“I Left There Crying”: Racial Microaggressions and Implications for Caregiver Retention in Long-Term Care

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ABSTRACT

This exploratory study addresses racial microaggressions in long-term care (LTC) settings in the United States to address and better understand the impact of racial dynamics on Black/African American direct care workers. Drawing from ethnographic research and interviews with LTC administrators, paraprofessional healthcare workers and other support staff as part of a larger National Institute on Aging (NIA) funded study, narratives indicate that while minoritised LTC workers are encouraged to be understanding of residents of LTC settings prejudices, they are also acutely aware of the harm that repeated, racially charged labels and negative comments by residents can have on their social and emotional well-being. Implications include: (1) More LTC research needs to be done through the lens of direct care staff. (2) LTC needs targeted policies and practices including training for administration on how to prevent, recognize and navigate racially charged behaviour such as racial microaggressions. (3) Leadership must provide minoritised staff members with appropriate support and follow-through. Together with improved wages and benefits, addressing microaggressions may offer a critical tool to solving the LTC challenge of retaining direct care workers by improving worker well-being and job satisfaction and by extension, improving the quality of care for older adults.

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KEYWORDS:
microaggressions; direct care workforce; DEI (diversity, equity and inclusion); racism

TO CITE THIS ARTICLE:
An article entitled “Nurse claims racial abuse in assisted-living center” appeared in the local newspaper in Sioux Falls, SD. The nurse claimed her employer “failed to protect her from abusive racism from residents” (Hult, 2014). For over 20 years, claims such as these have been reported in United States (US) long-term care (LTC) settings (Berdes & Eckert, 2001; Mercer et al., 1994), with workers reporting they felt as though they were “treated like a girl or maid” to, in the Sioux Falls case, being “called the N-word.” While the peer-reviewed literature addressing microaggressions in the workplace, schools and hospitals has proliferated (DeCuir-Gunby & Gunby, 2016; Fattoracci & King, 2022; Hunter, 2011; Levchak, 2018; MacIntosh et al., 2022; Molina et al., 2020; Pitcan et al., 2018; Washington, 2022), there is very little literature on LTC settings and the impact of racial microaggressions upon LTC direct care staff from racially minoritized1 groups.

We propose an application of the theory of racial microaggressions, which can present as subtle or overt racist communication, to better understand and address racialised experiences of racially minoritized workers in the LTC environment (Harris-Wallace et al., 2016). In this exploratory analysis, we apply this conceptual lens by presenting selected data from a large qualitative study based in Maryland, that focused on stigma as it affects older adults (+55 years) residing in LTC. Because the larger study was not specifically focused on the lived experience of staff in the LTC settings, this article presents serendipitous discoveries through ethnography and interviews with staff members that call for greater attention. We posit that acknowledgement of the impact of microaggressions upon LTC staff of colour could be an important factor in the successful retention of staff in LTC settings.

**BACKGROUND**

Extant research on the LTC paraprofessional direct care staff (e.g., certified nursing assistants, personal care aides/ workers and personal service attendants) consistently shows that these workers have long been considered the frontline of the LTC industry, providing the majority of paid, formal care services for older adults (PHI, 2021; Stone & Weiner, 2001). The COVID-19 pandemic witnessed a loss of millions of healthcare workers and has been slow to recover, especially among LTCs whose direct care staff are primarily racially minoritized workers (Fragnier & Dill, 2022).

Over 50% of the LTC direct care workforce are Black/African American, immigrants or belong to other racially minoritized groups (PHI, 2021). LTC direct care workers cite lack of respect by both residents and their families as a factor in their desire to leave the job (Sloane et al., 2010) is associated with low job satisfaction and poor health (Amateau et al., 2023) in the US and in South Africa (Mapiro et al., 2019). With few exceptions (Dill & Duffy, 2022; Mercer et al., 1994), the impact of racism on direct care staff in US LTC has been absent from the literature. In the years since the COVID-19 pandemic and the US racial reckoning that took place in 2020 (McGovern & Waloo, 2023), systemic and structural racism in LTC services has been addressed in the literature, with a focus on outcomes for minoritized older adults (Shippee et al., 2022; Sloane et al., 2021).

The data we present in this paper is best understood through the context of the location and demographics of those working and living in the LTCs. The five LTC settings we have included in this analysis are located in Maryland. Maryland’s population is nearly 30% Black/African American, which is approximately 10% higher than the national percentage of 12.1% (Health and Human Services, 2021; U.S. Census Bureau, 2021). As a Jim Crow state, Maryland’s history of systematic racism continues to reverberate in red-lined neighbourhoods that are today areas of concentrated poverty (Brown, 2021). The LTC settings in this study catered to were primarily White and affluent older adults. This reflects the racial makeup of LTC residents in the US who are on average 80% White (Bates et al., 2018; Harris-Kojetin et al., 2019). The executive-level staff members were all White, with the exception of one director. Those providing direct care were majority Black/African American.

Retaining LTC direct care workers is critically important. While the number of US adults aged 85+ years old will triple in the next 30–40 years, the number of adults of working age who could care for older adults will remain static (PHI, 2021). Some have recommended a trauma-informed lens for understanding LTC direct care workers to address job turnover and burnout among LTC direct care workers (Amateau et al., 2023; Kusmaul et al., 2022). Exploring racial microaggressions in LTC settings could provide a tangible way to put trauma-informed care into practice, caring for the Black/African American direct care staff who are at the receiving end of racial microaggressions. Attending to the emotional well-being of racially minoritized LTC workers has the potential to increase job retention and satisfaction, a necessary goal to meet the demands for good quality care.

**THEORETICAL BACKGROUND**

Racial microaggressions (referred to as microaggressions) can be subtle or blatant messages surrounding the racial and ethnic inferiority of people of colour (Pierce, 1970; Sue & Spanierman, 2020). According to Sue et al. (2007), microaggressions are pervasive in the US, and often lead to negative health and well-being among victims (Hall & Fields, 2015; Sue & Spanierman, 2020).

Two forms of microaggressions, which frame our findings are microinsults, the often unintentional verbal expressions that reflect a devaluing of a minoritised racial and ethnic identity; and microassaults, conscious, verbal, as well as non-verbal, indignities toward the intended victim using tactics such as name calling and
purposely avoidant and discriminatory behaviour (Sue et al., 2007). These forms of microaggressions are harmful in that they inflict psychological distress, stress, anger and further marginalisation upon the victim (Sue et al., 2007). Additionally, “micro” does not suggest that these are small or minor incidents but are in fact considered by mental health professionals as “death by a thousand cuts” (Sue & Spanierman, 2020) due to the increasingly harmful nature of the damage they inflict by their regular recurrence. The power of injurious speech (Butler, 1997) to do harm is inextricably tied to context and past experience. Through repetition over time by institutions, individuals and culture, these words represent a lifetime of encounters with attitudes that promote racial reification and particularly the devaluation of racially minoritised individuals.

This article contributes to the literature by addressing the impact of racial microaggressions on racially minoritised direct care staff in LTC, building upon very limited peer-reviewed literature on the topic (Harris-Wallace et al., 2016; Sethi & Williams, 2016). While the concept of racial microaggression theory has been used to address professional healthcare workers from minoritised groups who are in training and working in clinical settings (Acholonu et al., 2020; MacIntosh et al., 2022; Wittkower et al., 2022), our work brings a model to LTC leaders and organisations for addressing the impact racial microaggressions has upon LTC direct care staff.

This work aims to (1) apply the concept of microaggressions to better understand and address the experiences of racially minoritised LTC care staff and (2) highlight the particularly salient role LTC organisations and leaders can play as an intervening force to create work environments that better support and retain racially minoritised staff.

METHODS

This paper analyses a small segment of data from a much larger qualitative National Institute on Aging funded study examining stigma in eight multilevel LTC settings (Roth et al., 2015; see Table 1 for descriptive characteristics of settings). Data from residents, staff and family members (N = 341) were collected between 2007 and 2010 in suburban and urban Maryland. The overall research aim of the larger qualitative study was to understand social dynamics among residents of multilevel LTC settings through qualitative interviews and ethnographic fieldwork. The interview guide did not specifically include questions about microaggressions nor did interviewers directly ask staff about their experience with prejudice and stigma. However, we found that the following questions in the interview guide for some staff elicited responses that addressed social dynamics that involved them personally: “Do residents treat each other differently because of ethnicity/race? Does anyone here discriminate against others? Disapprove of others? Exclude others? Avoid others?” “Are there residents that staff members stay away from? Who? Why?” Additional questions flowed from the initial prompts.

RESEARCH PERSONNEL

Ethnographers with multiple years of research experience conducted interviews in eight LTC settings. All interviews were conducted in person and in English, with each lasting approximately 1 h. All interviewers were White women with advanced graduate degrees. This secondary analysis was conducted by one of the co-investigators, a Black woman and by one of the interviewers, a White woman. Both women have advanced degrees and were part of the original study. Interviewer–interviewee concordance has been identified as a mechanism to engender study participation as well as participant comfort and responsiveness. While racial, ethnic and social class status were often incongruent between ethnographers and LTC staff and workers, the researchers on this project were cognizant of racial and class positionalities and power dynamics, and how these might impact responses.

PARTICIPATION-OBSERVATION

Ethnographers spent on average nine months (10–15 h/week) in each setting, informally observing social interactions while helping staff with activities. Ethnographic research that includes participation, observation, fieldnotes and informal and formal interviewing is time-intensive and particularly valuable in a secondary analysis such as this because it affords a deep understanding of the social and cultural contexts from which the interviews and fieldnotes were gathered (Gubrium & Holstein, 2002; Seidman, 1998).

ANALYSIS

The co-authors identified the emergent sub-theme of racial microaggressions among the staff member interviews and began to meet to discuss and explore data from the larger study. We used ATLAS.ti, a qualitative data software tool, to conduct a keyword search of all staff interviews, including variations of the word race, prejudice, stereotype, coloured, White/Black and girl(s), as well as “African American”, “treated differently”, and “the N-word”. We also searched the larger study’s codes – ethnicity/race, power/control and recognizing difference/similarity.

To better understand the underlying ideology embedded within these narratives and strengthen the accuracy of our themes and interpretations, we engaged in discourse analysis, listening not only for what was said (reference) but how it was said (inference) (Cameron, 2001). Discourse markers such as a hesitation or an “oh” or “well”, hedges such as “sort of” (Weatherall, 2011) the use of pronouns indicate attitudes or perceptions the speaker has toward another person or persons (Jucker, 1997), including prejudice and racism when analysed in the context of place and time (Wodak, 2007).
Because the larger study’s aims were focused on residents’ stigma-related experiences, the numbers of staff discussing their personal experiences with racial discrimination are relatively few. As such, in this paper, we are presenting data from interviews with eight staff members, working in five LTC settings (see Table 2 for description of selected participants). Each staff member included in this analysis offered commentary on racial dynamics within the work environment. Six of the eight staff self-identify as Black/African American. Two staff members self-identify as White. Three out of the eight staff are administrative level employees (one Black/African American and two White). Due to the sensitivity of this topic, participant and LTC setting names were changed to protect their identities. Recorded, verbal consent was obtained for all interviews as per Institutional Review Board approval.

**FINDINGS**

The themes that emerged from the analysis have been grouped by staff racial identity (self-reported) and include (1) Emotional Response to Racial Microaggressions and Rationalisation of Racial Microaggressions from Black/African American staff perspectives and (2) Not Seeing Racism and Acknowledgement of Racism from White staff perspectives. Given that the larger study focused on social dynamics among residents in LTC and did not specifically attend to staff, the themes presented here represent serendipitous discoveries that are suggestive for further exploration in future research projects.

**BLACK/AFRICAN AMERICAN STAFF PERSPECTIVES**

The narrative data presented in this section reflects the perspectives and perceptions of Black/African Americans who work within the various LTC settings.

**Emotional response to racial microaggressions**

Racially charged words, according to the Black/African American staff members who spoke to this, had a powerful emotional effect upon them. In the moment, these experiences can be upsetting and demoralizing, but the consequences can have lasting existential and material consequences. For some, this meant needing to step away from direct care work. Monyette, a recreation assistant at Sacred Heart Rehab and Nursing Home, had daily contact with residents and noted how she felt after she overheard a White resident say, “Our forefathers would be turning over in their graves if they seen a Black [President Barack Obama] in the White House.” According to Monyette:

> And after that he [the resident who made the comment] just looked at everybody with a sideways glance. I know you’re not supposed to judge people by that or really take that into consideration or get upset about it because it’s just a look − he can look at anybody how he wants − but that’s the vibe that I got.
Monyette prefaced her sharing about “the vibe” she got by saying, “I know you’re not supposed to judge…”, a commonly held idea that staff members should be more understanding of the generational context of the older adults in their care. The interviewer followed up with a question:

Interviewer: Does it really bother the staff when it happens do you think, or is it just something they just kind of shrug off?
Monyette: I think it does because they [the staff] feel like, “they’re [residents] still human, they’re still adults,” you know, they’re not that gone [cognitively] to not know exactly what they’re saying.

Gilda, another direct care worker who worked for individuals in their homes at the Active Adult Community, Woodhaven, noted how upset she had become due to one notoriously difficult resident.

I don’t want to say it, but she was different, how else can you put it. She was just different. And she would yell at you and she would call you the “N-word” and all of that, you know. I left there crying a couple of times. It just hurt to think that people still, at this day and age. But then when you look at the generation; it’s still there.

Gilda had been warned by the home health coordinator about the resident’s verbal abuse, noting that several aides decided to quit because of it. The coordinator, who Gilda noted was White, thought if anyone could withstand the abuse, Gilda could, because of her years of experience, but Gilda lasted only 1 week: “I thought I could do it, but it got too much for me.”

Another worker, Anisha, was a direct caregiver for many years before she left that position to work as a housekeeper at Fatima Place Assisted Living. When asked why she went from direct care to housekeeping, she said she was tired of “certain things that came with it, just dealing with some of the residents’ family members and the residents.” When asked if she has similar challenges in her position as a housekeeper at Fatima Place, she answered, Anisha: I try to go in there and find their lipstick or their brush where they have placed it. Instead of saying, “I moved it,” [they say,] I stole it. And [I] just say, “Here you go. Here go your brush.” “Oh, where did you find that at?” “Don’t worry about it. Here it is.”

Anisha’s experience of being accused of stealing was “nerve-racking”. However, she purposely pushed aside her feelings, referring to the exchange as “water under the bridge”, when the brush was eventually found.

Anisha spoke more directly when asked about racially charged interactions between residents. She described an incident in which Mr. Jones, an African American resident, saved a White female resident from falling.

Anisha noted that the female resident did not thank him and even seemed hostile.

Anisha: I intervened. I’ll [sic] say: “Thank you, Mr. Jones. That was nice.”
Interviewer: And what did the other resident do then?
Anisha: If she could have cut me, she’d have cut me with them eyeballs [sic], [laughs] yes.

Anisha interpreted, from the look in the resident’s eyes, that she was not welcoming of Anisha’s intervention.

Kevin, the housekeeping manager at Stonemont, a fraternal-affinity Continuing Care Retirement Community, recognised the emotional impact negative racial dynamics had upon his staff.

You know, some guy up there calling them coons and monkeys, you know what I mean? I mean, at the moment it might get [to] them, but after I get them, once [my staff] pass through here, it’s a different story, you know. Because they come to me, “So and so said—” “Well you know, that’s what it is. They can’t help it, how are you going to get upset with them.” You know what I mean?

As an African American man, he understood the pain caused by the negative comments, yet as a manager, he counselled staff to be tolerant of residents’ racial prejudice, while also recognizing the social reality that residents are not often held accountable for their treatment of staff. His way of dealing with racial microaggressions overlaps with the second theme we expound upon below.

**Rationalisation of racial microaggressions**

Many of those staff members who spoke about race acknowledged the presence of racial prejudices within the settings and were often quick to rationalise, noting that many residents grew up in the context of Jim Crow Maryland. Tracy, a long-time employee at Fatima Place
Assisted Living said of her position at the front desk, “I'm kind of like the first person you see. [...] From time to time I do cue and coach [the residents].” She made these observations about race:

I’ve heard some of them talk about different incidents and things like that. And at the very beginning when it initially happens and I realized it's a part of the brain, it’s not the person. [...] A majority of [the residents] are Caucasian and they may remember the Black person, you know, or even more derogatory type things. I don't get bent out of shape about that. This person has a 90-year mind; they're going back to what they know.

Tracy's contextualising of the residents’ early life experiences echoes throughout the other staff interviews. For example, Gilda and Kevin’s comments on the residents' use of racial slurs is similar to what Tracy describes as “part of the brain”; and is reflective of social norms of behaviour experienced within a specific generational context. Monyette and Anisha encourage themselves not to “get upset about it” and treat the behaviour as “water under the bridge”, respectively.

These experiences are significant and have ongoing consequences that go beyond the emotional burden. Indeed, they can do have an impact on the retention of these frontline workers. For Gilda, Monyette, Anisha, and Tracy, these experiences led them to change careers and leave jobs. It is left to the individual staff members of colour to deal with racism on the job internally or among their peers.

WHITE ADMINISTRATORS PERSPECTIVES

Our exploration of White administrators’ perspectives is presented here within two themes: “Not Seeing Racism and Acknowledgement of Racism”. The interviewees quoted in this section are all White except where noted. What we found in each of the LTC settings is a lack of cohesive policies to support staff of colour. The staff did not seem to know how or if racist attitudes were dealt with, noting the inconsistency with which situations were addressed. Administrators, although often well-intentioned, were quick to defend the offending resident’s perspective and to encourage the staff member of colour to be understanding.

Not seeing racism in the LTC setting

This theme, Not Seeing Racism, describes White administrators’ minimisation of racism or failure to see how it manifested itself within these facilities. Susan, an executive-level administrator at Covenant Home, spoke from her own experience, concluding that race was not an issue where she worked because she had not seen anything that would indicate otherwise. The interviewer asked about any potential conflicts related to cultural differences given the racial make-up of the residents, mostly White, and the direct care staff members, mostly Black/African American or African immigrants.

I’m sure there are some [cross-cultural misunderstandings] and again if there is, it would not be stood for. I know we celebrated inauguration day [2008]. We had every TV turned on to it and, you hear comments from people, like residents and sometimes the older residents – But hey, it’s history, their president. [pauses and then returns to the question about conflict.] No, I don’t think so. I think we all get along. I think we really get along very, very, very well. Mm-mm, no ... I mean I haven’t seen it; you know what I’m saying?

She implies that some residents, especially “older residents” may have made racial comments. Susan does not think there is a conflict, noting, “we really get along very, very, very well”, although she qualifies her statement by acknowledging she might not be noticing any concerns with the staff’s experiences. If there were a problem, Susan went on to say, the setting’s director would demand everyone get along: “If I’ve heard [the director say] anything, it’s: ‘find a way to work this out.’”

In effect, Susan is reflecting a belief that many in the US held at the time the first Black/African-American president was elected, the idea that the US is in a post-racial society and therefore racial conflict was a thing of the past (Tesler and Sears, 2010).

ACKNOWLEDGEMENT OF RACISM IN THE LTC SETTING BY WHITE ADMINISTRATORS

Acknowledgement of Racism is in contrast to Not Seeing Racism and was demonstrated by one particular leader. Carol, the administrator of Fatima Place, was the one White administrator who spoke to the racial issues within the assisted living she directed. Fatima Place is located adjacent to a city which is majority Black/African American, although the majority of Fatima Place’s residents are White. Her awareness and willingness to acknowledge racism may be due to her location. Carol said she values speaking openly about racial conflicts as they impact the direct care staff. She acknowledges its existence and works toward understanding, both residents’ life experiences and the effect racial microaggressions have upon the staff members.

Carol acknowledged that while some residents can be hurtful toward the staff, she counsels the staff to be understanding of the resident’s context. The interviewer asked about Carol’s communication with residents’ family members, prompting Carol to tell a story about a difficult resident whose daughter shed some light on the situation:
[It turns out that there are some things in this lady’s history that she kind of sees the staff as servants, and she lived in another country at one time. [...] And they had a staff in their household and they knew that staff would steal from them, and she managed the staff appropriately and she put the staff in their place, and she sort of thinks that you kind of need to put the staff in their place from time to time. That probably isn’t a real good plan.

Carol’s strategy was to first approach the family.

And so, you know [the daughter and I] talked about how the [family] could help her [their mother] see that maybe that that isn’t the terminology she should use and that isn’t the way to get the best service. But it helps to know where that comes from. It even helps me then to say to our staff, that this is where this comes from and she does assume that you might steal from her because she lived in another country where that was a common situation and you know it’s hurtful, but it’s part of her culture, and we have to kind of work around it.

When Carol says she feels it is important to provide some context to encourage understanding, she is rationalizing the racist behaviour. And continued by saying she recognises the pain it causes the staff members and can see the consequences of staff members feeling insulted.

I don’t know if that always takes away the pain, but you know at least – I always think if we talk about stuff instead of pretending it doesn’t exist, it’s a little easier to deal with. And if nothing else then the staff can come to me and say, “You know, she said this and I feel insulted. And I’ve always done all good things for her, and it makes me not want to do the stuff.”

The staff member, as Carol recalls it, told her how feeling insulted may impact the quality of care she is willing to give, noting “it makes me not want to do the stuff” [for the resident].

Carol recognised the need to protect residents from racist attacks, although this was relatively rare since the residents were majority White. Sandra, the African American nurse manager (Licensed Practical Nurse) at Fatima Place noted how Carol would respond:

The few experiences that we had [with residents engaging in racist talk], Carol will address and nip in the bud, kind of, for the most part. She’ll have a talk with the resident and usually you’ll never hear of it again. Sometimes they [the staff] [over]hear certain things in the dining room, but if it becomes a problem and it becomes something outright with the other residents here or get involved, then it has to be brought to Carol, and Carol will deal with it.

Sandra hedges her statement about Carol’s ability to “nip it in the bud” by qualifying with a “kind of” and “for the most part”. She appreciates Carol’s effort to address racism with the residents, but Sandra recognises the challenge.

**DISCUSSION**

These preliminary findings suggest that Black/African American direct care staff have developed ways to rationalise residents’ racist attitudes and verbal assaults and indignities. With no clear alternatives, they find themselves essentially bearing the emotional labour of dealing with what could be described as verbal abuse. Additionally, we have found an absence of direct discussion and predictable practice in this area. It is important to sensitise the organisational leadership to the variety of ways racial discrimination presents and is experienced within their settings from the perspective of the staff. Without open support from higher-level administrators, direct care workers may feel as though the silence of those in leadership positions fosters a lack of respect, which then causes them to leave the workforce rather than stay in a negative environment.

Susan, the White administrator’s emphatic statement about getting along suggests the need for self-assessment at the executive level of administration. Research has acknowledged the need to recognise gaps in racial diversity at the managerial and professional level in LTC, and offers that, “as well intentioned as they may be, these professionals may still engage in racist behaviors” (Capitman, 2002, p. 12). White administrators, like Susan, believe in the value that “everyone’s treated the same”. Benign or good intentions, however, do not erase the impact microinsults continue to have in the racial context of the US. For example, Anisha describes the stress she felt when accused of theft, leading her to work to quickly resolve the situation by finding the item for the White resident. Invoking the idea of theft has a racialised, emotional effect. For Black/African Americans, being accused of criminal acts by Whites is a weaponised form of racial profiling, historically associated with traumatic events and outcomes (Stewart, 2020). The White resident may not have intended this impact upon Anisha but administrators can and should anticipate these impacts upon the people of colour who they supervise and support. Conversely, the intentional and degrading microassaults experienced by Monyette and Gilda, in their interactions with residents, impacted their feelings toward the residents and even the quality of that care, and in Gilda’s case, her subsequent decision to leave the position.
An extensive academic literature and ongoing public discourse have brought the concept of microaggressions to light. While much of workplace microaggressions scholarship has focused on work environments outside of long-term care communities, microaggression theory provides a framework for recognizing and addressing racism within this setting, as well. Understanding how these seemingly small slights may impact the health and well-being of people like Anisha, Monyette, and Gilda, can open discussions around racism in tangible ways that provide support and understanding.

From the literature, we know there is considerable pushback when microaggressions are pointed out, especially one-on-one (Sue et al., 2019). Critical scholars and commentators question the validity of the receiver’s perception of what may be unintended comments by the speaker, and they resist what they argue is undeserved blame and guilt of the speaker (Williams, 2020). But this is missing the theory’s critical insight into how history, culture, power differentials, injustice, and personal past experiences all come together to pack a punch beyond what the speaker may have intended. Carol was one White administrator whose awareness began to chart a path toward what we think is a critical first step.

In our examples, because the racial microaggressions are coming from the older adults and not from the leadership or fellow staff members (though that does not mean it is not happening there too), we argue that addressing residents’ racial microaggressions may be a good place to begin because it is one step removed; there may be less pushback and defensiveness on the part of LTC staff and administrators who are White. Ideally, with some good training in recognizing and addressing racial microaggressions, LTC staff and administrators who are Black/African American or immigrants will feel comfortable speaking up when something is said. And White LTC staff and administrators will become familiar and grow in understanding, better able to hear how their own words may be interpreted.

**IMPLICATIONS**

1. **More LTC research needs to be done through the lens of direct care staff.** The preponderance of research on abuse and mistreatment in LTC aims to protect residents, a vulnerable population (Castle, 2012; DeHart et al., 2009; Rosen et al., 2008). Because staff members have such close physical contact with residents, they are often the ones in the room when incidents of physical and verbal abuse happen, leaving them vulnerable to being seen as both perpetrators and victims (Payne & Appel, 2007).

   The experience of care staff regarding abuse by residents has not received the same level of investigation in the larger literature examining the sociocultural dynamics within LTC, despite nursing assistants having one of the highest incidences of assault in the workplace in the US (Bureau of Labor and Statistics, 2015). Over two decades ago, Gates and co-authors concluded their intervention work by stating: “Although the incidence of violence cannot be eliminated, it can be decreased and it should never be tolerated or accepted as ‘part of the job’ because to do so devalues the nursing assistant” (Gates et al., 2005, p. 119; Gates et al., 2003; Gates et al., 1999). Since then, the literature continues to bring attention to the way healthcare workers experience violence in the workplace and the need to attend to the consequences (Brophy et al., 2018; Lanctôt & Guay, 2014; Wang et al., 2011). Our work echoes and expands this research by bringing it to LTC, encouraging leadership to take seriously the emotional well-being of workers in the workplace, its financial impact on individuals’ lives as well as the LTC settings.

   We are not alone in calling for verbal assaults to be taken as seriously as physical assaults. Workplace violence, as defined by the US government recognises verbal abuse as violence, stating that violence includes “verbal violence (e.g., threats, verbal abuse, hostility and harassment)” (DHHS-NIOSH, 2006, p. 5). Non-physical violence goes largely underreported (DHHS-NIOSH, 2006; Ferguson, 2016; Nevels et al., 2020), some of which may be because of job insecurity, lack of power, normalisation of verbal abuse and past experience of reporting with no accountability (Brophy et al., 2018). For Black/African American women who make up much of the LTC direct care staff, racism and sexism in the US is one more way they experience workplace violence (Cottingham et al., 2018; Wingfield, 2010).

2. **LTC needs targeted policies and practices including training for administration on how to prevent, recognize, and navigate racially charged behaviour such as racial microaggressions.** They need alternatives to “they can’t help it” to address the staff’s experiences. We recognize the challenges, particularly in a society where discussion around race and racism can be uncomfortable. While we acknowledge that it may be difficult to create viable options to address the need to protect LTC staff members given the policy and advocacy focus on the industry has been on protecting vulnerable older adults, it is imperative to do so due to the need for quality services and growing demand for LTC services in the population. We encourage organisational leadership to create an environment of recognition and acknowledgement that racial microaggressions have a cumulative effect and over time can be emotionally upsetting and painful for staff members of colour.

   We also encourage settings to incorporate leadership training principles as guided by Truth, Racial Healing and Transformational Centers [TRHT] (Christopher et al., 2024). The TRHT Centers have as their goal the development of leaders who are trained and positioned to break down social hierarchies, and more specifically to work toward...
dismantling belief in racial hierarchies. The incorporation of these principles into leadership training within the geriatrics workforce would be a novel approach.

Another strategy is to make the culture of acceptance of difference one that is espoused from the time of admission. For example, we suggest including language in the marketing materials which speaks to having appreciation for those of various cultural and/or religious backgrounds. We believe that by providing this up front, it sets an expectation in the setting thereby making it easier to address with residents (and their family members) when situations arise. It is also imperative that settings set policies that explicitly address these matters when they occur. Workplace bullying policies in residential healthcare settings are growing and we believe may be replicated in LTC settings as well. These approaches show support for staff and, we posit, assist with staff retention.

It has also been suggested in previous research that (staff) sensitivity and communication related to racial and ethnic differences in LTC settings are important in improving dynamics within the environment (Ejaz & Noelker, 2006) and are two of the critical elements of a culturally competent organisation (Cross et al., 1989). Additionally, new hire orientation and continuing education courses for staff are important factors in the retention of workers (Institute of Medicine, 2008) and may provide excellent opportunities to incorporate staff training in the mediation of racial dynamics within the LTC setting. Notably, Capitman (2002) reported on two LTC housing communities that developed in-house intervention programs to bridge issues of cross-cultural communication and address issues of diversity and inclusion between staff and residents. They note:

...an assisted living center in Southern California creates opportunities for front-line caregivers to teach elders Spanish or other languages, while a North Carolina day health center provides literacy and Bible study classes that participants and staff can take together (p. 13).

3. Leadership must provide minoritised staff members with appropriate support and follow-through. Administrators who allow staff members to share feelings of anger, hurt and resentment without judgment or a need to dismiss their feelings or explain away the hurtful behaviour is critical to creating a supportive environment. Sitting with the discomfort and listening to the pain being expressed is a necessary first step.

We suggest having executive-level administrators and their staff, at all ranks, work together to develop a formal policy to reduce the effects of these racialised interactions. Discussions that include the perspectives of all staff are important in promoting inclusive organisational environments with higher retention rates (Brimhall, 2019). Additionally, the presence of more LTC leaders from the same minoritised groups may lead to greater empathy with direct care staff who experience racial microaggressions. These leaders then have the power to follow through with established policies.

The bottom line for retaining workers is to offer better pay and benefits, increase job security and provide opportunities for advancement (Campbell, 2018). In recent years, labour organisations have begun to gain traction (Veselka & Cotterell, 2022). Those organisations working to protect workers, need to be aware of the emotional and existential toll racism has upon the well-being of LTC’s frontline workers (Dill & Tanem, 2022). Racial equity and justice for these workers are directly linked to the quality of care LTCs can deliver (Campbell, 2018; Race Forward, 2017).

LIMITATIONS

We acknowledge these findings are suggestive and limited exploration of racial dynamics related to racially minoritised staff in LTC settings. Because the focus of the larger study was on resident social dynamics and experiences, the questions we asked did not directly address staff members’ experiences. As a result, the number of interviews where race and racism were discussed in the context of staff members was very few in comparison to the larger study.

Additionally, there was a lack of follow-up, probing, and clarification within the interviews with staff of colour, as all interviewers were White women from an academic setting. The level of comfort, understanding, and openness racially minoritised people experience in the interviewee–interviewer interaction is undoubtedly affected by this racial discordance (Holstein & Gubrium, 1995). The interviewees may have been unaware of their own discomfort and would have missed some opportunities to probe specifically for racial conflict because of a lack of understanding and shared experience (Davies, 1999; Oakley & Roberts, 1981). We suggest that it is exactly this lack of researcher diversity that has led to the paucity of research literature on the topic of racial prejudice and abuse in LTC.

CONCLUSION

As the current generation of LTC residents gives way to the baby boomers, coupled with the groundswell of social movement activity due to civil unrest surrounding the treatment of racially minoritised groups in the US, the LTC social environment will likely experience changes. As societal expectations around justice and inclusion rightfully increase, staff members and LTC organisational administrators may have higher expectations and less
tolerance for older adults who espouse racially negative and insensitive views in these settings. And conversely, there may be fewer racially motivated comments made by a new generation of residents. Future research in this area should investigate the changing resident-staff social dynamics in LTC housing as the baby boomers transition into these spaces. In addition, research should address how contemporary social movements shift policy and practice in the LTC environment.

None of the settings in this study had formal practices in place to address racist speech, which indicates that cultural competency training has not gone far enough. Moreover, expecting a new generation of White older adults in a still racially divided society to have changed racial attitudes may be naively optimistic. However, efforts to protect and support staff of colour from all forms of racial indignity should be an ongoing priority for all parties involved in LTC environments.

We need to move the conversation beyond cultural competency to implementing policies and practices that can support the frontline workers of LTC, many of whom are from minoritised groups. Together with improved wages and benefits, addressing microaggressions may offer a critical tool to solving the LTC challenge of retaining direct care workers by improving worker well-being and job satisfaction and by extension, improving the quality of care for older adults.

NOTES
1. See Black et al. (2023) for information regarding the term “racially minoritised”.
2. LTC settings included in this analysis are Stonemont (independent/assisted living/nursing care); Fatima Place (assisted living) adjacent to Sacred Heart Rehab and Nursing Home; Covenant Home (assisted living, memory care, and nursing care); Woodhaven (55+ active adult retirement community with in-home care options).

FUNDING INFORMATION
This work was supported by a grant from the National Institute on Aging [5R01AG041709 to J. K. Eckert, PI].

COMPETING INTERESTS
The authors have no competing interests to declare.

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TO CITE THIS ARTICLE:

Submitted: 11 December 2023  Accepted: 17 May 2024  Published: 25 June 2024

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