway that leads toward small offices and more patient rooms. Hence, on Ward 17, there are two areas with small hallways that could be potentially used by patients to hide from glaring eyes. It is ironic that frontline staff does not have cameras to watch patients, but administration has cameras to watch staff. I will leave that analysis for another time. Toward the north end of the ward is the day room for patients on the A side of the ward. Just past the nurse's station heading toward the south end is another smaller dayroom for patients on the B side. There are around 18 rooms on Ward 17 for a total capacity of 36 adolescent girls. Ward 17 is different from other wards (including ward 6) in that only one room as a bathroom inside. The rest of the bathrooms are located outside of the patients' rooms. This allows for staff to control patients who might want to go through connecting rooms to other patients' rooms for inappropriate contact (usually of sex). Ward 17 has historically (at least since I have been a MPH) a volatile ward. One of the biggest challenges lies within the population itself. Oliver Smith, a PA, described his difficulties of just working with a young female population. Carlotta reiterated similar problems of feeling uncomfortable. I have had my share of problems working there as well with both patients and other staff.

Ward 18 (Adolescent boys 'ward). Ward 18 houses the adolescent boys. It is one of the largest wards in Mirage Hospital. It stretches from almost the front of the hospital to the middle. There is one long hallway which can be divided into different

sides by a steel door. If this door is left open, the hallway would measure the size of a football field (about 100 yards). The rooms are the same as described with the other wards, two beds inside. There are two day rooms. Toward the entrance of the ward (the north side) there is a medium size dayroom. All the way in the back, there is another smaller dayroom (the South end). Ward 18 is located east of ward 5. There are two nurse's stations on Ward 18. The first main nurse's station is located at the entrance of the ward (the north end). The second nurse's station, used when the population of young males is divided, is located right beyond the steel door dividing the long hallway. Ward's six's layout is significant in that with teamwork, as Dent Perry, indicated in his interview, it would be very difficult to monitor the adolescent boys. Ward 18 came under scrutiny when allegations of abuse made the local news. With the setup of the long hallway, and minimum staff, there is no wonder why allegations of assault have been made. In my nine years at MPH, nothing has changed other than trying not to let the population of boys extend into the total capacity of the ward. Ward 18 was known for houses up to 40 patients back when I started. Now, the typically population is around 20 to 25. Some of the main problems pointed out by workers on this ward were involving patients and the number of staff provided by administration. Jonathan talked about being jumped by the mostly black adolescent population. Dent Perry spoke of the same fears about safety saying, "I don't know if I could fight 12 people, I have never done it before." In addition, the very long hallway makes it challenging to watch all of the bodies.

Ward 12 (Mentally challenged/ autistic adult population ward). Ward 12, the mentally challenged/autistic ward is a relative new ward. It is not physically new, but as indicated above, it is new in focus. Before ward 12 was designated the ward for the

mentally challenged. It was used for boarding populations of all sorts. Boarding populations are particular patients on wards that are relatively full who “board” or sleep on another ward. This is done in case there are admissions during the night. In this sense, the hospital is able to still admit new patients and make money. Usually patients do not like this, but have little choice. In 2012, that is after nine years of my work at Mirage, the administrators decided it was important to have a specialized ward for patients who have special needs (or simply to respond to the demands of other patients that they be separated from these types of patients). Mirage never tells frontline staff why they implement changes, they just do it, and the rest of us say, “It’s about time.” Structurally, ward 12 is one of the smaller wards. There are 10 rooms on ward 12 for a total capacity of 20 patients. There are rooms on both sides of the ward. There is one medium size hallway. There are five rooms on each side of the hallway. Ward 12 runs north and south. The entrance is in the north part of the ward. Toward the front is a nurse’s station and day room. Relative to the other wards, ward 12 is rather simply to monitor. However, its population is not. The difficulties of this ward lay with the patient population. The mentally challenged patients function at slower and cognitively low levels. They tend to be sloppy when they eat, so there is fair amount of cleaning up behind them. They also tend to have hygiene and toileting issues, so staff has to be prepared to help clean or change them. Most PAs, despite their lower status in the wards, are not nursing aids. They did not go to school to do this work, nor are they trained. However, resistance is generally low in this regard because workers want to keep working (they want to keep their jobs).

Ward 11 (Children's ward). Ward 11 houses the children (as young as 5 and as old as 12). It is set up is parallel with Ward 5. There is one long hallway running from east to west. There is one main day room in the back (the west end). There are rooms on each side of the hallway. One important difference between ward 11 and the other wards is that only one room as a bathroom located inside. The rest of rooms have no connecting bathrooms. In this sense it is like the girls' adolescent ward. If children want to use the restroom, they must leave their rooms and get staff to open the locked bathrooms. The nurse's station is located similar to ward 5, at the front of the hallway toward the entrance. There is one day room and other make-shift rooms which can be used for visiting or separating patients. The major challenges that frontline PAs indicated were the short-staffing and high energy level of the children. I heard of a horrible event happening on this ward where a nurse who was supposed to watch a child, but failed to do this, and reportedly this child make another child perform oral sex on him. It was supposed caught on video tape and the nurse was fired. This event is alleged to have occurred at the beginning of this year or end of last year.

Ward 24 (Long term sex offender teenagers' ward). Ward 24, the long term sex offender teenage ward has been in existence for the last four years or so. When I first got to Mirage Hospital, it did not exist. In fact, I did my emergency intervention training on it. It is separate entity in a lot of ways. There are different rules for this patient population. It is also physically far away from the other wards in the hospital. This makes it more difficult to respond to codes for help on the ward. There is no hallway on ward 24. It is shaped like a bowl. There are around 8 rooms on the ward with four on each side of the box shaped ward. There are chairs and tables located in the center of the

ward. The medication room is located in the middle of the ward on the east side. Toward the back of the ward (going west is a nurse's station, and further in the back is staff's area with the manager's office inside. Patients' rooms on each side are separated by a wall. There is one patient per room. It was a huge rumor that one patient make a hole in the wall and had sex with another patient. The culture of ward 24 is different from other wards. I had to the opportunity to work there one day, and I was shocked how patients had to ask permission to leave there rooms by sticking out there hand and waiting for staff to acknowledge their request. Additionally, I noticed how staff called patients names like "fat ass" and how patients were made to admit openly in group who they molested or raped (usually a family member). This ward seemed very similar to the total institution that Goffman (1961) described. I say this because the feel of ward 24 reminds me of a prison setting of total control by the guards (patients have to ask permission to leave their rooms or cells). Additionally, the master status of the sex-offender patient seemed to be drilled into the patient's heads during group and during the name-calling. I last worked on ward 24 about a year ago. The physical structure of the ward, no long hallways, shaped almost in a square or circle, is designed so that frontline staff, PAs, can view the actions of the patients at all times. There is a small day from located right next to the nurse's station. The major challenges that staff voiced about this ward involves the "nature" of the sex-offending population. Staff generally voice a great distrust of this population and have said, "When it gets bad, it really gets bad." What staff means by this is that an emergency code rarely happens, but when it does it is usually a very bad one.

In summary, when we mention Mirage Psychiatric Hospital, we are not talking about the cafeteria or other accommodations. We are talking about the wards where the

patient lives and the frontline staff primarily works. The wards are the places where the patients are controlled, cared for, and kept safe by frontline staff (both nurses and PAs). Each ward has its own subtle and informal rules in which the frontline staff govern (Goffman, 1961). With the implementation of cameras and policy documentation, the governance over the wards decreased from the time they were implemented (2009). Nonetheless, the structures of the wards factor in tremendously on how PAs work. A long hallway means more space for PAs to cover to keep patients safe (a major objective according to all interviewed). Not only this, a longer hallway makes workers more tired and less willing to do rounds.⁵ Wards in which patients cannot easily be seen pose problems for keeping patients safe as well. The wards have their sounds, odors, patients, and staff which make up the experiences of frontline work at MPH. The wards can contribute to a safe and therapeutic stay for the patient or contribute to a chaotic occurrence for both patient and staff. Too often over the past nine years, I experience the latter. Longer wards require more staff in order to do the work. More staff is something in which for-profit institutions refuse to provide (Diamond, 1992; Chambliss, 1996; Rapport, 2009).

Specialized Mirage Psychiatric Hospital Terms

The Time Clock. The time clock is a place where non-salaried employees punch in and out, i.e., clock in or out for working periods or lunch breaks. Supposedly there is a seven minute grace period to punch in before your shift or after, but many workers have said various different grace periods of on two to three minutes if you want your check to be full eight hours of work. In addition, Mirage has mandated that workers take breaks,

⁵I will describe “doing the rounds” later in the chapter on the meaning of being a PA.

whether they actually take one or not is irrelevant, but workers must punch in and out for break for face potential disciplinary action (usually to be written up and put into one's permanent working record).

Purple shirts. The purple shirts were mandated on PAs at the beginning of 2009. PAs, unlike therapists, social workers, doctors, and other hospital personnel should always wear this shirt. This was not the case before 2009.

Light brown shirts. The light brown shirts were mandated on nurses at the beginning of 2009. As of 2012, when a new ownership group took over Mirage, some nurses have mentioned that they no longer have to wear the shirt if they wear hospital scrubs instead.

Registry. Registry is a term used for registry workers who register their availability to work. These workers often have other jobs. However, it appears that Mirage's new policy is that all new employees start on a registry basis then earn their regular position. Mirage depends on these non-benefit part-time workers to run the hospital because the full time and part time regulars are kept at a bare minimum. All most every day every shift there will be a registry nurse or PA working in the hospital.

Weekends. Weekends refers to the fact that all regular PAs, nurses, and other low-end workers (those in housekeeping and those in the cafeteria) must work at least one weekend every two weeks (i.e., twice a month). The new policy I heard was that if a worker called off on a weekend, then the worker would need to make it up the following weekend.

The overnight. The overnight refers a term used to mean the overnight shift or night shift. The hours are from 11pm to 7am.

My ward. My ward is an expression used by workers (PAs and nurses specifically) to indicate the regular assigned ward they work on.

The Second Shift. The second shift is a term used to mean the workers who work from 3-11:30pm or the second shift.

Float. Floating is a hospital term for when workers are assigned or asked to work another ward that is not their regular ward. Workers are less familiar with the patients, staff, and arrangement of the ward they are floated to.

Meds. **Meds** is short for medication.

I am working a dub. This means a worker who is working a double shift

Holding it down. This is a phrase for keeping the patients under control.

Booty juice. This means giving a patient a shot in the buttocks.

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VITA

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