"We are not a machine": Personal support workers' (ante)narratives of labours, leisure, and hope amidst politics of genderacialised care in long-term care homes

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

ABSTRACT

Systemic processes rooted in and reinforcing neoliberalism and capitalist production work to racialise, gender, and class bodies engaged in caring. Engaging in caring through labouring bodies, racialised women working in long-term care (LTC) homes as personal support workers (PSWs) are over represented in labours of care when compared to other sectors of the workforce. In this critical narrative inquiry, individuals through their labouring bodies tell corporeal stories of invisibility and marginalisation, as a result of intricate, complex, intersectional oppressions of racialising, gendering, and classing in settings of care. To best learn through stories told by women's bodies engaged in caring, intersecting lenses of critical race and feminist inquiry frame how we might hear and see marginalising processes and oppressive practices that shape caring. Unpacking the caring literature revealed several politics occurring in Canada, which reinforce socio-political and economic structures that work to structure who is engaged and how caring happens. I identify eight processes related to caring work that shape the ***politics of genderacialised care***. New language of ***genderacialisation*** was needed to inform understandings of the intricate systemic processes that weave together gendering, classing, and racialising in narratives about caring work. Genderacialisation in a care context manifests as systematic deficiencies and points of tension negotiated by individuals who work in stratified care environments. Genderacialisation also acknowledges processes working to render individuals powerless through the imposition of singular categories of race, gender, and class. How genderacialisation is embodied describes, then, experiences of ***genderace*** - the various ways gender, race, and class are attributed to, lived, and storied by individuals.

The purpose of this study was to reveal genderacialisation and to: (1) understand how it works to structure narratives of PSW care in Canada and (2) create hopeful change-spaces with PSWs. More specifically this activist, critical narrative research has objectives to: (1) deepen knowings of genderacialisation and story how genderacialisation occurs for PSWs working in LTC homes (to inform impacts of racialising, gendering, and classing in care work); (2) story genderace as it is navigated by PSWs in settings of caring (to inform manifestations of genderacialisation); (3) map racialised women's stories of current practices in care, leisure, and labours of care as PSWs working in a LTC home (to inform how care work is structured); (4) reveal how ideals of self-care, leisure, and care work are storied by PSWs working in LTC homes (to inform alternative realities of care labour inclusive of what the labouring body seeks); and (5) discuss implications of stories with PSWs and act to change structuring of care work (to inform sustainable labours of PSW care in LTC homes, self-care, and leisure).

This critical narrative inquiry takes a closer look at antenarrative (*cf.* Boje, 2007, 2011), grand narratives, and counter narratives appearing in women's stories about the labours of caring. To see possibilities beyond systemic politics and depart from oppressive structures, women looked to the body. First, body mapping was used as a method to hear stories of five PSWs who self-identified as racialised women. In response to guiding questions we mapped stories onto two paper "shadows" of the body. The first body maps told stories of current practices of the labouring body while caring and the second body map told stories of how one cares for the labouring body followed by reflective discussion of each map and then, the juxtaposition of both body maps. In a second meeting, women created storyboards for the creation of a digital story by selecting segments from their transcribed texts and photos of their body maps. Five digital stories were then created, one by each woman, from the storyboards

women assembled. In the third and final workshop, women who participated in the study viewed the digital stories and engaged in reflective discussion.

In the final step, I illuminated an antenarrative of caring by hearing into how women of colour were (un)able to wield agency in caring roles within larger socio-economic and political structures. Specifically, by pulling together the politics of genderacialised care, body maps by racialised women engaged in labours of PSW care, and reflective discussions that followed re-listening to stories of care, I saw how the narrative of labour gave way to an antenarrative (a pre-emergent body story) of *worth*. *Worth* was revealed as the antenarrative of the labouring body seeking *worth*: worth within the system, reclaiming self-worth, and self-worth as interdependent and unamenable. Snapshots of *hope* (for change in caring practices) were also held in the labouring body. *Hope* facilitated the antenarrative of worth within caring systems (and society more broadly) to come through women's body maps of labour.

Findings from this inquiry propagate a need for further research in the areas of the labouring body, caring, and worth and hope. Of particular interest to leisure scholars is the positioning of leisure within this conversation. Theoretically, this research contributes understandings of genderacialisation and genderace in different areas of caring labour with possibilities of application to other sectors where marginalisation creates disparities in access to care for self, worth, and hope. Methodologically, pairing narrative inquiry with the method of body mapping and a focus on antenarrative presents a new and exciting way of knowing individuals' stories through their bodies and the potential for hope. Specifically, findings of this work with the politics of genderacialised care are important for further supporting PSWs in their ongoing negotiations for fairness in pay, time for reprieve and reflection, and access to resources (like leisure) to care for their labouring bodies. I plan for future work to include: the creation of resources to assist individuals in understanding and supporting PSW roles in caring; making available online the digital stories that women in this study agreed to share broadly for community engagement and labour practice change, integrating *being with through caring* into care policy towards sustainable, rejuvenating, and relational care practice; and deepening understandings of *worth and hope* as antecedents to meaningful labour and socially justice in caring, leisure, and labour practices.

ACKNOWLEDGEMENTS

Embarking on this research has changed the way I listen to and see stories, engage critically with my own positionality, and think about relationships within society. Rather than an end, I see the completion of this dissertation as a beginning of a new path to learning more about how the labouring bodies each of us live in engage with and are engaged by society. Five years (and one term) later, I reflect on my project as a whole and give thanks to a very special community that supported me on my journey.

To Nena, Nicola, Clara, Maria, and Jenny, I am honoured that I was able to share time, space, and story with each of you. Thank you for making this dissertation possible for me and for contributing your stories in helping others to see, hear, and be reminded of the importance of your labours of care through personal support work.

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Thank you to everyone who is engaged in the labours of care, formal or informal.

Last but not least, thanks to **you**, for picking up this document as a reader. As you engage with and reflect on this work, you become a part of how this research story unfolds.

DEDICATION

For my mother, with love.

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CHAPTER 1. Introduction

[Two women meet for an airing of five stories digitised from their contributions to this project. Following the airing, Nicola and Maria share final thoughts on their roles as personal support workers in a final research meeting.]

Nicola: Even though a few people can afford to hire a nanny [for elder care] but then other than that, if there's a -- one has to sacrifice working night or days, and--
Maria: Childcare is expensive too.
Nicola: It's sad first because it's truly worth if it -- each and every video, [story] it's the reality of this kind of work that we do. We are there, we love our job and everything, we are there to help the residents or the patients and the workload, and dealing with the family member, and they expect so much from you. But at the same time, we're happy. Always, a lot of people say, "Wow, I don't have a heart to do that kind of job," but I just tell them, "Well, this is what somebody has to do it, right, somebody--" We can't be all working in the bank, we can't be all working in offices and stuff. Who's going to take care of the elderly? This is-
... Yes, this is what I do and just -- it's a workload, it's too much, it's too heavy with the cut downs and but I don't know.
Maria: Yes. That's true, what she said, it's so sad, it's very – like it's touch your heart, the story. Then like she said, someone has to do that job too, okay. I'm happy to have a job especially in a hospital, that's what my dream... The other [comment] I have to add, it's good because you can show [our stories] this clip over the [research] program to someone and then people listening, and then they should understand—
Nicola: They'll know that's it's not easy.
Maria: It's not easy and then we are not born to do this, we have different knowledge and we are smart too.
Nicola: ...For example, when you go to school, teacher teach you something and then we don't see what teacher has in her or his real life back in their house, okay. Whatever problem, she cannot show into the class. She has to smile and teach, because that's what a student expect to learn over there and the parents of that student also expecting the teacher should be perfect, smile and be kind. The same like our job. Yes, I think this help to people to understand we also have life, we understand their situation too because we have mother, father, sister, brother, uncle, children, so we -- they also go through those situation, we understand, because we are not like robot over there, *we are not a machine.*

To me, this conversation between two of the five women who participated in this study, provides a glimpse of what lies beneath perceptions of what it means to care. I hear these snippets of story tap into broader discourses around care, work, race, gender, and class.

My response to racism is anger. That anger has eaten clefts into my living only when it remained unspoken, useless to anyone (Lorde, 2007, p. 131).

The conversation between two personal support workers (PSWs) lies in contrast to a discussion I had at the start of my research endeavor with a graduate student named Eric, who studied social robots and the impact of robots in the lives of older adults. When he asked me to share what I studied, I said:

> Ultimately, I'm hoping to explore stories of gender, race, and class in narratives told by personal support workers (PSWs) who work in long-term care (LTC) homes. Eric responds with a disinterested, "Oh ya?". "The structural inequities that exist for women of colour engaged in care work are of interest to me," I continue. Unnerved he asks, "How's that? That's a thing?" without interruption and a half smirk he says, "Do you really think *that* is a priority for Canadians today?"

My anger is a reminder that I am not to let my guard down about the unknowing of individuals who do not live narratives structured by racialising, gendering, classing, and care work. Though these instances serve as a cue, I am repeatedly exasperated by colour-, gender-, and class-blindness, unchecked privilege, and neoliberal assumptions of equity that pervade every day exchanges. In light of recent rallies to shed light on race, gender, and class (c.f. women's march 2017, protests on anti-immigration bans, black lives matter movements, anti-racist/anti-white supremacy clashes in Charlottesville, VA in August 2017), there is more visibility in anti-oppression movements. Unfortunately, though there is a pervasive lack of commentary on race, gender, and class in care, in Canada especially, that continues to elude me. Eric not only failed to be aware of labours of care commonly assumed to be "women's work" (Evans, 1991, Robinson, 2011) but also of the structural inequities created by race and class (Cloyes, 2002; Puka, 1990).

Blindness to these issues in everyday discourse deepens invisibility experienced in caring roles in both formal and informal care settings. Much like my interaction with Eric, I am often asked to defend my position. I raise questions in response, "do you not feel or notice that inequity is pervasive in labours of care?" and present disparities such as:

> in long-term care (LTC) homes over 90% of workers in assisting professions are women. Racialised women in care work makes up somewhere between 18 and 25%, an overrepresentation when compared to the overall proportion of women of colour in the Canadian labour force, which is something like 13 or 14 per cent.[1]

Intentionally in this research I move women's stories of care to the foreground. Their stories are powerful and speak for themselves. Narratives (or stories) at the centre of this research serve to convey richness, complexity, and messiness in women's stories about their perceptions of their own roles in the labours of care[2]. Their narratives of being in care and living through labour transcend my anger and the futile loops of dialogue I sustain with individuals like Eric.

I continue to make comments on disparity to draw attention to the living racialised, gendered, and stratified realities of women of colour. These moments provide opportunities to talk about structural issues in care that hit close to home for me. They create spaces where I can reflect and draw attention to the existence of injustices in care. And yet, these discussions of over representation, pay inequity, colour, gender, and class overrepresentation in care only scratch the surface of living stories of subjugation. While extant literature illuminates challenges faced by direct care workers (i.e., low wages, lack of employment mobility, lack of health and other benefits), they provide little support to meaningful change in labour equity or issues related to the overall health and well-being of PSWs for whom care for self is also compromised

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[1] Women and Health Care Reform (2009)

[2] In this dissertation, I use the term "labours" to emphasise the pluralisation of the many forms of labour (i.e., organised, informal, and personal) a woman of colour caring in Canada endures simply as a result of her positionality.

(Arat-Koç, 2012). Throughout this dissertation, I critique neoliberalism, capitalism, and invisibility through marginalization as the socio-economic and political structures that maintain oppressive PSW care practices. Part of the persistent challenge connected to neo-liberalism is language steeped into social policy, law, and everyday conversations, which obstructs thinking beyond fragmentations of identity, like the layering that occurs with race, gender, and class (discussed later). In Chapter 2, I discuss how each structure serves to reinforce processes that racialise, gender, and class individuals through caring work in describing eight politics of care.

One who experiences minority status in *any* area of identity is said to be less visible by society (Darder, Torres, & Gutierrez, 1997) and is positioned further and further away from what is perceived to be the centre, middle-class, white, heterosexual, cis-gendered, male norm. Yet there has been little critical consideration of how politics of power in race, gender, and class play out in care relationships of PSWs. Notable exceptions are Evelyn Nakano Glenn's scholarship, which illuminates invisibilities of women of colour working in paid and unpaid care settings in post-war, American contexts (c.f. Glenn, 1985, 1987, 1992, 2000, 2010, 2011) and Arat-Koç's work on transnational identities in policies related to foreign workers in neoliberal Canada. In her 2012 paper on gender, policymaking, and policy discourse she writes,

> The status and conditions of migrant domestic and care workers in Canada constitute one of the most striking examples for how gender and race inequalities are constructed, condoned, and/or reproduced by the state. For domestic and care workers, the replacement of permanent resident status with temporary work permits in the early 1970s marked the development of a status that created conditions of extreme vulnerability (p. 7) ... [and further,] policy discourse treats gender inequality as a problem solved for white Canadian women, and an ongoing, cultural (baggage) problem for immigrant and racialized women (p. 9).

Both Glenn and Arat-Koç agree that racialised women experience multiple and simultaneous oppressive processes by engaging in labours of care that are further pronounced by state policies. In this dissertation, I introduce *genderacialisation* (multiple systemic processes that work to

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label and subsequently marginalise individuals) as a core theoretical idea to this work. Genderacialisation builds from static articulations of categorical oversimplifications (like, race, gender, and class) to acknowledge complexity, evolution, and even synergy, in social processes that work to label. I describe genderacialisation and ***genderace*** (narratives told about experiences of marginalising processes that work to label) in more detail later in this chapter and in Chapter 3.

This dissertation highlights reproductive work (like cooking, caring, and cleaning also known as women's work or "pink-collared" labour) as the means to which racialised women engage in the system of production. This work also places focus on processes (policies and ways the system becomes inaccessible to racialised women) that maintain divisions of LTC labour. These issues are relevant to Canadians for a number of reasons. First, the Canadian population is aging and the need for care, especially 24-hour care and support, is on the rise (Speller & Stolee, 2015). Second, histories of reproductive work continue to play out into public spheres, which now more than ever, impact the transnationalisation of care work (Glenn, 1985, 1992; Robinson, 2011). Third, given the elusiveness of gender, race, and class stratification in Canada, colourblindness is commonplace and denies historical differences that persist—such as a lack of access to higher education, employment mobility, and adequate social assistance—for racialised individuals due to socio-political and economic disparities (Fleras, 2014). Fourth, the number of racialised individuals[3] are trending upwards in Canada, six times faster or 25% more quickly

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[3] often referred to the in literature as 'visible minorities.' In this dissertation, I use the terms racialised woman and woman of colour rather than "visible minority." Largely a Canadian label (Chui & Maheux, 2011; Malenfant, Lebel, & Martel, 2010) and a term that is placed on individuals, 'visible minority' is commonly used to describe individuals not recognised as white. It essentialises, centres whiteness, and is a neoliberal label of convenience. The term visible minority points out difference without meaningfully acknowledging inequity and so, I choose not to perpetuate the use of a label that is valueless to me. The language of colour is complex and I acknowledge that all women experience racialisation (and are racialised). The terms "racialised" and "colour" offer some knowing that is not whiteness. In this

than Canada's total population (Chui & Maheux, 2011). Ignoring labour divisions in this way

continues to make genderacialisation invisible from public scrutiny. As a result, racialised

women are increasingly susceptible to the stresses and invisibilities incurred within caring roles.

Care systems structured in capitalism maintain divisions of labour occurring at the

intersections of race, gender, and class (hooks, 1989). Society continues to commoditise care by

moving reproductive work[4] into the public sphere and capitalist economy. As developed

countries began the shift towards industrialisation, women of colour[5] were sought to support

direct care responsibilities in economically advantaged families (e.g., personal home care) and in

institutions (e.g., LTC homes) (Robinson, 2011). Society has normalized invisibility and stress

experienced by women in caring roles in a variety of care settings worldwide (Hondagneu-

Sotelo, 2007; Robinson, 2011; Tronto, 2013). Taken-for-granted biological determinisms and

pre-scribed constructions of identity continue to shape narratives of women's care relationships,

threatening to reduce opportunities for self care, and changing the value one places on care of

self for individuals engaged in reproductive work (Cloyes, 2002). Structures that remain

colourblind maintain inequity and restrict movement away from stale and stagnant gender and

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document, I use *racialised* to describe women whose experiences are deeply shaped by oppressive
processes of racialisation. Critiquing language and lack of policies to support racialised women in care
roles is a starting point for this inquiry. In Chapter Two, I discuss the politics and structures that
perpetuate racialising, gendering, classing, in care work in the politics of genderacialised care.
[4] gendered roles in society assumes women should take traditional roles in homes such as cooking,
cleaning, and care to support capitalist aims of production and consumption (Glenn, 1992).
[5] To respond to colourblindness, I also will sometimes choose to use woman of colour to reclaim the
word 'colour' in describing individuals who experience a loss of privilege as a result of socially created
binaries that label based on perceptions of coloured and white. I believe both terms are necessary in this
document to express both meanings to describe the processes and power that each term aims to articulate.
To me, to self-identify as a woman of colour is a powerful self-imposed label of reclamation rather than a
term of segregation. I use both of the terms "racialised woman" and "women of colour" in this
dissertation. Minority status itself is not problematic to me. What *is* problematic is the imposition of
socially constructed differences which create perceptions that minority is 'less than' and/or alien and the
resulting sentiment held by minoritised individuals who may not see themselves reflected in popularised
culture (i.e., film, television, literature) and in other prominent social sectors (i.e., government, education,
justice system).

race roles through reproductive labour. This enables others to extrapolate and typify individuals based on labels (i.e., visible minority, woman, immigrant) which then act as constraints to limit racialised women's mobility outside of reproductive work. These processes, taken together, create an inability to move beyond archaic constructions of what it means to be a woman, a person of colour, or both.

When dreams of racialised women are extinguished by expectation, and individuals ignore how subjugation continues to render invisible the strengths that exist in difference, society is robbed of the gifts alternative understandings and actions would provide. In response to this, this dissertation facilitates how we can listen to stories told by women of colour who labour through care. Their stories are an opportunity for reflection, transformation, and action, to illuminate strengths, challenges, struggles, and resistances about labours of care that many individuals require to thrive in community.

This research also recognises that individuals labour to navigate simultaneous turnstiles of invisibility and hypervisibility (Mowatt, French, & Malebranche, 2013), reproductive work and leisure, and agency and oppression in settings of care. Robinson (2011) describes that, "in Canada, as in all nation-states, poverty, race, and social exclusion cannot be disentangled from questions regarding the need for, and provision of, care" (p. 2). How do individuals engaged in labours of care as PSWs in long-term care (LTC) talk about confronting, navigating, or bumping up against intolerances, prejudices, ignorance, and essentialisations of what it means to be Canadian or a woman of colour or both? Race, gender, and class in care will increasingly be encountered, confronted, and negotiated by racialised women who work in caring professions. Listening to stories by women can help in bringing the multiple narratives about the labours of care to the surface.

Invisibility of PSWs

My story is connected to a larger structural experience in Canada. My interest in women's racialised experiences of care began with me not being able to put words to the feeling of "continual pull, strain, a tautness" (Skovholt & Trotter-Mathison, 2011, p. 3) I felt when women of colour, who worked as PSWs told me stories about their relationships with residents, family members, and colleagues in LTC homes and their lives beyond the walls of their workplaces. I came to recognise that PSWs wear many hats in caring roles spanning the spectra of health care services across Canada. Individuals working as PSWs are providers of 75 to 80 percent of direct care to LTC home residents in Canada (Janes, Sidani, Cott, & Rappolt, 2008; Kontos, Miller, Mitchell, & Cott, 2011), and yet their work is largely invisible and considered 'ancillary.' Ontarians commonly use and are familiar with the term PSW; however, in other parts of Canada, individuals with similar job descriptions may be referred to as a health care aide, care aide, personal attendant, or respite worker. These various titles make it difficult to estimate how many workers have similar duties across Canada. Despite PSWs' important role in the health care system, there is no centralised database for demographic statistics on PSWs and the information offered by various health care organisations is largely variable, outdated, or fragmented across the spectrum of care. Estimates though suggest that there were approximately 100,000 employed PSWs in Ontario in 2006 (HPRAC, 2006). PSWs are also hired privately, and some care workers also have different job titles that represent work similar to personal support work and are thus not included in the approximation of PSWs in Ontario (HPRAC, 2006). This number is largely an under estimate because of its dependency on independent LTC home reports, employer, and relevant association reports and consequently, I suspect this number is largely under-representative.

In most settings where care is offered (i.e., hospitals, community care, private employment, and LTC homes), PSW or similar roles can be found. Structures in LTC homes allow for relatively stable conditions (i.e., familiarity with a home's structure, procedures, and longer-term relationships with residents, staff, and family members) with which PSWs engage. However, in a capitalist society, the cash nexus politicises and commoditises care based on how society perceives productivity and value – both as care workers in LTC and residents who are often older adults, living in LTC homes. Care work with older adults is one of the fastest growing labour of care sectors in Canada (Alzheimer Society of Canada, 2010; Canadian Institute for Health Information, 2011). Structured in ageism, LTC homes are stigmatised as places where disease, illness, and death predominate. Care work in LTC homes is more broad in scope and perceived to be 'less specialized' despite the facts that residents often have multiple and complex health needs. Racialised women are often employed in LTC homes to support resident care through cooking, cleaning, and engaging in some of the most physically labourious care of all direct care work as PSWs. Discrepancies faced by racialised women between PSW training offered and circumstances faced in LTC homes is what makes this form of care work more precarious than in other, better-funded, more prioritised areas of health care.

In hospital settings, PSWs work primarily in rehabilitation and complex continuing care supporting activities of daily living under the direction of other care professions like registered nurses (RNs), registered practical nurses (RPNs), physicians, occupational therapists (OTs), physiotherapists (PTs), and registered respiratory therapists (RTs) (Government of Ontario, 2013). In community care, PSWs are employed by agencies contracted by Community Care Access Centres who then hire PSWs to work in private residences (Health Professionals Regulatory Advisory Council [HPRAC], 2006). According to the Government of Ontario (2005),

the proportion of PSWs who hold multiple jobs is more pronounced in community care work

(caring that takes place in personal residences), and PSWs are more likely to be women (92 per

cent according to Women and Health Care Reform [2009]). Private employment for PSWs may

come in the form of private personal homes or private LTC homes. Much like in LTC homes, in

the case of private employment, PSWs support recreation opportunities, activities of daily living,

and homemaking duties (HPRAC, 2006). The majority of care workers in LTC homes are PSWs

who are expected to follow orders, manage personal care and residents' complex physical needs

(Ikegami, Morris, & Fries, 1997), and work in and amongst organisational complexity and

staffing strain.

My Positioning within this Knowledge Construction

My process in developing this research has been to document my awareness of structure,

weaving together living stories and knowledge drawn from research literature, reflections from

my own history and positioning, and a critique of patriarchal, marginalising, and exclusive

language used to construct knowledge. My earliest experiences in health care organisations in

Canada were in person-to-person service, first as a volunteer, then as a program coordinator,

finally as a therapeutic recreationist. I was eager to learn, keen to take in the nuances of my

surroundings, and I always kept my head up. I noticed how many women of colour worked in the

kitchen, laundry room, housekeeping, and in care – the lowest paying roles – in LTC homes.

Admittedly, as I continued to work and visit many LTC homes for research, the persisting

disproportion of women of colour employed in reproductive work was all too common. So

common, that the overrepresentation of racialised women in LTC homes quickly faded into the

normalcy of my everyday. I struggle to recall exactly when I failed to notice the skewed

disproportion of racialised women working as PSWs; however, since exploring the nature of care

more deeply as a researcher of care, sensitivity to my own positions as a racialised woman have since re-awakened.

I grew to recognise that many women feel they care because they *just have to* and often have few choices around matters of care. I am the sole child of immigrants from the Philippines. My mother (or ma as I call her) was the eldest of three children. She left her home (first in a rural area of Philippines, then to Manila) to work in Amsterdam in the Netherlands as a health care aide. Multiple moves were necessary for her (either for education or work) to tap into sustainable earning potential for herself and her family (a trend that is maintained today). Every month, she would send a portion of her income to her family and set aside a little for herself. As she neared the end of her contract, she applied to immigrate to Canada. She landed in Canada on August 28, 1976 and moved in with a girlfriend who immigrated a year before. The day after she landed, she called the director of nursing at Providence Centre in Scarborough, Ontario to inquire about work: "she [the director] said to me, 'is that really how you plan to apply for a job? By calling me?'" My mother laughs about her perceived naiveté as she retells this story to me. Shortly after she hung up the phone with the nursing director at Providence, she travelled to the LTC home to fill out an application for work as a health care aide. Following a more formalised interview, my mother was hired earning $2.65 hour (minimum wage at the time[6]).

After working for six years, she and her colleagues were given the opportunity to attend college part-time towards a RPN designation through a joint program between Humber College and Providence. For students of this program, class time was tacked on at the end of shifts offered on days, evenings, and weekends. Ma was among 200 health care aides who took the entrance exam and applied to the program. She recalls many of her colleagues having difficulty

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[6] Government of Canada (2016). *Hourly Minimum Wages in Canada for Adult Workers (1975-1984)*
Retrieved from: http://srv116.services.gc.ca/dimt-wid/sm-mw/rpt2.aspx?lang=eng&dec=2

meeting the demands of care work, family time, and study. Two years later, in 1984, she was fortunate to be one of only 28 who graduated from the program to be a RPN.

I am often told about her long kept relationships that flourished through care with others and stories of many women, like my mother, who migrated to North America with very little to engage in care work for a better life. As her daughter, I observed a single-mother who juggled multiple caring roles, both personally and professionally. I learned that caring takes its toll, and that the physical and mental wear-and-tear becomes normalised and accepted as conditions of employment. Stories of hardship, self-sacrifice, and servitude are reproduced in many Canadian care settings today. My mother's stories inspire this inquiry into labour, leisure, and well-being; the genderacialisation of care; and individual capacity within the Canadian health care system.

Growing up it was common to hear ma's fellow care workers discuss how to best ration sick days so they could care for a family member or volunteer for their child's field trip. Taking sick days to tend to personal illness, on the other hand, often raised personal debate for my mother and her colleagues. Since her retirement from caring work (after 42 years in various paid care roles), ma and I often reflect together on how double-duty caring continues to be a precarious balancing act for care workers today. The gendering and racialising aspects of double duty caring, I feel, stems from demands placed on individuals to navigate the ways they are subjugated by complexities of poverty intertwined within processes of employment, immigration, and education (among others).

This research asked individuals, including myself, to stare in the mirror long enough to recognise genderacialisation and reflect on: how lives are experienced through a lens of genderace, how women of colour are made invisible when constructed as 'carers', and how racialised women working in PSW care roles, experience invisibility as a result of the structuring

of care work. Acknowledging the roles race, gender, and class play in the subjugation of women of colour meant touching that hardened skin, those calluses of protection, and thinking about what caused them to become so thick and impenetrable in the first place. I believe this acknowledgement was key to *seeing* genderacialisation.

Beyond constructed, systemic oppressions that exist and contextualise each individuals' life story (i.e., poverty, ability, culture, etc.), a will to care is not who individuals are as racialised, gendered, and classed citizens; it is who one is as a human. This is why an understanding of genderacialisation is needed. Genderacialisation does not reduce processes into the creation of discrete categories to only be layered through recognition of intersectionality; it acknowledges processes that categorise and reduce individual wholes to one aspect of an identity that he/she/they may or may not take up themselves. As an Asian-Canadian woman, I journey amidst grand-narratives of a Canadian dream of equity and inclusiveness, perseverance and prosperity; I feel heavy with expectations I inherited from generations before. I can connect to the tensions individuals feel when women of colour are collectively valued as no-different, same-as, and welcomed Others, yet continue to be identified as "visible minorities" or "doubly marginalised" on paper. I live it.

A Search for a New Way Forward: Genderacialisation

There has been extensive work on how "multiple-subordinate group identities" have contributed to invisibility (Baines, Evans, & Neysmith, 1991; Daly & Szebehely, 2012; Purdie-Vaughns & Eibach, 2008). Purdie-Vaughns and Eibach (2008) describe intersectional invisibility as the "subtle practices that marginalize subordinate group members by excluding their experiences and perspectives from prevailing social representations and discourses" (p. 387). Reynolds and Pope (1991) discuss complexity of diversity as "multiple identities [that] follow

overlapping, interweaving spirals of development" (p. 3921B), engaging multiple oppressions of traditionally marginalised identities. To describe many parts of identity (one or more of traditionally constructed categories, like race, gender, class, for example), I borrow the term 'anticategorical' from a branch of intersectionality theory that believes "life is too irreducibly complex—overflowing with multiple and fluid determinations of both subjects and structures—to make fixed categories anything but social fictions that produce inequalities in the process of producing differences" (McCall, 2005, p. 1773). Hypervisibility or spectacles of difference exist to construct a paradox of hyperinvisibility-invisibility (Mowatt, French & Malebranche, 2013) in living with multiple, marginalised identities. Bodies that engage in different forms of work (known to body studies as 'labouring bodies') too are marked by different social meanings that subsequently produce inequalities. Conceptually, Kimberlé Crenshaw (1989) coined intersectionality to articulate the multiple and layered labels of being racialised, gendered, and classed in specific ways.

Racialisation emphasises the interplay of subjugation and dehumanisation occurring as a result of colonisation. As Garner (2010) states, "to be racialised was thus to have been dehumanized as part of the colonial process" (p. 21), and includes subjugation resulting from the categorisation of populations of the world (Banton, 1978; Fanon, 1967). Ikemoto (2006) provides historical and political examples of how women of colour have been ill acknowledged in law and health policy, as typically these practices only approach racism and patriarchy as distinct phenomenon. A feminist theoretical framework (Brown, 1997), intersectionality theory originated from a shift in thought from the idea that a gendered lens alone could speak for all women (McCall, 2005). Intersectionality acknowledges that racialisation never works in isolation (Rattansi, 2005), and always works in conjunction with power associated with gendering and

classing (among others processes of subjugation) in society. Although structures (policies, normalised processes, beliefs, procedures, and organized bodies, including government Acts) are designed to support individuals who face disadvantages, critical inquiry driven by intersectionality is needed to create a better understanding of how multiple structures simultaneously privilege and discriminate, include and exclude, essentialise and render invisible, and both provide and limit access to life-enhancing resources.

I draw from Carles and Jubany-Baucells (2010) and use the notion of ***genderacialisation*** to inform my understanding of the intricate systemic processes that weave together gendering, classing, and racialisation in working with narratives of stratified care work. ***Genderace*** (Carles & Jubany-Baucells, 2010) then, articulates the various ways gender, race, and class are attributed to, experienced, and described by individuals who live realities of labeling. It acknowledges processes that work to render individuals powerless as a result of designation into specific and singular categories of race, gender, and class. Understanding how individuals continue to be stratified and labeled through caring work means acknowledging capitalist, patriarchal, and racist structures that fragment identities and ignore inequities associated with these complexities. Genderace is a useful term because it is fluid and interrogates the necessity of boundaries between spectra of identity; reflects the complex nature of how gender, race, and class are lived together and become embodied; and furthers a need to reflect individual narratives as notions of genderace ebb and flow over time. Genderacialisation in a care context manifests as systematic deficiencies and points of tension negotiated by individuals who work as part of stratified care environments. I work with the ideas of *genderace* and *genderacialisation* to make sense of politics of power associated with stratification of specific individuals into caring roles. This

concept, supported by intersectionality theories, is an anticategorical way of acknowledging the multiple subjugations at play.

As Glenn (1992) and Arat-Koç (2012, 2001) describe, differences in caring experiences between white women and women of colour hinge on multiple and complex differences. For example, due to class differences, no residual income is left to pay for cleaning or caring at home, and due to cultural differences, there may be extended family members living in the home (i.e., aging parents, etc.). The analysis of one category of identity (i.e., race, gender, or class) aims to address power relations of *one* part of one's identity, however when parts of identity remain fragmented (separated and siloed from one another), oppressive power that exerts influence on individuals as a whole with multiple identities remains nameless, invisible, and unchallenged. Structuring of caring contexts maintains oppression by ignoring genderacialisation, keeping it in the background, muting its influence, and making its ever-present power invisible to Canadians. As a result, stories of genderacialisation in PSW care work remain unseen. This synergistic power that often remains nameless is genderacialisation at work.

Theoretical frameworks of intersectionality that I use in this research are guided by critical race feminism (CRF) and feminist ethics of care. Applications of CRF aim to: illuminate differences of experience that shape perspectives of women of colour from those of all men and white women; interrogate oppressions and how they manifest at the intersection of race, class, and gender; challenge essentialism and recognize the multiple political identities of women of colour; and take a multidisciplinary approach to combat both racism and sexism (Evans-Winters & Esposito, 2010; Wing, 2003). Intersectionality is a key theoretical foundation for the narratives I take up through genderace – which I see as an embodied knowing of processes of genderacialisation.

In addition, feminist ethics of care critiques the notion that women are biologically determined to care. Metanarratives of care - those narratives that claim a comprehensive knowledge or meaning - reduce woman's morality to virtuousness through acts of caring, reproducing the dominant belief that it is a woman's "duty" to care. These meta-narratives dissolve care into oversimplified essentialisations, and reproduce inequities and oppression (Cloyes, 2002). Further, inequality arises through physician-centred hierarchies, meritocratic devaluation of informal care over formal care support, and biologically deterministic assumptions of emotionality and nurturing involved in care, which are still dominant perceptions in Western society (Robinson, 2011). A feminist ethic of care gently shifts the power-imbalance in notions that solely emphasise care *for* to incorporate principles where "receiving care" (Rummery & Fine, 2012, p. 326) is legitimised and recognised.

Critiques raised in the feminist ethic of care literature encourage us to be critical of how care roles are allocated to (or assumed by) all women and, to an evidently greater extent, racialised women. Counter-narratives raise awareness that women are more likely to be left outside positions of privilege in the healthcare system (O'Brien & Armato, 2007) and this is especially true for women of colour (Evans, 1991; Hondagneu-Sotelo, 2007). In addition, according to Baines, Evans, and Naysmith (1991), "policies, programs, and professional practice assume that caring is a female mandate, yet services are organized in ways that do not respond to, or take account of, the daily realities of women's lives" (p. 13). As structures of care are genderacialised, women of colour may find themselves in situations where moral obligations of care (or other reproductive work) become inescapable and personal agency within structure is dislocated or remains interrupted. As such, morality is embedded within traditional structures of care wherein a meeting of care needs of others is privileged and praised before personal needs of

care workers can be expressed. I critique "women's work" and discuss intersectionality with a special focus on racialising, gendering, and classing labouring bodies in more detail in Chapter 3.

I am not aware of literature that describes genderacialisation as I have conceptualized it: as a process that considers complex and multiple subjugating processes of power that structure and shape individual narratives and negotiations of care. To inform processes of genderacialisation, I move next to a critique of politics of genderacialised care as the starting point for this research (Chapter 2). This improvised critical narrative inquiry then moves to illuminate the anticategorical intersectionality of racialisation, patriarchy, and social stratification as inherently intertwined, experienced, and told by PSW care workers (Chapter 4). Reconceptualising structures of care as genderacialised critiques oppression more broadly in a way that does not seek to maintain only women within systems of care or reduce understanding to a simplification and reduction that categorises different underprivileges (race, class, gender) as a function of specific aspects of identity. In this dissertation, women's complex and embodied stories are represented through body maps of genderace in labours of care (Chapter 5). Then, I reveal genderacialisation in care and substantially develop its understanding by describing how it works to structuring care. Specifically, through narratives of PSWs I shed light on how genderacialisation is at the crux of silencing PSW stories and creating structures where care workers themselves are rendered invisible (Chapter 6). I move to unpack what stories of genderace can teach listeners of racialised women's stories about embodied meanings of seeking worth through labour (Chapter 7). An analysis of stories of genderace allows for depth and complexity when listening to narratives where simultaneous and tangled processes of genderacialisation are pervasive. In the final chapter, I take up theoretical, methodological, and *practical implications for seeing and hearing care stories of genderace, specifically those stories*

of *hope in labour* and *worth through labour* (Chapter 8). In a section that follows my research questions (presented next), I discuss how PSWs are made to be invisible through bodies that labour, which I refer to as labouring bodies.

Purpose and Guiding Research Questions

This dissertation takes up calls made by several authors to expand the care and leisure literature to: (1) understand how care frameworks reflect racialised, gendered, and classed contexts (Cloyes, 2002; Ferdman, 1999; Robinson, 2011); (2) contextualize (anti-)racism discourses "within frameworks that examine social and structural inequalities such as racism, power, ideology, and white hegemony" (Arai & Kivel, 2009, p. 464); (3) describe the "types and range of discrimination" (Floyd, 1998, p. 7) as they affect leisure and care choices and opportunities; and (4) engage diverse methodologies for examining race[7] (Arai & Kivel, 2009). This inquiry, then, does not solely explore race, gender, and class as separate areas of experience or even racialised women's experiences of subjugation or empowerment. Rather, it draws from and illuminates alternative stories using embodied stories of *labouring bodies seeking worth* to see and hear how women of colour are (un)able to wield agency in caring roles within larger socio-economic and political structures.

The purpose of this study is to: (1) reveal how genderacialisation works in social structure and narratives of PSW care in Canada, and (2) create hopeful change-spaces with PSWs where visions of self-care and leisure can be envisioned alongside supported labours of care.

This critical narrative inquiry is guided by the following research questions:

1. How do personal support workers' stories told through body maps take-up, negotiate, or reconceptualise notions of labours of care, self-care, and leisure?

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[7] in welcoming a fourth wave of race and ethnicity research in leisure studies.

2. How do body maps reveal genderacialisation in the structuring of labours of care and navigations of current care practices by PSWs in LTC homes?
3. How do personal support care workers' stories take-up genderace?
4. How are hopes for labours of care, self-care, and leisure storied by PSWs working in LTC homes?
    a. How are these hopes juxtaposed against body maps of current labours of care, self-care, and leisure practices?
    b. How are these hopes juxtaposed against the structuring of care work through genderacialisation?
5. What do PSWs discuss as the implications of personal stories of labours of care, self-care, and leisure practice?
6. What recommendations for change do PSWs recommend in light of their participation? To whom and how do we disseminate this information?

Addressing colourblindness and reduction of stories.

In Canada, where labels of difference are subtle, and acts of discrimination are less pronounced than in other areas of the world (Fleras, 2014), hearing stories of genderace through critical narrative inquiry was crucial to this endeavor. Critical narrative inquiry supports a platform for bringing stories told by women of colour to the fore by questioning expressions of marginalisations in a society that facilitates neoliberal colourblindness. Colourblindness around women's stories essentialises narratives of each racialised woman to be like narratives of care of all other women. Narrative responds to essentialisation by valuing nuances occurring within unique stories of marginalisation to move beyond the limitations of dichotomous or categorical understandings of race, gender, and class in exploring power and negotiations of structure and agency.

Not only is storytelling a historically regarded method by critical race and feminist theorists for critiquing structures of hegemony, locating inequity, and promoting valuable agendas (i.e., anti-racism and anti-sexism) (Delgado & Stefancic, 2012), stories by women of colour function to negotiate and deconstruct grand narratives *within* grand narratives (i.e., from a conglomerate group that experiences marginalisation, like racialised or gendered individuals, for

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example). Stories are one of a kind, situated in distinct social contexts with unique circumstantial

(dis)advantages influenced by racialised, gendered, and classed histories. Each bodily identity is

inextricably tangled with one another as a result of these social processes.

To further support my etymology of genderacialisation, I use narrative methodology as a

means to describe how processes that identify individuals act as power in structure and through

power relations. In grand narratives, subjugation through power takes place in the *fragmentation

of identity*. An 'add-and-stir' approach with discrete categories of identity (i.e., gender + race +

class + ...) reduces individual's identity in grand narratives (i.e., stereotypes of angry women of

colour). A story mosaic created through collective narratives *fragments story* so audience see

many parts of many stories. Collective narratives that tell many parts of many stories, describe

layered identities (i.e., many individuals' stories of gender + race + class + ...) to arrive at

consensus from the fragmentations of many individuals' stories. Counter narratives (a non-

dominant version of a story different from a socially constructed norm) and antenarratives

(stories that live beyond conscious awareness) exist amidst and between the fragmented elements

of story. I describe my use of critical narrative inquiry and the forms of narrative (i.e., grand

narrative, counter narrative, antenarrative) I draw on for this study in Chapter 4.

A part of narrative tradition, antenarratology is a narrative movement through critical

narrative inquiry (as it is inherently critical in its method of critique) that seeks to know what

stories come after history and are held in the body as one's current living story unfolds. In other

words, antenarratives can manifest as pre-emergent stories that live in the body. An antenarrative

is the metaphorical space that considers narrative (i.e., past experience) and living stories (i.e.,

current experience) where possibilities of *what could be* (i.e. future experiences), and what *is* in

the body are sought. Uncovering antenarrative was a meaningful avenue for our collective,

polyvocal work. Antenarrative enabled a knowing beyond individual and collective narratives: enabling audience to see and acknowledge spaces between narratives, situated temporally between present and future, and held in the body as pre-emergent body narratives. It was in these spaces where genderacialisation lived, enacting on individuals in complex and unseen ways, which when brought into focus, enabled a shift in thinking to recognise one's self/body/being.

Thinking about antenarratives as rhizomatically *becoming* allows the process to unpredictably unfold with a freeness to hope and redefine being/story in communion with others. Through antenarrative we can see narratives that lie beneath forces of genderacialisation. Where an anticategorically complex lens of intersectionality in narrative inquiry would highlight the intricate nature of social relationships - which work together to deconstruct and resist traditional conceptions of race, gender, and class interactions (Bhattacharya, 2012; McCall, 2005) situated in society - antenarrative provides a complement and extension by providing insight into narrative of beings that exist apart from structures of genderacialisation. Stories of genderace articulate interpretations of genderacialisation through the body (antenarratives) and each individual story is connected to one another through genderace. Genderace reflects the antenarratives that live in the body apart from structural forces that exist to define it.

For these reasons, I saw narrative inquiry as being most appropriate for hearing and unpacking anti-essentialist narratives told by women of colour to inform genderacialisation. Methodologically, this critical narrative inquiry aligns with the unpacking of genderacialisation as a relational (Glenn, 1992) and embodied construct. With the body brought into focus as subject of genderacialisation, this inquiry begged for creative methods that could tap into hearing stories of the body including body mapping and digital storytelling.

Using Body Mapping and Digital Stories to Unpack Genderacialisation

Sensitisation to genderacialisation was an awakening to how fragmentations of personal identity are made invisible. *Seeing* genderacialisation meant recognising the calluses formed as a result of constructed difference and also how women of colour thrive despite languages and practices of racism, sexism, microaggression, or essentialisation (offences that mute and further reduce pieces of identity prescribed to oneself). By making stories of genderacialised care visible, space is created for shifting dialogue from injustice, through disparity and struggle, to hope and finally to a reflective knowing as a community of what the labouring body is seeking. Through my review of the literature, constructions of care relationships ignored 'the what' yet imparted reminders of difference, servitude, and reinforced narratives of care as an idealised avenue for agency – wherein, agency was ultimately compromised. Here, the ethic of care towards individuals who engage in labours of care did not appear to apply. In these instances, genderacialisation was a process that subjugated and rendered individuals powerless, unless illuminated by individuals who live stories of genderacialisation themselves. That said, it was necessary for this research to take an approach that listened to stories of women engaged in labours of care through their voices. I worked with racialised women who work as PSWs in LTC homes to engage in the consciousness-raising of genderacialisation.

With five participants and myself, this research consisted of two critical narrative methods, body mapping and digital storytelling. To do this, participants engaged in the making of body maps, which are life sized human images that have aspects of people's lives, their bodies, and the world they live in drawn onto the paper body (Gastaldo, Magalhães, Carrasco, & Davy, 2012; Devine, 2008). Stories of everyday life in care were mapped onto one body map, and on a second map, women mapped how they would like to be seen and how they felt care

could look when their bodies were considered in the caring relationship. From these body maps, storyboards were created and then transformed into a digital story. In Chapter 4 and 5, I describe the critical narrative methods of body mapping and digital storytelling in detail.

Following the completion of three workshops (body mapping, storyboarding, and digital story airing, respectively), I analysed counter- and ante-narratives to re-represent women's stories and provide insight into genderacialisation occurring in narratives of care in ways that considers and moves through some politics that structure care to listen to narratives of what the labouring body is seeking. Finally, through our discussions and reflections throughout the process, I attempted to see what was left unseen in embodied narratives and collective reflection through antenarrative. In doing so, I drew genderacialisation into focus by looking at how women situated personal narratives of PSW care work while creating space for stories of hope for transformation in labour. In this inquiry, antenarrative looked beyond critiques of modernity, relevant for understanding genderacialisation as it is situated in capitalist and neoliberal structures, and dialogues through to new stories – stories that were somewhat novel and unreckoned with in the day-to-day realities described by racialised women through the first body map. Antenarrative was able to accomplish this because it simultaneously departs from and adopts criticality to resist and move beyond structures of disempowerment.

It was my strong love for eclectic mediums in representation that drew me to body mapping and digital storytelling. In challenging linearity, I felt many voices and narratives were honoured by quilting pieces of body maps with text, photos, and video. Ely (2007) discusses these multi-modal quiltings as a form of representation called pastiche. With fragmentation and non-cohesiveness being characteristics of antenarrative, storyboarding as a form of pastiche in both the formation of the digital stories and the identification of *worth* an antenarrative of labour

through *hope*. The poetisation of women's spoken reflections also served well to effectively hold space for the emergence of genderacialised antenarratives on labour held in bodies. I discuss the narrative guided analysis of embodied narratives and my creative representations in Chapter 6. I realise my theoretical groundings, lenses, and constructs framing this study are not as simply stated or related. There is an immense amount of complexity that is left unaccounted for here and is merely a starting point for how this inquiry unfolded.

When Heard through Genderace: Hopes for this Critical Narrative Inquiry

When embarking on this research I had several hopes. First, to draw attention to the tension that exists between care, leisure, and personal wellness; socio-economic status mobility; and personal agency for care workers, institutions of care, and other bodies that work to structure care employment. Second, for governments, I hoped this work would be able to increase visibility of systemic challenges in Canada's healthcare system and mobilise change towards equitable and sustainable care practices for PSW care workers. Third, I hoped to demonstrate how women of colour live and work amidst the complex politics of gender, race, and class that structure Canadian care systems and inform and transform the existing ways well-being and requirements for wellness for care workers is conceptualised. Fourth, from better understanding of the ways processes of genderacialisation in care manifest and are talked about by PSWs in Canada, I hoped to inform future work of health care administrators and health care policy developers by outlining strategies towards eliminating stress related to the devaluing of labours of care. Fifth, through doing this research with individuals engaged in care work, I hoped we are challenged to develop deeper and clearer language around narratives of genderace. Sixth, by paradigm shifting through critical theory to alternative ways of listening to complexity in embodied processes of genderacialisation, I hoped processes of genderacialisation would become

visible in care work and the subjugation of racialised women would be acknowledged.

Unpacking an antenarrative of labour through a lens of genderace, with an acknowledgement of

genderacialising processes, contributes a new theoretical lens to hear stories in a way that

maintains richness, nuance, and complexity of beings in their living stories. As a result, I hoped

that new stories of hope, care, and labour would emerge which could critique, resist, and

transform how individuals engaged in labours of care are known. A reflection of learnings and

potential for transformation from this research is presented in Chapter 8.

CHAPTER 2. Politics of Genderacialised Care

Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare (Lorde, 1988, p. 131).

Over the last 50 years, understandings of race have grown in complexity. The focus of critical race discussions ebbed from critical historical analyses of legitimised differences created between racial groups in systems of law (e.g., Derrick Bell's work in Critical Legal Studies) and education (cf., Ladson-Billings, 1998), flowing into identification of racialised patterns, issues, and implications of race in various contexts. This was eventually enriched by the narration of racialised histories by people of colour. This chapter examines how race, gender, and class influence the structuring of systems of care. Drawing from discussions of intersectionality in academic and grey literature, this chapter discusses how race, gender, and class operate to marginalise, silence, and oppress through settings of care. While intercategorical understandings emphasise that distinctions between categories of identity do exist and are conceptually separate, I discuss how other understandings of intra- and anticategorical intersectionality, work to conceptually reframe stratification in ways that politicises genderace more explicitly as we move through and beyond these politics. The eight politics of genderacialised care I highlight in this chapter collectively serve as a benchmark to inform and locate PSWs' stories in larger narratives within Critical Theory. As such, the functions of capitalist production, making of unnatural neoliberal nature, and invisibility through marginalisation shape these politics as metanarratives of sociopolitical culture. These three threads – each serving to fortify deeply embedded class structures – run through each of the politics I describe. Common themes occurring across the politics include the ability for labour to isolate individuals in their roles through strenuous workloads; stratify individuals by relative access to educational, wellness, and other sociopolitical resources (i.e., language proficiency, Canadian work experience, ability to take

time off, etc.); and the maintenance of a profit-focused meritocracy. Each of these processes

maintains structures that contribute to the violence and discrimination that plays out in

capitalism. The eight politics serve to demonstrate and name specific ways inequity occurs at the

forefront of genderacialisation in Canadian front-line care work. The final chapters of this

dissertation will connect back to how inequity and subjugation, as a result of these politics,

manifest through narratives of body.

The Constitution of Canada, the Citizenship Act, and the Canadian Human Rights Act

describe an equality of "rights, powers and privilege" with each citizen of Canada, "subject to

the same obligations, duties and liabilities" (p. 1). In each of these acts, discrimination on the

basis of race, nationality, ethnic origin, or colour is denounced, and access to society's rights,

freedoms, and protection (Minister of Justice Canada, 2015, p. 1) is seemingly ensured. The

preamble of the Canadian Multiculturalism Act, which leans on the Canadian Constitution,

Citizenship Act, and Human Rights Act, also outlines Canada's participation in the International

Convention on the Elimination of All Forms of Racial Discrimination, stating that Canada strives

to achieve the "equality of all Canadians in the economic, social, cultural and political life of

Canada" (Minister of Justice Canada, 2015, p. 2). However, Canadians have largely subverted

and veneered over difference by failing to acknowledge the racialised nature of privilege and

societal marginalisation in various aspects of Canadian nationalism (i.e., government, policies,

national identity, and other beliefs) such as narratives of multiculturalism (Fleras, 2017).

Multiculturalism, according to the Canadian Multiculturalism Act, section 3 part (a),

"reflects the cultural and racial diversity of Canadian society" (p. 4), which promotes the notion

that every individual -- "male and female persons [sic]" -- are equal "under the law and has the

right to the equal protection and benefit of the law without discrimination" (Minister of Justice

Canada, 2015, p. 1). Further, this act assures Canadians that everyone is guaranteed the freedom

of: conscience, religion, thought, belief, opinion, expression, peaceful assembly, and association

(Minister of Justice Canada, 2015, p. 4). With Canadian Constitution and other Canadian Acts,

the Canadian Multiculturalism Act, "aims to preserve and enhance our multicultural heritage of

Canadians" (p. 1) and in doing so, believes that each individual should have equal opportunities

in "mak[ing] the life that the individual wishes to have" as explicitly outlined by the Canadian

Human Rights Act (Minister of Justice Canada, 2015, p. 1). Related to discussions of gender,

race, and class in front-line care work in LTC homes, within the Canadian Multiculturalism Act,

section 2 part (g) states that, "federal institutions shall ensure that Canadians of all origins have

an equal opportunity to obtain employment and advancement in those institutions" (Minister of

Justice Canada, 2015, p. 5). We, as Canadians, are encouraged to project the "multicultural

reality of Canada in their activities in Canada and abroad" (section 5, part 1a, p. 5) and to

assemble a Canadian Multiculturalism Advisory Committee (section 7, part 1, p. 5) to support

the implementation of this Act. Multiculturalism is a protected image that Canadians are to

accept and project in reflecting the ways Canadians engage in discourse on race, creed, culture,

and ethnicity. It suggests that diverse bodies are to be treated equally and accepted as such in

Canada.

Acts are created with the best of intentions, however, what is demonstrated by a closer

read of Canadian legislation is neoliberal language working to promote colourblind perceptions

of equality regardless of race, nationality, ethnicity or gender. Racisms, are *embedded* and

structured through institutions, as "[r]acism is historically anchored and ingrained in dominant

cultures" (Goldberg, 2001 cited in Essed, 2007, p. 234). Multiculturalism blankets diversity in a

way that erases histories of structural inequity, violence, discrimination, and intolerance, where

"from afar, Canada look like a paragon of virtue in managing its race, ethnic, and aboriginal relations" (Fleras, 2017, p. 151). Discounting histories of structural racism in Canada work to reproduce oppression encountered by individuals in aspects of life, like employment, effecting opportunities and resource access for present and future generations. Histories of racism cannot be erased with the adoption of racelessness, multiculturalism, and colourblindness as replacements for acceptance of racialised difference within government Acts and institutional policies (Fleras, 2014).

I draw from a critique of liberalism (Decuir & Dixon, 2004; Delgado & Stefancic, 2012), specifically legal liberalism that promotes the ideology of law neutrality, equal opportunity for all, and application of colourblindness, to frame my understanding of colourblindness. Subscribers of CRT (cf. Delgado & Stefancic, 2012) suggest colourblindness and racelessness overlook histories of subordination and stand in the way of reform by not accounting for systematically created differences to, in turn, dismiss individuals who fall 'outside' of dominant groups. In an attempt to move beyond the past, society uses specific language to un-name histories of racism. Fleras (2014) describes racism as structure by stating that a:

> … post-racial colour-blind society is articulated instead, conveniently ignoring the racialization of its constitutional order, from founding assumptions to foundational principles. In turn, institutions are so racialised in power and privilege that inequities are transmitted from one generation to the next without much disruption to the status quo. Not surprisingly, the system is designed and organized to ensure that even successful racialised minorities confront enormous pressures to conform or excel. The end result is a system both self-perpetuating and resistant to change, and more potent than ever… (p. 50).

If racism is embedded in thought processes and social structures as deep as many believe, then the "ordinary business of society – the routines, practices, and institutions that we rely on to do the world's work – will keep minorities in subordinate positions" (Delgado & Stefancic, 2012, p.

27). Racial, gender, and class blindness is a grand narrative that lends itself to care in the form of the segregation of labour in health care systems. For example, the importance placed on the roles of doctors and nurses largely make these professions visible, allowing PSWs and other care workers to fade into the background, becoming invisible.

In light of the re-packaging of race, the language of divisions that hide and make some forms of care work more precarious than others appears to move further and further away from the ugly idea that systemic racism is still a part of our world today. In considerations of colourblindness, tensions are revealed when structure and agency are brought together. Structure dictates dominant culture, evidenced in the context of care. For example, to care for others before self is moral and a noble act and, as a result, personal care for self is often compromised (Robinson, 2011), reinforcing society's valuation of self-sacrifice for the collective good. I feel it is necessary to consider how processes of racialisation, prescribed gender roles, and class positioning influence roles that women of colour play in care today. What is seen through the politics of genderacialised care is that despite the adoption of multiculturalism into our everyday vernacular, it is not enough to illuminate racialisation, misogyny, socioeconomic disparities, or the perils of colourblindness faced through participation in labours of care. I hope to illustrate systemic deficiencies of care systems by describing the following eight politics of care that contextualize labours of care in LTC homes:

- Politic one - recognizes the classed nature of PSW labour as reproductive labour structured in poverty, in which women of colour are responsible for care described in literature to be "less skilled" and moreover, "less respected" than care provided in acute settings.
- Politic two - reveals the many ways individuals navigate confusing systems for one to demonstrate proficiency in PSW work in a LTC home.
- Politic three - reveals the systematic undervaluing of health care work and visible over-representation of racialised women who work as PSWs in the labour of care, compared to other professions.

- Politic four – describes how ageism contributes to the stigmatised nature of care in LTC homes, rendering PSW care to be less visible in the health care sector.
- Politic five – explores stressed labour conditions of PSW care workers in LTC homes and invisibilities of precarious work
- Politic six – speaks to the systematic inequality within structures that maintain transnationalisation of care work wherein divisions of the labour of care are not only distinguished by privileged nation states, but larger genderacialised systems that dictate socioeconomic privilege (e.g., cultural expectations).
- Politic seven – explores the underwhelming response to change the nature of care leading to stress, burnout, and invisibility in front-line PSW care positions and perpetuating the likelihood of poverty, and putting self-care at risk challenging one's ability to tend to individual well-being.
- Politic eight – explores the impact stratification has on PSW labour of care and its subsequent effect on time outside of work, rendering dedicated leisure and self-care time ultimately out of reach for individuals caught in complex structures of PSW labour.

I organised these politics intentionally to reflect the movement of theories and frameworks from which I borrow. I describe politics in an order that (I see) best suits the lens(es) that characterise the literature that describe these care dynamics. Politic one sets the tone for overall systemic blindness towards individuals who, from the outset, are marginalised by the feminization and racialisation of poverty within a capitalist society. Politics two, three, and four speak through a critical race and/or critical race feminist perspective wherein women, and women of colour specifically, move into roles of precarious and undervalued care work through processes of racialisation, gendering, classing, and notions of "women's work." Politics five, six, and seven describe the intersectional ways reproductive work are perpetuated and consequences of systemic invisibility on self in care. Lastly politic eight, describes how an examination of leisure in welfare and self-care can create spaces where leisure and self can be communally reconceptualised and restored in contexts of care work to move beyond systemic –isms that define and confine and identity silos on which these –isms are based.

Politic 1 – Racialising and Gendering Oppressive Reproductive Labour

To outline the ways effects of the past maintain perceptions of caring roles in public

spheres of care today, I draw on the feminist concept of reproductive labour as described by

Glenn (1992):

> The term social reproduction is used by feminist scholars to refer to the array of
> activities and relationships involved in maintaining people both on a daily basis and
> intergenerationally. Reproductive labour includes activities such as purchasing
> household goods, preparing and serving food, laundering, and repairing clothing,
> maintaining furnishings and appliances, socializing children, providing care and
> emotional support for adults, and maintaining kin and community ties (p. 1).

Both women and men engage in production, however, reproductive labour (including

biologically deterministic notion that women are required to care out of necessity), mostly takes

place in the home and is more often than not considered to be women's work (Glenn, 1985). This

reduction of gender privileges men's work as predominately outside the home. Early in the

American (and presumably Canadian) industrial period, women of colour worked as servants,

engaging in reproductive labour for white families (Glenn, 1985). In histories of classed labour,

white women were given more privilege or desired forms of care work (i.e., administrative,

skilled or specialized reproductive work), while women of colour were left to tend to

undesirable, 'dirty' work such as cooking, cleaning, light repairs and other maintenance of the

home (Glenn, 1985). Though immigrant white women were also employed to perform similar

reproductive labour roles, "the dirtiest and most arduous tasks" (Glenn, 1985, p. 104) were often

given to black servants. Glenn (1985) comments that, "the situation of white women has always

depended on the situation of women of colour" (p. 105). Understandings of white womanhood

are often cast in contrast to understandings of racialised women (Palmer, 1983; Shaw, 2001).

Similar to gender reductions made to distinguish productive and reproductive work between men

and women, gender and class differentiations occurred to further fragment identities and privilege white women's labour within the home.

Divergences between racialised women from white counterparts persisted as work moved outside of the home. White women remained at the top of the hierarchy, followed by white immigrants, and racial ethnic women were often the last to be considered (Glenn, 1985): "as members of colonized minorities, their definition as laborers in production took precedence over their domestic roles" (Glenn, 1985, p. 102). Specifically, duties of care and housework needs of others, particularly individuals identifying with privileged racial and class statuses were prioritized, as there was a: "lack of consideration for [racialised women's own] domestic functions" (Glenn, 1985, p. 102). Although reproductive work was necessary to maintain the labour force in the public sphere (predominantly better-earning, more respected, men's work) to best secure welfare of families in the private sphere, it was often racialised families who were not given the same opportunities to nurture productive workers to secure welfare of their own families in the same way. Women of colour were responsible for sacrificing care for themselves and kin to care for more privileged others. With domestic care roles still largely presumed to be the function of women, gender differences would continue to dictate girls and women as, "the 'default' givers of care when a situation [arose]" (Tronto, 2013, p. 107). Women engaging in reproductive work roles that mirror care work done in the home often have lower job status, are poorly paid, and have much less employment security, which indirectly leads to an increase in vulnerability to poverty (Evans, 1991; Ostaszkiewicz, O'connell, & Dunning, 2016). Partially a result of this divide, women of colour and children are caught in cycles of poverty, marginalisation, and invisibility.

As reproductive labour evolved into the public health sphere, divisions were maintained within care labour between PSW work and more specialised, privileged areas of care in new and subtle ways. Glenn (1985) was foundational in illuminating the complexity of multiple oppressions in her article, *Racial Ethnic Women's Labour: The Intersection of race, gender, and class oppression* and in critiquing the nature of hegemony faced by women in institutions. She discussed how histories of reproductive work have moved to public spaces, like LTC homes, while continuing traditional gender roles at home (Glenn, 1985). Although efforts were made by health care leaders in Canada to create stricter guidelines around the professionalisation of PSWs and the nature of care work (i.e., resident-staff ratios and controlled acts), racialised women who pursue personal support work continue to be left behind white women in the workforce (Glenn, 1992).

Racialised women in reproductive caring roles persist today in a more contemporary industrial period, a knowledge economy, where economic capital interests consume more and more of everyday life activities. As a result, women with post-secondary education and good job prospects (Kofman, 2007) continue to be subject to societal pressures to maintain reproductive work in both their private lives and through public service. Specific to personal support work, two Ontario working groups[8] describe PSWs to be responsible for: home management (i.e., shopping, house cleaning, and meal preparation); personal care (i.e., dressing, mobility, and other routines of daily living); family responsibilities (including care of children); and social and recreational activities (Personal Support Network of Ontario [PSNO], 2014). This list of roles PSWs may be responsible for, however, becomes contested when working in a LTC home

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[8] A role and scope of practice for PSWs in Ontario resulted from collaboration between the Personal Support Network of Ontario (PSNO) and the Ontario Community Support Association (OCSA) in 1994.

environment as many of these activities fall into scopes of practices of various other care team members or family members (i.e., food preparation, home management, and care of family members) (HPRAC, 2006).

PSW work is thought of as, "undervalued and assumed to require very little skill" (Women and Health Care Reform, 2009, p. 3). Despite the essential tasks PSWs engage in, the PSW field of practice is unregulated and individuals who identify as PSWs are frequently referred to as "non-professionals" (Canadian Research Network for Care in the Community [CRNCC] & PSNO, 2009, p. 1; Estabrooks, et al., 2015). In a skill-divided workforce, statistics on "ancillary workers" (Women and Health Care Reform, 2009, p. 5) through Statistics Canada are often unreliable; no one standard is agreed on so employers will use a number of different labels to classify work in which PSWs engage. A lack of a unified role description of PSW work makes PSWs more susceptible to being invisible and isolated from benefits skilled care workers receive, as much value is placed in these numbers for policy makers and decision makers who allocate funds and other resources. The division of labour of care for PSWs is also highlighted by significantly lower pay scales and a greater tendency to hire for part-time, contract, or temporary employees over full-time workers to minimize payouts for health benefits, parental-leave, long-term disability benefits, and pensions (Diamond, 1995; Women and Health Care Reform, 2009). Evans (1991) articulates the trend of tentative labour:

> Dual labour market theory has sought to understand the processes at work in the labour market that both create barriers between "good" jobs and "bad" jobs and consign particular groups, notably women and visible minorities, to the lowest paid and least stable employment (p. 176).

According to Women and Health Care Reform (2009), "in 2000, a woman working as a home support or personal care worker in Canada had average annual earnings of $16,008" (p. 10). Further in 2009 the Women and Health Care Reform reported,

> In 2005 a single person living in a large Canadian city needed an income of $20,778 and a single parent of two small children needed to earn $27,630 to be above the poverty line… [Neither a] home support worker nor a personal care worker earn[s] enough to support a family above the poverty line (p. 10).

In 2009, of personal care and home support workers, 41.3% were women who worked part-time (Women and Health Care Reform, 2009) with an over-representation of PSW roles being taken up by women of colour (Evans, 1990; Glenn, 1985, 1992; Robinson, 2011). Notwithstanding the normalcy of labour inequities and devaluation of care workers in today's care environment, numerous reports (Estabooks et al., 2015; Canadian Union of Public Employees [CUPE] & Ontario Council of Hospital Unions [OCHU], 2012; CRNCC, 2008; St. Elizabeth Health Care, 2008; Women and Health Care Reform, 2009) have advocated that more PSWs are needed in LTC homes to improve working conditions and resident care, and will continue to be needed as the demand for care and the complexity of care required increases. Structures supporting the movement of PSWs into LTC homes, and maintenance of PSWs in LTC as the benchmark, have been and continue to be overlooked. Despite (or in light of) an increased need for PSWs, the current state of neoliberalism, undervaluing of PSW labour, and underfunding in the Canadian health care system leads me to believe that rate of pay, lack of benefits and full-time employment for PSWs will remain unchanged. The emphasis on capitalist production structures the nature in which women of colour engage in labours of care. Structured in capitalism, movement of care into the cash nexus maintains that acts of care labour are paid at the lowest possible wage (Stacey, 2005). Downloading labours of care to individual families continues to perpetuate allowances for individuals with access to economic capital. This reemergence of this neoliberal public-to-private dynamic of caring reinforces class disparities, especially when care was offered primarily in family dwellings. Invisibility is, thus, maintained through a structuring of

marginalisation in the lack of employment mobility away from care professions and a normalisation of racialised women as "carers."

Politic 2 – Lack of Clear, Accessible Information Creates a Roadblock to PSW Readiness

The lack of attention or importance given to foster and protect PSWs is reflected in the lack of clarity and accessibility to information about education, formal governing bodies, and regulation. PSWs are expected to be flexible and adapt to a range of care environments, which makes PSWs both valuable to the various demands of LTC work, yet vulnerable to unsustainable work practices that impact personal well-being. In this section, I discuss the breadth of structures and systems a prospective PSW would need to navigate to work as a PSW including: education and education required, bodies of governance and status of professional regulation, and employment avenues and trends.

Education.

Routes to PSW certification have caveats and vary across Canada in their educational requirements for individuals intending to work in LTC homes. In this section, I largely use Ontario as an example to convey the diversity of PSW educational standards. Until changes to the LTC Homes Act in 2011, PSWs did not need a certificate (or any specified training) to work as a PSW in Ontario (CRNCC & PSNO, 2009). Though, in 2003 approximately 63 per cent of PSWs had either a post-secondary certificate or diploma (Statistics Canada, 2004). It is interesting that despite the high rate of post-secondary education, PSWs engage in work that is undervalued and paid less than counterparts with similar education in a profession that lacks protection and recognised governance. The National Association of Certified Caregivers/Personal Support Workers (NACCPSW), a group working towards one national educational standard, describes that the Ontario standard for PSW educational programs

replaces, "Health Care Aide, Home Support Worker Levels I, II and III, Personal Attendant and Respite Worker training programs" (NACCPSW, 2013). Though, to this day, one national standard does not exist (Berta, Laporte, Deber, Baumann, & Gamble, 2013). A joint report by CUPE and the OCHU on the education standards in Ontario was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in Ontario in 2012 and the contents of this report summarised three avenues through which individuals can achieve PSW certification: (1) community colleges; (2) private career colleges; and (3) boards of education.

Community colleges.

PSW training provided by Ontario Colleges of Applied Arts and Technology (CAATs) through community colleges (like Centennial, George Brown, Georgian, Conestoga, for example) is set by a standard developed in 2005 by the Ministry of Training, Colleges, and Universities (MTCU). There are 770 required hours (386 lab/practicum hours and 384 classroom/theory hours) for these PSW programs (CUPE & OCHU, 2012). Community colleges are one clear route an individual can take if they wish to be employed by an Ontario LTC home as a PSW.

In 2006, 121 private career colleges offered PSW programs (HPRAC, 2006). As of 2011, all private colleges offering a PSW program (Everest [closed 2015], Trillium, TriOS, for example) must adhere to standards of either the National Association of Career Colleges (NACC) (who developed a curriculum in 1997 with MOHLTC) or Ontario Community Support Association (OSCA), making graduates following the implementation of this policy eligible to work in LTC homes following completion of their program (consisting of 640 total required hours, 355 lab/practicum hours and 384 classroom/theory hours) (CUPE & OCHU, 2012). Before 2011, however, an individual wanting to work in a LTC home after having completed a

PSW program would have had to ensure their private career college's curriculum adhered to either the NACC standards or the OCSA standards. A disclaimer should have been provided to prospective students if the PSW curriculum did not support these standards (CUPE & OCHU, 2012).

Boards of education.

PSW programs provided through Adult Continuing Education programs are intended for individuals wanting to complete a high school diploma through a board of education (i.e., Toronto District School Board, Waterloo Catholic District School Board, for example) (HPRAC, 2006; CUPE & OCHU, 2012). The Ontario Ministry of Training, Colleges, and Universities (MTCU) standards or OSCA standards are used in school boards for administering PSW programs (consisting of 810 total hours, 270 lab/practicum and 540 classroom/theory hours) (CUPE & OCHU, 2012) thereby making them eligible for work in a LTC home.

Prior to the implementation of changes to the LTC Home Act (2011) for mandatory certification of all newly hired PSWs, OSCA standards in 1997, the MTCU standards in 2005, and the shift to NACC or OSCA standards in 2011 by private career colleges, it is not clear how PSWs gained employment in LTC homes or to what standard PSWs working in LTC homes were trained. A 2009 report prepared by the Canadian Research Network for Care in the Community (CRNCC) and Personal Support Network of Ontario (PSNO) (prior to the implementation of a majority of standards described above) identified that in a non-randomised sample of 364 PSWs surveyed across Ontario, 64 percent of PSWs working at that time received their training through boards of education or private career colleges (CRNCC & PSNO, 2009) and that of the 7000 PSWs trained annually that only 20 percent of graduates were trained in MTCU recognized programs (CRNCC & PSNO, 2009). Stakeholders have also voiced support

for a decision to standardize a PSW curriculum towards a better understanding of capabilities

and responsibilities of PSWs, especially in regard to delegating controlled acts (HPRAC, 2006).

PSW education in Nova Scotia, British Columbia, and Saskatchewan.

As mentioned, PSW education standards vary across Canada (CRNCC & PSNO, 2009).

Before describing the PSW workforce, I hope to briefly summarise positions on PSW

educational standardization in provinces of Nova Scotia, British Columbia, and Saskatchewan

here. I chose these provinces specifically because there is a lack of comprehensive PSW

educational data for other provinces found outside of the CRNCC and PSNO report released in

2009. In Nova Scotia, the PSW-equivalent Continuing Care Assistant (CCA) and Personal Care

Worker (PCA) programs require a minimum of 840 hours (330 lab/practicum hours and 510 of

classroom theory) (Health Association Nova Scotia [HANS], 2009). These programs are offered

by community colleges, licensed LTC homes, home support agencies, private career colleges,

and through Nova Scotia Work Activity programs (HANS, 2009). On the other side of country in

British Columbia, a standardised curriculum for the Health Care Assistant program was

implemented in 2008. Though the program ranges in length (between 24 and 38 weeks) and the

PSW registry in British Columbia continues to observe progress of the one standardised training

program (CUPE & OCHU, 2012). According to a study conducted by the Home Care/Special

Care Aide Sector Partnership Steering Committee in 2007[9], Saskatchewan's mandatory

requirements for graduating from a PSW-equivalent program from one of four institutions

ranged from 683 to 930 learning hours. The division of these hours across classroom/theory and

practicum/lab hours also varied from institution to institution. However, the Saskatchewan

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[9] Funded by the Saskatchewan Association of Licensed Practical Nurses

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Institute of Applied Science and Technology is lobbying to develop a standard program throughout the province (Sawchuk, 2007).

While developing this overview of PSW training/education, it was clear that no comprehensive information on PSW education existed. Information that did exist was fragmented and difficult for the public to access. When available, the information is confusing and often sends mixed messages about standards of education and routes to LTC home care work. This is particularly true for prospective PSWs who seek to inform their decisions on how to better qualify themselves for a position with better wages as a PSW through employment in LTC homes (as opposed to individuals employed through personal agencies or as a private PSW by a family).

According to CUPE and OCHU, who advocates for one educational standard in Ontario, the MOHLTC is currently exploring the standardisation of PSW educational standards. However, a number of challenges exist in the rolling out of a standardised curriculum (CUPE & OCHU, 2012). A primary challenge would be how to address additional training needs required for adequate practice in LTC home environments with residents who have increasingly acute and complex medical challenges. CUPE and OCHU (2012) identify funding, PLAR (Prior Learning Assessment and Recognition) and mentoring, apprenticeship programs, and compliance of educational institutions as challenges for the implementation of a PSW educational standard. On top of these considerations, additional curriculum is needed to better prepare PSWs for the diverse environments they may be asked to work. Some suggestions for these additional PSW training areas include: communication skills, needs of older adults, abuse, dementia, and palliative care (Smith, 2003); complex care requirements including dementia and medication

(Canadian Nurses Association [CNA], 2008); and teamwork and literacy skills, information on people living with disabilities; and Alzheimer's and related dementias (HPRAC, 2006).

Unless otherwise stated, all PSW programs through community colleges, private career colleges, and boards of education can, currently (and as of 2011), potentially lead to LTC home employment. With confusing standards and so many providers of PSW education, employers are left to decide whose program best fits their organisations' needs. This may mean opting for education that is affordable for most, but least able to generate reasonable wages (CUPE & OCHU, 2012). Until recent efforts to ensure there was some accountability by various education providers, this risky business of PSW education has and continues to maintain class disparities by making the quickest and cheapest curriculum standards readily accessible to individuals in already marginalised social positions. In particular, motives for profits in LTC home continue to favour PSWs with less training for cheaper care labour (CUPE & OCHU, 2012). To make PSW education more precarious, a report by CUPE and OCHU (2012) maintains that inconsistent standards across the province of Ontario and across Canada put residents and PSWs who work in LTC homes at risk. Unbeknownst to many, until *one* educational standard is decided on in Ontario and readily transferrable between provinces, the three educational standards will remain in Ontario and will continue to affect the career fates of PSW graduates who seek to be employed in *relatively* reliable work in a LTC home.

Governing bodies, regulation, and workforce challenges.

Health Canada does not recognise personal service work as a unique profession (CUPE & OCHU, 2012); therefore, accurate data on PSWs in Canada is difficult to come by. I was challenged to locate dedicated literature that spoke to governing bodies for PSWs' registration and regulation. In this section, I highlight literature on "unregulated care providers" as described

by the College of Nurses of Ontario (2013) and some of the concerns brought forward by

advocates of PSWs who support fair work practices in LTC homes. Failure to recognise personal

service work as a unique occupation by Canadian or provincial governments (College of Nurses,

2013) contribute to the invisibility of individuals who take up care work as PSWs. Lack of

recognition (through better wages, benefits, opportunities for advancement, etc.) devalues

personal support work and similar forms of care, maintains divisions between classes of workers,

contributes to the continued subjugation of racialised women in care, and ensures reproductive

labour is persistently taken up by marginalised women.

Like PSW education, there is much obscurity and variation across Canada with respect to

governance, regulation, and registration. Each province has multiple reports regarding progress

toward regulation and status of registration. What *is* prominent in reports and the academic

literature, however, are the voices of various organisations and advocacy groups that write to

various levels of government to make the case for a scope of practice for PSWs, better wages,

and overall attention to protection of PSWs in the workplace. I have cited many of these

organizations (CUPE, St. Elizabeth Health Care, OCHU, PSNO, to name a few) throughout this

chapter.

With regards to governance, there is no sole regulatory organisation responsible for

overseeing PSW care. Often these organisations are founded by passionate PSWs willing to take

on roles as organisers who take initiative to set up websites and forums to foster communication

among PSWs working in a given region. This may be due to the roles hiring organisations

(individual LTC homes) play in managing additional training, setting standards of practice,

managing union affiliations, and disciplinary action. There are few independent studies that

speak to the registration process in some provinces; however, to my knowledge no literature

exists to indicate that regulation is being actively pursued for PSWs anywhere in Canada (though

this is not for a lack of trying – c.f. Canadian Broadcasting Corporation [CBC], 2010). Whether

through regulation or registration, legitimation or some other form of recognition is needed to

protect PSWs and to oversee PSW care. Without such measures, PSWs (especially individuals

who work in non-publically funded LTC homes) are often put in unpredictable situations in their

employment.

In one paper on unregulated PSWs in LTC homes, Estabrooks and colleagues (2015)

reviewed the progress of the registration process for PSWs and health care workers with similar

roles in Canada. They report that although it is not mandatory, registration processes exist for

PSWs who work in LTC homes in Ontario and British Columbia and may exist in other

provinces (Quebec, Alberta, Nova Scotia) (Estabrooks, et al., 2015). In settings where

registration is necessary, characteristics submitted by each registrant also varies from province to

province. For example, PSWs who work in home care settings in Ontario are required to be part

of the PSW registry (developed in 2012), however, it is optional for all other settings, for now.

There are plans to have mandatory registration for PSWs who work in LTC homes (Estabooks et

al, 2015). Since writing this chapter, the Government of Ontario announced on September 29,

2017 that a PSW registry is set to launch January of 2018 through the Michener Institute

(MOHLTC, 2017), however, local organisations like OPSWA are furious that they were not

involved in this decision. The Ontario government's first attempt at a registry in 2012 had major

deficiencies including inconsistent background checks (Zlomislic, 2016). Former OPSWA

president, who ran the organisation as a volunteer, comments that the registry "was a huge

failure and now they are bringing back the same thing again, using yet another organization that

has nothing to do with PSWs" (Zarzour, 2017). No further information about the Ontario new PSW registry is available to date.

In British Columbia, Quebec, and Nova Scotia there are minimum educational requirements for being able to be part of the registry, but not for Alberta (Estabooks et al, 2015). Each of the four provinces mentioned keep PSW data on demographic and contact information; workforce employment, attrition, and mobility; and educational background/certification (Estabooks et al, 2015). There is an annual cost for being part of the registry in Quebec ($100) and Nova Scotia ($57.50) and the benefits of registration include: online visibility to employers and employer and public verification of registration (Estabooks et al, 2015). Also reported on the PSW registries, which varies from province to province, are incidences of alleged abuse and opportunities for professional development for PSWs (Estabooks et al, 2015). Quebec is the only province that provides a collective/group insurance plan with registration (Estabooks et al, 2015). With the complex and intimate nature of PSW care, adequate training and protection is necessary for protection of residents, PSWs, and employers. Without standard training and processes in place, care becomes risky and places all parties involved in vulnerable situations.

PSW education is sold as a quick, fast, and is perceived by some as an easy way to attain skills and training for a practical career. Capitalist production creates a system where educational institutions have much to profit from greater enrolment numbers and shorter programs, like PSW certificates. Attaining PSW preparedness requires careful consideration of the many avenues for PSW education. As exemplified by bogus advertising for PSW programs (e.g., promises of NACC recognised exam preparedness[10] [there is no recognised national exam that unifies PSW education] or ability to work in LTC homes upon graduation) and even the closure of private

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[10] National Association of Career Colleges (NACC) – PSW program http://nacc.ca/personal-support-worker-2/?

colleges offering PSW programs (e.g., Everest), the selection of an inadequate PSW program can be quite dubious. The increasing amount of private colleges offering PSW training paired with the lack of support to assist women in finding a program that, not only adheres to Ministry standards, but also fits with one's future goals and current skills contributes to the expectations of self-direction within complex systems of education. Limited access to comprehensive information on PSW programs offered, transferability of qualifications between workplaces, and requirements across different provinces/territories makes PSW education a tricky endeavor. Without supports for finding secure employment that recognises or translates previously acquired training (in the case of new Canadians), the accelerated PSW certificate appeals to women who require work quickly to ensure basic needs can be afforded. Fast, cost effective training is especially appealing to women of colour who are over represented in PSW roles and experience the feminisation and racialisation of poverty prior to and after entering employment as a PSW.

Politic 3 – Visible Over-Representation and the Labour of Care

Employment being a core issue for racialised women (Frisken & Wallace, 2000) depends on a number of factors including education, economic resources, language, professional credentials, and Canadian work experience (Women and Health Care Reform, 2009). In capitalism, the focus remains on production for financial prosperity. Capitalism privileges individuals who are able-bodied, able to care and provide for themselves, and contribute to a productive workforce. From this perspective, individuals who participate in the labour force and the productive labour they contribute are commoditised. When care is commoditised, divisions of labour are made between public and private organisations leading to perceptions of "better" and "worse" care conditions. Such a system prioritises productive labour ahead of reproductive

labour, creating care situations where the bottom line/profit is hierarchised over safe and sustainable care practices. As LTC homes seek to decrease the cost of care, "bed and body work" (Gubrium, 1975, p. 29) is emphasised and the marginalisation of PSWs becomes invisible.

Gender roles in labours of care continue to be inequitable today (Tronto, 2013) as women are still reported to engage in more direct roles to support caring (Metlife Mature Market Institute, 1999). Taken-for-granted histories of care work by racialised women have shifted to public spheres of care, and most visibly so in developed countries (Kofman, 2007), where racialised women are disproportionately responsible for labours of direct care. Overrepresentation of women of colour in undervalued positions in health care is echoed by a report by the Women and Health Care Reform (2009) called *Hidden Health Care Work and Women*, where women are considered:

> … the overwhelming majority of health care workers employed in nursing homes, residential facilities or private homes. In nursing homes and residential care facilities, 94.0% of the laundry workers, 81.9% of the light duty cleaners, 82.8% of the cooks and 91.9% of the workers in assisting occupations are women. Among those health care workers categorized as visiting homemakers, housekeepers, and personal care workers, 91.5% are women. […] Workers belonging to visible minorities make up 13.4% of the Canadian labour force, but visible minority workers are 19.9% of medical laboratory technicians and 18.5% of the nurses' aides, orderlies, and patient service associates, and 23.5% of dry cleaning and laundry supervisors (p. 7).

Beyond the home front, racialised women work in paid public sectors to provide goods and services reminiscent of forms of reproductive work of the past. In LTC homes, white women are often responsible for white-collar tasks in administration as decision makers or as registered care workers (i.e., RNs), whereas racialised women are providing more direct care (as PSWs/Health Care Aides) or non-direct care roles (i.e., cleaners or food services) (Glenn, 1985). Glenn (1985) argues, that still within these female-typed forms of work, racial stratification is maintained. According to Glenn (1985), "activities as caring for the elderly (old age homes), preparing food

(restaurants and fast food stands), and providing emotional support (counseling services) have

been brought into the cash nexus" (p. 104). Yet, Canada often is applauded for muting

stratifications such as race, gender, and class (Fleras, 2012, 2017) in employment, making it even

more challenging to account for the stresses experienced from sexism and racism in the

workplace. As not one report gives a comprehensive picture of demographics for this group of

workers (Estabrooks et al., 2015), it is difficult to outline summaries with any accuracy.

Separate Canadian studies have gleaned that the PSW workforce is largely composed of

women (>90%), who are on average 46 years old (CRNCC & PSNO, 2009; Morgan, Stewart,

D'Arcy, Forbes, & Lawson, 2005), and that racialised individuals are over-represented in PSW

roles (CRNCC & PSNO, 2009). In Ontario, where individuals of colour accounted for

approximately one-fifth of Ontarians (2.7 million) in 2006, of those employed in PSW care,

racialised individuals made up approximately 42% of this labour force (CRNCC & PSNO,

2009). Chappell and Novak (1992) also reported that about half of PSWs are Canadian-born,

with the estimation of racialised individuals in this work likely to be higher today and likely an

underestimate in Canadian metropolises (Chui & Maheux, 2011). What is clear across bodies of

literature is that the vast majority of PSWs are women, with a large percentage of women in

PSW roles being racialised.

Also clear across bodies of literature, is that perspectives of PSWs are notably absent in

the tellings of PSW experiences, yet form the "backbone" of the growing LTC home sector,

which is proposed to see "notable acceleration by 2015" (Government of Canada, 2013). As

women are a prominent group in the care industry with racialised women accounting for a great

percentage of supportive and direct care positions, racialised women as PSWs are an appropriate

group to be speaking with to describe stories about how PSWs embody stories of care in a Canadian context.

Politic 4 – Ageism Working to Stigmatize LTC Homes and PSW Care

Genderacialisation is fueled and, simultaneously, subverted by the various intersections that encircle care by racialised women. Specifically, systemic ageism is rooted in a meritocracy of productive labour, where individuals living with disabling conditions are marginalised and, in turn, made invisible. Within a stratified LTC home context, residents are made the focus and narratives of care in the caring relationship are often left unheard. As a context for this examination of PSWs, I place special focus on older adult stigma in our communities, and most especially in LTC homes as ageism and aging trends of many Canadians living today perpetuate invisibility of PSWs as a result of care stratification in LTC homes. Further, structures in LTC homes allow for relatively stable employment conditions (i.e., familiarity with a home's structure, procedures, organisational politics, and longer-term relationships with residents, staff, and family members).

The Canadian government allocates more funding to LTC for older adults than other countries part of the Organization for Economic Cooperation and Development (OECD, 2005). One might perceive that as an indicator that Canada is doing well in age relations[11]. Like all nations structured by capitalism, however, the cash nexus politicises and commoditises care in a very real way based on how society perceives productivity and value – both as care workers in LTC and residents living in LTC homes. For example, older adults are discriminated against because of the following stereotypes described by Rowe and Kahn (1998):

old people are sick; cannot learn new things; cannot make lifestyle changes that would matter to physical and cognitive health at that point in life, or that genetics are the most

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[11] "the ways that age serves as a social organizing principle such that different age categories gain identities and power in relation to one another" (Calasanti, 2015, p. 1095).

important predictors; that old people lack sexual energy; and that old people are dependent (p. 11).

Butler described ageism as, "a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender" (Butler, 1969, p. 243). The structuring of ageism in capitalism is bound up in the perceived abilities of one's productivity, (in)ability, and use of societal resources. In this light, Othering occurs when individuals subscribe to the notion that "people become inferior because they have lived a specified number of years" (Hessel & Kuhn, 1977, p. 13). This belief is observed in a number of social norms including age of retirement, child-rearing, and the age at which one should begin 'beautifying' anti-ageing regimens (Hurd Clark, 2011).

Kuhn (1986) discusses how ageism benefits industry most and, in turn, commodifies and marginalises older adults from society through social policy (Estes & Portacolone, 2009). In writings on her talk at the 1986 *Wingspead conference on Disability and Aging*, Kuhn states,

> Ageism, sexism, racism and economic imperialism are grounded in an economic system that oppresses most of us and sharpens the class divisions among us. Our competitive profit-centered society is divided by social class, income, age, race, and education (Kuhn in IHA and WID, 1986, p. 14).

Complimentary to Kuhn's work, Estes (1979) describes three aspects of "the ageing enterprise", specifically that it:

> (1) provides social control by the bureaucrats, the professionals, and the state; (2) promotes power and profits for the experts and private industries; and (3) instantiates dependency-generating treatment of elders through the atomized provision of individual commercial services, in opposition to collective or public solutions for the old and the broader intergenerational society in which they reside" (p. 20).

The ageing enterprise is couched in the notion that old age is in opposition to progress and productivity and as a result, older adults are subject to othering (Hazan, 2002). LTC homes continue to exist as spaces where older adults are made invisible through marginalisation due to

the perception that older adults are no longer productive (Butler, 2006, Hazan, 2002). Due to power relations in favour of individuals who are productive, individuals are meant to feel valued when fuelling the capitalist machine, and thus, older adults are socio-culturally devalued and experience inequalities in distributions of authority, status, and income (Calasanti & Slevin, 2006; Calasanti, 2015). LTC homes not only are spaces of stigma due to ageism, but also contribute to the structuring of private sector profit. Despite perceptions individuals living in LTC homes are unable to participate in the sphere of production, old bodies are relegated by society to become managed by systems of caring. Hazan (2002) writes that the "near-death cannot serve as a symbolic device in representing relevant structures of meanings" (p. 326) and therefore, to preserve modernity, older adults are put "out there" (p. 327) in LTC homes that operate as devices for "statusless" (p. 327) and total institutionalisation. In light of this, LTC homes remain stigmatised places where disease, illness, and death predominate.

A number of authors discuss how older adults are differentially treated by doctors, who essentialise older adults' conditions as related to aging, and treat age itself as a pathology (Calasanti, 2015; Estes & Binney, 1991; Robb, Chen, & Haley, 2002). These ageist discourses with the marginalisation of LTC homes away from "the cosmology of modernity" (Hazan, 2002, p. 327), further stigmatises individuals who live and work in LTC homes. Additionally, reductionist approaches in older adult care in LTC homes, in LTC home research, and in media (mis)representations of LTC homes fuel stereotyping, discrimination, and the dismissal and minimising of older adults who, "are depicted as a figurative ball and chain holding back an otherwise spry collective society" (Rowe &, Kahn, 1998, p. 12). I briefly discuss examples of the ways older adult care in LTC homes, LTC home research, and media promote ageism and subsequently, stigmatise PSW care work in LTC homes.

Older adult care as "dirty work."

Some literature on PSWs in LTC homes describes work with older adults as "dirty" work (Ostaszkiewicz, O'connell, & Dunning, 2016; Stacey, 2005) due to the facilitative nature PSWs play in supporting personal hygiene of older adults. Ageism and the infantilisation of older adults (Gresham, 1976; Neville, 2008; Whitbourne, Culgin, & Cassidy, 1995) largely contribute and perpetuate the notion that older adults lose their abilities to exert control over their bodies (Estes & Binney, 1991; Robb, Chen, & Haley, 2002). This discourse of vulnerability constitutes much of the discrimination older adults face in relation to perceptions of inability in old age. A body that is old and has lost control of mind and body, when compared with idealised versions of productive adult bodies, is de-citizened and becomes a de-civilized body (Elias, 1978; Gilleard & Higgs, 2008). This dissonance is inadequately reflected as 'dirty' in perceptions of caring work with older adults. The notion of "dirty work" here in the context of older adult care resonates with and recapitulates reproductive work described as poor, coloured women's work in Politic 2, but in a way that subjugates older adults as subject to labours of care by racialised women.

Stacey (2005) describes the nature of perceived 'cultural skill' when it comes to "dirty work" in her paper, *finding dignity in dirty work*, wherein black and filipina women in her study specifically acknowledge their ability to do personal care work well. This suggests the attractiveness of specific types of individuals as care persons and having an innate predisposition to care (Hondagneu-Sotelo, 2007; Stacey, 2005). In a 2016 study on incontinence and low-occupational status, PSWs discussed that they were sensitive to their roles being perceived as centered on "addressing residents' hygiene and personal care needs" (Ostaszkiewicz, O'connell, & Dunning, 2016, p. 2533), when registered staff (i.e., RNs, RPNs) had "greater role autonomy and could legitimately spend time interacting with residents in pleasurable activities" (p. 2533).

In the same study, PSWs discussed being negatively affected by low occupational status brought on by care work with older adults and were reinforced of this notion by lower wages when compared to other care members part of the LTC home (Ostaszkiewicz, O'connell, & Dunning, 2016). The perceptions that care labour with older adults is 'dirty' and older adult bodies are treated as the refuse of productive society remain central in the persistence of ageism and stigmisation of LTC homes.

Ageism in research.

Ageism in research is reflective of the ageist views held by society (Bowling, 1999). There is much literature that suggests that through research, the scholarly community reproduces ageist notions that are then translated to care practices with older adults (Wilson, 2001; Kane & Kane, 2005). A number of scholars point out ways ageism is promoted in various fields of research including cardiology (Bowling, 1999), psychology (Schaie, 1988), and nursing (Haight, Christ, & Dias, 1994). As older adults become subject to essentialisations of calendar age (Wilson, 2001) and the resulting stereotypes of unproductivity, socio-economic rights of older adults as citizens are lessened and representativeness of old age are skewed or worse yet, ignored all together. Phillips (1999) writes, "the problem with economic inequality is not just that it constrains the exercise of political rights but that it shapes (and damages) perceptions of fellow citizens" (p. 82). Ageism in research has implications for the ways older adults are perceived, how older adults perceive themselves, and how voices of older adults are listened to or dismissed (Dionigi, 2015). Further, in clinical practice, ageism in research has implications for the ways individuals who work with older adults, like PSWs, are stigmatised and valued less in their work with older adults (Stacey, 2005).

LTC homes and PSWs in the media.

Media portrayals of PSW labour and older adults deepen stigmitisations about LTC home

care. Miller, Tyler, Rozanova, and Mor (2012) describe the ways media plays a role in further

marginalising older adults and individuals with whom they work in America,

> The predominantly negative media reports contribute to the poor public opinion of
> nursing homes and, in turn, of the people who live and work in them. These reports also
> place nursing homes at a competitive disadvantage and may pose challenges to health
> delivery reform, including care integration across settings (p. 760).

According to this paper by Miller and colleagues (2012), the top three themes that were recorded

in their review of LTC home news were quality (57%), financing (33.4%), and negligence/fraud

(28.1%). These messages highlight serious issues in LTC homes conveying LTC is unable to

adequately finance and maintain quality care and LTC home worker support. In Canada, LTC

homes are not immune to criticisms against PSW labour and deficiencies of the LTC home

system. Take for instance the following national headlines selected from three months in 2017

alone:

- 'Why is it taking you so long to die?': Long-term care home treatment horrifies family -
  Incident this week marked 6th serious allegation of abuse against a city-run care home
  since 2015 (http://www.cbc.ca/news/canada/ottawa/peter-d-clark-long-term-care-home-
  abuse-1.4314533) - September 29, 2017
- Support workers in long-term care homes need more training, says expert - Mistreatment
  in long-term care homes a 'systemic' problem, says Council on Aging of Ottawa member
  (http://www.cbc.ca/news/canada/ottawa/long-term-care-stress-ottawa-1.4315684) -
  October 1, 2017
- City councillor doesn't want high-profile incidents to tarnish entire long-term care system
  'I don't want to leave the impression with the public that this is systemic in our homes,'
  Diane Deans says (http://www.cbc.ca/news/canada/ottawa/diane-deans-responds-garry-
  armstrong-long-term-care-1.4246837) - August 17, 2017
- Support worker who punched patient gets 90 days in jail, Jie Xiao pleaded guilty in July
  to one count of assault (http://www.cbc.ca/news/canada/ottawa/jie-xiao-assault-guilty-
  sentencing-ottawa-1.4363754) - October 20, 2017
- Wettlaufer inquiry commission comes to London today, Thursday's meeting in London,
  Ont. is the last of three community meetings ahead of the inquiry
  (http://www.cbc.ca/news/canada/london/london-ontario-wettlaufer-inquiry-meeting-
  1.4361262) – October 19, 2017

- Is government ignoring PSWs and their patients?
  (http://www.cbc.ca/news/canada/ottawa/programs/ontariotoday/is-government-ignoring-psws-and-their-patients-1.4296858) – September 19, 2017

It is these sorts of headlines that call attention to (and, in some ways, reproduce) injustices occurring for older adults and PSWs in LTC homes. The free press facilitates knowing of the growing areas of concern surrounding LTC homes, but also, creates fear and further distrust of a system and PSWs who aim to ensure individuals are supported in old age.

Though strides are being made to shift the discourse of LTC homes as spaces of living and living well (Dupuis & Smale, 2000; Dupuis, 2000; Lopez & Dupuis, 2014), narratives of ageism and conditions that disable are all too commonly tied to LTC homes. So long as LTC homes continue to be places of stigma and invisibility, marginalisation of individuals living and working in LTC homes will persist. Due to ageism, LTC stigmatisation, and a misunderstanding of conditions that disable LTC homes, invisibility and marginalisation of older adults and PSWs be can added to a list of qualities influencing genderacialisation in the scope of LTC home care.

Politic 5 – Labour Force Invisibility: Precarious Conditions and Workplace Stressors

In 2007, Statistics Canada reported that 50 percent of residents living in LTC homes lived in commercially owned homes, 25 percent lived in charitable homes, and another 25 percent lived in public facilities. In 2006 an application for PSW regulation was submitted to George Smitherman, who at the time was, the Ontario Minister of Health and Long-Term Care. The Health Professions Regulatory Advisory Council (HPRAC) outlined the following trends, which continue to pose challenges for PSWs in various care settings:

- increasing demand for services based on growth in absolute numbers of the [older adult] population,
- continuing interest in replacing traditional models of hospital-based care with community-based services,
- increasing acuity of residents in both long-term care homes and clients in

community settings as a result of shorter acute care stays,
- [individual] preferences for aging in place,
- fewer informal caregivers in the home,
- new technologies (2006, p. 5).

Workload pressures and stigma that surrounds PSW care in LTC homes (popularised by current events circulated by news) create multiple systems for a PSW to navigate on a daily basis.

Workplace stressors found in LTC settings described by a number of studies included: workload (overload and underload), physical exhaustion, administration, lack of control, shift work, violence, heavy lifting and lack of benefits/opportunity for education or advancement (Danna & Griffin, 1999; Daly & Szebehely, 2012; Hasson & Arnetz, 2007). Additionally a study of PSWs in the United States reported to have limited access to "benefits such as health insurance coverage, pensions, and paid sick leave or vacation time" (Stone, 2001, p. 1). Welfare for direct-care workers is threatened with such high stress and little control over one's day-to-day work in caring (Karasek & Theorell, 1990). In a report by Statistics Canada (2015a, b, c), the health care sector faced one of the highest amounts of, "days [of work] lost due to illness" in 2014. The employment output from 2014 stated that days lost are higher among women (14.0 days lost) when compared to men (8.6 days lost) (Statistics Canada, 2015a, b, c). Given an understanding of women (and especially racialised women) in roles of reproductive work through care roles, days lost may reflect one outcome of the challenges in health care faced by care workers today. Days lost may illustrate lack of care worker well-being (i.e., burnout, illness, etc.). It is suspected that the prevalence of these challenging working conditions and few self-care opportunities by front-line care workers may be reflected by the "declining enrolment in nursing programs throughout the 1990s" (Pyper, 2004, np). Low nursing enrolment with financial constraints in health care has encouraged hiring of more lower-paid unregulated workers (CNA 1995; Canadian Practical Nurses Association [CPNA], 1999; Registered Nurses

Association of Ontario [RNAO], 1996) in a PSW workforce that is overworked and overstressed (Baumann et al., 2001; Robinson, 2011).

In 2004, Statistics Canada reported that women generally engaged in more part-time work, and that part-time work was much more common among care workers. The trend of precarious work among women is a central manifestation of genderacialisation. One report by the Canadian Research Network of Community Care (CRNCC) with the Personal Support Network of Ontario (PSNO) (2009) suggests that one third of PSWs have multiple jobs and report working in more than one setting. Daly and Szebehely (2012) discuss a "need and a desire for full-time jobs" (p. 141), likely because 45 per cent of Canadian part-time workers they surveyed worked less hours than they preferred. In the 2012 study, Daly and Szebehely report PSWs engaged in "task-specific" (p. 143) and less relational care work, which did not account for residents' needs for social care (Daly & Szebehely, 2012). Canadian care worker participants commented they "wanted time to talk and listen while doing personal care, stating that they wanted '...to be more social and not rushed while caring for residents'" and that they did not "like the feeling of assembly line care" (Daly & Szebehely, 2012, p. 145). One PSW participant in this study suggested that they would enjoy, "[s]itting and chatting to our residents, listening to their concerns and fears and also to their stories, history of their life" (Daly & Szebehely, 2012, p. 145). On average for each 24-hour period, Statistics Canada (2007) reported an average of 4.7 staff-hours per resident per day but states that this amount of time is different from the time care workers actually spent with residents as this estimate includes general services, such as administration and support staff (Daly & Szebehely, 2012). Though PSWs arguably spend the most amount of time with residents, the broader public knows little about how hours are located and the nature of time spend by PSWs with residents.

PSWs carry a bulk of the physical workload in LTC homes and unfortunately, manage

staff-to-resident ratios that are "too low" (St. Elizabeth Health Care, 2008, p. 17). Heavy

workloads strain the ability for meaningful relationships to be developed between residents and

PSWs, creating barriers for relationship-centred care. Direct-care workers are under increasing

pressure as organisations of care are faced with fewer resources for the increasing need for more

complex and specialised care (Estabrooks, et al, 2014; Pyper, 2004). In British Columbia, PSW

staff report that they currently do not have enough time to perform basic necessary duties, like

take vitals and simple dressings (MacKinnon Williams, 2010). Increasing LTC home occupancy

and complexity of residents' health needs within long-term home care (Doupe et al., 2012;

Ikegami, Morris, & Fries, 1997) subsequently demands for more PSW employment (Estabrooks,

2015) and also asks more of individuals currently in PSW positions who already express

significant stresses as a result of engaging in PSW care work (CUPE & OCHU, 2012).

PSWs represent a large portion of the stretched workloads that already exist in the LTC

sector (CUPE & OCHU, 2012) and with needs for resident support in LTC changing, it is vital

that PSWs exercise abilities to use a full scope of PSW practice (CUPE & OCHU, 2012) and

have adequate opportunities for self-care. Projections of older adults requiring more support

through LTC homes mean there is a need to address LTC homes now. LTC are increasingly

complex environments where residents living in LTC care will also require support in

maintaining focus on living well (Lopez & Dupuis, 2014). With these and other pressures and

demands on PSW care roles, sustainability of care worker well-being, staff retention, and quality

of care cannot be guaranteed (Estabrooks, et al, 2015).

Adequate staffing levels are needed to maintain both resident and personal staff well-

being (CUPE, 2009) and required staff increases are necessary to respond effectively to growing

LTC home needs. It is difficult to imagine that mandatory levels of direct care for each resident are only about 3.5 hours per day; however, Harrington (2008) reports that when this level of staffing in a LTC home is achieved, that care quality increases and health conditions leading to resident hospitalisation (i.e., urinary tract infection, congestive heart failure, sepsis, dehydration, etc.) are avoided (Abt Associates for Centers for Medicare & Medicaid Services, 2001). As I explore in a later politic, PSWs are affected by insufficient staffing and incur consistent and ongoing stress from care exhaustion. The emphasis on capitalist production creates circumstances where work is prioritised and "consumers" of care services (i.e., residents and family members) remain the focus of the systems of care labour. Though wellness focused programs for care workers have been studied to stave off emotional exhaustion (Kravits, McAllister-Black, Grant, & Kirk, 2010), other structures like shift work, the racialisation and feminisation of poverty, and a need for efficiency and outcomes demand that workers largely focus on tasks. A lack of benefits for many part-time PSWs further deemphasises mental and physical breaks for wellness through leisure and self-care.

Most discussions around career development, shortages, recruitment, retention, salaries or conditions of work in health care are centered on doctors and nurses (Women and Health Care Reform, 2009). PSWs and related care workers' jobs, "are considered secondary or ancillary and their issues are relegated to the background" (p. 1). Though in recent years, concerns over resident abuse and neglect (Long-term Care Home Task Force Ontario, 2012), improvement of working conditions for staff (Tolson et al., 2011), and attention to LTC home staff recognition and benefits including career development opportunities (Tolson et al., 2011) have been raised about PSW care in LTC homes at the provincial (Long-term Care Home Task Force Ontario, 2012), national (National Advisory Council on Aging, 2005), and international levels (Tolson et

al., 2011). Many authors agree that pressures on PSWs impact individuals who live in LTC

homes and care workers themselves (Daly & Szebehely, 2012; CUPE & OCHU, 2012). Daly and

Szebehely's 2012 study is a cornerstone for beginning to understand the gaps in hearing

experiences of care workers' needs for sustainable work practices and labour inequities that exist

in Canadian LTC homes, shedding light on some realities of care work. Daly and Szebehely

(2012), discuss tensions experienced by care workers in LTC homes:

> …care workers [in this study] expressed their desire to provide good care, but
> resource constraints, the size of the facilities and the way that work is organized
> hampered their intentions. This is particularly the case amongst Canadian care
> workers. If care workers with high ideals can be recruited and are willing to remain
> working, and if the organisation of the services leaves enough time and space for
> workers to provide good quality care, only then can residential care be a welfare
> resource for all three parties involved. […] It is unrealistic to expect that care
> workers will continue to accept the poor working conditions, elevated health risks
> and the low pay associated with care work as it is currently organised. And it is
> indefensible from a social justice perspective to expect that the rewards they get
> from relating to and with the residents will compensate for low pay, exhaustion and
> health problems caused by scarce resources and uncaring organisational principles
> (p. 147).

The predominant focus on resident care in LTC homes stems from care workers being tasked

with personal/moral responsibilities to care for others before self. Despite movements that

consider all persons involved in care experiences, like in the culture change movements

occurring across Canada, emphasis on staff wellness frequently falls short.

The broader public, who receive messages that PSWs are "non-professional," become

wary of direct-care workers as reports of limited and variable training and resources, minimum

education standards, and care ratios become more commonplace (Estabrooks, et al, 2015). The

invisibility through marginalisation lies in the recognition of skills PSWs possess and the failure

to maintain centralised statistics on PSWs to recognise their work and dedicate resources to PSW

labourers. These challenges fail to be attended to by key decision makers impacting needs affected by care work, particularly residents living in LTC homes and individuals who support their care. Recommendations made by Estabrooks et al. (2014) to improve working conditions for PSWs include: mandatory registries for PSWs working in LTC homes in all provinces; compatible training and education across Canada; processes where a portion of public funds are dedicated to ongoing PSW education/training; human resource plans where minimum ratios and quality person-centred care can be outlined; a national discussion on regulation; and special consideration for gender, race, and class. It is difficult to imagine that attention can be paid to issues of inequity in PSW work when work conditions are rendered invisible and identities of individuals are fragmented through subjugative powers that structure care work.

Notwithstanding the various stresses contributing to high turnover in LTC homes for PSWs (Dill, Morgan, & Konrad, 2010), little is told from first-hand account of racialised women as care workers (i.e., PSWs, or similar care workers like Health Care Aides and Nursing Assistants, for example) in LTC homes (Daly & Szebehely, 2012). In 2012, Daly and Szebehely (2012) who published their work on LTC home care work with older adults in Canada reported that "[t]here is no articulation of care workers' working conditions, and the encounter between the care worker and the recipient is rarely linked to the broader social, political and economic context" (p. 139). This suggests that the outcomes of an increasing care labour force within structures of marginalisation are largely unknown. Daly and Szebehely (2012) stated, "[t]his knowledge gap is problematic because it tends to render invisible a large, women-dominated sector of the workforce" (p. 139-140), a central message of this politic. Narratives of women in "ancillary" (Women & Health Care Reform, 2009) care roles are largely silenced in mainstream media. There are a few ethnographies and narrative texts written on the front-line care

experience (c.f. Diamond's [1995] – *Making Gray Gold: Narratives of Nursing Home Care*; Gubrium's [1975] – Living and Dying at Murray Manor; Henderson's & Vesperi's [1995] – The Culture of Long Term Care: Nursing Home Ethnography). The ethnographies that exist examine care roles mostly from an American perspective and none have focused specifically on gendering and racialisation of care workers in Canada.

Politic 6 – Crises of Care[12] in Canada that Maintain Systemic Inequity through Transnationalisation of Care Work.

Globalisation of care is linked to discussions on contemporary states of need for more care in Canada (Browne, & Braun, 2008; Robinson, 2011) as "opportunities" are presented to women of colour to realise a better life through care and service of self to others. In less economically advantaged countries, governed by patriarchal traditions and cultural values as rule, women are faced with few choices in their involvement in familial caring roles. Freedoms around care choices are lessened by capitalist agendas exacerbating pressures for women to contribute through care outside one's personal home. Under these circumstances, women are required to balance responsibilities of others with the care responsibilities for "elderly, infirm, or disabled adults; and acutely or chronically ill family members" (Robinson, 2011, p. 68). According to Robinson (2011), twin trends of urbanisation (i.e., industrial acceleration in "home" countries [of birth] and an increasing number of women working outside of the home in economically advantaged countries) create circumstances where women from disadvantaged families in the Global South are: (1) moved into poor working conditions in their home countries; or (2) seek better lives for themselves and their families by moving into positions of care in different countries. The latter option provides women with a 'choice' for a 'better life.' In

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[12] Robinson, F. (2011) takes a global perspective in discussing a "Crisis of Care and Transnationalization of Care Work" (p. 63).

other words, women with good education and good job prospects, leave their families to care for wealthy families in different countries (Kittay, 2009).

Life in Canada is perceived as better for work than the societies in which women who immigrate are born. Instead individuals migrate to societies where there is a need to renegotiate genderacialised identities and to align with reproductive employment, with many of these roles being in care positions. Female migrant workers from countries like the Philippines, Indonesia, and Sri Lanka significantly outnumbered men (Bakan & Stasiulis, 1997; United Nations Development Fund for Women [UNIFEM], 2005) who enter into care roles as nannies, private care, or domestic support care workers. Where the focus of migration tends to be on caring work, many individuals, mostly women, come as participants in live-in caregiver programs or temporary foreign worker programs with aims to end up in formal care work in LTC homes, hospital, or community settings (Kolawole, 2009).

Rhacel Parreñas, a professor of sociology and gender studies at University of Southern California, writes extensively about the implications of leaving a home country to engage in caring or for domestic labour abroad. In her 2000 paper, she specifically cites filipinas in describing an *international transfer of caretaking,* which is a three-tier transfer of caregiving responsibilities between social classes (Parreñas, 2000). Parreñas (2000) describes how working women in wealthy countries hire filipinas for low-wage care, who in turn hire even lower-wage filipinas in the Philippines to care for families the women 'left behind' who are too poor to migrate. Filipinas in her study describe the pain of family separation (i.e., feelings of loss, guilt, and loneliness), displaced mothering or displaced caretaking (i.e., caring for an individual as if they were a member of the family left 'back home'), and conflicting class mobility (i.e., low-status worker in Western country with higher pay, versus a high-status worker in the Philippines

with lower pay) as some of the experiences of transnational care work. Though women from the

Philippines are only one group of transnational care labourers, Filipinas are highly visible in

caring roles in elder care around the world. International class and social inequities are

perpetuated through transnational caring work. In Canada, research is currently being done

through the Centre for Global Social Policy – Gender, Migration, and the Work of Care (c.f.

http://cgsp.ca/) to address some of the issues faced by women in their migrations for work.

According to UNIFEM (2005), women made up almost 50 percent of the world's 120

million migrants at the beginning of the 21st century. Consistent with misogynist work practices

around the world and over time (i.e., wage gaps between men and women, predominance of men

in positions of power to hire and promote, access to education for men relative to women in

different parts of the world), it is unsurprising that women migrants in "low status" sectors

(Women and Health Care Reform, 2009, p. 9), are likely to have higher qualifications than men

(Dumont, Martin, & Spielvogel, 2007). Individuals who engage in front-line forms of work are

asked to negotiate challenging terrain both personally and professionally, especially difficult for

individuals navigating immigration, and for some, it is only to be placed in job "ghettos" (CUPE

& OCHU, 2012, p. 14). New Canadians navigate a number of challenges in settling, seeking

work, and being gainfully employed in Canada including becoming language-proficient (Duff,

Wong, & Early, 2000), hiring discrimination (Teelucksingh & Galabuzi, 2005), lack of or

barriers to transferability of skills/credentials (Bauder, 2003), as well as potential navigations

of/barriers to access education as described in Politic 2, earlier in this chapter.

Racialised women engaged in reproductive labour continue to be silenced in Canada,

likely due to the "depoliticising of difference" (Fleras, 2014, p. 25) in a multicultural society.

Health care in Canada aligns with and operates according to tradition and is further "legitimated

by ideologies, and institutional practices that [branch from] dominant systems of belief"
(Wilpert, 2003, p. 249). Douglas (1986) describes this institutionalisation of inequity as a, "the
naturalization of social classifications" (p. 48). Invisibility results from the lack of supports
available to support such transitions with few international skills recognised in the immigration
of labour experiences, marginalising individuals through the maintenance of insecurity in
employment from a lack of seniority. Systematic inequity, which "privileges one group of
persons over another on the basis of assumed consensus of rights or abilities of favored
group/class" (Wilpert, 2003, p. 249), is perpetuated by a number a reasons: blindness to
institutional discrimination in Canadian systems of care, the need to cheaply supplement current
care resources to support an aging population, and a neoliberal illusion that LTC home care can
provide the secure employment opportunities one seeks as a new Canadian.

Politic 7 – Invisibility of Stress and Burnout in Caring Work

I pull on the following quote by Hilfiker (1985) to illustrate the complexity of
compromise in caring relationships. He writes, "all of us who attempt to heal the wounds of
others will ourselves be wounded; it is, after all, inherent in the relationship" (Hilfiker, 1985, p.
207). Individuals engaged in caring work, negotiate resources in caring to support and maintain
caring relationships. In pursuing self-reflective and morally integral care practices, supportive
care workers frequently make choices between giving and taking; self-care and other-care; self-
preservation and altruism; and exhaustion and guilt (Skovholt & Trotter-Mathison, 2011).
Sustainment of self by meaningful work is important in care disciplines (Skovholt & Trotter-
Mathison, 2011); however, over time and with reduced ability to care for self, it becomes
increasingly challenging to shield self from burnout, moral distress and residue, stress, and
violence occurring in caring environments. Caring brings with it the potential for stress,

exhaustion, and emotional labour (Benner 1994; Leidner 1999). A study in the United States

conducted by Metlife (1999) reported that of individuals engaged in care who were surveyed:

33% of working women decreased work hours; 29% passed up a job promotion, training or

assignment; 22% took a leave of absence; 20% switched from full-time to part-time

employment; 16% quit their jobs; and 13% retired early as direct or indirect results from caring

activities with older adult family members. For individuals who, in addition to caring at home,

are engaged in caring work with others at work, the "wear and tear" from care activities is

exacerbated. Distress of care work can be impactful over time, transcending environments of

care work to affect other aspects of personal life (if that distinction can even be made with care).

Three broad topics appear in the use-of-self in practice and self-care literature: stress

and/or trauma, exhaustion, and moral distress. According to Todaro-Franceschi (2013), primary

trauma refers to any action or behavior that directly affects a care person (i.e., physical or

psychological harm, violence in the workplace including bullying or subjugation by colleagues).

Secondary trauma (also known as vicarious trauma) occurs when one witnesses or learns of

another's personal suffering (Todaro-Franceschi, 2013), common in workplaces of care

practitioners. Repeated exposure or experiences of primary and/or secondary forms of trauma

can lead to burnout, also commonly known as compassion fatigue (Todaro-Franceschi, 2013;

Skovholt & Trotter-Mathison, 2011; Stamm, 2002). Individuals who experience trauma in their

care work settings and "internalize pain or anguish related to other people" (Todaro-Franceschi,

2013, p. 76) may experience exposure responses including: feeling helpless and hopeless, a sense

that one can never do enough, hypervigilence, diminished creativity, inability to embrace

complexity, minimising, chronic exhaustion/physical ailments, inability to listen/deliberate

avoidance, dissociative moments, sense of persecution, guilt, fear, anger and cynicism, numbing, addictions, and grandiosity related to one's work (Lipsky & Burke, 2009).

Related to secondary trauma are issues of care practice integrity, moral distress and moral residue. Rather than pain experienced by a care person as a result of anguish experienced by another, discomfort occurs within a care person when "there is an inconsistency between one's beliefs and one's actions" (Hardingham, 2004, p. 128). These situations occur when a care person is unable to pursue, "a right course of action" (Jameton, 1984, p. 6) because, "institutional constraints make it nearly impossible" (p. 6). Estabrooks and colleagues (2015) report that although PSWs stated that they find their caring work to be meaningful and purposeful, the same PSWs reported high levels of exhaustion and cynicism, and in turn, were vulnerable to experiencing burnout. Other physical and emotional symptoms tied to caring work stress tied with lack of encouragement and support in the workplace reported by PSWs (nursing aides, health care aides, etc.) include: sleep disturbances (Erikson, Bjorvatn, Bruusgaard, & Knardahl, 2008), pain (Jensen et al., 2006), fatigue (Erikson, 2006), job dissatisfaction, depression, and psychosomatic symptoms (Landsbergis, 1988), and burnout (Shinan-Altman & Cohen, 2009).

Webster and Baylis (2000) describe the notion of moral residue as long lasting and deeply felt, resulting from a care person having compromised moral integrity through the practice of one act and the profession of another. In experiences of moral residue, self is compromised or allowed to be compromised (Webster & Baylis, 2000) resulting in, as is the case with compassion fatigue and burnout, "a chronic lack of self-care" (Todaro-Franceschi, 2013, p. 76.). Care workers who overlook self is troublesome as the most essential activity that supporters of care can do to maintain meaningfully engagement with others is to care for self (Joinson, 1992). Connected to neoliberalism, health has become, not only an individual's responsibility,

but a moral imperative (Mitchell, Dupuis, Kontos, Jonas-Simpson, & Gray (2017, in review).

The inability to adequately support one's own health, or be constrained from facilitating health in

others, creates moral quandaries for PSWs working LTC homes (Mitchell et al., 2017, in

review). Further, as a result of the surveillances that occurs in the home (i.e., measures to ensure

care workers are accountable to their work, LTC homes are accountable to the government, and

LTC homes, residents, and families are protected) PSWs may feel unable or afraid to care in the

ways they feel are right (DeForge, Van Wyk, Hall, & Salmoni, 2011). Ultimately, stresses of

care work extend beyond the walls of the work environment affecting care at home, care for self,

and the ability to engage in self-sustaining activities such as leisure.

All previous discussions considered, demands of caring in LTC homes can aggravate

opportunities for stress and burnout, decreasing time and available energy to support workers'

care for self. Access to welfare and expression of agency are key for mitigating effects of

burnout and stress that stem from persistent pressures in caring work and lack of validation

experienced in workplaces of care (Baines et al., 1991). The final politic will discuss the politics

of leisure in creating spaces for reflecting on one's own welfare and the restoration of self-care

amidst labours of care stresses.

Politic 8 – The Politics of Leisure in Welfare and Self-care

I refer to welfare as the social, education, and health supports (Morrow, Hankivsky, &

Varcoe, 2004) that are accessible to individuals. Maintaining "welfare" may also describe one's

condition of being well and speaks to how one's wellness is maintained by the state (Veenhoven,

2000). In either case, racialised women's welfare – how and by whom it is maintained and what

supports are accessible to women of colour -- is of concern as it relates to mitigating arduous

(Ungerson, 1983), emotionally labourious (Lopez, 2006), and uncertain livelihoods of women in

care work. Therefore, I feel it is important to explore how racialised women's welfare comes into play to support individuals as it relates to their caring roles. This research asked me to do a lot of self-reflection in raising my personal consciousness around what it would mean to explore self in care, self-care, and critically analyse the politics of care that engage with constructions of race, gender, and class.

With the main benchmark of eligibility for social assistance being income, individuals who are supported by and have the most access to government social programs often have little to no employment for supporting the basic needs of life (Veenhoven, 2000). For individuals who live just above the fluctuating poverty line access to government and social programs is constantly threatened. In 2011, the after tax dollar amount to be considered living in poverty for a single adult in Canada was $19,330 (Statistics Canada, 2011). This number jumps to $28,195 (after tax) for an adult with a child under six years of age (Statistics Canada, 2011). With the 2015 announcement that PSWs working in Ontario publically funded LTC homes would be making $16.50 by April 2016 (Government of Ontario, 2015), a PSW at one full-time job would make $30,030 before taxes (calculated at 52 weeks per year, 35 hours/week). This gross amount of earnings means that some social services may not be fully subsidised for LTC home PSWs who work overtime or more than one job, leaving individuals earning a low-wage for a living (with few benefits if any) responsible for paying for some social and medical services out of pocket. An earning wage just above the cut-off line for social supports puts care workers in a double jeopardy situation where social services may not be availed to them and basic costs of living in expensive real estate markets requires higher income. Further, lack of time for self-care, reflection on emotionally heavy caring practices, and ability to take extended periods for rest and

rejuvenation even when ill, not only maintains conditions for burnout and stress but also perpetuates invisibility of the feminisation and racialisation of poverty.

In 1948, in a document endorsed by the United Nations, the Universal-Declaration on Human Rights lists the right to rest and leisure as a human right (Veal, 2015). However, when time and energy beyond caring work are affected, time for leisure engagement and self-care to sustain well caring work is compromised. This politic raises racialised, gendered, and classed assumptions about women's private lives and what time outside of work looks like for people of colour (i.e., tensions that arise with questions like: why don't you just go to the gym and work out? Why don't you just take a long vacation?). A strengths-based perspective to leisure would ask, could leisure be a beacon of light for self-care and wellness in the lives of front-line care workers? The short answer, I believe, is yes and no.

Webber and Williams (2010) describe the need for women to strategise part-time work, home and family responsibilities, and time for self. This, 'gender strategy' (Webber & Williams, 2010) is a result of the desire to remain productive in the workforce while contributing to under-valued care work in the home. Individuals placed outside normative coupled relationships, without support from a spouse or family members, are required to adjust their gender strategy accordingly. To further complicate these matters, Fleras (2017) describes that despite increased racial diversity in the labour force, racialised individuals continue to encounter challenges with securing employment, promotions, and benefits consistent with educational qualifications. With caring centred in these discussions of both work and home, the work and leisure dichotomy does not adequately reflect the experiences of racialised women. These challenges, in addition to considerations of resources required for caring (Chapter 3), keeps leisure at a distance for racialised women.

Colourblindness in Canada positions racialised women as having equitable access to time and space for leisure. Genderacialisation, however, suggests racialised women are faced with far more barriers to leisure. With this discrepancy, some may perceive leisure to be "lacking" or "imbalanced" in lives of racialised women care workers. In effort to decentre work, the field of leisure and recreation has striven to rectify imbalances and barriers to "achieve" some optimal resemblance of leisure-work balance through models and studies on barriers. Though studies on constraints, like access to resources, immigration factors, and discrimination issues in leisure are conceptually useful (c.f., Crawford Stodolska, 2008; Hubbard & Mannell, 2001; Schneider, Shinew, & Fernandez, 2014; Walker & Virden, 2005), some of these efforts are rooted in neoliberal assumptions of capitalist 'have' and 'have not' and do not consider processes that work to stratify individuals away from the white, cis-male, heterosexual, middle-class, able-bodied, middle-aged, educated body through reproductive work. Shinew and Floyd (2005) describe that leisure studies lacks understanding of "the complex nature and multifaceted impact of constraints associated with racial stratification" (p. 40) and I would argue that assumptions and appraisals of Western leisure and the politics and precarity of caring work further complicates an understanding of racialised women's leisure in and beyond care.

I am critical, however, of leisure being an easy-fix for racialised women in such roles. There is a complex interplay of stratification for individuals with non-dominant identities who work in stigmatised settings (i.e., LTC homes), the experience of lack of privilege in their roles (Stacey, 2005), and the invisibility that accompanies PSW contributions to caring work. The discussion of leisure here is not intended to dichotomise leisure and work, rather offer a picture of leisure experiences in the lives of LTC home workers. When I refer to narratives of leisure in this context, I conceptualised leisure as part of embodied stories women held in addition to the

dichotomising perspective that looks at leisure as separate from work. Specifically, I aimed to look at how one is able to engage in leisure with residents and team members or at home to mitigate stresses of care to continue working in care environments. While reviewing the leisure, care, and body studies literature and in working with racialised women through this study, I considered the following questions: How is leisure, broadly defined, impacted by racialised women's experiences of race, gender, and class in LTC home contexts as care workers? What, then, would the forms and fit of leisure look like in caring work lifestyles? Are these forms of leisure restorative? How, through the language of embodiment, do women story the purpose of leisure? I discuss different forms of self-care as 'body work' in a discussion of labouring bodies in Chapter 3 and with women's embodied knowings I revisit leisure in Chapter 7.

I believe that prejudgment and disciplining occurs when individuals perceive how one *should* engage leisure. Well intentioned comments like, "you need a vacation," "you should get out more," or, my favorite, "you should try [insert activity here]." These comments reaffirm the illusion that privilege blinds individuals to see only the preconceived utility of these suggestions for leisure rather connecting it to the larger structures racialised women navigate on a daily basis to be recognised as existing. More often than not, these comments do little to change the day-to-day realities of individuals navigating complex care situations (Deem, 1996) and consequently, place guilt and feelings of judgment on individuals who are unable to easily access, make time, or prioritse specific forms of leisure.

Stormann (1984) describes leisure as an illusion for the everyday worker due to the very nature that leisure exists in an industrial society focused on overconsumption and overspending. As such it is often difficult for individuals who engage in leisure that require time and money to recognise how those forms of leisure is privileged. This discrepancy in perception challenges

ways leisure is engaged in by care workers whose leisure time and activities may be undervalued and trivialised by a consumer culture that is, not only steeped in the maintenance of appearances in leisure norms, but an insistent need to "one up," out do, or be a spectacle. The very definition of leisure in women's lives has been problematised in the leisure literature (Henderson, 1996). Moreover, literature that unpacks negotiations and meanings of leisure constraints in relation to one's social position (Condon, 2005; Klitzing, 2004; Shannon & Shaw, 2005) continues to offer hope that knowing women's leisure is more complex than knowing what work is not. An examination of paid work, unpaid work, family and leisure through feminism has resulted in new theoretical ways of thinking about women leisure (Deem, 1992) and leads me to think about ways the current study can inform even more nuanced understandings of racialised women's leisure.

The purpose of this inquiry is to not only understand, but also reimagine and move towards the restoration of all forms of leisure as essential components to life and living. As a graduate student, recognising disparities in leisure privilege, it is part of my everyday conversational experience. Let's just say that reading bedtime stories, long-weekend camping adventures, and Thanksgiving or Christmas dinners (as holidays often paid my mother time and a half), were not the norm for me growing up. Just like "girls night out," dating, or dinner parties were not the norm for my mom – a woman who worked, both full-time and part-time jobs, schooled part-time, and cared for me.

> I can remember times when my mother's many care responsibilities and leisure intersected. During my summer vacation away from school, when I was too young to be left alone at home, and when she could not afford care for me or could not arrange it quickly enough, I spent my time between 7:00 am and 3:00 pm in the nurses lounge at the hospital where she worked. She and I would have lunch together and over her breaks, she would call friends to see if they could watch me in the afternoon/evening so she could go to school or to her other job. I remember that in her work as a care aide, she was happy, often laughing from "green" jokes shared between her friendly colleagues and patients. Later when mom graduated as a registered

practical nurse (RPN), she no longer needed to take me to work with her. Though from what I can remember, in these playful joking instances, brief phone chats with her friends on her breaks, rushed lunches, and listening to Engelbert Humperdinck in the car on her way to and from work, these moments, however short, constituted much of her leisure.

Acts of leisure can be used as resistance to challenge one's own lack of power, expected roles, and behaviours (Shaw, 2001). In these instances, leisure is used to create space for release in an otherwise chaotic world. With few choices around when and how leisure is created, racialised women in multiple caring roles, can agentically choose how leisure manifests in the context of structure, care work structure, or otherwise. Henderson and Allen (1991) weigh the possibilities and constraints for women within an ethic of care framework based on two assumptions: (1) all individuals are entitled to a quality of leisure life; and (2) many women differ from one another and men regarding how ethic of care influences their leisure. Critiques of the ethic of care framework with respect to women's leisure include: needs (including leisure needs) of the family come before those of self (Henderson & Allen, 1991), focus on family structure through which leisure experiences occur (Horna, 1987), role overload, the belief that leisure in the family context is familiar and easy (Kelly, 1983), and ability to freely choose leisure (Lenskyj, 1988). Leisure through an ethic of care lens can be also be a positive experience in its ability to extend past the context of the family, support friendships between women, and engage women with their families (Henderson & Allen, 1991).

Self-care may come in the form of leisure, as it is a means to reenergize oneself, create space for self, and find balance (Iso-Ahola & Mannell, 2005). For many PSWs who choose to work overtime hours or multiple jobs, more hours are spent supporting care with others instead of attending to leisure and caring for self (Bernard, Phillips, & Chittenden, 2002; Brown & Warner-Smith, 2005). Making decisions around how time for self and leisure fits into the picture is often times difficult and exacerbated with experience of stress and symptoms of burnout.

Many who are made invisible spend more time working (i.e., individuals who are financially underprivileged are likely to be racialised women) or simply do not have time outside of work and other caring responsibilities (Chambers, 1986). As discussed earlier, there is a lack of state welfare for certain wage earners and the responsibility to rejuvenate, recuperate, and maintain health for the body is downloaded to individuals. Given how neoliberalism puts pressures for maintenance of health on individuals as a moral imperative, this can add to pressures and stress experienced by individuals unable to attend to this. With already over-obligated time and other resources, this makes rejuvenation through reflection and leisure difficult. Invisibility through marginalisation occurs by placing self-sustaining social programs, mental health services, and access to rejuvenating activity out of reach due to the demands of work that is also low paying; resulting in time and financial barriers. It is a cycle where in caring disciplines, self-care and leisure are integral for sustaining balance and counteracting stresses and strains associated with caring, but is often inaccessible by supportive care workers (Skovholt & Trotter-Mathison, 2011). Self-care, including leisure, needs to be considered a collective ethical imperative for each person involved in the care relationship. Taking a stand together towards ensuring 'care for all' means that society must privilege all persons involved in the labours of care so that each individual can engage caring as best as possible. Doing so requires systemic critique and attending to a reprioritisation of what is valuable – people over profits.

Looking at leisure and self in care through a lens of genderace has potential to see what lies beyond constraints of neo-liberalist structures and create space to illuminate different ways of knowing self and leisure in care. Doing so can open doorways for the restoration of new stories of self inclusive of leisure in a community of others. Multiple oppressions creating invisibility, exhaustion from stress or burnout, or challenges experienced from demands and

pressures of the workplace transcend caring work: when pressure for use of self in care is high, one's time and ability to engage in leisure for wellness and thus, care for self – is inevitably, at risk.

Many authors have discussed uncertainties around the future of care in Canada including, resource depletion, care worker burnout, and accessibility of care. Among many significant issues (e.g., cost of prescription drugs, access to mental health support, veteran-care, rural care, staff shortages, and access by Canada's indigenous peoples to non-stigmatised care, to name a few), a large demographic of the nation's population, older adults and their families, are requiring more care support in this country. My intent for this research is not to describe how tensions within Canadian LTC home systems of care can be eased by more funds, more staff time, or a transnationalisation of care workers, but to draw attention to the different ways issues in care compete, intersect, and compound upon one another, with insight provided by women of colour employed as PSWs in LTC. It is these stories by women with whom I worked that provide glimpses of processes of genderacialisation at play in care systems today.

CHAPTER 3. Towards Genderacialisation and Genderace informed by Anticategorically Complex Narratives

In this chapter I attempt to move from pre-scribed and systematised constructions of identity, to processes of racialising, gendering, and classing the body, and then to thinking about stories of the labouring body as holding stories of genderace as a result of genderacialising structures. This chapter is not only a nod to histories of understanding, knowing, and critiquing conceptualisations of race/racialising/racialised, gender/gendering/gendered, and class/classing/classed, but also a discussion of bodies that story these marginalising processes. As mentioned in my introduction, genderacialisation and genderace are terms that reflect the complexity of power relations inherent in narratives of invisibility and marginalisation by individuals with intersectional experiences. Knowing processes that function to fragment parts of identity is a first step to departing from pieces of story to see the body through genderacialisation and genderace. In the following section, I outline how existing and imposed race, gender, and class identity categories inform this discussion of genderace and genderacialisation in narratives, and work to resist processes that position individuals into these three specific and narrow categories of identification in society.

Racialising and the Racialised Body

Described predominantly by American authors (cf. W.E.B. Du Bois, Robert E. Park, [German-American] Franz Boas, Mari Matsuda, Patricia Williams, Kimberlé Williams Crenshaw, Michael Omi, Howard Winant, Gloria Ladson-Billings, Angela Harris, and Gloria Jean Watkins, to name a few) and authors from largely outside of Canada (Les Back [UK], Satnam Virdee [UK], Syed Alatas [Singapore]), race is described as an ideology and as biology. Discussions on race also articulate racism as culture, structure, and power in a Canadian context (Fleras, 2014) in effort to resist dominant frameworks for the re-creation of culture, structures,

and power. For example, in Canada, terms like visible minority are systematised to describe racialised individuals who are non-white. When taken literally, away from the context of institution, "visible minority" is unclear and, in its most literal sense, can refer to any form of marginalisation (i.e., disability, religious minority, etc.). Systems have a way of operationalising labels (i.e., race = visual minority) to frame meaning with other notions (i.e., mention of visual minorities = inclusion) without directly addressing its root (i.e., race) and associated histories (i.e., of oppression, subjugation) that accompany the root meaning. Imposition of race labels on individuals together with the operationalisation of such labels in a given system is how I understand racialisation.

Critical race theory (CRT) emerged in response to critical legal studies (CLS) in the US, specifically from the desires of legal scholars to advance law reform agendas (that had stalled in the United States) that would support the over turning of law that perpetuated hidden interests and class domination. Where analyses of racial injustice were not being served by CLS frameworks, early work by Derrick Bell and Alan Freeman responded to the need for new strategies to combat subtle and blatant forms of systematic racism (Yosso & Solórzano, 2006), and subsequently, helped to spur the emergence of CRT in the mid-1970s. CRT hinges on the Gramscian notions of hegemony (Ladson-Billings, 1998) and capacity building to think differently (Gramsci, 1971). CRT helped to inform the way I rethink the roles race play in hegemony and what it means to be on the margins of society because of race. Despite a shift to a more sociologically comprehensive understanding, the illusion of race (Fields, 1990; Omi & Winant, 1994, 2013) plays out through the essentialisation of histories and futures through a lens of panethnicity (Espiritu, 1993). Critical theory works to fundamentally question race as a construct and centralise alternative understandings of race, expressions of race, and experiences

of race. Listening to stories of racialised experiences can illuminate power inequities that can lead to opportunities that create social justice.

Drawing from CLS and education literature, central tenets of CRTs help to inform understandings of genderacialisation. I begin with CRT's identification of racism as an ordinary phenomenon also known as the permanence or normalisation of racism (Bell, 1992; Decuir & Dixon, 2004). Delgado and Stefancic (2012) discuss racism as a naturalised process. Systematised oppression and society's acceptance of racial segregation as a normative and an appropriate way of classifying individuals eventually subverted race into an illusion (Delgado & Stefancic, 2012). Omi and Winant (1993) offer two critiques for the illusionisation of race. First, they believe that longevity of the race concept and effects resulting from race are so significant, that effectively eradicating race as a notion is inconceivable (Omi & Winant, 1993). Race was deeply embedded in the systems in which Eurocentric society is structured, so complexly and intricately so, that the extraction of discrimination would effectively mean a "cognitive de-colonization" (Lee & Lutz, 2005, p. 4) of society and the structures governing it. The second critique involves the impermeability of race in forming identities; "to be raceless is akin to being genderless" (Omi & Winant, 1993, p. 6). Race as an illusion (and its critiques) sit on the cusp of a critical shift towards troubling the function of race entirely and instead shifts to the consideration of race as process of racial formation. Race evidently serves a critical purpose for developing identities, but at what cost and to whom?

The second tenet promotes the notion that racism is largely a product of interest convergence or material determinism (Delgado & Stefancic, 2012). Material determinism is rooted in Marxian beliefs that materialism, politics, and economy drives social processes and, when used in a context of race, refers to the material gain of elite whites and psychic gain of the

working-class (Delgado & Stefancic, 2012; Eyerman, 1981). Law, education, government and other institutions comprising society's systems have been extensively written about as being hegemonic, situated in Eurocentric, white, heteronormative states of power (Delgado & Stefancic, 2012; Lee & Lutz, 2005). McIntosh (1988) discusses how white privilege influences all relationships and processes that form and broker access in her paper called, *Unpacking the Invisible Knapsack*. This "invisible knapsack" of white privilege enables whites to access "special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks" (McIntosh, 1988, p. 1) with few questions if any. Conveniences and privileges for one race group coincide with grand essentialist assumptions for others, leading to both extreme and subtle attitudes or actions (i.e. micro-aggressions), which further oppress specific groups (i.e., systematic oppression through inaccessibility, delegitimised knowledge, perceived cultural ineptitude). These privileges have been constructed on the cruxes of exclusion and unaccepted science.

A third tenet describes the construction of race as a social phenomenon (Delgado & Stefancic, 2012). Evolutions of race have not made it any easier to understand race as it exists in Canada in the present time because, as Lee and Lutz (2005) write, "accepted terms and concepts of race are problematic, because meanings attached to words form a system of representation about people that comprise racial ideologies" (p. 4). This social construction thesis is based on the notion that race is a product of social thoughts and relations (Delgado & Stefancic, 2012). These formations of race, based on typified (i.e., constructed) understandings, are embedded in common language and formal systems, reinforcing processes for fixing race as a framework for othering (Lee & Lutz, 2005), systematic discrimination, and reproducing oppressive forces pervasive in education, government, law, health care, places of employment, and beyond. To

silence and normalise othering in everyday language, identity categories like race are discussed

under different guises to maintain the interests of a certain few. Neoliberal language advances

the notion that individuals are equal – with equal rights, privileges and opportunities – and has

the power to provide access to some individuals free from discrimination, while structures that

stratify are largely subverted from public scrutiny. This colourblindness sets the stage for

essentialisation, which necessitates identification. Identification maintains the need to

differentiate and categorise. This paradox -- one that subverts race and yet demands its

differentiation -- demands an approach that neither makes individuals invisible, nor a spectacle.

Rather seeing race requires an approach that anticategorically recognises socially constructed

differences and holds power in a way that does not stratify or play into reproductions of

hegemony.

Racial differentiation and the consequences of racial differentiation is a fourth tenet of

CRT (Delgado & Stefancic, 2012). This concept relates to racialisation, where a making of

discrete races produce difference. Differentiating individuals or groups based on race create

arbitrary (and sometimes conflicting) portrayals of race, reflective of historically, politically,

inappropriate language (e.g., Canadian census categories, use of the term "visible minority" to

describe racialised individuals, racial slurs). Racial differentiation is a notion entangled with the

normalcy of racism, interest convergence, the social construction thesis of race, and the voice of

colour thesis (to be described later). Race continues to be historically created and contemporarily

recreated, enforced and manifested through everyday actions (Marable, 2002; Omi & Winant,

1994). Fields (1990) comments on the persistence of race groups despite biological

insignificance in modern day:

> Nothing handed down from the past could keep race alive if we did not constantly reinvent and re-ritualize it to fit our own terrain. If race lives on today, it can do so only because we continue to create and re-create it in our social life… (p. 118)

Fields' comment reflects how race in Canada has not disappeared; rather, it exists in less apparent ways because society has reformed its conceptualisation to fit the status quo and living narratives of this time period. Systemic racialising continues to attribute classifications of race as if individuals belonged to specific and defined race groups (Delgado & Stefancic, 2012; Inwood & Yarbrough, 2009; Ortega, 2013). Alongside stereotypical phenotypic features congruent with biologically deterministic thought, characteristics like attitude, behaviours and mannerisms, beliefs, material conditions (Fields, 1990), and other stereotypes began to attribute race to individuals.

In addition to the biological and social constructions of race, racial formation is a conceptualisation used by critical race theorists to describe how race maintains permanence. Racial formation theory situates race as a political and economic 'project' that shifts over time. According to Omi and Winant (1994), racial formation theory must be applicable: 1) to contemporary politics; 2) to a global context; and 3) across historical time (p. 7), each of which are areas of relevance in this ongoing discussion of understanding genderace, labour of care, and systemic inequity. Specifically, racial projects look at distribution of knowledge and power through politics and social structures, which historically tend to delineate access to resources and decision-making based on majority in-group identity and association with dominant ideologies. "Racial fabrication," a term used by Haney-López (1994), embraces racial formation, but furthers the understanding of racial projects to acknowledge the following assumptions: 1) humans produce races; 2) race constitutes an integral part of social fabric including gender and class; 3) meanings of race change quickly; and 4) races are constructed against each other, rather

than in isolation. Racial formation theory is useful to my knowing of racialisation because it attaches the illusion of race making (i.e., social construction) to power and language (i.e., critical theorisations) to race as a part of discourse and momentary relating.

I feel that race understood as a process of racial formation, though, is still limited as it cannot fully appreciate or gauge the nuances of rapid societal shifts in understandings of race for any meaningful political action to occur: "[m]eanings of race are complex and unstable because political actors create and contest those meanings" (Lawrence, 2012, p. 249). For example, Ladson-Billings (1998) describes language and constructions of race as being so embedded and hidden that denotations are offensive "without identification" (p. 9). These new racialisations develop into new race affiliated categories (i.e., conceptual-blackness and conceptual-whiteness [King, 1995]), which encompass a range of common stereotypes so race is implied but not addressed forthrightly. Ladson-Billings (1998) discusses that presumptions and racial associations are involuntarily made through phrases like "school achievement," "intelligence," "beauty," and "middle classness," which are thought of as conceptually white descriptors. I would add that these contemporary descriptors, which imply race, cut just as deeply as the blatant slurs used in the not-so-distant past.

In racialising, gendering, and classing processes, biologically deterministic ideologies promote characteristics as useful benchmarks to assign varying statuses of privilege on the basis of these categorizations (Carles & Jubany-Baucells, 2010, p. 242). Meanings applied to bodies via stereotypes and cultural discourses persist into racist behavior and action against racialised bodies. Racialised bodies and actions of racialised bodies are "spectacles" that are "constructed to serve," and engage "domination and submission" (Farley, 2002, p. 94). Farley (2002) discusses the spectacle of racialised bodies as not only a lens for justifying inferiority, exclusion,

and commodification of racialised bodies, but as "an entire field of vision..." (p. 136) and that, "the field is the world" (p. 136). Racialised bodies as a spectacle (and all the psychic harm and violence that results from being surveilled) only continues because society has accepted the condition and given these acts and silences "the green light" (Farley, 2002, p. 137) in which the racialised-body-spectacle has forwarded self-interest and privilege. For example, lynching as leisure (Mowatt, 2009), racialised bodies in sport (King & Springwood, 2001), media's reproduction of people of colour in service positions (McDowell, 2009), stereotypes of idealised caregivers (Pratt, 1997), and "mail-order brides" (Võ & Sciachitano, 2000) are some examples (which remain prevalent in popular culture) of how racialised bodies are made spectacles through exploitation and/or hypersexualisation in historical accounts. Racialised bodies being subject to difference, marginalisation, and oppression in a capitalist, meritocratic, patriarchal society is made normative through racialising processes of racial formation.

Racialised groups continue to retain value in research; for example, notions of race appear to be acceptable for describing discrete categories for special interest (i.e., leisure, health, and epidemiological research). As such, the operationalisation of race has become deeply embedded into practices and understandings of practice to play a role in: "cultural, educational, and legal institutions; norms and practices; group identity; self-perception and image; economics; power and influence; politics; social relations; understanding history; public discourse; and beliefs, perceptions, and values" (Henry, Tator, Mattis, & Rees, 1998, p. 17). However gradually, these ways of thinking about race have worked to hide the normalcy of racism in Canadian culture, which continues to disadvantage groups of individuals in subtle yet significant ways. Understanding race is, indeed, a complex undertaking given its variability across time, place, and theory.

Interrogations of race, and subsequently racism, anti-racism, and intersections of race with other stratified positions (i.e., class, gender, [dis]ability), "requires an inter-and-multidisciplinary effort" (Nash, 2003, p. 638). I acknowledge that researching race involved my responsibility as a researcher to reflect on "the potential ethical, emotional, analytical, and methodological dilemmas generated by racial subjectivities, racial ideologies, and racial disparities" (Winddance Twine, 2000, p. 5) as I moved through this inquiry. Distinct from ethnicity, nationality, and culture, race as a concept is often challenged because, unlike the others, it is often ascribed to an individual often before one is able to articulate it for oneself (Anthony, 2012). Yet, race continues to be a sensitive and potentially 'taboo' topic in Canada. Racial colourblindness in Canada is articulated by Lawrence Hill in a description of his experience of race in Canada, "[i]n the strange and unique society that was Canada, I was allowed to grow up in a sort of racial limbo. People know what I wasn't – white or black – but they sure couldn't say what I was…" (Hill, 2007, p. 5). Essentialised and constructed racial labels, loaded with histories, statuses, and privileges, inevitably follow understandings of race.

Racial formation theory decentralises race as a biological state and social illusion/ideological construct, and instead, places emphasis on the political nature of race (Omi & Winant, 1994) to challenge racism and racialisation with the aim of anti-oppression. In Canada the concept of racialisation has not been considered in Canadian government policy or initiatives (Canadian Centre for Policy Alternatives, 2010). Knowing race through racial formation theory recognises how we, as a society, legitimize/delegitimize, hide/highlight, or silence/speak of race and the political implications of how race is approached. Racial formation theory informs my study by shedding light on underlying political structures and mechanisms of racialisation which, whether intentional or not, maintain and overtly ignores race for political gains.

I see four meaningful underpinnings of CRT that are helpful for the aims of this research. These four aims of CRT research are important for understanding my intentions and approaches to understanding how divisions in care labour can be acknowledged and reckoned with through a lens of genderacialisation. First, engaging with CRT involves a commitment to social justice (Delgado Bernal, 2002; Matsuda, 1991; Yosso & Solórzano, 2005). It does this by elevating discourses that interrogate race by contributing to agendas of anti-essentialism and anti-racism by avoiding structural determinism. In the context of CRT this means there is a need to address and strive for change before times when gaps "between practices and ideals becomes too great" (Delgado & Stefancic, 2012, p. 37). Second, critical race theorists and activists (also known as 'crits') have a forced awareness, in that they are cautious of the ways race is portrayed and taken up in the literature, media, and daily practice and conversation, wanting to avoid reproduction of grand narratives and essentialist overtones. Third, scholars also believe that this effort towards (or beyond) anti-racism should be tackled on many disciplinary fronts (Solórzano, 1998). Lastly, CRT recognises the complexity of race and racial formation. CRT acknowledges the negotiation of and/or intersection of race with other forms of subordination (i.e., DisCrit, QueerCrit, and FemCrit) in addition to being able to hone in on racisms and other topics relevant to specific groups (i.e., AsianCrit, BlackCrit, Latino/aCrit, or WhiteCrit) (Yosso, 2005). As a racialised woman having pursued this study with racialiased women, I have read, know, and feel the power that racialisation has in masking the salience of race while assigning power to its meaning.

Gendering and the Gendered Body

Like constructions of racial categories formed then imposed on individuals who share specific physical or cultural characteristics (Miles, 1989), dominant understandings of gender refer to socially constructed roles individuals are taught based on an interpretation of biological

sex at birth. Gendering refers to a process whereby gender labels (binary gender labels like, masculine/feminine and man/woman), "are assigned to someone or something" (Gallop, 2002, p. 25). Gender roles ascribed by people and systems vary greatly across societies, cultures, and religion (Carles & Jubany-Baucells, 2010, p. 241) and often refer to states of gender (i.e., male and female) as opposed to referring to how one identifies on a spectra of genders.

In the mid-1980's *gendering* began to be used in the social science literature (Martin, 2003). This opened the door to conceptualising gender as a process where one is identified through language and practices, "in addition to such static properties as an identity, social status, what is learned via socialization, a system of stratification, and so on" (p. 342). Martin (2003) discusses the practice of gender and describes this practice to be:

> a moving phenomenon that is done quickly, directionally (in time), and (often) nonreflexively; is informed (often) by liminal awareness; and is in concert with others. […] conceptions of gender dynamics and practice inform the analysis and argues that adequate conceptualization (and potential elimination) of harmful aspects of gendering practices/practicing will require attention to (1) agency, intentionality, awareness, and reflexivity; (2) positions, power, and experience; and (3) choice, accountability, and audience (p. 342).

This performance of gender is closely related to how individuals perceive gendered bodies.

Women's bodies are often subject to imbalanced amounts of scrutiny with the aim being social and cultural control (Demello, 2013). Feminists have commented on how women's bodies are described in comparison to men's bodies, specifically around which cultural expectations are normalised about what men's bodies can *do* and *achieve* and what women's bodies can *look like* and *produce*. Fertile, nurturing, white, small, and slender are ideals (read: "beautiful") of women's bodies that are still pervasive today (Demello, 2013). Media has reinforced and emphasised the rhetoric around men's bodies being instrumental while women's bodies are reduced to being ornamental (Demello, 2013). One only has to observe the multibillion-dollar

beauty and cosmetic surgery industry to see how women are perceiving deficiencies on their bodies and working to change how their bodies present to the world. Society's homogenizing power on gendered bodies (Bordo, 2008) continues to hypersexualise women's bodies (as evidenced through popular culture) and undervalues them in other realms, like the workforce. In a predicament like labours of care, gendering of women's bodies and what women do for labour with their bodies become heightened and tied to normative expectations of feminine work.

Gendering concerns one of three intertwined aspects of this project. First, I acknowledge that I spoke with individuals who identified as women and, with this label some women may have carried perspectives with them of how women are expected to perform or practice. Second, gendering of actions and practices applies to workplaces and acts engaged in at respective places of work. The notion that "women's work" closely reflects responsibilities engaged in by PSWs today is troublesome as the political gains made by feminist movements have not yet changed much in the structuring of arenas of care. I continue to weave how gendering plays into processes of care for women in effort to move beyond acts of caring as "women's work." Understanding processes of gendering influences how I consider *being gendered* as part of a larger picture of stratification and move beyond centering only gender in hidden health care work and towards knowings of genderacialisation in care.

Classing and the Classed Body

Constructions of class exist to distinguish groups and individuals in societies, designating power, status, rights, privileges, and freedoms based on wealth, capital, mobility, and access to resources. Class, like race and gender, is often subject to how sociopolitical authorities position individuals in reference to others. On the topic of class in relation to other social positions, Bourdieu (1987) writes:

> ...the real is the relational; reality is nothing other than the structure, as a set of constant relationships which are often invisible, because they are obscured by the realities of ordinary sense-experience... (p. 3)

Power relationships within structure form the context for which individuals experience class.

Bourdieu (1987) articulates that perceived differences in relative power and privilege translate to one's access to social and capital:

> The social world can be conceived as a multi-dimensional space that can be constructed empirically by discovering the main factors of differentiation which account for the differences observed in a given social universe, or, in other words, by discovering the powers or forms of capital which are or can become efficient, like aces in a game of cards, in this particular universe, that is, in the struggle (or competition) for the appropriation of scarce goods of which this universe is the site. It follows that the structure of this space is given by the distribution of the various forms of capital, that is, by the distribution of the properties which are active within the universe under study- those properties capable of conferring strength, power and consequently profit on their holder (p. 3-4).

Like Bourdieu, I agree that theory cannot fully explicate knowings of class. Class is lived and known through the body. It is important to distinguish what I mean when I refer to class when discussing the classed body. I refer to class as a collective of macro-level socioeconomic stratifications as opposed to class as a micro-level grouping (i.e., class as a broad term for group). Rooted in Marxian beliefs that materialism, politics, and the financial economy drive social processes, I refer to class as the sum of socioeconomic circumstances and resources that an individual has or can utilize to navigate social worlds. I believe that living wealthy or impoverished (based on a fluctuating "poverty line") is only one piece of the larger picture of class. However, with class structured in the capitalist society within which individuals in Canada live narratives of poverty often picks up on silences that contribute to the make-up of class (i.e., marginalisation and/or isolation, stigma, wellness, education). Three broad conceptualisations of poverty that I came across in the literature discuss processes of classing into perspectives including: (1) stigma of poverty; (2) culture of poverty; and (3) perspective of poverty.

The stigma of poverty was a concept developed by Waxman (1977) to describe negative social perceptions associated with human attributes outlined by Goffman (1963). The three groups Goffman identified to inform Waxman's stigma of poverty perspective, included individuals subject to physical stigma, group stigma, and stigma due to "blemishes of individual characters" (Sharma, 2012, p. 7). In Goffman's conceptualisation of the three stigmas, physical stigma referred to individuals who experienced physical disabilities; group stigma referred to individuals who were negatively perceived due to their race, nationality, or religion; and blemishes of individual characters referred to individuals who faced stigma as a result of imprisonment, addiction, mental illness, and unemployment. From each of these stigmas, attitudes interfere with relating between individuals who are stigmatised and non-stigmatised and between poor and non-poor, creating a locally understood culture of poverty (Sharma, 2012). As long as stigma persists, "poverty persists" (Sharma, 2012, p. 8).

The culture of poverty perspective argues that cultural knowings existing amongst individuals who are not socioeconomically privileged occur away from dominant values and norms. Excluded beliefs are said to include a disengagement and skepticism with mainstream institutions (i.e., banks, institutions of higher education, systems of justice) and result in alternative forms of organisation (i.e., unions, cooperatives, etc.) (Sharma, 2012). Sharma (2012) describes four social indicators of individuals who are a part of a culture of poverty: individuals often have higher incidence of subverting the law (Miller, 1958); higher prevalence of mental illness (Hudson, 2005); insecurities around education (Sharma, 2012); and have larger families than common of the middle-class (Sharma, 2012). Understanding that poverty can be conceptualised as a culture is not stigmatised in and of itself. It is marginalisation from dominant standards and norms that create the illusion that groups of individuals, who fall outside of

socioeconomic privilege (and thus other privileges), are associated with behaviours and attitudes that are undesirable. The culture of poverty creates stigma and further excludes individuals from the knowledge and resources needed to move out of poverty.

The structural perspective of poverty sees poverty as a condition of individual environments (Sharma, 2012) not individuals themselves. In this perspective, it is not up to individuals living in poverty to change their circumstances, but the structures and surroundings to change in order to eliminate the conditions, constraints, and stigmas of poverty. This ecologic-model of poverty changed the way some sociologists understand and speak about poverty, specifically in terms of social exclusion (Alcock, 1993; Jordan, 1996; Rodgers, Gore, & Figueiredo, 1995). Though social exclusion can be viewed in many capacities, Sharma (2012) provides an overarching description of social exclusion:

> Social exclusion occurs when individuals are unable to participate in any of the key economic, social, and political activities of a society in which they live. The factors that prevent an individual from participating in the economic, social, and political activities of a society could be a lack of resources, insufficient financial means, or inadequate social networks (p. 9).

Some specific examples of social exclusion outlined by Sharma (2012) include: legal exclusion; democratic political exclusion; cultural exclusion based on sexual orientation, race, or gender, ability, religion; exclusion from the welfare state; exclusion from mainstream; and political and economic exclusion.

However, rooted in capitalist understandings of privilege, difference in classed bodies is closely related to the types of work engaged by individuals (Demello, 2013). Just as classed bodies have impact on habitus – 'one's place' in "the hierarchy of social differences and inequalities" (Dirks, Eley, & Ortner, 1994, p. 13) – so does habitus have impact on classed bodies. Bourdieu describes that habitus influences an actor in such a way that s/he comes to

embody assumptions made by the social ordering of things (Bourdieu, 1977) and "reproduce in its specific logic of the universe of the social structure" (Bourdieu, 1984, p. 83). Dirks, Eley, and Ortner, (1994) argue that the relationship between habitus and actor is so strong that "the effect is one of near total naturalization of the social order, the forgoing of homologies between personal identity and social stratification" (p. 13). Further, Bourdieu (1986) suggests that the "most indisputable materialization of class taste" (p. 190) may be storied through descriptions/imagery of labour (including emotional labour), differential tastes, appearance, habits, and lifestyles (i.e., clothing, food, or sports). In a culture of consumption, ways the body is nourished through food and supplements or harmed by unhealthy food and substances is indicative of how classed bodies are stratified (Demello, 2013). Bourdieu (1986) writes: "taste, a class culture turned into nature, that is embodied, helps to shape the class body" (p. 190). Bakhtin (1984) describes that the privileged body image, of a "refined, laminated, orifice-less body" (Demello, 2013, p. 157), lacks physicality of a working class body. This is reflected through popular culture, which privileges the idealised body and in doing so often makes poor, working-class bodies invisible.

Similar to racialised bodies and gendered bodies, ideal conceptualisations of classed bodies are dynamic and vary across time, social cultures, and politics. What was reinforced for me as I reviewed the literature on class and poverty is that in classing, like gendering and racialising, larger socio-political structures shape the way privileges are assigned and the ways perceptions of class are interwoven with gender and race. There is, however, a role for CRT in reproaching understandings of class. Yosso (2005) discusses CRT as playing a role in shifting away from the, "deficit view of Communities of Color as places full of cultural poverty disadvantages" (p. 69), towards understanding racialised communities as possessing "cultural

knowledge, skills, abilities and contacts," (p. 69) which often go unacknowledged. Informed by CRT, body mapping in this study aimed to reveal the "internalized form of class condition which informs the ways that one inhabits one's body" (Demello, 2013, p. 156) (i.e., physicality and toll of classed labour), in ways women chose to express class (i.e., disadvantaged or rich with cultural capital) creating potential to identify internalisations of "pink-collar bodies" (Demello, 2013, p. 160) engaged in invisible labours of care. Next, I describe the ways care work is structured serves to maintain and reproduce silos of identity through notions of "women's work" and also, how care work can be seen differently through intersectionality.

Critiquing the Care Literature: Moving beyond Care as 'Women's Work' through Intersectionality

Processes of genderacialisation through time serve to ground this research in the way I see genderace as integrally linked to narratives of care in contemporary public spheres of care. Within the literature, care has been positioned as: (1) a necessity for all; (2) racialised, gendered, and classed as poor, coloured "women's work"; and (3) a "labour of care," which dominant ideologies translate to a woman's "labour of love." Set in these frames, acts of care are often reinforced as a biologically determined moral obligation for women. The designation of this moral expectation on women, specifically poor, racialised women, to take up care work in private (i.e., personal residences) and public spheres of care (like public residential homes, including LTC homes) becomes a starting point for interrogating a genderacialisation of care. This challenge of understanding how care is entangled with genderacialisation begins with stories of women of colour who are constructed to belong within this normalized system of reproductive work and the medical hierarchy. In the literature "women's work" is often explicit about the impact of caring on women; however, its impact as a result of intersectional identities

is less clear. Processes of genderacialisation influence the ease in which certain individuals move towards caring professions. In this section I look at a number of ways care is conceptualized as women's work in effort to reconceptualise care as a non-essentialised and dynamic relationship that is more broadly influenced by genderace.

Cloyes (2002) identifies that within the nursing literature there is a valorisation and celebration of care as an essentialised construct. In nursing literature, care is described to be a central essence to nursing practice (Sitzman & Eichelberger, 2004; Todaro-Franceschi, 2013), where care broadly refers to a unidirectional relationship that involves "…assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (Leininger, 1984, p. 3). With relation to caring culture, Martin (1989) describes the nature of care relationships to be comprised of three parts (the three "Cs"): care, concern, and connection. In her work, *care* is characterized by vulnerability (experienced by one who is 'cared for'); intimacy and trust, which sustain a *connection* (between "carer" and "cared for"); and where affection or *concern* becomes an integral part of a relationship (Martin, 1989). Aims of formal caring in nursing focus on transforming quality of living (i.e., health and healing) and dying (i.e., heartful and holistic) (Todara-Franceschi, 2013) involving,

> direct (or indirect) nurturant and skillful activities, processes and decisions related to assisting people in such a manner that reflects behavioural attitudes which are empathetic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or group being assisted (Lelininger, 1984, p. 4).

Care can be a labour of love or "love's labour" as described by Kittay (1999) in her discussions of dependency work focused on the unidirectional actions of care given to another. Finch and Groves (1983) discuss that care is both love and labour. When care is described unidirectionally,

as they are in the definitions above, it implies that care constitutes acts that are largely focused on one individual recipient (i.e., care provided by a caregiver in response to a need or the needs of another or others) rather than something that is reciprocated. A moral obligation is placed on an individual to *provide* life-sustaining activities *for* another's needs.

Understanding the nature of care relationships in this way lends itself to the Vulnerability Model (Goodin, 1985), where the moral basis of care relationships arises out of the vulnerability of one individual on the labour of care of another individual. In the Vulnerability Model, actions of care are obligations, or "vulnerability-responsive obligations" (Kittay, 1999, p. 55), where an individual who is obliged is obliged because they are considered to be in the best position or the best person to engage in such caring acts (Goodin, 1985). A slight variation on the Vulnerability Model, is the Voluntaristic model (Goodin, 1985) where care is provided by a consenting carer (rather than an obliged one) through the form of a promise to care.

Reflecting on these models, a tension arises, specifically the need to consider care as an obligation as it comes in the form of labour of care. I feel that entangled with the notion of labour, obligation, and care, is the imposition of the moral imperative to care based on the context of work. In the models of caring I described, the vulnerabilities of carers are *not* acknowledged. The language used to describe individuals engaged in the labour of care (i.e., carers, caring for, caregiver, obliged, voluntaristic, etc.) and individuals requiring support in care relationships (i.e., vulnerable, cared for, etc.) is very limited and is in contrast to how I speak about and value caring partnerships. These differences in language create a good point of reference for describing a feminist ethic of care. In this section, I reflect dominant language I pulled from the care literature to develop my argument around why anti-racist, feminist politics are in need of consideration in forwarding understandings of care.

In my Master's thesis I wrote about the work of Tom Kitwood (1997) and person-centred care in the context of persons living with dementia and the aims of this approach to challenge "depersonalizing tendencies" (p. 46) of traditional, biomedical approaches to care. In this approach, Kitwood (1997) describes the need for inclusiveness of individuals living with dementia and the recognition of their personhood and individuality. Person-centredness also emphasises: (1) valuing individuals and individuals who care for them; (2) treating people as individuals; (3) looking at the world from the perspective of individuals requiring support, and (4) that a positive social environment can contribute to individual well-being (Brooker, 2004). The person-centred approach to care began to set the groundwork for relational care in considering the broader care environment including valuing individuals who engaged in the labour of care. Relationship-centred approaches moved the focus broader from person-centred care. Relationship-centred approaches to care aimed to "capture the subjective and perceptual dimensions of caring relationships and reflect both the interpersonal processes involved and the intrapersonal experiences of giving *and* [emphasis added] receiving care" (Nolan, Davies, Brown, Keady, & Nolan, 2004, p. 49). In a care approach where all individuals in the care relationship are considered, care is ideal when needs required by all in the care relationship are met.

Relational theory holds the assumption that each individual is striving for health (Biurski & Haglund, 2001) and that individuals develop through relationships with others (Jordan, Walker & Hartling, 2004). The notion of *power-with* is conceived with the understanding that power mutuality is necessary for relationships to be relational (Walker & Rosen, 2004). Foundational to relational theory in the therapy context are four pillars: (1) "relational differentiation and elaboration, rather than separation, characterize growth; (2) mutuality and shared power are

markers of mature functioning; (3) mutual empathy is an essential process in effective therapies; and (4) therapeutic authenticity is necessary for the development of mutual empathy" (Jordan, et al., 2004, p. 7). In relational care practices, all individuals in the caring relationship are entitled to clarify their needs, safety of person and relationship, privacy and protection, and mutual support (Jordan, et al., 2004). With an under-emphasis on any one individual in relational theory, caring responsibilities must fall with all individuals in caring relationships. However, all too often, in the current systems of care that exist, it is the responsibility of the care person with limited outlets for personal agency within stratified systems of caring to claim responsibility for personal self-care. One practical-theoretical relational care framework that attempts to consider all voices in caring relationships as part of decision making, is the authentic partnerships approach to care (Dupuis, Gillies, Carson, Whyte, Genoe, Loiselle, & Sadler, 2012). Dupuis and colleagues (2012) describe three guiding principles (i.e., genuine regard for self and others, focus on the process, and synergistic relationships) and five enabling and sustaining factors (i.e., conducting regular critical reflection and dialogue, connecting and committing, creating a safe space, valuing diverse perspectives, and establishing and maintaining open communication) that need to be in place to mobilise authentic partnerships in dementia care. Regardless of context, the authentic partnerships approach suggests that all care perspectives and caring individuals need to be equitably considered to ensure each person experiences care that is relational by working *with* one another.

The Fisher-Tronto process of care (Tronto, 2013) acknowledges that an individual's navigation of each care setting comes with complexity. The five parts of the Fisher-Tronto definition of care include: (1) caring about; (2) caring for; (3) care-giving; (4) care-receiving; and (5) caring with. Caring about is about an individual taking notice of the care needs of another

(Tronto, 2013). Caring for involves responsibility-taking of unmet care needs (Tronto, 2013)

wherein, care-giving requires the labour of care. Care-receiving involves the response or reaction

to how, previously, unmet care needs are now satisfied. Finally, in caring with, Tronto (2013)

describes the ways in which caring needs are met, should be met in ways that demonstrate

"commitments to justice, equality, and freedom for all" (p. 23). Though these descriptions are

helpful for understanding the different aspects of caring relationships, caring is more nuanced

and complex than this dissection of caring may suggest. Understanding caring in the process of

care through the Fischer-Tronto process is problematic as it assumes individuals or groups of

people are taking responsibility for unmet care needs of *all* others. Given what is known about

the response to vulnerabilities of PSWs through the politics of genderacialised care, identifying

unmet needs is often not the case for care workers.

> Tronto (2013) follows her description of the Fisher-Tronto definition with a caveat:

> From this standpoint, the Fisher-Tronto definition is meant to provide a way to analyze
> when and how caring is done, and to be able to make assessments about care. It is not
> meant to be romantic or perfectionist. Sadly, within human existence and the larger global
> environment there are more needs for care than can be met. But some caring needs do get
> taken seriously and do get met, while others are ignored or met only in desultory fashion
> (p. 23).

In my experience, ensuring the needs of all are met is a difficult reality to realise in care

environments today, when residents have difficulty simply connecting with care staff about their

own lives due to staff time constraints. In *power/knowledge*, Foucault (1977) describes, with

respect to operating systems like those of healthcare, penal systems, and other structures, that

"power [is] kept subordinate to the economic instance and the system of interests" and that with

"struggles at the grass roots level," "there was a tendency to regard these problems as of small

importance" (p. 116). In these words, Foucault conveyed that the (economic) interests of the

system continuously prevail over interests of individuals, rather than the respective system taking responsibility for the welfare of individuals who contribute to sustaining the system. Further, with intense demands on staff time and staff responsibilities to care, I imagine it would be less likely that staff share personal needs (further highlighting invisibility that occurs in labour of care) before learning about and tending to needs of residents as these are interests privileged by capitalist systems of production.

In the field of transcultural nursing care, Leininger's Culture of Care: Diversity and Universality theory (1994) opened doors for discussions of intercultural caring. In her theory, Leninger describes universal acts (i.e., care, caring, health, and nursing), "evident across many cultures," as a means to connect and uphold one's culture in care (Leininger, 1994). Though I feel that Leninger aligns culture with ethnic culture in this model, there may be something embedded in the shared symbolic and linguistics of caring, specifically around the structuring of genderacialisation in care culture. Aside from structural similarities of care labour, my belief in individual uniqueness rejects that universalities exist in individual relationships and experiences of caring.

In developing an understanding of care in relation to self and others, Tronto's (1993) widely cited description of caring is less limiting than other definitions and captures care as a notion that encompasses self:

> Caring can be viewed as a [human] activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web (p. 103).

Tronto's definition embraces the many ways (through leisure, for example) individuals are able to engage care and caring to support the wellness of the world including self and others. It also means everyone is, or should be, involved in caring.

Exploring different constructions of care is helpful in so far as I am now able to better describe how one cares and what actions constitute caring. Understandings of caring, thus far, have revealed little about how care workers are to be valued and how they are drawn to care in the first place. The labour of care in LTC homes presents less than ideal circumstances to foster the bidirectional relationships needed to fully realise relational caring. In Mitchell and colleagues (2017, in review), authors highlight several works (Ayo 2012; Cheek 2008; Crawford 2006) that discuss how the "increasing emphasis on individual responsibility, control, and autonomy has been linked to the rise of neoliberalism and economic rationalism" (p. 8-9). Further, these authors draw on Foucault's (1978) notion of technologies of surveillance and Ellis et al. (2017)'s work on the increased attention to person-centred care models in dementia care to underscore unnatural, securitised, and unbalanced attention to care the system places on individuals living with dementia. Taken together, work by *Collective Disruption* (Mitchell, et al., 2017) emphasise that neoliberal systemic processes (i.e., surveillance in the name of security, efficiency, cost effectiveness, human capital, people as beds = $) are privileged over the ability to form authentic partnerships (Dupuis, et al, 2012) and value perspectives of individuals who engage in acts of caring.

Complexity of labours of care, morality to care for, and politics that exist with genderacialised care structures create barriers for listening to personal narratives of front-line care workers, let alone moving to recognise PSWs' needs in fostering relational caring in "women's work." However, feminist ethics, a movement from care ethics broadly, advocate for: (1) notions of care to not represent universal experiences, (2) relational care, and (3) the need for descriptions of care to encompass care of self (Raghuram, 2009). In this light, in beginning to understand women's experiences of caring from both an ethic of care and feminist ethics

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perspectives, it is important to be wary of uncritical and overextending constructions that potentially essentialise what it means to care as a racialised woman, *with* racialised women. To further explore the context of care I hope to explore in my research, I describe an ethic of care and its alignment with societal expectations of gender.

Upholding conceptualisations of frameworks of care (described in the previous section), are embodied motivations individuals who care hold for caring. The ethic of care literature described care as being driven by justice and/or morality. An ethic of care describes the individual values and orientations (morality, justice, feminism, etc.) one brings to their approach and desires for care/caring. May (1996) describes moral integrity as comprising three aspects: (1) critical thinking; (2) coherence of value orientation; and (3) the disposition, or commitment, to act in a principled way. Three orientations that underlie morally integral caring, described by May (1996), are those related to justice (i.e., cultural traditions, religion, and philosophy particularly critiques of power inequities), morality (i.e., notions of universality, virtuousness, righteousness), and ethic of care (Clement, 1996). Elements of care justice and morality are integrated into the ethic of care paradigm while encouraging flexibility and fluidity as particular connections, emotions, and relationships form differently in each care situation (Gillian, 1982; Hamington, 2004).

Authors have critiqued that these paradigms, in and of themselves, are gendered, with ethic of care being "socially coded a feminine ethic" (Clement, 1996, p. 3) and positions of justice as being of a "masculine ethic" (Clement, 1996, p. 3). They also have been critiqued for privileging Western understandings and Whiteness (Clement, 1996). Theorising about care ethic and justice in ways that are not as well as informed by individuals living through the joys and toils of daily caring work may in itself be hegemonic. I move to describe the main tenets of an

ethic of care as it begins to open up a dialogue for troubling dominant discourses and opening up alternative dialogue around racialised women's experiences of care.

Several key features of the ethic of care describe how embodied caring and relational care experiences are entrenched in personal and public lives. Additionally, understanding an ethic of care informs how critical frameworks (intersectionality theory and CRF, for example) can be complementary in working with ethic of care perspectives to reflect on individual care experiences. Four main features of ethic of care include: 1) the belief in a relational ontology (Gillian, 1982; Held, 2006; Tronto, 1993) and that care forms the basis of life (Noddings, 2002); 2) the epistemological process of morality (Tronto, 1993); 3) the conviction to address issues of morality specific to individual contexts (Barnes, 2012); and 4) the critical examination of the relationship between care in public and private spheres through the lens of feminist care ethic with reflection and use of narrative (Robinson, 2011).

First, and central to ethic of care ontology, is the understanding that every individual spends time requiring some level of support in some way or another and having the moral openness and desire to assist and "meet the needs of others for whom we take responsibility" (Held, 2006, p. 10). The most basic understanding of care, that care is expressed or experienced by all individuals and through relationships, philosophically underpins this relational ontology (Hutchings, 2000) from "which all other claims about morality and human flourishing flow" (Robinson, 2011, p. 29). A relational ontology sees the ethic of care as involving two main features: (1) belief that the self is relationally understood and therefore, morality is said to only exist in the context of self in relation with others (Gillian, 1982; Robinson, 2011); and (2) relationships of care are the most basic units for understanding "moral substance" (Hutchings, 2000, p. 123). Walker (1989) describes "moral understandings" to comprise a collection of

"perceptive, imaginative, appreciative and expressive skills and capacities, which put us and keep us in unimpeded contact with the realities of ourselves and specific others" (p. 21). The two parts of a relational ontology (i.e., self as relationally understood and care relationships as the basis of understanding morality) suggest that personal perspectives may be best understood when contextualized by care relationships formed with others. I am cautious, though. Some relational approaches lack consideration of power relations and, as a consequence, impose limitations on being able to locate personal moralities and requirements for self-care. This lack of consideration of power restricts the ability to see individuals and their personal stories within the context of the relationship. With the understanding of care relationships as supporting knowings of morality, a collective approach for telling narratives with others (who have shared similar experiences) is needed to contextualise processes of genderacialisation that are woven into the milieus of care (i.e., constructions of care, care relationships, institutions of care) and what it means to enter into caring relationships within a genderacialised system as a racialised woman.

Stemming from a relational ontology is a second feature of an ethic of care, the "epistemological process of trying to understand what morality would recommend and what would be morally best for us to do and to be" (Held, 2006, p. 10). In this tenet, conceptualizations of care, individuals as caring selves, and acts of care are integrally linked to morality. Tronto (1993) elaborates on the tie between ethic of care and morality. She emphasises the "importance in care ethics not of moral principles as such but of practices as constitutive morality" (p. 10). Practices of constitutive morality (or substantial morality) include attentiveness, responsiveness, responsibility, nurturance, compassion, and meeting others' needs (Robinson, 2011; Tronto, 1993). Though, individuals must be cautious to avoid solely focusing on a morality of responsibility in which the emphasis is on connection and the relationship itself

rather than the individuals in it. A feminist ethic of care looks beyond individual relationships, to

where morality in caring can exist in critically understanding the distribution, recognition, and

resources of care, and asking individuals to consider power imbalances, indifference, and

conflict that characterize traditional care relationships (e.g., mother-child relationships)

(Robinson, 2011). As gender is often prominent in the conceptualisation of care as women's

work, it is not difficult to see how race and class are treated as separate proponents to care work.

To me the impacts of genderacialisation on individuals involved in care in the care literature are

largely invisible.

To link invisibility, CRF, anticategorical intersectionality, and complexity of stratification

with the discussion of caring work at hand, I draw on Robinson's thesis from her feminist ethic

of care work,

> Care work is overwhelmingly overtaken by women of colour and of ethnic
> minorities of low socioeconomic status. Similarly, within many developing
> countries, the legacy of colonialism maintains the situation whereby domestic and
> caring work is done for the white minority by poor women of colour (Robinson,
> 2011, p. 70).

Robinson adds, "women working outside of the home have often turned to poor women of colour

– often immigrant women – to [support] care for their children", adult children with disabilities,

or elder family members (Robinson, 2011, p. 70). Agency websites, like freefromcare.ca, will

often advertise private care for a lesser cost and splay images of women of colour on the banners.

In the case of freefromcare.ca, a tagline, "Less Cost, More Care" (freefromcare.ca, 2016), further

articulates how cheaply care can be bought in the commodification of care. In these places of

work, stereotypes of racialised women are commoditised and women of colour experience more

discrimination on the basis of race, gender, and class when compared to white women or

racialised men (Chui & Maheux, 2011). Connected this discussion of stratification, hidden care

work is well documented in the nursing literature as invisibility occurring when moral concerns are routinely dismissed (Bjorklund, 2004; Jackson, 1997; McQueen, 2000). In labours of PSW care, which is less visible and more precarious than registered nursing work (Zeytinoglu, Denton, Plenderleith & Chowhan, 2015; Lilly, 2008; Stacey, 2005), more opportunities exist for moral distress and residue to occur, including in interactions with nursing professionals with whom PSWs work. This health care hierarchy of professions compounds the silencing of PSW voices – voices that support caring relationships and advocate for residents when met with moral dilemmas in care.

Stories of self in care relationships as a racialised women are key to providing insight into how constitutively moral care practices are in tension with systemic equalities of misogyny, racism, and class politics that result in stress and invisibilities from engaging in the labours of care work. Through this work that looks at genderacialisation, it is important that I, together with women of colour as narrators, explore tensions between caring as morality and systemic imbalances of resources and power that emerge around the constructions of gender, race, and class. Narrative inquiry was an appropriate approach for working with stories to shed light on disjunctures existing between constitutive morality, stories of genderace, and distribution of socio-economic privileges. Recognising broader systemic inequity while remaining conscious of processes that essentialise required individuals to draw on everyday stories (i.e., narratives) to inform how broader communities understand system-constitutive morality dynamics from both individual and collective perspectives.

A third feature, a feminist ethic of care decentralises the abstractness and universality of moral theories in guiding caring acts and rather, focuses on the "particularities of day to day interactions" (Barnes, 2012, p. 17). With "peculiarities of the day to day" (Barnes, 2017) in

mind, individuals must consider their own perspectives as genderacialised individuals -- in everydayness -- in understandings of care within a broader socio-political culture of hegemony. However, recognising genderacialisation as a means to structure care labour would take into account historical divisions structuring care systems and be more understanding of personal navigations racialised women experience within systems of care. Dominant moral theories address personal or private relations as being the most necessary to be cared for, wherein feminist care ethic renegotiates this understanding of care to examine how power is privileged in the existing socio-political society as a result (Held, 2006). Thus, a feminist ethic of care is devoted to addressing moral issues in the context of each individual's story, varying from situation to situation, with historical and special contexts considered (Gillian, 1982; Held, 2006). Morality within this sphere moves away from Kantian logic (i.e., non-emotive morality) and instead values closeness and vulnerability within relationships and emotions evoked through care (Held, 2006).

Fourth, a feminist ethic of care reimagines traditional understandings of distinctions made between public and private spheres of care (Held, 2006; Noddings, 1984; Slote, 2008). The traditional understanding of the private sphere (i.e., home, family/friendly relations, religious affiliations, etc.) is where there is little influence of formal structure (i.e., government) and where men have the greater economic, political and cultural power (Robinson, 2011). A feminist ethic of care permeates through all ethic of care principles, but I believe is most strongly grounded in this tenet as gender norms, roles, and power relations are most explicit in the discourse of care as "women's work" (p. 63) in private and public contexts (Robinson, 2011). The languaging of "personal support work" in and of itself diminutizes this form of care work, reinforces the dominant discourse of women's work, and renders PSW front-line care workers supporting acts

of care invisible. The words "personal support" references a personal assistive role that an individual incurs within a larger structure of care labour, a title that is more "client" centred than relationally power balanced. In other sectors (i.e., business, law, education) similar nomenclature (i.e., personal assistant, legal aide, developmental support worker, respectively) is prominent when an individual is designated as working *under* the supervision of a higher-ranking employee (i.e., corporate executive, lawyer, teacher, respectively). The subordinate-superior relationship in reflected in the health care hierarchy with dominant discourses suggesting PSWs engage in care work *for* residents *under* the supervision of RPNs/RNs, doctors, and family members. Through this research that aimed to shed light on the structures that maintain divisions of care labour by troubling the histories and systems that work to genderacialise care, I hoped care workers, specifically women of colour, had space to reclaim voice by sharing their personal narratives within our supportive collective to raise consciousness on oppressive structures of reproductive care work.

Understandings of care as an aspect of femininity troubles women's rights, specifically their agency, autonomy and ability to make decisions about their roles in care based on biologically deterministic thought and traditional Western familial norms (Robinson, 2011). The feminist ethic of care agenda aims to find "solutions to the problems of care conditions towards ensuring that they are non-exploitative, equitable, and adequate to ensure flourishing of all persons" (Robinson, 2011, p. 33). By moving through the notion of caring work as obligatory racialised women's work that make bodies labeled with intersectional identities invisible, part of my goal in doing this research was to create new language to support racialised women in telling their stories of care differently.

Intersectionality in Critical Race Feminism and the Emergence of Genderace

Intersectionality theory, seeks to challenge boundaries while seeing how racialising, gendering, and classing become a part of political processes. As Rattansi (2005) describes,

> Racialisation tells us that racism is never simply racism, but always exists in complex imbrication with nation, ethnicity, class, gender and sexuality, and therefore a dismantling of racism also requires, simultaneously as well in the long run, a strategy to reduce relevant class inequalities, forms of masculinity, nationalisms and other social features... (p. 296).

With regards to the care work of PSWs, racialising, gendering, and classing amass to set a foundation for conceptualising expressions of genderace through which narratives of genderacialisation can be illuminated. A new culture is created through intersectionality where there is recognition of labels that marginalise, and in this new culture, traditional siloes of race, gender, and class are no longer relevant.

Critical race feminism (CRF) is an intersectional framework that responds to and is critical of interpretations of experience that seemingly speak *for* women of colour. A principle that is discussed in both CRT and CRF literature is the voice of colour thesis, is the idea that individuals of colour have something unique to add to discourses on race that are unique to experiences of being racialised (Delgado & Stefancic, 2012; Tyson, 2007). Counter-story telling is a valued method for expressing experiences of race and countering dominant voices (Decuir & Dixon, 2004; Solórzano, 1998; Yosso, 2006) by colouring the literature (if you will). The voice of colour thesis from CRT creates space for bringing racial positionality or perspectivism[13] to the fore, speaking to how individuals represent or self-represent racial identities and the stories that go with these identities in the literature and beyond. I understand this to mean that respective voices of women of colour are not reflected by grand narratives by women, or by individuals of a

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[13] Perspectivism is "belief that a person's or group's position or standpoint greatly influences how they see truth and reality" (Delgado & Stefancic, 2012, p. 169).

particular race, but respective stories are one of a kind, situated in distinct social contexts with

unique circumstantial (dis)advantages influenced by genderacialisation. In other words,

narratives told by women of colour are specific to an individual (Bell, 1992). Kimberlé

Crenshaw (1989), a leading legal scholar on race and gender who coined intersectionality,

discusses her perspective as a Black feminist (where the study of intersectionality originated):

> Black women are regarded either as too much like women or Blacks and the compounded
> nature of their experience is absorbed into the collective experiences of either group or as
> too different, in which case Black women's Blackness or femaleness sometimes has
> placed their needs and perspectives at the margin of the feminist and black liberationist
> agendas (p. 44).

Erasure, stereotypes, and essentialisms may also emphasise and ratify race, gender, and class in

specific contexts or social structures. For example, the "dragon lady", mute and subservient,

exocitized, asian sex workers, and nannies, are just some of character tropes that many racialised

asian women are familiar. These stereotypes create assumptions around how gender and race are

"supposed to" preform together. Brainy-math-kids from immigrant working class families,

"crazy-rich" Asians, and convenience store families are stereotypes of how class and race

emphasise one another while erasing gender narratives. In each of these stereotypes, derogatory

labeling is used to exert dominance to maintain control of material and knowledge production

and to commodify reproductive work (cooking, cleaning, caring, and sex) for capitalist gain.

Social justice scholars are keenly aware of the ways labels cause tensions for the ways

individuals move through the world. In this light, it is important to be mindful of the ways these

labels may emphasise or erase another or each other (for example, gender erases race, race erases

class, or class erases gender and race) and also of the impacts of these erasures. With processes

of genderacialisation influencing how personal support work is socially constructed within a

neoliberal system, there is systemic erasure of gender, race, and class and blindness of

individuals who engage in hidden labours of care. Rather than examining environments that immobilise individuals, influential powers of structure that work to genderacialise individuals remain invisible through essentialisation. Essentialisms occurring at intersections of race, gender, and class often exclude racialised women's voices. Identity categories de-emphasize whole living narratives by fragmenting an individual into their identities subsequently reducing the power of their intersectional experiences.

The critiques posed against CRT ("radical multiculturalism" [Dusche, 2004], excess negativity and lack of direction for action, for example) do not necessitate the need to bracket race, gender, or class as discrete identities held by each woman of colour (Espinosa & Harris, 1997). Rather they necessitate the need to challenge essentialisms and move towards recognising negotiations that women of colour face. At the forefront of this movement, feminist legal theory scholars who centralise gender, advocate for voices of women to be included and stories to be wielded as means to interrogate distribution of power amongst genders. Falling out of this, however, are the essentialising characteristics of dominance theory (MacKinnon, 1982) -- binary gender (i.e., male-female), race (i.e., black-white), class (i.e., rich-poor) -- and the interplay of race, class, and gender (i.e., white economically privileged, able-bodied, and heterosexual female women as all women) (Espinosa & Harris, 1997; Jean Baker Miller Training Institute, 2012).

Some intersectionality theories describe identity categories (i.e., race, gender, class) as intertwined and/or inseparable (McCall, 2005). I, like other subscribers of intersectional theories, do not acknowledge a single analytical category to be sufficient (McCall, 2005). Thus, it is necessary to consider constructed identities together, embracing language that reflects realities of intersectionality to depart from limiting labels, which reinforce processes that marginalise. The politics of genderacialised care, in the previous chapter, work to critique the making of gender,

race, and class – processes of gendering, racialisation, and classing – and subsequently show how rarely each are acknowledged together, if at all. The subversion of these processes work to make intersectional narratives invisible in contexts of care. For this study, it is important I emphasise intersectionality because of the existence of genderacialisation as an amalgam of intersectional processes. This is important because without an acknowledgement of intersectionality, and subsequently what exists beyond this conceptualisation, there is limited capacity to know what knowings lie beyond silos of racialising, gendering, and class (in addition to other processes that work to marginalise). Within intersectionality theory, McCall (2005) describes three forms of intersectionality theory from gender and race literature. The three forms of complexity she describes within intersectionality are: intercategorical (or categorical), intracategorical and anticategorical (McCall, 2005). I describe each briefly here to better situate my position on approaching how processes of racialising, gendering, and classing are intersectional.

Intercategorical complexity adopts dominant identity structures, strategically working with existing constructions, and the relationships that exist between them, to challenge inequities (McCall, 2005). I believe an intercategorically complex approach works well to bring visibility to traditionally defined social phenomena, but does not interrogate how groups are situated within specific labels in the first place or how they exist in relation to one another. An intercategorically complex approach makes the assumption that distinctions between social identities do exist. On the other hand, intracategorical complexity is used to critique dominant categories and boundaries, while challenging traditions of mainstream intersections to recognise complexity (McCall, 2005). Though intracategorical inquiries critique mainstream identity

categories, this form of intersectionality theory also recognises the necessity of categories in modern and everyday life (Bhattacharya, 2012) through language and practice.

In contrast, anticategorical complexity moves away from underlying essences of what it means to be constructed within a particular category and instead, raises "questions about whether to categorize and separate at all" (McCall, 2005, p. 1778). Though McCall's (2005) statement could be interpreted to mean that society could do away with race, gender, and class *categorisation* all together (which I address through a critical antenarrative method in the fourth chapter), it could also be understood to mean that anticategorical complexity troubles the notion that identities need to be separated and categorised into groups that reinforce inequities as a result of being pigeonholed into constructed social groupings. Anticategorical complexity departs from the need to reproduce practices of domination through the reconstruction of language and abandoning historically structured categories (Ronquillo, 2008), as dichotomised labels reflect little in the way individuals perform, express, and assign value to their embodied experiences and narratives.

I suggest that each historically created label, makes up part of an amalgam – that of genderace. Genderace are the stories that live in the body as a result of genderacialistion. In effort to acknowledge complexity within an intersectionalty framework, I use *anticategorial* (McCall, 2005) to describe the indistinguishable entanglement of living story and oppressions of identity fragments (dominantly labeled gender, race, and class). From my experiences, I feel this is one way of articulating some forms of discrimination. This is not to say that individuals are not able to label experiences as discrimination on the basis of race, gender, or class. It is not intended to erase narratives of racism specifically or specific instances of misogyny, for example. I am simply saying that an individual's understanding and experience need not be categorised based

on type (i.e., racism, misogyny, etc.) and may move between categorical (discrete) and anticategorical (indistinguishable) as individual persons are tied to many identities and it is sometimes difficult to distinguish the intent of an offense. An anticategorically complex approach embraces the intricate nature of social relationships and understandings, which work together to deconstruct and resist traditional conceptions of race, gender, and class interactions (Bhattacharya, 2012; McCall, 2005). Though I lean in favour of moving beyond scaffolds that create discrete identity categories, and I feel an anticategorical approach acknowledges complexity of genderace – a notion I explore while remaining critical of hegemonic structures that continue to marginalise – it is important that each of the forms of intersectionality are considered in this discussion.

An anticategorical approach to intersectionality frees inquirers to be boundless and respect fluidity in a process that explores interplays of race, gender, and class through a conceptualization of genderace. McCall (2005) argues against the necessity of categories and explains how the process of "dividing" supports the further marginalisation of individuals who bear the labels of those categories. An anticategorically complex approach to intersectionality serves to inform the current discussion by describing my understanding of the complex nature of multiple, interacting, and blurred social constructs of identity. The merged and blurred term genderace reflects how I understand narratives that speak to one's personal, embodied position. Thus, I refer to genderace in place of discrete internalised notions of gender, race, and class to talk about the boundlessness and dynamic nature of these ideas. In the next section, and through the rest of this document, I hope to describe the complexity of genderace and the diverse ways genderace is expressed through the body.

Genderace.

At first, I found it difficult to see race, gender, and class, let alone understand processes behind racialising, gendering, and classing, to name it and interrogate it in the contexts of care. I landed when I began to explore the CRT literature. Before this, it was difficult to identify with frameworks that mentioned race in an uncritical way. CRT helped to validate my feelings around race (the same way CRF and anticategorical intersectionality together validate feelings around genderace) and served to ground my positioning to begin to examine the world through a critical lens inclusive of genderace.

Within care settings in Canada, the interlaced and complex nature of race, gender, and class are not meaningfully captured by stating simply that differences exist between a rich, White male doctor and a poor, Black female nurse, for example. However, these constructions have been meaningful to society historically and create a starting point from which these constructions can be critiqued and alternative narratives can flourish. Many authors believe that limited descriptions exist to discuss and describe race, gender, and class beyond the dichotomies of black-white, masculine-feminine, and rich-poor (Fineman, 2008; James, 1997; Ladson-Billings, 1998). Much of the feminist and critical race literature I encountered spoke of normativity as a white, middle-class, heterosexual benchmark from which, individuals, like myself, are in some ways distinguished and othered. Further, labels beyond familiar dichotomies, such as bigender, gender fluid, genderqueer, third gender, two spirit, hybrid, multiracial, biracial, triracial, mixed, and among other local or in-group terms are limited and have only begun to proliferate in the literature in the last few decades (Fleras, 2014). Descriptions of processes that subjugate individuals into reduced identity categories from a Canadian perspective, too, are limited.

Together with the intercategorical and intracategorical presentations of intersectionality I read in formative literature for this project, anticategorically complex intersectionality theory is how I make sense of genderacialisation and genderace as part of a broader milieu of sociopolitical influence, which occurs at intersections of dominant languages, actions, and cultures. Evans (1991) in her chapter in *Women's Caring* on the consequences of gendered caring, describes the "feminization of poverty" (p. 169), wherein poverty is not only described by a lack of income, or living below the "poverty line" (p. 171), but with an accompanied sense of powerlessness, isolation and stigma. The undervaluing of "women's work" in the home and labours of care in public sectors results in a large proportion of women in poverty (Evans, 1991).

The term genderace is borrowed from scholars who feel that one construct of identity layered or interlocked (c.f. Patricia Hill Collin's 1990, in *Black Feminist Thought*) with another discrete identity category (i.e., gender plus race plus class) are not adequate representations of how either construct manifests in individual stories, even when added together (McCall, 2005). Developed in Europe, one such collaborative project called, "*Genderace: The use of antidiscrimination laws – gender and citizenship in a multicultural context*", explores accounts of multiple discriminations. The genderace project's website (Hedblom, 2010) states the following:

> As the phenomenon of discrimination entails complex and diverse understandings, so too may we view identities as multiple, often characterised by the intersectional experience. GendeRace advances the view that social relations based on gender, racialised identities or ethnicity influence the perception and use of antidiscrimination laws. […] the project demonstrates that multiple-discrimination based on racialised identities *and* gender remains inadequately addressed [emphasis added].

I infer class to be integrally woven through the conceptualisation of genderace and the politics of genderacialisation that create opportunities for genderace to be told through stories of the body.

In building on the usefulness of genderace in the project by Carles and Jubany-Baucells (2010) above, I would describe genderaced identities as being,

> subject to stereotypes, prejudices and ideologies that traditionally exist in societies […]. [Further, i]t should be stressed that although there exists the possibility of internalizing this identity, all people who apparently carry these identifiers may not feel a sense of group belongingness (Carles & Jubany-Baucells, 2010, p. 243).

Ideologies of inferiority bound to identity, or genderace, maintain systemic genderacialisation, discrimination, oppression, and the subjugation of individuals. Genderace and genderacialisation are terms that are conscious of the processes that occurred to create racism, misogyny, and socio-economic stratification and abandon this former language to create a new culture of language, power, and action.

In my attempt to articulate the powers that position individuals in static identity groups that align themselves with specific disadvantages, I hope to instead lean on the following description of discrimination, adapted from the description of everyday racism (Hedblom, 2010) in a way that moves beyond traditional limitations of identity spectra. Prejudice through language, practice, and attitudes is something that I challenge through this research, but more broadly I challenge:

> any -ism based on reproduced personal or embedded structural ideologies that reify another group as inherently inferior to the inherent superiority of dominant powers, which include processes that disadvantage individuals due to the belief that physical characteristics, such as biologically assigned sex or skin colour, is inferior or responsible for producing immutable negative behavioural traits or poverty. Ideologies that believe one's socioeconomic circumstances, socially assigned race, and biologically determined sex dictate the value and behaviours of individuals, which justify oppression, discrimination and genocide (Hedblom, 2010, n.p.).

I am intentionally broad with aims to challenge hurtful and exclusive ideologies that aim to disenfranchise individuals, as through genderacialisation undervalued labourers of care are often met with multiple, intersectional *-isms*. Again, the challenge is not locating one point of

discrimination (i.e., racism, sexism, etc.), but to reposition power with individuals who experience injustice in a non-essentialising way while maintaining focus on structures that perpetuate the injustice. An inquiry that is anti-racist, social justice focused understands "that bodies and identities (race, class, gender, secuality, [dis]ability, etc) are linked in the production of knowledge and, specifically interpretations of experience" (Dei, 2010, p. 3). By moving beyond historically laden knowledge and labels, together with PSWs with intersectional identities, I vision a reformation of a binarising culture and a reclamation of worth through stories of genderace that live in the body.

To summarise, genderace is fluid in its consideration of processes of racialisation, gendering, and classing. I use the term genderace to acknowledge and describe: (1) bodily reflections of processes that socially construct traditional silos of identity; (2) the various processes that work to acknowledge complexity through intersectionality; (3) fluidity and variation in the application of genderace constructs of identity through time and context; and (4) how stories of genderacialised women of colour will differ from white men, racialised men, white women, from narratives of other racialised women classed across the socio-economic spectra. Through this research, I interrogate these constructions by hearing narratives of care in the context of PSW work in LTC homes, in effort to paint a broader picture of care that is more complex than "coloured women's work." The next section examines the paradox of labouring genderacialised bodies.

Labouring Bodies as Invisible, Genderacialised Bodies as Spectacles

As mentioned, I have yet to come across works on genderace or literature that links processes of genderacialisation to labouring bodies. I do know that processes of racialisation, gendering, and classing are done *to* bodies and that labouring bodies are also racialised,

gendered, and classed. As juxtaposition to knowing the body as a biological and phenotypic presentation of identity and as a functioning object, here, I describe my knowing of the genderacialised labouring body as a paradox, a body that becomes both invisible and a spectacle. As I continue to unpack structures that marginalise bodies, I am asked to consider the tension that exists between the visibility/spectacle of bodies of racialised women who engage in the labour of care and the invisibility/hiddenness of care labour. Specifically, with body as subject, I describe how we can know stories of the genderacialised body through narratives that embody labour.

Subscribers of critical theory understand the world to be composed of historically created, and contemporarily recreated, struggles for power and justice within socially constructed systems of economics, politics, education, religion, culture, discourses, ideologies, and identities (Delgado Bernal, 2002; Kincheloe & McLaren, 2005). In pursuing research grounded in critical theory an assumption is made where, "...all human relationships embody negotiation[s] of power and narrative (due to its grounding in human relationships) [and] must also be associated with power relations" (Prosser, 2009, p. 610) and hegemonic structures. This assumption is key to understanding how we can glean insights on the embodiment of genderacialisation through personal narratives by PSWs employed in heirarchial structures of caring. Power in systems of caring is often unidirectional and top-down in any sphere structured within the capitalist production machine. The labouring body/worker, then, becomes situated as "an appendage of the machine" (Marx & Engels, 1967, p. 87), "a cog in the machinery of capitalism" (Marx & Engels, 1967, p. 87), and "disposable assets" (Synnott, 1993, p. 24). Engels (1968) discussed how labouring bodies engaged in factory work become frozen in the stances of repetitive working positions. In care, there is an understanding that, after many long years of bedside work that

physical tolls are incurred on the body's joints, including those of the lower back (Jensen, et al, 2006) and neck (Ariëns, van Mechelen, Bongers, Bouter & van der Wal, 2000). Mooers (2003) described how the level to which one is visible, "is ultimately determined by where one stands in the chain of social relations linking the sphere of production and the public sphere" (p. 2) and that only certain bodies are "worthy" enough to become socially visible. Works on embodied narratives of labouring body in care structures have not addressed the invisibility that occurs with production through care.

Knowing care as a constructed responsibility of women and subsequently a feminine act is helpful for understanding the gendered nature of care. However, processes of genderacialisation that maintain care as reproductive work, discussed in the previous chapter, is often overlooked. Together with the processes of racialising and classing, the labouring body is, too, acted upon and shaped by our production-centric society. The distinction here is the disparity that exists between the invisibility of labouring bodies in PSW care work (despite the labouring body under constant surveillance to ensure the body remains labouring) with the spectacle of the "othered" bodies (Hall, 2001) – bodies that are made spectacles by difference from socially normative, socially visible, white male bodies to reproduce inequities (Connell, 1987; Freund, 2006). As noted in previous sections, the discourse on racialisation is structured by binary oppositions (Hall, 2001), and as such, there is a need to move towards genderace and knowings of genderacialisation to more adequately frame the complex and nuanced embodied knowing of visibility, hypervisibility (Mowatt, French, & Malebranche, 2013), and body as spectacle (Hall, 2001), especially when structured as a socially invisible labouring body.

In addition to how labouring bodies are shaped by and perceived in society, individuals also have a role to play in altering presentations of the body. According to Freund (1990), it is

what or how one invests into the different forms of self-body work that dictates perceptions of status including that of labour engagement on body subjects. Further, work on the body constitutes much of how society determines social stature through traditional categories of race and gender (Shilling, 2012). Self-maintenance and appearance work, emotion work, and inter-corporal work are three forms of body work (Gimlin, 2007). Self-maintenance work is the work put into our bodies around activities of daily living (i.e., bathing, feeding oneself, dressing, make-up, brushing teeth, etc.). According to Hochschild (1983) in paid labour, emotion work has three components: (1) face-to-face interaction with other individuals, (2) the necessity that workers produce specific emotional states in others, and (3) supervision that enables employers to have control of the emotional states of employees. Emotion work may involve "surface acting" (Hochschild, 1983, p. 33), (i.e., feeling something and showing a different emotion), which is linked to moral residue (i.e., feeling one way and acting in a different way) in care work. Inter-corporal work, in particular, concerns labours of care as it pertains to work done to the bodies of others, which is both intimate and emotionally exhausting in many cases (Twigg, 2000).

Ailments, lack of body work, or other presentations on the body may be mitigated by 'status shields', a notion popularized by Hochschild (1983) who suggested that status shields protected people from a loss of control in working environments and injury to one's self esteem. A lack of status shields, Hochschild suggests, facilitates one's feeling of disempowerment and dependence on structure for a sense of being. Understanding more about body work (i.e., care of self and intra-corporeal body work) and being in structure through body maps is the key to knowing more about in the paradoxical invisible/hypervisible genderacialised labouring body and the relations between the body in care and society. Embodied knowing is needed to reveal

the genderacialised body as a spectacle, "a mask of identity" (Shilling, 2012, p. 226) or 'body

mask' (Fanon, 1952) as a 'second skin' (Fanon, 1967) with tensions of working body as shaped

by the labouring needs of production. How one relates to disconnections and tensions that live in

one's body and how one takes up or suppresses self-body work as a labouring body in hidden

health care emerges and becomes visible on the body by body mapping embodied stories. I will

talk more about this in Chapters 5 and 6.

The labouring body and embodiment.

The body plays an important role in knowing aspects of narrative that have not yet, or

never needed to be articulated in words. Cregan (2006) describes how selves are lived and

storied through the body. Cregan (2006) considers the body by acknowledging:

1. We relate to each other as social beings through our embodied being, and the fact our social interrelationships shapes the way we constitute our embodied being (p. 5).
2. Different societies, cultures, constitute embodiment in different ways (p. 5).
3. As social formations change over time, the settings in which bodies are lived layer more abstract disembodied relations over more immediately experienced embodied relations. Importantly, however, that does not mean prior understandings of embodiment disappear; different 'embodiments' can and do co-exist, albeit in tension (p. 6).
4. Those shifts, and the intensification of the processes of abstraction, are related to wider shifts in interpretations of the physical world and our relation to it, which in turn lead to an intensification of the rationalisation (the body as particularized, divisible object) and commodification (the body as property) of embodiment (p. 6).

Cregan's notions of embodiment reflect how I understand and navigate the power and

potential of the body in telling narrative and how narratives can be told from a perspective of the

politicised body. Embodiment is a way of knowing, living, and understanding existence:

Embodiment is lived across all forms of community as a deeply-embedded social-relational category. It is an ontological category constituted as both the context and the outcome of patterns of social practice and meaning [...] Different social formations are framed in terms of fundamentally different senses of embodiment [...] Across history, more abstract modes of living our bodies have become more layered across more concrete ways of doing so, reconstituting rather than replacing those 'prior' forms. That is, across world-time and world-space, bodies are constituted

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> differently intersecting levels of abstraction [...] This reconstitution of embodiment
> has political consequences intimately connected to the abstraction of time and space
> [...] As dominant ways in which we live become more abstract, our bodies have
> become more open to the processes of rationalization, objectification,
> commodification and political-cultural management (James, 2006, p. 181).

Through stories of the body, in the excerpt by James (2008), what is known is a coalescence of social context and meaning. Embodied stories are socio-political formations that can help people to better know processes at play that maintain oppressive narratives. Embodied narratives may also hold insights for understanding what resistance or alternative stories to narratives of commodified bodies looks like. To do this, we must frame body as subject – a body that is "invested in the individual and in individual experience within a wider social complex" (Cregan, 2006, pp. 6-7). Thinking of body as object, as "a body shaped to conformity to external rules and regimes" (Cregan, 2006, pp. 6) is narrative that will be considered and critique in the earlier stages of this inquiry, specifically around the first body mapping exercise (described in Chapter 5).

> Our relationships to one another and ourselves are all mediated by the spectacle. We see
> one another, and ourselves through the spectacle of race, nation, gender, sex, and sexual
> orientation. These spectacles come with imperatives that, being hidden within, remain
> beyond critique (Farley, 2002, p. 136).

The labouring body as subject encompasses body work and all identities and meanings imposed by culture discourses and social identities. In the next chapter, I discuss the need for flexible narrative approaches with multi-method analysis and creative representation within this inquiry to complement the dynamic positioning and plurality of genderace.

CHAPTER 4. Engaging with/in Narratives of Care: An Improvised Intersectional Narrative Inquiry to Hear Genderacialised Women

Disenfranchised people of color theorize, but they theorize in different ways.
They tell stories. Hear us, and hear us in our own voices. It is only then that
you will truly hear us (Brown, 1995, p. 514).

In chapter two, I described a collection of politics of genderacialised care specific to racialised women working in LTC homes. Collectively, these structures of invisibility exist through capitalist production, neoliberalism, and systemic marginalization, which together prop up the illusion that women working as PSWs are *given* opportunities to participate in work. Critical narrative inquiry moves from a need for reliability, objectivity, generalizability, and validity (Pinnegar & Daynes, 2007) to shed light on the particularities of a context and an individual's experience within this context. I refer to critical narrative inquiry as a starting point, because not only do I as a scholar-activist need sight of a better reality but also, to become conscious of an ideal version of care work we must make reference to or have knowledge of those things that are not working. Understanding what this study aims to be critical of at the outset, I feel, is a necessary beginning to bridge to new knowings beyond practices already established and entrenched. This inquiry critiques structures that continue to construct realities of difference, and subsequently construct inequities, for racialised women in effort to forward neo-liberal and capitalist agendas that situate individuals as projects of a larger socio-political machine. The psychic gain of being part of workforce does not account for the biologically deterministic nature of classed, racialised womens' care work, nor does it take into account the unquantifiable social and personal negotiations that occur as a result of difference making and resulting stratification of these differences in labour.

As a reference for the rest of this document, I outline definitions of: living story/story/stories; memory/personal narrative/narrative; identification of the grand

narrative/master narrative; counter-narrative; collective/collaborative and polyvocal narrative; and unbecoming through antenarrative. I integrate notes on temporality as it relates to each narrative form and how I intended and used it in this study. Specifically, though the methodological lens of critical narrative inquiry, I discuss body mapping and digital storytelling as methods for telling and hearing women's stories. These methods are two examples of collective narrative and antenarrative work that we, a collective of racialised women narrators and care persons, embarked on. In this chapter, I make the case that body mapping and digital storytelling as narrative methods are useful for attending to stories that have been rendered invisible. In Chapter Five I describe the step by step process that unfolded in this research and how participants connected with body, located stories to tell, and began to articulate stories about labours of care.

Creating a Critical Narrative Inquiry for Hearing

Outside of the research context, participants naturally engage life stories as storytellers and as active agents in forming personal reflections and interpretations. Feminist scholars consider women's voices to be muted, multiple, and contradictory (Chase, 2005) and like advocates of CRT, have aims for creating forums where voices of women are included and explored through narrative. For example, according to Brown (1995), "feminist scholars have been vigorous proponents of including women's stories in legal analysis" (p. 517) and have been considered allies of critical race theorists in broadening understandings in ways different from other methodological forms. In feminist ethic of care literature, for instance, scholars use narrative (e.g., in narrative ethical theory [Martin, 2007; Meyers, 2004]) to challenge grand narratives of women's roles in caring relationships (among other subjugated gender roles) (Lawrence & Maitlis, 2012). In traditional ethic of care understandings, acts of care as moral acts

are conceived on universal terms. Understandings of morality can shift to consider particularities of each individual's "past history, present state, and future plans" (Martin, 2007, p. 10) in life stories about caring through a feminist ethic of care lens and with the use of narrative inquiry.

Critical race narrative inquiry confronts a paradigm based on merit and perceived value of work by challenging "objectivity, neutrality, meritocracy, and colour-blindness" (Brown, 1995, p. 514), which have been taken-for-granted in traditional forms of research. In illuminating experiences of race (among other stratifications), CRT's reliance on narrative is "explicitly pragmatic" (Brown, 1995, p. 514). Drawing on the multiple lenses used in this study is a means to emphasise the importance of hearing through complexity and acknowledging the peculiarity of each intricate story of genderacialisation.

Centring genderace in listening to experiences of care demands an approach to listening and *telling* different from ways master narratives, or dominant stories, are communicated. *Telling* privileges a way of fashioning self and identity (Bamberg, 2004). If the ways in which individuals are asked to tell stories are limited, then so too is what we can know about expressions of self, identity, and living story. In this section, I describe critical narrative inquiry followed by two collective methods I thought would be most useful for listening and the different tellings of stories of genderacialised care by racialised women in PSW roles. I use an improvised critical narrative following methodological scaffolding[14]. Improvisation of this narrative inquiry involves use of body mapping and digital storytelling, two methods for conveying reflective, projective, and iterative personal and collaborative narratives. I describe in detail how I facilitated discussion/activity groups as qualitative methods for engaging narratives and critically reflecting on stories.

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[14] Scaffolding through the eight-points of decision making considers ontology, epistemology, theory, methodology, methods, methods of collection, implicit interpretation, representation, and conclusions or non-conclusions to "construct an aligned, yet fluid research design" (Berbary & Boles, 2014, p. 403).

In critical narrative inquiry, some guidelines were helpful for me in situating methods and my methodological practice of narrative. Guidelines outlined by Kincheloe and McLaren (2004) conveyed that in narrative/story: (1) all thought is mediated by socially and historically created power relations; (2) that facts cannot exist in isolation separate from dynamic values and ideologies influenced by capitalist agendas; (3) subjectivity[15] is integral to interpretation and awareness; (4) inequity of privilege exist and are most clearly stated when subordination is accepted "as natural, necessary, or inevitable" (p. 304); (5) that oppression exists in many forms and recognizing one over another often ignores interconnections that marginalise; and (6) research often reproduces systems of race, class, and gender oppression (Kinchleoe & Steinberg, 1997). In reflecting on my use of critical narrative inquiry, critical values were reflected through my considerations of relationships with participants including, negotiations of voice and power in working towards the location, development, and positioning of each unique story in analysis and representation through lenses of CRT and feminism(s).

Although forms of CRT, like AsianCrit, BlackCrit, Latino/aCrit, or WhiteCrit place a greater focus on issues that pertain to any one specific group, for me, an alternative must be explored away from grand-essentialisations (grand narratives) and, what may come across as, microessentialisations of a specific group (i.e., representative counter-narratives, which appear to blanket over a specific marginalised group). Critical narrative inquiry seeks to: 1) "treat narrative as a separate form of discourse" (p. 656) in understanding one's own and others unique actions, statements, and points of view; 2) value realities brought to the fore by PSWs as narrators of personal stories as verbal action; 3) recognize systemic, socio-economic and cultural constraints

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[15] Bernasconi (2011) describes, "Foucault's work in the 1970s and 1980s documented the history of subjectivity, analyzing structures of discourse and how their use forms and rearranges the codes of knowledge through which the self is produced" (p. 21).

that inform negotiation of care and leisure; 4) capture a perspective told from a socially situated place formed from ongoing dialogue within a group; and 5) view each co-researcher as one narrator of interpretation throughout the research process (Chase, 2005).

For the purposes of this study, living story, stories, or story will refer to overarching descriptions of one's many narratives; in the moment understandings and experiences, interpretation, and insight; and hopes for future realities. Ryan (2007), who conducted an analysis of definitions of narrative used by narratologists, suggests narratives that individuals tell are about problem solving, conflict, interpersonal relations, human experience, and the temporality of existence. She also suggests that narrative consists of four common elements: "material signs, the discourse, which convey a certain meaning (or content), the story, and fulfill[s] a certain social function" (Ryan, 2007 p. 24). The terms 'narrative' and 'story' are often used interchangeably. Schwandt (2007) defines the term narrative as "a personal experience story that relates the teller to some significant episode, event, or personal experience" (p. 201). Story or stories are plot lines used to describe individual(s)' past and present experiences and plans for the future. Living story refers to an individual's unfolding-in-the-moment beingness (Bakhitin, 1990, 1993). From my reading of the literature, terms like memory, personal narrative, or narrative refers to one's description of past events, a retrospective telling of a part of a story, which may or may not coalesce with (historically or contemporarily relevant) dominant societal discourses.

Challenging the grand narrative: Counter-narratives and the emergence of power in discourse and language.

This critical narrative inquiry seeks to challenge established grand narratives. Grand narratives are largely reflective of and rooted in dominant culture/structure (i.e., popular culture, mainstream media, privileged narratives, etc.). Grand narratives have been historically shaped by

societies' elite and are reproduced contemporarily to influence relations of power within societies, communities, organizations, and in relationships. Use of narrative inquiry is found extensively in CRT literature in an effort to first, include voices of colour (Delgado & Stefancic, 2012) traditionally excluded from mainstream discourses of privilege and second, to challenge a meritocratic paradigm (Brown, 1995; Ladson-Billings & Donner, 2008). In using critical narrative to attend to muted voices in favour of anti-essentialist, anti-racist and anti-sexist writings and agendas, women of colour can "claim identities outside of the master narrative" (Ikemoto, 1995, p. 313) by using personal stories to centre participants' own unique realities. I refer to broader discourses, privileged as "universal" in nature, as grand or master narratives (Schwandt, 2007). Counter-narratives are alternative narratives that may or may not conform to grand or master narratives; they are what Bamberg (2004) refers to as the "small stories" that are told in passing, in everyday encounters with each other.

Counter-narratives are often compared against or have some resemblance of master narratives and these differences and similarities may create tensions of power for the storyteller (i.e., assimilated understandings to fit in with the dominant group). Counter-narratives may present as personal narratives or collective narratives. In this inquiry, personal narratives, collective narratives, and narrative(s) participants were asked to compose/locate, were uncritical reproductions of grand narratives, uniquely personal counter-narratives, or suggestive of something much deeper than narratives that were most directly addressed (i.e., no wage increases, poor treatment of staff, little respect from family members, etc.). Though I felt it was important to critically reflect and interrogate reproductions of grand narrative through this critical narrative inquiry, it was not useful nor the purpose of this inquiry to discredit individual participant's narratives if individual narratives reflected impositions of grand narratives in care,

labour, or identity categories. I went into this process with recognition that the narratives shared would be far more complex than distinctions of master/counter narratives suggest.

My use of critical narrative was most appropriate for supporting stories by women of colour given that "investigations of counter strategies seem to be guided by a deep concern with power and hegemony" (Bamberg, 2004, p. 353). Discourse can disrupt hegemony in the production and transmission of power (Shaw, 2001) by interrupting how dominant ideologies are perceived to maintain dominant power relations. Foucault's (1972) work on discourse sheds light on the perspective that power is created, shared, and recreated through discourses. Discourses are concerned with the production of new knowledge and new power vis-á-vis resistance of dominant power (Ramazanoglu, 1993).

Beyond resistance and transformational change, my agenda for narrative stories was to create awareness of genderacialisation that informed participants' care and leisure experiences, and to contribute to relevant bodies of literature by centralising whatever emerges from stories. As this process was relational and collaborative, it was difficult for me to control and predict its path; nor would I choose to direct or force a particular outcome. Instead, I intended to open space for dialogue that engaged women in reflection on aspects of their personal stories to see what could be revealed in a collaborative process of *conscientization*[16] (*conscientização*) (Freire, 1970), which, may or may not have lent itself to the creation of counter-stories. Solorzano and Yosso (2001) describe, "at least four theoretical, methodological, and pedagogical functions" (p. 475) that could guide the creation of counter-stories. Framed by CRT and feminist theories, counter-narratives:

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[16] "intensive reflection of oneself in relation to society" (Freire, 1970 in Carr, 2003, p. 8). *Conscientização* is possessing critical consciousness and having perception of the political, economic, and social "contradictions", critical reflection towards "action against the oppressive elements of reality" (Freire, 1970, p. 35).

1) build community among individuals at the margins of society;
2) challenge dominant discourses built by society's 'mainstream' by transforming and contextualizing established belief systems;
3) expose new realities beyond existing grand narratives and communicate solidarity to others in similar positions; and
4) (de)construct rich alternative realities by weaving parts of reality with story.
(Solorzano & Yosso, 2001)

Counter-narratives satisfy a need to resist established stories by departing from grand narratives. Personal narratives through body mapping and tellings of body maps illuminate nuances of care experience that traditionally sat silently beside established grand narratives of modern, white, fem culture (from the "we-can-do-it-too" to beyond the "we-can-do-it-better, have-our-cake-and-eat-it-too, achieve-it-all" ideology of womanness). By seeing what processes stratify present living stories, space is created to shed established structures to self-liberate in self-creating new stories.

The notion of genderace attempts to lay claim to new territory, a new discourse, that resists dominant essentialisations of a subject (i.e., gender, race, and class) while acknowledging histories that have shaped each subject,

> I don't believe the problem can be solved by historising the subject as posited by phenomenologists, fabricating the subject that evolves through the course of history. One has to dispense with the constitution of the subject within a historical framework. This is what I would call genealogy, that is, a form of history which can account for the constitution of knowledges, discourses, domains of objects, etc., without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history (Foucault, 1977, p. 117).

With this in mind, I continue to emphasise that languages and resistances within narratives offered by racialised women who act as PSWs often times did not reflect new language described by this inquiry (like the language used in my guiding research questions, for example). Languages and resistances by racialised women, at times, reflected colonised thought that

privileged White merit and power through the use of language that reproduces oppression and neoliberal values. For me, this necessitated a transition to knowing stories apart from counter stories often thought to resist discourses of dominance. Separate from hearing how and where one describes their bodies in relation to the milieu of forces that work to stratify, label, and control, I aimed to hear how the labouring body seeks to address care for others and themselves. By listening to embodied knowings, where identity is anticategorical (i.e., genderace), I could begin to tap into stories of genderacialisation acquired through the senses from the perspective of the labouring body.

Anticategorical antenarratives.

In this antenarrative work, I supported women working as PSWs by facilitating a process that saw possibilities for labour beyond current experiences of genderacialisation. My role was also to support iterative recording of a "new story" (Boje, Rosalie, Durant, & Luhman, 2004, p. 756) that shed multiple meanings for different individuals and may provide a glimpse of what is missing from our current system of care. I believe antenarratives function differently than counter-narratives. Counter-narratives serve to resist, to which racialised women fulfill not only through stories told, but also through their living story of being. Counter-narratives live on the body and are cognitive knowings of what is. Antenarratives are pre-emergent body narratives. Antenarratives are not composed; rather, antenarratives *become* through a process of liberation from dominant narratives (which work to reduce and fragment identity). These types of narratives are spoken from within (embodied and felt knowings) and are told through the body. An antenarrative is the space between narrative (i.e., past experience) and living stories (i.e., current experience) where possibilities of *what could be* or a reckoning of *what is* are explored. Antenarratives have, according to Boje (2006), a double meaning, encompassing both fore-

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having (prior to having knowledge of) and fore-telling (predictions); are situated in the middle of

macro (grand narratives) and micro (counter-narratives) narratives; and are "in between" (Boje

2001, p. 293), "refusing to attach the beginnings and endings needed to achieve narrative

closure" (Boje, Rosalie, Durant, & Luhman, 2004, p. 756). An anticategorically complex

understanding of intersectionality can be realised by remaining open to, and at the same time,

critical of existing privileged understandings of race, gender, and class. Antenarratives arising

from collective reflection on stories are important vehicles for learning how the labeled body is

tied to hope for change, transformation, and what story *is* in the moment. David Boje, a scholar

in organisation science who extensively uses various forms of antenarratives in his work

provides a number of examples to guide antenarrative location. In one of his many antenarrative

papers, Boje and colleagues (2004) describe theory that informs anternarratives:

> Antenarrative theory is closely tied to Kristeva (1986, p. 36) and Bakhtin (1981),
> who suggest that each text has 'intertextual' trajectories that are historical and
> social (Boje, 2001a; O'Connor, 2002), and to Fairclough's (1992) critical discourse
> idea that the intertextual trajectory is embedded in hegemonic struggle. (p. 756).

In her antenarrative representation, Vickers (2005) weaves her reflections with segments of

conversation that capture snapshots of ambivalence, uncertainty, heterogeneity, fragmentation,

and paradox in the life stories of participants who live with chronic disease and work. Vicker's

antenarrative representation conveyed many messages, but for me, it communicated the need for

organisations to work with individuals with unseen illness in creating environments of

acceptance of diversity, openness to multiple voices, inclusion, flexibility and respect "– a just

workplace" (Vickers, 2005, p. 74).

I also feel antenarrative also occupies liminal space epistemologically. Though there are

inherently critical tendencies of antenarrative (and a body of literature to support this),

antenarrative supports post-humanist notions and adopts a post-structural lens for being and

hoping. Narratives by racialised women are *already* counter-narratives. Antenarratology simply offered a way of conveying knowings and desires through narrative in ways resistant to the linear, coherence that traditional, hard-and-fast, morale-as-conclusion narratives typically offer. I pulled on antenarrative literature because of the consideration antenarrative gives to history of story, considerations of narrative inquiry, and the attempt antenarrative makes to open up space for being as-is without striving to fix raw story, make pretty, readable, accessible, or be apologetic to audience for doing so. I believe, antenarratives simultaneously attempt to become (are not composed) and un-become (resist and redirect). This is powerful as: (1) there was freeness[17] in *becoming* rather than *making;* and (2) structures construct racialised women in ways that fragment and reduce story, so, *un-becoming* the rigid dominant story yielded power in a meaningful way for women. If counter-narratives existed in telling of genderacialised stories, then antenarrative storying offers a new way of seeing, hearing, and feeling stories. New stories told simultaneously through, with, and beyond knowings of genderace. Revealing antenarratives, meant unpacking the momentary, shifting, embodied, and genderacialised discourse effected by structures interacting with genderace. To do this, it was necessary for a collective of women in care to come together and share living stories within a genderacialised structure of care.

Collaborative and polyvocal narratives.

At any point during research, collaboration can inform any decision (Berbary & Boles, 2014) and may range from little participant input where researchers guide the majority of the analysis and representation, to full participation where participants shape all directions of research from project inception (i.e., participatory action research). I use collective or

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[17] Rather than freedom from. In notions of freedom there is no attachment to meanings that exist prior to subject interaction with storying narrative, where in antenarratology there is an assumption that a pre-emergent narrative (informed by previously formed assumptions, ideologies, structures, etc.) lives in body prior to narrative becoming.

collaborative narratives interchangeably because, to me, they refer to the input of many in the co-operative manner through which narratives are composed in a group. This collective narrative is positioned away from dominant, systematic narratives. But, as I suspected, there were also reproductions of discourse as individuals discussed negotiations of dominant systems. In individual tellings of embodied story and through reflection, participants engaged in dialogues revealing the complexity of what it means to navigate prominent discourses allowing for complexity, paradox, and tension to be expressed.

Collective narratives are polyvocal; that is, many voices contribute to these collaborative representations and as "we assemble different pieces of the Story, our bricolage begins to take not one but many shapes. Slowly it dawns on us that there may not be one future, one "moment" but rather many…" (Lincoln & Denzin, 1994, pp. 583-584). Polyvocal narratives are not theme-focused, universalising, and consensus oriented collective approaches. Instead, it is a "'new story' [that] offers a reflexive narrative that articulates the taken-for-granted core assumptions and ideological position" (Thompson, Stem, & Arnould, 1998, p. 115). The collective narrative is:

> …not one "voice" but polyvocality; not one story but many tales, dramas, pieces of fiction, fables, memories, histories, autobiographies, poems, and other texts to inform our sense of lifeways… (Lincoln & Denzin, 1994, pp. 583-584).

Narratives, grand narratives, and counter-narratives are temporally situated and compared against one another as the nature of a story permits itself in socio-political relevance and as each of these narratives are informed by history.

Selecting Among Collaborative Visual Methods

Some examples of collaborative narrative methods include: body mapping (c.f. Solomon, 2002); digital storytelling (Gubrium & Harper, 2016; Otañez & Guerrero, 2016); collective

memory work (Huag, 1987; Markula & Friend, 2005), duoethnography (c.f., Berbary & Boles, 2014; Norrick, Sawyer, and Lund, 2012), collaborative narration (c.f., Leung, 2009; Norrick, 1997), convergent/braided narrative (c.f., Goodall, 2008; Skloot, 2010), antenarratology (c.f., Boje, 2007), and other combinations of participatory storying (Bishop, 1999). In an initial proposal draft, I thought collective memory work would be appropriate as the chosen collective method for this research. As I reflected on the method more, a few assumptions about participants began to creep into my decision about whether collective memory work was the best way to hear participants' stories of their labours of care. Ultimately, I decided that collective memory work -- a time and writing intensive method -- might not have been the most appropriate approach. This decision away from collective memory work came with its own assumptions. With the understanding that women engaged in PSW labours of care have scheduled shifts and other home responsibilities, a time intensive research schedule would not have been conducive or respectful to women attending to other (self-)care priorities. At times in my research process, I felt that my study design impinged on women's ability to attend to other priorities, a negotiation of ethics I take up later in this chapter. Also, with an understanding that creative, reflexive writing is not a regular part of PSW work, writing intensive activities required by collective memory work may have been uncomfortable for participants. Given the politics of genderacialised care I presented earlier, I felt my assumptions were my way into seeking alternate ways of hearing and telling personal and collective stories through mediums besides writing, leading me to body mapping and digital storytelling as visual methods.

Both methods were amended to encourage narrator participation in composing representations of stories that, simultaneously, were forms of critical, present and future-focused counter narratives. Before describing the details of my approach to body mapping, I feel it is

necessary to describe the value of having engaged in multi-modal (i.e., visual, verbal, and written) tellings of living story. First, I discuss how visual methods communicate stories in ways different from traditional written story and then I go into detail about body mapping and how it aligns with the nature of the work we engaged in together as a collective.

In health research, there has been a greater uptake for hearing narratives through qualitative data, visual methods, and engaging methods of dissemination (de Jager, Tewson, Ludlow, & Boydell, 2016). Visual methods (including digital research) are cited as part of the "participatory shift" in the social sciences aimed to amplify decentered voices (Gubrium, Harper, & Otañez, 2015). In an interview-style paper by Gauntlett and Holzwarth (2006), Gauntlett presents five justifications for pursuing alternative ways for knowing through visual methods/methodologies. He argues that, first, methodologies are the heart of the social sciences, through which we gain information about our world and without a "good and varied set of tools for understanding how people think about and respond to their social worlds" (p. 84) our range of knowing is limited. Second, in asking participants to *create* as part of the research process, I sought a different way of answering my research questions. For me, this was particularly significant given the ways expert-knowledge is traditionally valued in hierarchical structures. What we know from the politics of genderacialised care and racialised women who participated in this study is that PSWs are more likely to: 1) not be equipped with credentials that individuals value, and thus/or 2) racialised women in PSW positions do not have a platform to voice stories that inform changes needed in settings of care labour. Third, Gauntlett and Holzwarth (2006) describe the trend of popular culture towards the visual, which means visual research, especially visual digital research has that much more access and reach. Fourth, art-, activist based methods (Dufour, 2002), including visual methods, facilitate more options for individuals to "thoughtfully

communicate their own meanings and understandings" (p. 84) (Gauntlett & Holzwarth, 2006),

rather than providing finite options and asking to confirm researcher assumptions. The

composition of art is activism and activism is art according to Dufour (2002). In this light,

exercises of art as activism mean "employing strategies that involve collaborations and

communities, processes rather than products, artistic production in the social realm rather than in

museums, [where] artists are able to effect and challenge social realms beyond the specific

context of art itself" (p. 157). Used in this way, "art is able to situate itself in new ways in

different social and geographic settings, posing and investigating questions through its particular

mode of meaning production" (Dufour, 2002, p. 157). Body mapping and digital storytelling as

art are engaged, iterative, and embodied processes that stimulate the want for action by

participants involved in the research and observers of subjects' mapped bodies and digital

stories.

The last justification authors Gauntlett and Holzwarth (2006) offer is in reference to the

wholeness of an individual involved in creation through creative and visual methods, rather than

participant acting as "audience" (p. 85). From this reading, I understand this to mean that when

research is represented *for* participants, meanings are unpacked about participants' stories

without their input. Interpretation *for* has social consequences for narrators of stories shared

through this project. In the visual representations of women's stories through digital stories and

body maps, women are the primary creators and directors of this work. I acknowledge part of

this research, specifically the antenarrative portion, moves through my interpretation of women's

stories without participant input. I value the need for both participant and researcher

perspectives. I believe that with participants' interpretations, different perspectives on a story can

build off one another in developing a nuanced knowing and a heightened *conscientization*

(Friere, 1970). I see researcher interpretations as valuable so long as reflective commentary and analyses are thoughtful, critical, and respectful of women's living stories.

Buckingham's (2009) criticism of Gauntlett's position (one that is rooted in media studies) on identity, as being innate to an individual rather than socially constructed, is a useful perspective. How one represents/expresses self (whether innately influenced, socially constructed, or some combination of both) is a debate that will likely remain unsettled. One's claimed identity (both with socially constructed and innate influences) and expressed embodiment through art (again, with both socially constructed and innate influences) links to expressions of embodied genderace as a reflection of genderacialisation at work (c.f. Bourdieu's notion of *habitus*). It was important to me that I focused on women's interpretations of their narratives as a reflection of genderacialised structures, as these interpretations of story formed the basis from which the antenarrative of labour through genderace could unfold. Women's stories of genderace (expressed through symbols, pictures, and words on body maps) reckoned with their positions in the prioritisation of care in the many hierarchies that existed in their lives (i.e., labour, leisure, and self-care). Insights on the influence and power of genderace and structures of genderacialisation could only be gleaned by women reflecting on the stories told by their genderacialised labouring bodies in care.

Body mapping: Moving to embodied awareness in narrative.

The first documented use of body mapping in Western research was in 1987 by MacCormack and Draper's (1987) who looked at comparative fertility rates between women living in rural Jamaica and the UK. This study used the full body to represent understandings of body awareness and revealed differences from Western notions of embodiment (de Jager et al., 2016). In other studies, body mapping has been used to: create space to discuss issues that were

difficult to talk about (c.f. Solomon, 2002); increase awareness, decrease stigma, and protest for affordable health care (c.f. MacGregor & Mills, 2011); and tell the stories of undocumented workers (c.f. Gastaldo, Magalhães, Carrasco, & Davy, 2012). Body mapping, a research method with therapeutic, artistic, and political roots (de Jager et al., 2016; Gastaldo et al., 2012) is used in a variety of fields, including psychotherapy (Crawford, 2010), health (Ludlow, 2014), labour studies (Mitchell, 2006), education (Ebersöhn, 2015), and social work (Huss, 2012), among other disciplines that aim to understand living story embodiment through visual methods. One major theoretical understanding of using the body as subject through this method (from anthropology) is that each body is "marked" by culture and society (Demello, 2013) and each body wears "social skin" (Turner, 1980). Across the body mapping literature, the body mapping technique works to provide insight to mobilise community development, social justice, and therapeutic and/or clinical settings (de Jager et al., 2016).

A systematic review on body mapping conducted by de Jager and colleagues (2016) revealed three aims of this visual research method: social justice, embodied awareness, and knowledge translation. Through personal narratives or *testimonios* (Gastaldo et al., 2012), body maps aspire to centre stories otherwise made invisible by oppressive structures (de Jager et al., 2016). The body is in focus through this method, however, the body is also symbolic of mindful processes such as feelings, beliefs, and reflective consciousness which implies participants have power to exercise agency (Capra, 2002). Body mapping can be used in a number of settings and can serve as a tool for: treatment information and support, research, advocacy, inter-generational dialogue, team building, art-making, and biographical purposes (Solomon, 2002). In this activist research, we engaged body mapping to draw out and listen to stories on embodied meanings of genderacialisation; corporeal stories of labours of care, self-care, and leisure; and knowings of

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PSW and/or personal identity to inform the aims of this study.

Body maps work to help individuals to articulate embodied feelings and notions of identity that are made invisible by social processes and systems that subversively work to stratify bodies. If embodiment is "the physical and mental experience of existence" (Cregan, 2006, p. 3), then body maps draw individuals to intentionally reflect on living stories (Gastaldo et al., 2012) and how individuals wish to include/represent specific sensations on a personal body map. Awareness to sensations of living stories draw out descriptions that would otherwise be overlooked through traditional narrative composition (de Jager et al., 2016). The group setting, in this study, was a supportive one, where familiar sensations about a particular story amongst two or more participants were reflected on as a group.

While many qualitative methods focus on verbal or written forms (Toles & Barroso, 2014), body mapping is a visual, collaborative, critical, participatory, playful, reflective, creative method for representing a person's embodied and corporeal stories. According to Gastaldo and colleagues (2012), body maps are life-size human images, while body mapping refers to the use of different mediums (i.e., paint, markers, photos, chalk, etc.) to visually represent aspects of living stories including an individual's body and the body's social world. The process of body mapping is a way to tell stories with words, symbols, slogans and descriptions unique to a storyteller and their living story (Gastaldo et al., 2012).

Body maps, as representations of thinking, feeling women, also reflect how bodies are shaped by and exert creative influence on the world around them (Shilling, 2012). What I have learned from the body studies literature is that the storyteller of whom a body map represents is the only person who can meaningfully interpret storied symbols and images of a body map. Individuals engaged in this process may awaken (*become*) to realisation of inequity and injustice

that emerge from the creative process, which then can be reflected and strategised on (*unbecoming*) by individuals living through the bodies crafted and created through this process, towards social action. In doing so, the body mapping method is aligned with aims to make change through community development, research, or through activist work (de Jager et al., 2016). The next two aims of this visual method, embodied awareness and knowledge translation, align well with antenarrative methodology. Pairing body mapping with digital storytelling created visually enticing and engaging material for social action and dialogue.

Mapping embodied difference.

It is difficult to argue that individual narratives of genderacialisation can be reduced to phenomena. I believe stories of race, gender, class, and labour are embodied, but individual. This perspective pales in comparison to the highly regarded and accepted medicalisation of the body, which creates norms and standards, and "influence the way we perceive and experience our bodies" (Cregan, 2006, p. 13). As mind-body dualism (cf. Descartes) pervades society, individuals rarely think about the intimate connection between cognitive interpretation and the body or the influence living stories have on the body (Crawford, 2010) or how living stories are reflected through the body. Storying through feeling and connecting with the body can be difficult as individuals are often asked, in many aspects of life, to cognitively interpret, compare, assess, and medicalise matters related to the body. What the body tells about itself is seldom considered, because we are, more often than not, counting on the trusted process of cognition to figure it out. Nonetheless, the discussions in this study revealed that the body-centric and embodied exercise of body mapping elicited cognitive, emotive, and embodied reflections of the labouring body as it engaged with representations of identity, care, and leisure. Embodied difference is a tension for the social body (Cregan, 2006), having been ascribed to it the broad

social labels of race, gender, class, worker, mother, neighbour, foreigner, etc. and all the while

still needing to acknowledge the complexities of subjectivity, individuality, and nuance.

Embodied stories of the social subject (racialised women) were means for listening to how the

body expressed genderacialisation and the influence exerted corporeally on PSW bodies.

While also recognising bio-physical manifestations of such stratifications, Shilling (2012)

offers, "acknowledging that social and biological processes are inextricably linked enables us to

recognize that while social relations, actions, and classifications do not create the body in a

Foucauldian sense, they do contribute to its development and become embodied" (p. 107).

Moreover, Foucault (1977) talks about how the body is not only a collection of stories, but also a

medium for social control, target of power, and source of power. According to Foucault (1977),

control, surveillance, and discipline of the body are a part of social relations and are not limited

to the authority of powerful institutions or the body politic. With this knowing, the social fabric

and institutionalisation of genderacialisation may have implications for one's "social skin" and

the embodying of specific social positions. Feminists suggest that one's positionality and identity

works within the social, historical, and political context (de Lauretis, 1986) and conscientization

through which "individuals come to understand the political dimensions of their [circumstances]

and act accordingly" (Carr, 2003, p. 9). Towards social justice and inclusion, body mapping

worked to counter and resist, traditional bodies, appearances, and biologically deterministic

value orientations (Cregan, 2006). Beyond *doing* and *creating* art, the *being* of art in and of itself

is disruptive, it renders visible a subject not previously represented, and it breaks the silence that

accompanies invisibility by speaking loudly and occupying space. Therefore, body mapping is

the process of turning the body into a political and activist art piece, "in community art and art as

social change, art can be used as an indirect form of resistance to the cultural context in which it is embedded" (Huss, 2012, p. 1444).

The body mapping literature helped to guide my use of body mapping in this study by placing value on alternative ways of knowing (like images, symbols, and oral narratives) to locate identities and embodiment of race, gender, class, and care labour. A de-emphasis on written language assisted in mitigating reproductive and colonising language. Instead, symbols brought forth a visual language to describe body as subject and placed value on bodies traditionally made invisible through systems that aim to control bodies (i.e., systems of labour, education, and care). As viewers of images applied to the body this is not to say imagery is not reproductive and colonial, because it can be. The imagery, when paired with oral narratives, created a tangible representation of *what* was working to control, colonize, and/or oppress the body. Ever-present in women's stories were structures of production and systems of care labour that worked to reproduce or reflect narratives of control, vestiges of colonisation, and systemic oppression. As body mapping is a visual, verbal, and collective method, it opened space to discuss and acknowledge corporeally, cognitively, and emotionally labourous narratives of care work by asking participants to creatively express where and how stories manifest on the body. Verbal and visual cues were necessary for this type of storying, both for audience and participants themselves, as maps were used to stimulate dialogue and tandem reflection with the potential for action towards social justice for PSWs.

Pastiche and collective narrative through digital storytelling.

In this shift to visual methods, I decided not to shift entirely away from the written narrative, but rather use body mapping and digital storytelling as a way to meaningfully bring together the written, visual, and verbal narratives that emerged, where images "can be

understood as opening up different ways of thinking about the connection between personal identity and society" (Huss, 2012, p. 1443). Making space for different forms of first-hand narratives gave nuanced meaning to the images/symbols applied to bodily representations of subjects. There was power in bringing together imagery with verbal/written accounts of narrative. Digital storytelling is a visual and participatory research method (Gubrium et al., 2015) that works to communicate narratives by synthesizing video, audio (e.g., voice, music), and visual recordings (i.e., drawings, text, symbols) to create short, cogent visual stories (Lambert, 2010). There is a rapidly growing body of scholarship that engages digital storytelling as an alternative way to decolonise the way we communicate and engage dialogue around a number of social justice issues. The Centre for Digital Storytelling in California, US began traditions of digital storytelling, which now proliferate discussions originating in areas of interest in public health, education, immigration (Gastaldo, et al., 2012), advocacy groups, and local, oral history projects. In this project, digital storytelling was used as a complement to existing, fragmented literature and statistics that suggests at an underlying set of genderacialised politics that structure care work; underlying politics that structure circumstances where oppression is maintained for racialised women.

When asked, 'why choose digital storytelling?' I am reminded by CRT and CRF traditions about the tenet of voice and perspectivism, which seeks to centre voices of individuals who are disempowered by oppressive structures. In my reading of digital research literature, I continue to be moved by the belief in the "power and possibility of voice" (Alexandra, 2015, p. 43) in communicating narratives through digital storytelling. Also acknowledged by this body of work is the necessary step of enacting on voice and recognising power by ensuring voices are heard and integrated into "the institutional framework of a community, a profession, or religion

[which] contextualizes and recognizes the act" (Jackson, 2002, p. 4) or "encounters of political listening" as described by Alexandra (2015, p. 43) and Dreher (2009, p. 448). This speaks to the necessary activist responsibility researchers have to not only support environments where reflexive, creative, and conscious-raising narrative practice can occur, but to ensure that messages move to change-makers and to institutions to act.

I saw participants and myself as researchers and as, "a bricoleur[s] of narrative conventions who [are] situated in a particular socio-cultural context" (Thompson et al., 1998, p. 114). In this position, I, as one of a number of weavers of "new stor[ies]" (Lincoln & Denzin, 1994, p. 583), acknowledged the diverse positionalities, ways of knowing, and mediums of telling each narrator had in contributing to each others' narratives while recognising my own lens as a supportive facilitator in the weaving process. Positioning participants and myself as bricoleurs (c.f. Levi-Strauss's work), someone who works to construct with different pieces, we married the visual and textual representations in showing through body mapping, then again in telling through storyboarding that later formed the five digital stories. Ely (2007) discusses quiltings, like pastiche as a form of representation:

> Pastiche is the product of textual experiments that seek to challenge linear, simplistic descriptions of meaning exactly because the nature of narrative research is antithetical to such linearity. Pistache may be composed of various chunks of data, analytical insights, layouts, multiple genres – art, musical notation, drama, poetry, photographs, layered stories, diaries, parodies, picture strips, multivoice accounts, collage in various configurations built to provide a meaningful whole (p. 586).

The iterative nature of this process allowed for flexibility in asking participants to decide which pieces of narrative were useful and meaningful to participants for inclusion in the creation of digital stories. In this study, I saw both body maps and digital stories as narrative forms coming together through pastiche. Bringing together the visual, textual, audible, and digital is valuable

for beginning to understand the complexity, fragmentation, and simultaneity of transformative stories in a way that appeals to the different ways we learn and process information.

The digital, visual, and participatory methods literature lend a number of goals that both aligned with goals of CRT/F and supported my use of digital storytelling in this project. Specifically, digital storytelling described by Gubrium and colleagues (2015) aim to make a public impact, break down the "fourth wall," illicit material deliberation and materialise knowledge, recontextualise and creatively repurpose narratives. During composition and in attempting to expose stories, the participatory acts of engaging stories aimed to develop alternative ways of seeing (Berger, 1972) that critically reckon with constructions of dominant culture, develop collaborative research relationships, and rectify power inequities (Gubrium & Harper, 2016). I am hesitant to posture that any method can "rectify" power inequities, but I do think digital storytelling works to counter or disrupt dominant discourses and re-situate power.

In the digital storytelling literature, a public impact is required at least on two levels: (1) in the research process both in the facilitation and telling of stories, and (2) in the structures of system that require to change as a result of those stories. The fourth wall metaphor is borrowed from preforming arts in that a metaphorical "fourth wall" exists between actors and audience, researcher/researched subjects and public (Gubrium et al., 2015). Engaging digital storytelling requires for the fourth wall barrier to be broken to forward agendas for making change. Digital storytelling moves away from linear text and using material culture to engage reflexivity through "artifacts as prompts for public engagement" (Gubrium et al., 2015, p. 32). In recontexualisation, Fabian (2008) discusses that material artifacts take on new meanings as audiences and storytellers engage with them in new ways. Creative repurposing speaks to the way individuals can re-creatively re-present artifacts in ways that shift objectification (i.e., from storyteller

through telling experience to an object with meaning-making constituted by a participant

(Gubrium et al., 2015).

Particularities of power and voice in critical (collective) narrative inquiry.

As researchers, we play a supportive role in facilitating processes of narrative with

narrators. However, over insertion of researcher voice can upstage narrators by privileging

researcher's interpretations, easily shifting the power of voice in favour of a researcher. This

authoritative voice reproduces the tradition of silence women of colour already face and creates a

spectacle of participant stories, rather than keeping with a feminist or CRT agenda, which seeks

to honour and focus on voices of colour and women rather than researcher interpretations. I

understand that as a researcher in this inquiry, participants may have perceived me as knower. In

doing this work, I worked to let go of control and expectations to reinforce value in and

importance of participant stories. It was not only important but necessary to be able to move

between what Chase (2005) describes as authoritative, supportive, and interactive voices in my

practice as facilitator, just as much as I felt I needed to support each participant to locate personal

story and use voice to articulate stories of care through this critical narrative inquiry.

Making sense of genderace and genderacialisation involves being aware of power in this

process. The narrative process and telling of life stories in this inquiry does so with the intent to

avoid speaking for *all* racialised women who work in care roles. Rather it attempts to provide

insight, from one perspective at a time, into care as genderacialised. Narrating and storytelling is

also a means to seek power and contribute to new language (Foucault, 1977) in the reclaiming of

voice in different arenas of life. Voice in critical narrative acts to centralise voices of colour

(Delgado, 1989; Delgado & Stefancic, 2012) by deconstructing grand narratives through

participant's own counter-stories (Bamberg, 2004; Landa, 2008). Critical narrative privileges realities and knowledge of narrators.

Voice can be understood from many angles (i.e., voice of a researcher, voice of participants, voice of a narrator, and voices of characters in stories) to question various roles of different participants in this narrative inquiry. With an authoritative voice, separations are made between dialogue or stories and their own interpretations that are developed through *how* and *why* questions (Chase, 2005). A supportive voice from a researcher brings narrator's voice to the fore, where there is little to no interruption from the researcher (Chase, 2005). When a researcher takes an interactive voice position, the complexity of her own voice is enmeshed with those of the narrator(s) (Chase, 2005). Even in partnership with narrators' stories, researchers heavily influence how voices are positioned relative to their own interpretations. However, in narrative space, critical researchers see narrators as powerful and thus, being able to derive power from constructing, de-/re-constructing, or fragmenting their stories. My role, in part, was to listen and support collaborative narrating -- to be a supportive voice. Titon (1980) writes, "[i]n the life story the balance [of power] tips the other way, to the storyteller, while the listener [the researcher] is sympathetic and his [sic] responses are encouraging and nondirective. If the conversation is printed, it should ideally be printed verbatim (p. 283)." Further, in Latino/a CRT literature, theorists are encouraged to welcome diversities of telling and, "to employ them as a tool of self-knowledge" (Valdes, 1997, p.7) and social change. Engaging in a critical narrative did not give me ability to have power or give power to anyone including when individuals chose to share stories with me and/or the collaborative working group. By approaching with a critical interpretivist lens, the process ebbed and flowed to feature different racialised women (including myself) in the forefront of discussions and narrative tellings at different times. For example, in

the interpretation of body maps and digital stories, women interpreted their own symbols and pictures as a starting point for discussion. Rather than the creation of a disconnected interpretation by a researcher sitting outside of the embodied story, a useful narration of the artifact emerges by an individual having embodied the story represented by the symbol. Gauntlett and Holzwarth (2006) describe this interpretive process by participants as moving away from an "expert" perspective of interpretation. As I describe each phase of this narrative project, I discuss how participant voice, researcher voice, and participant power in analysis, interpretation, and representation unfolded.

    Rhizomatic unfoldings and the social production of text.

Theoretically and methodologically, this collaborative narrative approach offered space for the narrative that emerged to be those of *becoming and un-becoming* and as such, I feel should be distinguished as new stories or antenarratives. Deleuze and Guattari (1987) used the metaphor of a rhizome to describe the proliferation of thought. In the same light, I borrow *rhizomatic* to describe the process of unfolding of story fragments. I believe the creation of a product is linear, so describe this inquiry as a rhizomatic becoming of antenarrative, with ante- in brackets as I can not say with certainty that my interpretation of what is or what is not antenarrative was indeed embodied by participants and manifested an outcome through body maps or digital stories in our research process. My interpretation of pre-emergent body narratives is limited to my perception of participant's expression of discomfort, tension, realisation, or acknowledgement.

    A body of literature on *critical* antenarrative exists (as explicitly critical rather than implied as I have described to this point) which do not differ from the antenarrative I have described, but encourage individuals engaged in narrative work to be critical in storytelling. To differentiate between narratives as story-as-text and critical narratology, Boje (2007) outlines

five main points. First, one can read stories-as-text without attending to narrators, narrative production, and dissemination; that is, "text is not treated as a social production" (Boje, 2007, p. 333). In contrast, within narratology and antenarrative, text *is* a social production. The telling of stories of the body following the body mapping activity created text in a group setting that women used for their storyboards and subsequently their digital stories. Body mapped stories were created in and built off the dialogue that was being collectively generated and re-generated in the room. Then, women re-read their text for the storyboarding workshop facilitating additional opportunities for critical personal reflection and further dialogue with me about their positions in care.

Second, I looked to create fragments of story in describing antenarrative, to depart from story as text, where lived story can develop pathways through antenarrative fragments to flourish in infinite ways. Compiling storyboards -- a process of combining text and pictures -- asked women to consider how they wanted fragments of their stories to be arranged and represented for viewing by others. This process supported women in rearranging fragments of the many stories they told to create a new, digital story. In addition, in working with fragments of text through analysis, I was able to see the many ways parts of story could work together to frame different antenarratives (for example, if I halted analysis prematurely or only chose to highlight certain fragments of story, perhaps I would only see "despair" as opposed to seeing "despair and hope and..."). This was the case for all of the narrative fragments that were revealed through analysis; each story fragment was important for building story lines that grew out of the rhizome's backbone (i.e., the narrative of the labouring body).

Third, where story-as-text narratively reduces stories, in critical antenarratology, "telling and listing are socially constructed in situ in a systemicity context that is more ephemeral,

emergent, theatric, multilinguistic, and dialogic" (Boje, 2007, p. 333). This makes the examination of power relations inherent in the juxtaposing of old, dominant stories with new story through antenarrative becoming. I felt that by fragmenting stories as participants (in storyboarding) and I did (through analysis), we could see aspects of the current/old discourses of care structures clearly when juxtaposed with seeing self in new visions for caring work. Telling embodied stories is inherently multilinguistic as women used their whole selves to express stories of care, reflect on self in stories, and add to and change understandings about their initial story fragments through critical conversation in the final workshop as a collective.

Fourth, critical antenarratology illuminated interactions of living story, storying, and history. The process of dialoguing and reflecting while storying and after storying is just as important as content of stories told. Each conversation in transcripts or reflective notes is a thread of living story, segments of which appear in the digital stories that were created. In contrast, in story-as-text history (frequently a large component of a story) is often retold by elites and from one point of view, reducing the impact of tellers, limiting intertextuality, and capacity for collective storytelling. The process of telling, reflecting, telling, and reflecting were abundant in this critical narrative process. The multi-phasic nature of this study gave each of us who were part of the workshops time to reflect on our own and as a group on the various snippets that collectively formed each woman's living story.

Fifth, critical antenarratology attends to hegemonic collective storytelling processes where voices of marginalized are ignored and "heroic façade[s]" are developed around the privileged. I felt antenarrative was a good fit for this study because it aligned with the social justice outcomes of critical theories (CRT and feminisms) guiding this work. The theoretical and methodological approaches wove together to help me design a project that could support women

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in amplifying, owning, and directing the messages of their stories in the ways they chose. In this study, woman's stories were privileged in a way that did not hold their narratives up against traditional narratives of privilege. Rather, antenarrative provided a space where women's stories could be heard for *what the stories are.*

Viewing race, gender, and class categories as ubiquitous and essenceless, yet impactful in daily lives, equipped me with a perspective for listening to diverse stories of care, and for negating dominant stories of race, gender, and/or class that inform (or misinform) dominant understandings of race, gender, and class and vice versa. This anticategorical approach to intersectionality attempts to account for stories of marginalisation (or inclusion) in ways that are more fluid than layered, consistent with my guiding theoretical framework of intersectionality informed by CRF. Each participant had the ability to hear one another's stories and contribute to this exploration through dialogue. Through this lens, tensions of invisibility and hypervisibility among racialised women appeared and were explored further by talking through and about stories. As a critical methodology, critical narrative inquiry was able to support my interrogation and the framing of dominant categories in conversations with participants, how different identities are negotiated, attached to, and detached from the roles assumed in labours of care in each individual's life.

Supporting the becoming/location of the antenarrative further unfolded the multitude of possibilities beyond existing living stories apart from grand narratives. Boje (2007) describes co-construction of narrative and antenarrative as strands that are,

> …interwoven, raveling and unraveling, weaving and unweaving in [social organizations] and in societal discourse. […] It is the storytelling organization struggle to control and to amplify that keeps story living, changing, and rearranging. It is collective ongoing, simultaneous, fragmented, and distributive restorying by all the storytellers reshaping, rehistoricizing, and contemporalizing (p. 332).

In antenarrotology, antenarration works together to inform story fabric (i.e., living story threads contextualised by relationships, time, and place) and are an effective collaborative method because of its consciousness of "[a]ntenarrative dynamics [which] include the plurivocal (struggle of languages, voices, practices), polysemous (rich in multiple interpretations), and dispersed pre-narrations that interpenetrate wider social contexts" (Boje, Rosalie, & Gardiner, 2004, p. 1). Antenarratology moved us away from coherence, chronology, and toward chaos and complexity. I saw spaces for collaboration occurring through reflexivity, collective dialogue, and opportunities to develop key insights on genderacialised care through embodied antenarratives spurring alternative rhizomatic lines of thinking around genderace in care. It is through antenarrative where "the narrative [could] be rewritten" (Onyx & Small, 2001, p. 777). The following description of antenarrative describes a way the collective further considered their narratives to move beyond construction and structure in the development of counter narratives of hope.

Antenarrative is a narrative method that recognises the complexity of storytelling and is collaborative in nature. In keeping with the messy nature of narration, recognising antenarrative as rhizomatic was a natural movement to understanding how narrative work could hold complexity in revealing various stories, inquiries, and tensions simultaneously. According to Boje, Rosalie, and Gardiner (2004), "[a]ntenarratives lack the cohesive accomplishment of narratives, and do not as yet possess their closure of beginning, middle, and ending" (p. 1) and are based on living stories that assume: 1) relativistic temporality (connecting past and the present); 2) living stories have a place, and places in themselves have their own stories to tell; and 3) living stories have owners, and one needs permission to tell another's story of a time or place.

An embodied shift to knowing antenarrative.

Within this method, there is a belief that, "[w]e live in living stories. Living stories have many authors and, as a collective social process, have no existence apart from, and is indeed inseparable from the event during which the story is performed" (Boje, 2007, p. 331). Living stories are held in bodies. Body mapping gave us access to pre-conscious and unconscious material before it is able to manifest as narrative in the social world. I share how I unpack antenarrative and other ideas, here and throughout this document, through text boxes that mark my reflections along my research journey.

April 4, 2017

Meeting with Sherry and Sue (prior to Workshop 3)

Sue: What is an antenarrative?

Kim: ... to me, it's a pre-story, Boje describes it as "a bet" a space where history and present stories live in the body for future stories to emerge. Possibly where spaces of hope live so hope can be created for hopeful manifestations of story to be realised in the future.

Sue: ...*thinking face*

Kim: It's a place where stories of what could be can become.

Sue: ...okay...

Kim: They are future stories that can *be* in the present.

Sue: How do you know when antenarratives become?

Kim: ...*deer in headlights*

Sue: What do you expect to happen, see, feel when an antenarrative is told?

Kim: uhhh... a shift in language?

Sue: ...okay...

Kim: I don't know. Discussions of what can change?

Sue: What happened in your journey when you came to your realisations of what you needed to do, what needed to change, or what you felt needed to be talked about? What happened before?

Kim: I fell apart.

Sue: What about the stumbling upon, the struggle to articulate, the falling apart?

Kim: That's where the shift happened. But I didn't know it then. I didn't know how to talk about it.

Sue: Those were moments of antenarrative. The pre-manifestation of story held in the body. It was a pre-story, a pre-emergence, an experience of landing, a pre-...You can figure out the language you need to talk about this experience.

Kim: okay...

Sue and Sherry: You'll know it when you see it.

Kim: Got it. Watch for "landing."

In this discussion, I believed that by telling stories after the fact, knowing what participants knew in the present, about what could have been – pre-structure – participants could *create* futures of hope. Though, I am not exactly sure in this moment why hope is so important to the story of care labour and future storying. I felt perhaps it was a way "out," a way to escape into wishing. Was that what participants needed, a wish? A dream? A hope for a different way of doing? Was this even possible? I was reflecting on my reading of Boje literally: pre-stories that are future oriented. Sue's interpretation related antenarrative to embodied stories: a pre-manifestation of story held in bodies that are future oriented. I was just one step behind in connecting antenarrative with the embodied nature of how future stories are experienced.

Boje and other authors of antenarrative literature do not directly consider knowing through the body and how it has the potential to uncover these new and potentially unheard stories. The systemicity of living stories refers to, according to Boje (2007), "the unfinalizedness and unmergedness of chaotic parts of the social" (p. 331). Antenarrative is practiced between the space of "coherence (narrativity) and incoherence (antenarrativity)" (Boje, 2007, p. 332) to avoid hegemonic tendencies to make a story sensible while adapting to the invisibility of the antenarrative (Boje, 2007). This method counters traditional storytelling by framing transformation of social systemicity (the fabric of a social system composed of varying levels of organized relationships (i.e., families, organizations, etc.) by acknowledging stories as living, changing, and rearranging.

Citing Deleuze and Guattari (1987), Boje (2007) refers to the nature of antenarrative by stating, "antenarrative is rhizomatic flight continuing as long as there is context left to re-territorialize" (p. 28). Living stories are also examined by constraints of systemicity including: simultaneity, fragmentation, trajectory, and morphing (Boje, 2007). According to Boje (2012,

Jan. 28), rhizomatic antenarrative, "change in composition as they traverse contexts and passageways. Antenarratives can split off elements, and incorporate new ones, as the tale extends with accumulated and dragged along debris" (n.p.). In this light, the unfolding of antenarrative is rhizomatic with the embodied stories being central to the narrative rhizome. In the unfolding of these narrative methods, processes of creating, (un)becoming through antenarrative, and transformation towards social justice occurred in reflecting on individual stories as part of a collective. My aim was that this activist research focused on creative processes and impact of stories more than creative production. In creation therein lied the embodied self-expression, reflection on self, and realisation of the connectedness with and situatedness within society (de Jager et al., 2016). In the next chapter, I describe the power of tapping into embodied narratives with racialised women, how the process of body mapping and digital storytelling unfolded, and how each fit as appropriate methods for this improvised narrative inquiry.

Ethical Considerations

Boydell et al. (2012) pose five important contemplations that were reflected on prior to engaging in this inquiry involving body mapping and these considerations are: (1) artwork ownership of body maps produced; (2) multiple, divergent interpretations of artwork and the question of whose interpretation is privileged; (3) informed consent and reconsidering confidentiality and anonymity if some participants wish to include identifying details, and longer-term implications of this; (4) the increased likelihood of arts-based methods evoking strong and sometimes distressing emotions; and (5) the tension between research and aesthetic principles in defining the quality of artwork. Included with point two was the issue of representation. I decided to address this consideration of representation separate from the rest as I described that I would adopt digital storytelling as a form of representation.

Below is a list of my responses, respectively, to the considerations presented in relation to this study on genderacialised labours of care with racialised women as body subjects of the body mapping exercises. These ethical considerations of the research process are limited to my knowledge, ownership of intellectual information from a researcher's perspective, and through the policies outlined by the research ethics board at the University of Waterloo and, in the construction of this study, do encompass reflections on ethics perceived by participants.

1. Artwork belongs to participants. Body maps may be photographed or discussed, but participants possess full ownership over their body maps. Further, through the storyboarding process, authors maintained ownership in representation of embodied stories. Beyond digitisation and thinking through theory in this document, participants voices were maintained and became part of discourse that was local and relationally created.
2. In this narrative space, all stories told are privileged. Antenarratives are open to the contradicting, paradoxical, simultaneous nature of multivocal interpretations.
   a. *Revision* – The initial interpretation and storytelling of each body map by each creator is privileged. It was privileged by way of each person "holding the floor" to share their story through the body map setting the stage with their chosen meanings. After this space and time, listening participants could begin to ask about and contribute to developing meanings of mapped symbols and the placements of each affect.
3. Naming oneself in stories told was an entitlement of participants that I chose not to interfere with so long as each participant was made aware of potential reactions to this work, which may be critical. No participants wished to be publically disclosed through their stories.
4. With the understanding that there was much emotional and physical labour involved in the work PSWs do, beyond care responsibilities of the home and in family life, it may be a rare opportunity that women are able to set aside time to reflect deeply. In a study such as this, similar stories revealed group solidarity through body mapping and digital storytelling in a group setting; "emphasis is placed upon the importance of the women being given a space to disclose their personal 'stories' to others" (MacGregor, 2009, p. 89). It was a very real possibility that body mapping and telling stories from body maps with participants would be a space for strong emotions to emerge, which did happen. The group setting was a space where individuals felt vulnerable but also supported. It was important to express respectful sharing and reflection in the group setting, especially as it pertained to personal narratives of a fellow participant. I made local counseling resources available that women could use to seek emotional support following any meeting (there are free, walk-in counseling services in Toronto). It was my intention to not further harm if emotional injury was felt and I was open to discontinuing any session that I felt ill equipped to facilitate. Fortunately, none of the sessions had to end in this way.
5. The most important piece for me when it comes to imagery, symbols, or slogans on body maps are the connections that are made with the first-hand embodied narrative to which it is attached. Art created through creative expressions on body maps were of different calibers,

none of which were judged for being less than another.

6. The forms of representation I was led to/chose to pursue included: poetisation, body mapping, and digital storytelling. Though this inquiry spurred from an examination of the self and the living story told from my body of difference (Kitzinger & Wilkinson, 1996; Rice, 2009), it was important to me that women maintained an authoritative voice over their stories and owned the compilation of their digital stories through the storyboarding process. The poetising activity was a way for me to express my interpretations of the data in a way that was guided by women's stories. This representation was not intended for broader dissemination, but was helpful to convey how I began to reflect on and unpack women's stories of genderace in care.

Some ethical considerations I engaged with specific to this study, beyond those listed by Boydell and colleagues (2012), above, included: (1) supporting limited participant time, (2) hearing and desiring to act on disturbing stories, (3) inclusion of others in women's stories, and (4) the need for researcher care.

The amount of time my study required of participants posed an ethical dilemma as most of the literature I looked at talked about women's time being taken up with full or multiple part-time roles and family care. I imagined that the many hours of participation could have been used for something rejuvenating (like sleep, for example). I hoped, though, that through their participation, women would leave some of their regular, day-to-day activities behind and reflect deeply on their practices and themselves to come to some recognition that, if only for a few moments at a time, it was necessary to spend time investing care for self just because, rather than a need to do it for work. I was cognisant of the time commitments and so was able to support participation in different ways. For example, rather than arranging time to meet over the phone to discuss availability (which was constantly changing from day-to-day), I set up a phone line for women to reach me via text message. Four out of the five women communicated with me through this line and expressed that they appreciated the convenience of this way of communicating. I also realised that the second workshop, focused on storyboarding, was not conducive to a group meeting due to women's shift work schedules. Instead, I arranged five

separate meetings with each woman individually. Lastly, Maria, Clara, and Nena worked evenings/nights and Nicola and Jenny worked days, so I arranged early morning workshops to best accommodate their availability.

Women often talked about family, friends, and co-workers in revealing ways in their stories. Even though their identities were protected, I felt in the future I would give more thought to the potential impact their stories would have on family and friends who may have knowledge of their participation. In this study, women chose to include more general sentiments than specifics in their digital stories and body maps. I would caution researchers to take care of the inclusion of other characters in personal narratives, should the side stories that fuel participant's stories make an appearance on representations that are shared with the public.

As with any research, injustices told through participants' stories could make a listener feel helpless and angry. It is important that all included in the sessions where sensitive stories are told take good care throughout the narrative work together. Mostly, I mention this because in stories where women are silenced and obliged to cover systemic inadequacies in some way, or privilege someone in a higher ranking, puts the supportive community of listeners in an ethically challenging position. I needed to consider what it would mean to look into the expressed injustices while weighing the compromise of participant anonymity (i.e., a retroactive attempt to protect women and others knowing it may potentially reveal participant's identities). Leading from this consideration was my own care as a facilitator of this study, which I describe in the next section.

Researcher care.

Like many qualitative researchers, I have a tendency to write close to home, and because of this, and the need to re-prioritise care for the body in labours of care, I felt this section on researcher care was essential. This dissertation is my labour of care. In my head I know that through labours of care, leisure is oh so racialised, gendered, and classed -- where needed and wanted leisure is dichotomised, politicised, and privileged accordingly. Individuals living outside of this reality may not understand what it means to live in this skin, hear the moment-to-moment internal dialogue that reckons with whiteness in the world, and may be outright dismissive of the need to know an alternative narrative for fear of being called out for blatant colourblind dominance. This is perhaps why popular media is not kind to the portrayal of PSWs, faulting and speaking poorly of individuals who are often in roles that are high stress and have little support to cater to the high expectations that families and registered nurse colleagues have for going beyond meeting supportive care needs of residents.

Despite this understanding, from the inception of this study, I struggled to articulate my discomfort with interactions between fellow care workers, family members, managers/administrators, and support workers (PSWs, porters, laundry, food, facilities and/or maintenance staff) in health care settings. Through these moments of struggle, especially in data collection, analysis, and reflection, I came to learn that it was critical to not bracket myself a part from stories that surrounded me. I felt women's stories, heard through this study, were part of my narrative and that distancing women's voices would be like denying my own.

I witnessed family and friends sustain careers in care and saw communities developed around care work, so I had a good understanding of how self-care was (not) taken up and structured to be seldom prioritised by individuals who often needed the most self care. I

connected with women in this study who expressed they were rarely asked about what was needed to feel supported, what was needed to feel heard, what was needed to feel visible, what was needed to feel appreciated. As far too often in this neo-liberal world, we happily espouse about what it is that we want but rarely what it is that is needed. This project on genderace and others like it are different. There is an ethical obligation for us, researchers, doing this type of work to examine our approach to practice just as participants in our studies examined theirs.

Raised in a "pink-collar" working class, single parent home, I, too, am trained to centralise work in striving for survival and security. Living with the privilege to, now, do work to care for myself, and in work with the realisation that survival to live does not have to be my everyday reality, has enabled me to continue to critique my practice of work and slowly move towards integrating reprieve, time for self, and self-care in my life. This process encouraged me to connect with my spouse, family, friends, colleagues, mentors, and the women I worked with for support. I gave myself permission to engage in planned and spontaneous activities to support my process including maintaining a daily reflection schedule, ensuring I made time to celebrate self, and meeting regularly with a mental wellness professional to sort through some of the heavier stuff involved in my dissertation topic. Journaling not only gave me fuel for my dissertation fire, but it rescued my aching heart on a number of occasions.

The heartbreaker is what is revealed and reinforced through this work, which is that freely chosen activity (or non-activity) creates spaces where the genderacialised labouring body engaged in labours of care are shamed, disciplined, and made hypervisible/a spectacle simply by pursuing one's needs for self-care through leisure. How this manifests, you'll have to read on and see, but I believe the transformation in these practices and knowings begins with paying attention to the ineffable fire that lives within until it is ready to make a statement and act. My

message in caring for self as a researcher is to take good care not to get burned by the flames that

fuel our needs for change and social justice.

CHAPTER 5. (De-)Marginalising Identities: Connecting with the Body and Telling

Through this inquiry, I worked with five participants in facilitating connections with the body to tell stories of their labours of care and leisure. In doing so, I hoped to create a space where racialised women began to think critically about the roles they play out in labour carried or worn on their body. Taking in what the literature helps me to know about the hypervisibility and invisibility of women of colour (Mowatt, French, & Malebranche, 2013), together participants and I strove to include identified racialised woman as subject in considerations of care by working with tensions of marginalisation, considering what it means to (de)marginalise, and by identifying oppressive barriers in the inclusion of subject in care. Through women's narratives I reflected these ideas, not in the words described here, but by centralising the body, expressing where care was experienced and for whom, and reflecting on the implications of these negotiations. This chapter describes my approach to hearing narratives and further revealing the antenarrative of the genderacialised labouring body in care told by women of colour who engage in care roles as PSWs in LTC homes. Specifically, I describe how personal embodied narratives were body mapped, told by participants, and re-presented (through poetisation and digital stories) to interrogate grand narratives to deepen and move through the critical and post-structural discourses of identity with specific attention to applied labels associated with race, gender, and class in labours of care. Stories of genderacialision in care are simultaneously personal and relational. Narratives of racialised women can be, "uniquely individual while at the same time both collective and connected" (Dillard, 2000, p. 676). Engaging in narrative inquiry individually and as a group opens up different settings to explore privileged assumptions and taken-for-granted truths presented in narratives by racialised women.

In this chapter, I describe how narratives were told through body mapping, how I improvised digital storytelling to compliment mapped bodies, and how participants told stories of care and leisure through body maps and then again through digital stories. In the following sections, I describe the approach to narrative, method and some questions for engaging narratives on care with women of colour. Table 5.1 provides an overview of the stages and questions pertaining to this study. A list of questions was also provided in participants' information package (see Appendix A).

Table 1. Overview of critical narrative methods

Part I: Recruitment and Introductory Meetings	• Recruitment posters and emails in LTC homes • PSW networks in Ontario • Personal networks
Part II: Body Mapping: Body Tracing and Telling	• Tracing and meeting the body • Articulating a personal slogan • Body scanning as a reflection of the created body maps • Re-tracing bodies and telling new stories ○ New personal slogan • Reflecting on representations of tellings
Part III: Representation of Tellings: Digital Stories	• Creating digital stories
Part IV: Spaces of Hope?: Airing Digital Stories and Recommendations	• Knowledge, action, and body ma-: Implications of "unfinished" maps

In this research, participants and I explored how a context of care relegates individuals into positions and how they, through narratives, can awaken to a positioning of self within settings of care. In this chapter, I outline where antenarrative sits within the research process (thanks in part to the limitations of text and the linearity of process when writing a dissertation), segments of unrecorded antenarrative were conveyed at each phase of narrative work. As participants collected thoughts and hopes for (an anti-racist and anti-sexist) future of labours of

care, I supported the recording of "new story" (Boje, Rosalie, Durant, & Luhman, 2004, p. 756) through a second phase of the body mapping process (body map two) that shed multiple meanings for different individuals. I appreciated that antenarrative work was a meaningful avenue for collective storytelling. In this chapter I also address the complexity of criticality (i.e., in voice, positionality, interpretation, and representation), reflexivity (i.e., personal and collaborative), and methodology (i.e., collaboration, narration, research questions, and subsequent methods) in supporting a narrative inquiry with the aims and positions of various frameworks, values, and agendas with which I chose to engage.

PART I – Recruitment and Introductory Meetings

I was fortunate to have five women approach me to participate in this study. Initially, I planned to have up to six participants, so I was happy with how many women were able to partake given the time intensiveness of the workshops. As the language I used in my proposal (i.e., genderace and genderacialisation) was different from language to describe identity, I relied on status quo language to describe "criteria" I sought from potential participants. My research poster and other communications said I was looking to discuss experiences of labour, leisure, and care with individuals who: work (post-PSW training) as a PSW, have worked in a LTC for at least a year, and identify as a woman of colour/visible minority/racialised woman (e.g., Asian, Southeast Asian, East Asian, African, Caribbean). I did not specifically ask for women who were new Canadians, just that they identified with being a person of colour.

To ensure recruitment was done efficiently, I took a multilayered approach to recruitment. The plan in my proposal (in order of priority) was for me to: (1) place recruitment posters (Appendix B) in local LTC homes across in the Toronto area, (2) connect with PSW networks in Ontario, and (3) spread word about the study through personal networks with the

hopes of connecting with around six women willing to participate. I chose this area because of

limitations of transit, affordable housing, and other services that may have made challenges to

accessing PSW training, the workplace, and childcare more complex. I was most familiar with in

the Toronto area, having grown up in this city. It was also necessary that I focused in on a

specific area because meeting areas needed to be relatively centralised to participants'

work/homes, easily accessible via public transportation, and located at highway/major street

access points.

    I arranged to have a temporary mobile phone number so women could call or text

message me directly. I felt this was the most appropriate option because I did not want women to

experience hesitation calling a University number with a different area code, connecting with me

though an unfamiliar party, or reaching me through a LTC home administrator. I also wanted to

protect myself as this number was, at the time, made public through the call for participants so

did not provide a personal number. Once an interested individual who was appropriate for this

study contacted me, I would inquire (through snowball sampling) whether more women could be

recommended for participation in this study.

      Recruitment posters and emails in LTC homes.

    My first recruitment strategy was to connect with administrators in LTC homes in

Toronto area to ask whether I was able to post information on information boards that PSWs

were readily able to access. From speaking with four LTC home it became clear that PSWs did

not have work emails, rather they were asked by LTC homes to provide a personal email to have

on file. I wondered whether the turn over of PSWs in LTC had something to do with the lack of

company-supported access to electronic information. When asked how PSWs typically received

information (as in some homes mailboxes were not provided), homes described a bulletin board

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system. Bulletin boards are not useful to workers who are not regularly at the home and it is

often up to individual PSWs to develop work networks where phone lists are compiled and

updated for shift exchanges and other coverage.

I started by searching parts of Toronto that had a number of LTC homes in close

proximity to another, while taking note of public meeting spaces (i.e., libraries). I decided on six

homes to call (see Appendix C for phone script). Of the four administrators I was able to reach:

- One administrator who was initially away, said to leave an email copy of the poster with him.
- One administrator refused to give me a better time to call her, rather insisted she return my call. As I suspected, she never did.
- One administrator asked for more information after which I sent her an informational email (Appendix D).
- One administrator took the time to chat with me and ask questions. I sent him an informational email that he sent to PSWs and permitted me to put posters in the communication boards on each of six home areas.
- I left a number of messages for two additional administrators and they never returned my calls.

In each of these instances, I called multiple times and left messages for LTC home

administrators. When I was able to access email addresses or when I was given email addresses,

I sent informational emails and copies of the posters. In instances when I did reach

administrators, I was met with mixed reactions; one administrator was very receptive and

welcomed me into the home where he worked and other administrators were completely

dismissive, which was discouraging. I went to the area twice to visit the two LTC homes I was

permitted to solicit potential participants and leave flyers for posting on communication boards.

As I communicated with administrators, to ensure no negative outcomes with employers

occurred as a result of participation in this study, I avoided disclosure of participants with the

LTC homes with whom they were employed by posting a phone number and email address on

the posters so interested persons could connect with me directly. This made it easier for

administrators as they did not have to act as liaisons between potential participants and myself. I

was intentional about connecting one-to-one with participants from the moment each woman

expressed interest in order to address any concerns and begin building a relationship with each

woman. This trust was essential to women feeling welcome and open to candidly discuss stories

about labours of care in PSW roles. Prior to leaving posters with administrators, I made the

decision that I would be welcoming to individuals who were interested that worked for the same

organization. Initially, I preferred for participants who worked in different homes, however,

given logistics of travel, limited free-time of participants, and level of comfort in speaking about

challenges at work with colleagues, I became open to working with group(s) of people familiar

with one another prior to participation in this study. Given the distribution of posters was my first

attempt at testing the waters to see whether there was interest, I was disappointed that there were

no calls or text messages of interest despite efforts to implement this passive recruitment method

over a longer period of time. This method may work for other groups in LTC homes, but passive

recruitment did not prove to be useful for connecting with PSWs in LTC homes.

PSW networks in Ontario.

With the closing of the Ontario PSW registry on January 25, 2016, a government list of

PSWs and person resources supporting this information are no longer available. However, two

non-governmental organisations, PSW networks, that operate independent of a specific LTC

home or group of LTC homes are the Personal Support Network of Ontario (PSNO) and the

Ontario Personal Support Worker's Association (OPSWA). The Personal Support Network of

Ontario (PSNO; http://www.psno.ca/contact-us.html) is an off-shoot of the Ontario Community

Support Association (OSCA) and is a network for individuals who work as PSWs/are qualified

to work as PSWs/interested in PSW work in Ontario and where they can find information on

employment, education, and other resources. The PSNO posts information on latest research concerning PSW work on the PSNO home page and has an office located in Toronto, Ontario. Though I did not have access to email lists, I could have connected with a representative to publish a post to subscribers of the PSNO's email list and/or post information about this study and how to participate on the PSNO home page.

The Ontario Personal Support Worker's Association (OPSWA; http://opswa.webs.com) was created by the original founders of the Canadian Support Workers Association (OPSWA, 2016) and is a body that produces a verification card of PSW status for vetted PSWs in Ontario. The OPSWA claims to be the "official" voice of PSWs in Ontario, however, the OPSWA does not have an address for a head office listed on the "About Us" section of the website and the email address listed appears to be for "media inquires." I proposed that I would get in touch with the OPSWA through the general inquires email box on the same OPSWA, "About Us" webpage and ask whether they would be open to disseminating information about this study. Another option I planned was to post information on the OPSWA website is a members only area for interested individuals/potential participants in my local area.

In the end, I did not pursue PSNO or OPSWA to connect with potential participants. I felt that information would be lobbed into the digital void on social media outlets and was not sure how I could engage in the process with PSWs across Ontario. In the short amount of time I allocated for recruitment, I felt that my time was better spent connecting in-person with key individuals who worked at multiple homes in the area who could pass the word along in the community area I planned to host the workshops.

Personal networks.

The recruitment strategy I found the most effective was connecting with women who work as PSWs through personal family and friends networks. As my mother, family-friends, and relatives lived and worked in the area in organisations of care, I felt that they would be a reliable source for connecting with women who were currently working in LTC homes as PSWs. Much of this work is inspired by a number of women relatives who work in care settings and could assist in the dissemination of study information.

I asked one friend to chat with me about the homes she worked with as a nurse practitioner and she gave me insight into the culture of the homes and the receptiveness of administrators at each of the homes I pursued. This was helpful for me in adjusting my approach to each of the home's administrators. I had other friends who I emailed posters to knowing that someone in their friend or family circle worked in LTC homes in the area and could pass the word around. Two participants who expressed interest early on from word of mouth were very much willing to pass information on to colleagues at the various homes they held part-time work, which was very fruitful in finding the remaining participants I needed. Information letters were passed along via hard paper copies of the poster and interested participants connected with me directly via the phone number provided on the poster. After two weeks, and the adding and subtracting of interested parties over a number of days, five participants assured me they were interested in participating in the workshops. I was quite happy with five participants. I knew that we would have rich conversations and share important stories.

Reflection re: Recruitment
February 6, 2017
In the wake of the pro-immigrant/anti-travel ban heavy superbowl commercials, a half-time performance by an out-loud activist against the current US administration, and in light of all of the media chatter for change – I feel this research is taking place at a especially sensitive time.

In my experiences speaking with women, I encountered barriers that confirmed some of the assumptions I held around time limitations. Each woman had very few options for meeting as a group outside of working hours. So far, three women stated they work multiple jobs and have kids. One woman backed out because she was an on-call worker in addition to having a steady part time job, so participating would prohibit her from being available for work should a call come through. Some work shifts at nights, with day jobs and children to tend to during the day. And yet others work days, with part time jobs at night. It's incredible what I am asking this group of women to commit to. How do I change this? I anticipate I may have to schedule multiple workshops to accommodate schedules...Thank goodness I set up the extra phone line. Women can text me when it's convenient for them and I respond in kind. This works. We make this connection work.

All of this said, I look at the date and I look at how many women have expressed interest simply by word of mouth in the amount of time I've been seeking participants. I had challenges with administrators, many of them not even wanting to hear me out. But I sense the women I spoke to are willing to rally around this work, wanting to rally together, and hope for something to be made from their work that is impactful. As I collect information and availability, I will continue to note my observations. This journal is an outlet for my own frustrations. PSWs certainly form communities around one another, supporting each other's navigations, and of individuals they care. For administrators, it always appears to be about how they can protect themselves from taking on more, when I am not asking them to take on anything at all. Just the opportunity to hear me out would be appreciated. I'm frustrated, that's all.

Incentives.

Especially due to the nature of this research, I arranged for remuneration of participants for their time in this study. With the average wage of PSWs starting at $16.50 per hour (Government of Ontario, 2016), I offered remuneration of five participants at $25.00 per hour. I also assisted with costs for transportation and potential care responsibilities that required pre-arrangement as a result of study participation. In my proposal, I indicated that costs for care may have entailed providing vouchers for an attraction (i.e., museum, Ontario Science Centre,

movies) or cover a portion of care work that would allow for relatives to engage in a supervised activity during a participant's time away. Timing and structure of each workshop changed as the research unfolded, but I adhered to what was committed to participants during the informational phone meeting. In addition to the transportation costs paid-out, rather than provide costs for care, I purchased movie ticket vouchers for participants and their families (four tickets for workshops one and two, two for workshop three), which was what participants preferred (after workshops women would text me about the movies they saw and how their families enjoyed their outings together!). For more detail on my initial plan for remuneration and incentives please see Appendix A.

Reminders, organizational materials, and collegial support.

A day before each workshop, I contacted each participant to remind them of the time and location of our meeting. I also reminded women whether meals or snacks would be provided, the length of the workshop, to wear comfortable clothes, and I offered to help them in finding directions from their home/work. Prior to each workshop or meeting, I ran through administrative checklists to ensure I had all of the paperwork and workshop materials I needed for the art-based group meetings.

With regards to paperwork, I created a number of documents for myself to keep organised and ensure I was keeping track of the little details that, I find, fly by when stories are shared, media is being collected, and synapses are rapid firing in the field. These included:

- Participant booklets that included a pen, notebook, a copy of the recruitment poster, a
  reminder flyer where participants could write times and dates of future workshops,
  participant information guide, a pen, a notebook, ethics and consent forms (see Appendix
  E), workshop agendas

- Kim's research folder, which included forms for participant information and workshop

  participation, remuneration and reimbursement, expense receipts, copies of consent

  forms, workshop agendas and both the participant information and facilitation guides

- On my computer I kept electronic files of examples of body maps, examples of digital

  stories, and a living document of process file which served as my reflection journal

These forms were updated on a regular basis and as needed after each workshop or following

communication with a participant. Just as the paperwork needed to be kept current, any art or AV

supplies needed for either the body mapping workshop (workshop 1) or the storyboarding

workshop (workshop 2) were replaced if another workshop requiring those materials was

planned to take place. Room bookings were made through the Toronto Public Library room

bookings where our research group was offered a discounted rate. There was a quick turn around

for room bookings, which was tricky. I often had less than two weeks notice between when

meetings were confirmed to the meeting date, which made finding appropriate room space a

challenge. Lunch was provided in the Workshop 1's because it was 4.5 hours in length (there

were more than one of each workshop, which will be explained later in this chapter). For more

information on workshop logistics and materials, please see the facilitation guide (Appendix F[i-

v]).

      With regards to AV equipment, I required assistance with the audio-visual recordings to

support (at times) simultaneous recording of multiple stories through audio, video, and digital

images. My advisors thought a supportive research person would be good idea to help float and

record images and audio while I facilitated exercises (it turned out to be a very good idea!). Prior

to the facilitation of the first group workshop, I submitted an amendment form to my ethics

application that included graduate student support in working with participants as a component

of my data collection. I requested recommendations from my advisors for graduate students in

our department before sending a call out for workshop volunteers. Due to the nature of this

inquiry and the stories I anticipated would be shared in this group, it was important to me that I

privileged graduate students who were racialised women themselves. I met with each volunteer

prior to the meeting we would facilitate and provided an overview of some expectations for the

session. I referred to the participant information booklet, facilitation guide, and audio-visual

equipment to be used to guide my discussion with fellow graduate students willing to help on

this project. I was very fortunate to have three interested graduate students[18] agree to participate

in one stage of the data collection process. For more information on how we supported one

another in the workshop space, see one of the email reminders to Arany in the box below.

Reflection re: Graduate student support
> *February 18, 2017 (for Workshop 1 - 1 of 2 on February 22, 2017)*

Hi Arany!

It was so nice to bump into you in Sherry's office the other day! I'm looking forward to the workshop with you this Wednesday, Feb 22nd. Here's the skinny:

- It's in Toronto and it's early [Arany and I were coming from Mississauga at the time]. The workshop starts at 9:30 am and the Malvern library opens at 9:00 am so we'll have to get our hustle on Wednesday morning. I may have to take the 407 to avoid traffic that will eat away at precious pre-workshop morning time.

- During the workshop, you'll be my right hand. Since you and I will be the only researchers in the room with only two other participants, I'll need you to operate independently of my facilitation. I've outlined in the facilitation guide where pictures, video, and audio recording is needed. We can talk about this more on the way over to the library too in case you have any questions. My attention will solely be on participants and their stories, so please float and use my AV materials as needed, no need to ask my permission for anything - just do. As this is my dissertation data, I will be taking home the body maps and taking extra photographs, so don't feel the need to capture every little detail with the camera. I would say the order of AV importance is as follows: 1) audio (I'll need clear audio to layover digital stories later in the process - this will run throughout the session, no need to stop audio) , 2) video (steady, and evenly divided between participants), and 3) photography (much of the body map stills can be done after the workshop, I'll need you to focus on in-action photos of participants working with their body maps). With the video and photography, I have informed participants we won't be featuring their faces in any shots. I will be able to edit the video, so taking it off and on the tripod and weird transitions will easily be cut out.

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[18] Shout out to Pooneh, Jasmine, and Arany. Thanks ladies!

- Materials include - iPhone 7 and a wide angle and macro snap on lens, Tripod for iPhone for video, Canon Rebel 3 DSLR, Audio recorders (I always use 2 in case). My computer and participant paperwork.
- This workshop will be long. I have the space booked from 9:00 am to 3:00 pm, with the workshop running from 9:30 am to 2:30 pm. I will provide lunch (actually my partner will be bringing lunch into the library for us at around noon!). Do you have any dietary restrictions? Bring water and snacks as needed. Following the session, you and I can hop back into my car and hurry back to Mississauga before the traffic picks back up.
- We can go for coffee and snacks after. Once we arrive in Mississauga, I'd love to debrief with you about your impressions of the day. We can find a place somewhere between our houses and chat over some hot bevvies and snacks before I drop you off. My treat!
So, if this isn't all too much to ask, please let me know where you live so I can gauge a pick up time. Please, please, please let me know if you have any questions! Thanks very much! I look forward to working with you!

Role of reflection.

Reflection was the only constant in this shifting research process. It was not until after revising previous and drafting latter chapters did I realize the integral role reflection played in guiding, deepening, and structuring the messiness of my knowing. Following ethics approval I began a steady regimen of free-writing my experience of the research process for at least 25 minutes each day. Each week during data collection, I would submit a weekly update (aptly named a SUP, or Sunday Update on Progress) to my advisors. In this note, I thought aloud by summarising my annotated reflections and discussing goal progress from the past week, upcoming goals, and new unfolding reflections as I thought through the plans I proposed versus what was enacted during workshops with participants.

With a steadily growing document of process notes, I used parts of my reflections to create drafting notes to scaffold the remainder of my dissertation. Reflection kept me connected to the literature and theory I drew from to shape my study. Most importantly, though, I saw the parabolic nature of my research unfolding in the connection between storied structural injustice

and the theoretical tenants of marginalisation, invisibility, and the subversion of control by systems navigated by racialised women.

Introductory meeting.

Before embarking on this narrative journey, I connected with participants through an initial phone call. The purpose of this informal introductory meeting was to meet briefly, begin building our relationship one-to-one, and discuss the purpose of this study and process for telling stories. This initial discussion gave me a sense of what participants' concerns were (availability, confidentially, for example), how to address concerns, and support participation or discontinuation, if desired.

Relevant to this research was my addressing of racialised women and the specific nuances in how I connected with participants on a personal level. For example, my relating to women as tita's and aunties (as they were all older than me). This is sign of respect no matter what age I am, women my senior in certain spaces are referred to as my aunties (west, east indian/south asian) and tita's (south east Asian). When some participants called me for the first time for example, they said "hi Kim this is your tita/auntie" so and so. It is this cultural connection that is unspoken and known within groups I grew up with.

During the phone meeting I asked each woman to consider pseudonyms they would like to use throughout the research process. We had a few chuckles together about the names that were chosen. Only one of the five women asked me to choose a pseudonym for her (four women chose to use their own pseudonyms). I documented women's choice of names into the participant information document I kept. After each participant confirmed they would like to proceed with me through this study, each woman decided their preferred way of communicating with me and I made note of this in the Participant Information and Participation file. Four women offered to

stay connected with me over text and as such, the temporary phone line I set up was our primary mode of communication for text and phone calls. Most expressed that their use of computers and email was limited, so we discussed how we would make digital stories accessible through YouTube so women who used smartphones could access videos on their phone.

After meeting with participants over the phone, I provided each person, who did not already have access to the participant information document, with an electronic or paper copy of the information package (see Appendix A) for participants to review prior to our first group discussion. As mentioned, I created a facilitation guide (Appendix E) that acted as a template for each stage of our research process. This facilitation guide included guiding scripts, activities, and reflection questions.

PART II – Body Mapping: Body Tracing and Telling

Though Solomon (2002), a seminal guide to body mapping, cites three essential elements to any body mapping process (a visual body map, a first-person narrative/*testimonio*, a key to interpret symbols/slogans on body map), 10 key elements were noted across the body mapping literature by de Jager and colleagues (2016, n.p.) that were planned for and integrated into our own body mapping process:

1. A life-sized body map
2. It is created by tracing around the participant, or if this was inappropriate, around the researcher.
3. It refers to the individual participant.
4. It is decorated and drawn on during a creative process, which
5. Includes meaning-making, for example in the form of reflection or qualitative interview (not developed into a [traditional] narrative).
6. The meaning-making is in the form of a first-person narrative (testimonio), and
7. The body-map includes symbols, and
8. Personal slogans.
9. It involves witnessing or reflection on the individual's body-map by others during the process of body-mapping.
10. It is disseminated through display in a public space.

The aim of this section is to describe how body mapping was facilitated in this study over the course of two workshops with five participants. The full facilitation script is available in Appendix F (Facilitation Guide). I end this section off with a look at how knowledge and action occurred as a result of our body mapping exercise and explore why unfinished maps had few implications on the richness of this research study. Body mapping that took place in Part II formed the basis for storyboarding and digital storytelling that occurred later in this project. As mentioned, I experienced challenges in finding dates and times that worked for all given participants' limited free time. To accommodate for this, I hosted two workshops on different days and at different times. The first body-mapping workshop took place on February 22nd, 2017 and the second on March 11th, 2017 both from 9:30 am to 2:00 pm. The gap between these two workshops gave me time to reflect, adjust, and refine my approach as a facilitator, something I reflect on in this section alongside the telling of how we mapped bodies to learn from stories of care.

I thought it would have been ideal for our group to be one large group. Though, in hindsight, I was thankful that our group of five was split into two groups. Room bookings were more manageable with just one person for AV support, two to three participants (depending on the group), and myself. I sent out reminders to volunteer AV support persons and participants before the workshop. I confirmed room space, arrangements for lunch, and made sure paperwork and AV was ready to go before each session. I also created an agenda (Appendix G[i]) for participants to refer to throughout the workshop (I realised the participant information guide was too big a document to digest in the moment). I readied all of my needed materials into three clear storage boxes and awkward-to-carry rolls of craft paper. Naturally, as I became more comfortable with facilitating body mapping, I made adjustments to my approach in my second

facilitation of Workshop 1. I discuss differences between workshops as I describe the different components (planned and unplanned) of the first workshop. After setting out all of the materials and getting AV up and rolling, we began the first session by introducing ourselves, discussing the research plan, and talking through any outstanding questions. This opening was followed by a discussion of how participants found themselves engaging in personal support work ("Tell us your story of becoming a PSW").

Tracing and meeting the body.

At the start of the workshop, I asked women to look around at some of the materials that they would be using for the workshop. Some women laughed recalling the last time they used markers and paint. I welcomed each group of women to tea and coffee before we got started. To review participant folders and fill out consent forms, Maria and Nicola and I sat down with one another on the carpeted floor in our workshop space, and in the next workshop, Jenny, Nena, Clara and I formed a circle with our chairs. Once paper work and discussions on confidentiality were out of the way, we moved to the mural paper to begin the first body tracing.

The initial exercise of body mapping began with body tracing. Prior to finding a partner to trace their chosen position, all participants began their body maps by considering the following questions:

- Think about how you feel when you get ready for work and when you are providing care. What body position reflects how you feel?
- What does this body position tell us about you?
- Tell us about this position best represents your care work as a PSW?

Since each person in both workshop groups knew each other, rather than using the body "shadows" to introduce oneself, I asked participants to share about their chosen postures and how it represented their PSW care work. The tracing process was met with anecdotal stories of PSW care to contextualise the chosen posture and lots of laughter. Following the initial tracing, I

asked participants to think about and reflect the following questions on their body map to ready

each woman for sharing with the group:

- Tell us about this position that best represents your care work as a PSW.
- What does this body position tell us about you?
- What does a typical week look like for you?

In the introductory meeting, prior to this workshop, participants claimed names for their bodies. I

refer to participants by their pseudonyms when I refer to each person individually. We talked

more about how the bodies traced on to the paper would be our bodies for the next hour or so as

women readied themselves to have their bodies traced. After outlines of each body were

complete, I shared examples of other body maps, described how individuals filled in their body

maps, and how words and symbols held different meanings for the person creating the body

maps. For the first group on February 22nd, I showed pictures of body maps that were done for

other studies. Despite assurance that there were no expectations for the body maps, participants

worried their artistry would not be up to the standard they expected me to have. After showing

body map examples, however, participants felt less pressure to perform artistically and shifted

focus to digging a little deeper and connecting to the body on the page before them.

The two workshop rooms for workshop 1 were very different. For the first group on

February 22nd, the rectangular room was brightly lit with florescent lighting, had opaque walls

with the only window in the room being the window on the door which was out of sight, tucked

into an alcove. In this workshop, women chatted all the way through the process, while I asked

reflective questions along the way. In this first group, women held on the questions they thought

were important (for example, what does a typical week look like for you as a PSW?) and more

prominently represented responses to these questions on their body maps, which I thought was

fine. I felt my voice and conduction of the first of two workshops was more authoritative, as

women often looked to me before doing. This way of facilitating was reflective of the traditional, silent expectation that I as a researcher held power and control, an assumption that everyone in the room subscribed to in moving through the activities that day. Though, I tried to be supportive and helped participants sift through magazines to find symbols they wanted to include on their body maps. In the first workshop with two participants, I felt the chatter was important as I thought it stimulated discussion to deepen connections to participants' respective bodies. Upon reflection and re-listening to audio play back, participants were somewhat distracting to one another by working on their body maps in tandem and out loud. Body maps from the first two participants had resemblances to one another, which one would think to expect given the similar nature of their work, migration experiences, etc. However, the expectation of similarity is perilous as it again reduces one's stories to sameness within difference.

In the second workshop 1 group, the body mapping activity was the same, but there were key differences that created an ambiance that facilitated participants' deep connections with embodied stories. The private library room we were in had the ability to dim lighting and also had two walls that were half walls with windows to the bustling library. Rather than setting up the craft paper on the floor side by side with materials between, I laid craft paper on the floor against each wall with materials to share in the centre of the room. In this arrangement, participants could not easily turn from left to right to catch a glance of what their peers were including on their body maps. I brought in a body map that was worked on by a participant in the February 22nd workshop and this served as the body map example for the second group of participants. Following the introductory blurb, the lights remained dim for the entire workshop. Women worked silently on their body maps until they felt they were at a natural stopping point. During body mapping, I was supportive and, while posing reflective questions during discussion,

I was interactive with participants' voices. I felt the shift in my facilitation style, quieted lighting,

and silence in the room cleared the room of mental clutter and facilitated the process of being

with their respective bodies.

Reflection re: Body mapping facilitation styles
March 17th and March 19th, synthesis (Post- Body Mapping Workshops)

Environment and my experience navigating the conversation seemed to make a big difference in the conversations between the first and the second body mapping workshops. In workshop 1 with two participants, lights were on and participants were chatting with one another over connecting with each others' bodies. In this workshop, I felt my facilitation was more authoritative. I was instructing the activity more than I was facilitating it. With the second group of 3 participants, noise was limited, lights were dimmed; participants worked by themselves in different parts of the room, and did not speak to one another. Though participants knew each other, just as participants in the first group did, they talked to one another less and worked less collaboratively than the first group. From my initial scan of the body maps, the second group's body maps more closely reflected the embodiment (*the body doing*) questions that were outlined in the facilitation guide whereas the first group discussed (*acts of doing)* practices of care labour and labour at home.

In the second workshop 1 during body mapping, I felt concerned. I experienced a significant shift into the back seat. I was no longer driving and I felt uncomfortable (mostly I felt that I was not doing anything but looking on and offering help with symbols participants looked for in magazines). My facilitation during the body mapping activity was more supportive with my voice acting as an interactive group member during discussion with the second group of participants.

With the first group, I felt frustrated restlessness was prominent. Maria and Nicola spoke over one another more rather than making space for the unfolding of each other's knowing. More prominently reflected in the second workshop on body maps and through discussion were emotions of passion (i.e., hope, fear, loss). During discussion with Jenny, Clara and Nena, I felt the dialogue was slow, intentional, and each participant's voice amplified the next speaker's story. I will continue to think about the role silence plays in connecting with the body (specifically as it connects to the differences in storying between the first and the second workshop).

Adding to body maps and telling.

The next step involved reflecting on feelings and stories connected to the body and where

in the body those feelings occurred. I asked participants to continue thinking about their present

PSW narrative and how it continues to connect to self, history, and hopes for their future. This

second set of questions aimed to encourage telling through body maps to inform:

genderacialisation occurring in PSW care (Q1), how women perceive personal identities in

settings of caring (Q2), and the structure of labours of care (Q3). I indicated which research

question each prompt refers to in brackets below. We did not take a break between the sets of

questions, participants continued mapping at their own pace.

- If people were to describe your identity, what would it look like on your body? How is your body involved in the ways your identity is taken-up/represented to others, celebrated, or negotiated in your care work? How does your body feel if care work gets in the way of how you want others to see you? What symbols or images represent your identity? (Q1)
- Think about negotiations or compromises you make in/for your caring work? How do those negotiations or compromises feel in your body? What symbols or images represent how you accommodate care work? (Q1, Q2)
- When you think about your care work, where do you feel it in your body? How does caring work affect your body? Where do you feel the tolls of care work? Where in your body do you feel the benefits of your caring work? What symbols or images represent how your care work makes you feel? (Q1, Q2)
- How do you care for your body as a PSW? How does caring for your body feel? How does not being able to care for your body feel? What symbols or images represent how you care or do not care for your body? (Q1, Q2, Q3)
- How does your body engage in leisure as a PSW? How does your body feel when you deprive yourself from time for yourself? How does it feel in your body when you have time for yourself? What symbols or images represent your leisure? (Q1, Q2, Q3)

For the first body map, participants had access to a number of different magazines in both

workshops. This was helpful to get participants started on their body maps by having symbols

premade so meanings could be ascribed unto them.

Reflection re: Discussion on self
    March 5ᵗʰ (Between Workshop 1's)
...As I review the transcripts, women are hesitant to spend much time talking about
themselves and what each need for being well. Through the two body maps, stories of
success, culture, expectations, happiness tied to both the material and intangible/emotive...

The reflection above was not at all surprising given how the literature described negotiations of

racialised women. I was surprised, though, about how little attention women gave to race,

gender, and class overall when talking about identity. As part of my reflections, I noted how this disconnection made me feel like I was entering a realm of colour-, gender-, class- blindness, while simultaneously negotiating my own tendency to both label and label-shame. I explore this tension more in the next chapter.

Articulating a personal slogan.

In the body mapping processes by Solomon (2002) and Gastaldo et. al (2012), personal slogans were used to punctuate stories being told by the body. In facilitating this brief exercise, I asked participants to "Think about what story this map tells. What would the personal slogan of this body be? Take 10 minutes to think about a short, memorable phrase to describe this PSW body. Think about where you would place your slogan on your body." In doing so, I hoped participants would think about how each of the elements they included on their body map may (or may not) connect to one another. In asking the body to tell these many, fragmented stories, participants' personal slogans lent to learning more about what the "backbone" of the rhizome could be.

This exercise was not as straightforward as I had originally planned. In the first workshop I referred to my facilitation guide rather than walking with participants through their version of the agenda. I asked Maria and Nicola retrospectively, what their slogan would be in our individual Workshop 2 meetings (rather than in Workshop 1 when their body maps were fresh in their memory). With Nena, Jenny, and Clara, participants took initiative to follow the participant agenda at their own pace with little prompting from me as the personal slogan prompt was already in the participant agenda. Hence, when it came time to share the first set of body maps with one another, personal slogans were ready to be shared and/or included on the physical body

map. I felt this exercise was useful for processing/analysing and then accepting the body as a whole, no matter how uncomfortable.

Body scanning as reflection of the created body maps.

Following the mapping of images and symbols onto the shadow body prompted by the questions above, as a group we reflected together by doing a "body scan" of each participants' body maps. I asked participants to examine their personal body map, then, "scan" the maps of fellow participants. As the bodies were scanned, I asked participants to discuss:

What are our bodies telling us about...

- How identity is taken up? How our identities are involved in care work?
- The way we negotiate or compromise for caring work?
- How care work makes us feel?
- Others involved or affected by our caring work?
- How you care for yourselves?
- Your leisure?

This discussion became part of our transcripts and that participants reviewed during the next phase of storyboarding.

It was my intention for critical insights on care as a genderacialised notion, the implications of stratified care work to begin percolating more discussion in and around the areas of: (1) what is or is not in place for the mobilisation of stories through genderace on a broader level in care? or (2) what takes place in a caring setting that maintains the invisibility of these conversation? This discussion was had, but in not so many words.

We mostly reflected critically on structure and remained superficial in discussing linkages between considerations of the body and the workings of broader socio-political injustices. There were times when I felt compelled to share my own personal stories and some of my own critical insights. In some instances, it was partly me wanting to fill the natural silence

(oops!) that took place in observing the power of embodied stories and in other times, it was reinforcing or observing points that were coming through in women's stories. As participants prepared to develop new body maps and tell new stories, through our initial body scanning, our collective discussion stimulated insight into what is often ignored and what discourses continue to dominate identity and front-line care in Canada. Discussions focused on the body maps pulled the stories out of the body and drew our attention to areas of individual concern. However, as suspected, with every layer of analysis and by working with stories through the process, the connection between self and system began to unfold and deepen organically.

Re-tracing bodies and telling new stories.

The purpose of retracing the body for a second map was to learn more about what exists beyond or beneath the surface of current narrative embodiments of labours of care, self-care, and leisure. A full facilitation guide for this activity can be found in Appendix E(ii). Participants were asked to move to a new blank piece of paper to retrace their bodies in a new position of participants' choosing. I asked participants to think of a position or a posture that they assumed when they felt unobligated, centred, grounded, relaxed, or energised. Unlike the first body map, it took more time to think about what posture or position this body would assume. Some participants thought about doing an activity, others imagined how the body position represented some of the narratives they wished to manifest.

In the second body map, I removed the magazines and asked participants to draw, paint, or write the symbols instead. I used magazines at the start of the workshop to begin dialogue and to ease into embodied ways of thinking. I offered the magazines specifically for the first body map to stimulate thinking about how modern symbols of status, work, culture, care, and well-being connected to the body – all ideas related to the genderacialisation of labours of care. After

reflecting on the use of these symbols in the moment, *I* thought that the second body map may have benefitted from a disconnection from these common symbols to deepen participants' connections with their body. At the end of this activity, we discussed the two body maps separately, then relative to one another.

Our final discussion for this workshop involved tellings on new maps to inform what labours of care, self-care, and leisure could be (Q4). The following are a list of questions and prompts I used to support participants in unpacking the new body maps participants created:

- How do you want yourself to be seen by others? What images, symbols, or words represent how you want others to see you?
- What do you hope for? Where does hope live in your body? What does hope feel like? What images, symbols, or words represent hope?
- Where does care for self live in your body? What does it look like? Feel like? How does it feel in your body when you feel supported? What does it look like? What images, symbols, or words represent care for self?
- Think about how you would change the way you engage in care work. How would you care for others while caring for yourself at work? What would need to change? What images, symbols, or words represent how you would change care to make sure you were caring for yourself while caring for others?
- If you could engage in leisure the way you wanted to at work, what would that leisure look like? Outside of care work? What images, symbols, or words represent how you would engage in leisure?

New personal slogan.

Just as participants were asked to create a personal slogan for their first body map, participants considered what a new slogan would be in relation to the images, words, and symbols chosen for their second body map. Following the body mapping activity that asked individuals to focus on specific elements that reflect personal, embodied stories, when participants' were asked to create slogans, participants considered their body maps as whole.

Reflecting on representations of tellings.

In closing the first workshop together, I asked participants the following questions about their body maps:

- What do you see? How do the bodies differ? What changes are needed to realize our authentic, hopeful, happy selves in the second body map?
- How do the bodies illustrate hopes for the future of PSW care?
- What would you like people to learn from your story about PSW care work? About self-care as a PSW? About leisure as a PSW?
- How does it feel to acknowledge your body in this way?

This last set of questions in the first workshop aimed to move the conversation from creating, becoming, and unbecoming to thinking about how stories work to mobilise change. The question, "how does it feel to acknowledge your body in this way?" considered how, through the process of body mapping, participants felt when listening to stories of the body. This prompt acted to tune participants in to acknowledging the body as a holder of new forms of knowledge.

Part III – Representation of Tellings: Digital Stories

In this phase, participants began to storyboard for personal digital stories. The digital storytelling workshops were scheduled as follows:

- March 9, 2017 from 9:30 am - 12:30 pm (Nicola)
- March 16, 2017 from 9:00 am - 12:00 pm (Maria)
- March 23, 2017 from 10:30 am - 1:30 pm (Nena)
- March 24, 2017 from 10:00 am - 1:00 pm (Clara)
- March 24, 2017 from 2:30 pm - 5:30 pm (Jenny)

I scheduled three hours with participants to accommodate for set-up and because I initially was not sure how long storyboarding and any voiceover work would take. Each meeting lasted approximately 1.5 hours with each individual (total time spent on this part was about 8 hours). Participants were asked to refer to a participant agenda [Appendix G(ii)] during this workshop. I began this process by asking participants to reflect on the body maps and stories told (through transcripts). My original plan was to have participants together in one workshop to do this, however, a chance instance (a participant calling in and letting me know she needed rest after a rough night at work) allowed me to connect with Nicola one-to-one in developing her storyboard. I decided in that moment that I would work to accommodate individual schedules to

complete the storyboarding workshops one-to-one and noticed that my role as facilitator

gradually became more passive after each passing storyboarding exercise.

My hope was that this improvisational way of doing narrative through storyboarding for

digital stories reflected, "texture of the everyday" (Johnson, 2001, p. 5) to inform a "living story

fabric" (Boje, 2007, p. 333). It was through these storyboards, which created the foundation of

digital stories, that facilitated antenarratives to emerge where complexities of genderace could be

reflected and we could attend to issues of stratification women of colour live in contexts of

caring relations. In this last phase of work with participants, I challenged racialised women to

imagine spaces where care maybe unnegotiated, unmasked[19], and unquestioned for themselves,

first in the creation of new body maps and second, in sharing stories through the digital method

of digital storytelling. As antenarratives are described as a, "'soup' of molecular elements to

spectacle, simmering before plots, characters, and frames congeal" (Boje et al., 2004, p. 756),

participants made individual decisions around what they included in their digital stories

reflective of our rhizomatic process.

Reflection re: Telling stories that matter
  April 5, 2017 (Doing this work, seeing this gap, and re-action)
  I went to the Transforming Health Research HeforShe event this past Wednesday. A pay equity commissioner was one of the speakers who talked about the gender wage gap in Ontario relative to the rest of the country. In her presentation she noted, "these differences are more pronounced for Aboriginal women, racialised women, and women with disabilities" and went on talk about to what extent racialised women were marginalized relative to white men, using her raised hand to illustrate a standard of pay, dropping her hand for each identified group until she reached racialised women.

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[19] "I put on my masks, my/costumes and posed for each/occasion. I conducted myself/well, I think, but/an emptiness/grew/that nothing/could fill. I think/I hungered for myself" (Villanueva, 1985, p. 324) from *Mother, May I?* Montoya (1994) feeling masked as "Presenting an acceptable face, speaking without a Spanish [or foreign] accent, hiding what we really felt – masking our inner selves – were defenses against racism passed on to us by our parents to help us along in school and society" (p. 190). The romantic ideology of being unnegotiated, unmasked, and unquestioned, was taken up in a personal reflection on what it meant to be Asian-Canadian in Canada.

During the Q and A, I asked what was being done to intercept the wage gap for new Canadians with specialized training. Specifically, why women with international training in traditionally male-dominated sectors (that are higher paid and carry more prestige) feel the need to take up "women's work" following migration. She said this was an immigration and a racialised women's issue, something that the working group she was a part of wanted to investigate but no substantial literature existed to support that line of questioning. Hmm…

I then asked what they suggested should be done to change this discourse of invisibility and both speakers said, more research (yay!) and structural change to raise compensation and prestige of women's work… I felt that this response was good, but lacking… Pay is only one side of the story, it makes the assumption that racialised women need to be given "a hand" to meet standards of others who are "successful" within a capitalist system rather than prioritising social infrastructure to support agency in employment. Nonetheless it was a good discussion.

With all considered (from this talk and in working through my dissertation), the gender wage gap argument is evidence of a human rights and a social justice issue, articulated by the politics of genderacialised care described earlier in my document. How should are stories told by PSWs best be heard by others?

Creating digital stories.

Data for this phase included transcripts generated from discussions, body maps, photos, video, an emerging antenarrative and reflections from and of participants' narrative work:

> While the researcher may not obtain conventional data from participant during the digital storytelling process, she may arrive at a more complex understanding of their lives and the ways they chose to represent themselves and their [stories]. The workshop places the multiple dimensions of participants' experiences on center stage instead of backgrounding them to the representation of the "real" data at hand (p. 129).

As part of continuing to listen to each individual voice, it was important that each participant had the opportunity to reflect on personal learnings as we moved through the narrative process. Each participant began to share more critical insights as we continued to work with the body maps, including discussion on the following statements:

- What should people know about what care work is like for PSWs?
- How does your body map reflect these messages?
- How would you express what care work is like for PSWs through your digital story?

In beginning to envision mobilising this knowledge, participants began to have conversations that looked at how narratives, reflections, and insights could be shared with others.

Here I present how digital storytelling is outlined in the literature, and describe how I altered the process to suit this project. Gubrium, Harper, and Otañez (2015) have outlined a typical, process for creating digital stories:

- Orientation and introduction to seven steps of digital storytelling
  - Showing examples of digital stories and a discussion of the process
- Script writing
  - Crafting a script, participants come with stories in mind or a draft story
- Story circle
  - Presenting rough drafts of story, creates space to talk about difficult parts of story
- Voiceover
  - Select aspects of story, photos, artifacts, participants create story boards where the "visual, oral, and textual – mesh with each other" (p. 28)
- Rough edit
  - Use software to create a rough edit
- Final edit
  - Use software to create a final edit
- Workshop airing
  - Screening digital stories as a research collective, celebrating the group's accomplishments (Lambert, 2010)
- Public airing
  - Inviting groups to screen and dialogue about the short stories

I integrated the **orientation** of digital storytelling in the introductory meeting with participants. Before engaging in narrative work together, I reviewed the digital storytelling process [above, and in Appendix G (ii)] with participants and showed examples of both body maps and digital storytelling to ensure each person was clear about the different parts of this project. Then, rather than **screen writing**, we used the body maps to access embodied stories. During the *body scanning* parts of workshop 1, each participant told about the words and

symbols selected on different parts of the body. During and after the workshop, video and digital

images were taken of the body maps to later accompany the audio recordings of discussion from

workshop 1's. The audio recordings from workshop 1 were transcribed so participants could

work with physical copies of text in the second workshop.

Reflection re: Narrative transcription trouble
  February 23, 2017 (Following Workshop 1 – Group 1)
  I am noting my frustration in requesting transcriptions for participants' narrative work in
the second workshop. The transcription service rejected my audio recording because, *"One or
more speakers has an accent and we do not have enough transcribers proficient with that accent
(e.g. British, Australian, Indian, Hispanic, any other non-American)"*. I listened to the playback
and it was clear... and loud... ugh. This hiccup in my research process was another reminder that
non-native English speakers were simply not listened to because of an inability for services to
accommodate in favour of efficiency. Thankfully, after a little searching, I was able to find a
transcription service (thanks, GoTranscript!) that worked with the recordings to generate
transcripts that were close to 85% accurate...

Also in workshop 1, rather than the formal **story circle** suggested in the digital storytelling

literature, at the end of the workshop, we were able to unpack the body maps further by

juxtaposing the initial body maps (embodiments of current structuring of LTC home work) and a

second group of body maps (embodied alternatives for labours of care). During this time of

reflection, we voice recorded participants' telling of their body maps again and began to discuss

some recommendations that would help to bridge change between the first set of body maps and

the second.

  At the **voiceover** stage (workshop 2), I brought transcripts of the stories describing maps

and dialogue from the previous workshop so participants could choose imagery from maps or

photos, audio, and text they wanted to include in personal digital stories. Prior to this, I reviewed

all transcripts and separated text into five separate booklets that highlighted participants

contributions to group dialogue (I discuss this process and its tensions in more detail in the next

chapter). As I re-listened to the audio, I made note of which sections of transcript were inaudible.

I, then, made note of this in each individual participant booklet so that if a woman selected this excerpt of text for their storyboard, I would rerecord the audio so that it would be more clearly heard in the digital story. Should parts of story need re-recording, I asked women to read the parts of transcript and make adjustments as desired. When preparing to storyboard, I asked women to read their transcript prior to mapping it on the craft paper. At this time, women would make any corrections or amendments/omissions to stories told during workshop 1 (e.g., dates, times, names, etc.). I also developed photos from photos taken of each of the body maps before and after workshop 1. When storyboarding, participants could choose to mix photos from body maps 1 and 2 in any way they liked, if at all. Following the identification of key parts of story (photos and excerpts of transcript), each participant was asked to tape photos with parts of transcript onto a length of craft paper labeled with each participant's pseudonym to indicate which parts of image, audio, and text co-occur. Due to the nature of this dissertation and the expressed level of comfort with movie-making software, I kept to my plan of keeping this process offline until the rough edit and final edit stages.

During the **editing** stages, I referred to participants' storyboards to craft an initial draft using iMovie, an iOS-based software. I refer to this initial process of creating the digital stories as the digitization of participants' storyboards. I first unrolled storyboards, wrote down all of the numbers printed on the backs of all of the images participants selected, and moved the images into digital story software from a digital images file folder created for storing all electronic media for this study. I then, put the images 'in order' according to participant's storyboard, located parts of audio according to participants selected excerpts of transcript, and to the best of my ability, matched the audio with the digital images selected. In some instances, long excerpts of text were selected to match with only a few digital images, so I supplemented the selected

digital images with pans of the body maps to the region/body map section described by

participants in the selected excerpt of transcript. Lastly, I scanned the drafted digital story for

awkward drop offs in audio and created title slides with participant's chosen name, participant

slogans (if identified), integrated music selected by participants, and appropriate sound effects. I

asked participants during the second workshop which types of music they would like used in

their digital story, or when desired, participants provided specific songs.

Following the completion of the first draft of the digital story, I shared the drafted story

with each participant. This took place alongside the airing and screening (described next) at

which point participants were asked to provide specific revisions. Following the integration of

suggested revisions, I completed a **final edit.** In our final meeting, we shared digital stories in a

first **airing**. We discussed organisations and groups of individuals for which the digital stories

would be impactful, or persons who are influential in areas of PSW rights, and/or advocate for

policy changes in care work. Our final research group meeting ended with a discussion of

recommendations for change. With permission from participants, I plan to place updates of any

public airings on a website in the form of virtual gallery (an interactive forum for public

commentary where the images of body maps and digital stories will live). This forthcoming

website will be done in work that extends this project to consider public engagement with

women's stories.

PART IV- Spaces of Hope?: Airing Digital Stories and Recommendations

In a final meeting together (workshop 3), I met with the two groups to engage in final

reflection and to celebrate the end of participants' process by reflecting on insights gained from

the narrative process. The purpose of the final meeting was three fold: (1) to reflect on both body

maps; (2) locate key insights from participants' narrative work; and (3) select which parts of

story must be retold and to whom. In our discussions following our watching of digital stories, we talked about general impressions of the digital stories (i.e., what were your overall impressions of your digital story?, how did it make you feel?, was it representative of your storyboard?), strengths of the short videos (i.e., what stood out for you?), and take-away messages for individuals watching the videos (i.e., what messages do you think your digital story tells to the world? What messages do you want your digital story to communicate?). I also ensured to ask women whether there were any specific changes they wanted to see made to each of the digital stories in an edit that would follow our meeting.

Once body maps were completed following a discussion of the initial body maps, participants began to understand and name the negotiations that occur in the "everyday" of racialised women in front-line care roles within LTC and perhaps in their personal lives more broadly. The main purpose of this work acknowledging antenarrative became, then, to reveal embodied and digital stories more fully, asking participants to name meaningful elements of personal stories of PSW care, labour, and leisure. I asked the following questions in a post viewing discussion [see Appendix F(v)] to connect more deeply with how PSW stories (un)become through body maps and digital stories, in addition to who they see would be key to acting on knowledge revealed through this process.

- What are your impressions of your digital stories? What stood out for you? What were some of the things you were seeing and hearing?
- Think back to your body maps. Tell us about how you experienced the body mapping exercise. What was new for you? What was surprising? What did you find challenging?
- What were the main insights you gained from engaging in this process? If you were to think about the messages you hope your work to communicate to others, what would those messages be?
- Which parts of your story should others hear? Who should hear your stories?
- How can PSW care work change to realise the hopes you talk about in your body map? What has to happen to make these changes? What supports do you need to make these changes?

Following this discussion, I compiled a list of messages that women discussed from our collective reflection on our process together. In effort for others to better support PSW care and towards more compassionate interactions with PSWs, women identified people they encounter in their day-to-day practices whom they felt could benefit from hearing their stories. Once digital stories are ready to go online, I will consult the list of stakeholders to make participants' stories and recommendations available to them. I also agreed to let participants know if any updates are made to the website (forthcoming) where body maps and digital stories are posted.

After looking through a number of virtual galleries online, I decided that I will use the free blogging website Wix (wix.com) to host the digital images of body maps and digital stories, unless future research funding is made available. Initially, I thought it would be viable for me to complete the website portion, with public engagement, as part of this dissertation. However, I felt that refining site content and building different aspects of the site (i.e., feedback forum, resources for family members suggested by women in this study, visual aesthetic, reposting a simplified methodological process, etc.) spans beyond the purpose of this specific project. The purpose of the virtual gallery was to create a space to share recommendations and narratives by participants. The flexibility of online spaces enables broader community engagement (through online message boards), a variety of layouts and pages, and different options for an audience member to choose what they would like to know more about. This living space is meant to be updated with questions, responses from individuals involved with PSW care, any follow up studies, related resources, and dates and times of airings.

For this study, narrative work illuminated new and fun spaces where discourses of care systems that racialise, gender, and class can look completely different from dominant knowing, perhaps, not even existing at all. In antenarrative and embodied space, narratives were told from

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perspectives where equity is not only desired but also described by women as a basic human right. By first identifying negotiations in participants' living stories through participants' body mapped narratives, we, participants and myself, moved to embodied, antenarrative, and transformative spaces where through our collective narratives we were mobilised to hope.

Knowledge, action, and body ma-: Implications of "unfinished" maps.

During our reflections, women often commented that their maps were unfinished. I assured participants that this was not the goal of the exercise and to focus on the elements of the body maps that they felt were most important and reflective of their caring stories. Research that engages visual, digital, and embodied information is relatively new in qualitative research (Gough & Deatrick, 2015; Gubrium et al., 2015). Art produced in body mapping is, itself, communicative and lends itself well to learning as it is an engaging, life-sized piece of art, supported by first-person narratives, and is generally something participants feel compelled to share (Conrad & Sinner, 2015). As a method that is creative and open, body mapping lends itself well to spaces where antenarratives and thinking about alternative futures can develop. These projections or trajectories of narratives elicited through body mapping were starting points for transformative action in the realm of care labour by racialised women working as PSWs. Moments of play and learning throughout the body mapping process, however, were also considered as unfolding knowledge and action occurring within the scope of creative, reflective development of the body maps. In the interview between Gauntlett and Holzwarth (2006), Gauntlett describes how learning and play naturally unfolds through engagement in creative methods:

> people think about things differently when making something, using their hands –
> it leads to a deeper and more reflective engagement. This applies too,
> unsurprisingly, in learning. In fact the Lego Serious Play idea, for example, builds
> on the work of Seymour Papert, whose idea of constructionism suggests that

> people learn effectively through making things [Papert and Harel, 1991], through the kind of bodily engagement highlighted by Merleau-Ponty. And Lego Serious Play also makes use of Mihaly Csikszentmihalyi's idea of 'flow' – the idea that people learn better (and enjoy life more generally) when they are creatively challenged [Csikszentmihalyi 1990] (p. 89).

Boydell and colleagues (2015) reflected that participants could experience pressure to produce a story with a positive ending. Though in my work with women, it was important that their maps were considered as part of unfolding knowledge and a process rather than a product with its own complete meaning and storied outcome. Play and learning are process oriented, and in our narrative space body maps were complete when participants felt they have expressed what they feel is needed in order to convey their stories of care labour. Women commented that their ability to work on their body maps free of judgment enabled them to feel relaxed and open up to themselves. Participants' ability to play and openness affirmed the complexity of their relationships with caring. More notably, women's openness and vulnerability facilitated new ways of thinking about labours of care.

CHAPTER 6. Emerging Stories of the Body

The workshops and my individual meetings with participants revealed complex stories that addressed the research questions of this study in different ways. For the purposes of this dissertation, my role was to re-represent how racialised women tell stories connected to practice, theory, and, through their labouring bodies in PSW care roles, to the world more broadly. Given the embodied nature of this inquiry and the shift from critiquing structure to stories of labouring bodies in this inquiry, I recognised the need for this inquiry to move into the language of post theories (specifically, post-structural theories including post-identity) to adequately frame the shift of this project from critical frameworks where this project started. I rolled with the ups and downs of this research, connecting with my guiding questions to continue to anchor my inquiry, which reminded me to continue to connect with and centre embodied stories of genderace lived through the labouring body. Research questions guiding this study included:

1. How do personal support care workers' stories told through body maps take-up, negotiate, or reconceptualize notions of labours of care, self-care, and leisure?
2. How do body maps reveal genderacialisation in the structuring of labours of care and navigations of current care practices by PSWs in LTC homes?
3. How do personal support care workers' stories take-up genderace?

To respond to these questions, we engaged in a narrative process that involved 10 body maps, several hours of audio, hundreds of photos, and five digital stories. The five digital stories were created from participants' 10 body maps and can be found on YouTube by accessing the following playlist or individual files:

https://www.youtube.com/playlist?list=PLmVyJD3PYnLucbyQ9MShhsJt5g3S4R3U6

Nena's story: https://www.youtube.com/watch?v=vcPqbL3QL4g
Nicola's story: https://www.youtube.com/watch?v=8NBVekyi9G8
Maria's story: https://www.youtube.com/watch?v=jL1OXoOuGv0
Clara's story: https://www.youtube.com/watch?v=vxx-o03B7uI
Jenny's story: https://www.youtube.com/watch?v=w_8rie4plsI

Early in the morning on April 24ᵗʰ, 2017, I welcomed tita Maria and auntie Nicola at my mother's house in Scarborough to watch the latest drafts of the digital stories. Nicola and Maria worked with my mother prior to her retirement in 2014 so they suggested using my mom's home rather than meeting at our usual public library space. As I pulled up the screen on my computer, I overheard Maria talk about her annoyances from the evening shift she was coming from that morning as Nicola made herself comfortable in a chair and Maria sat on the couch. We agreed that we would watch Nicola's story first followed by Maria's story before watching the remaining three stories.

I was careful to observe Nicola and Maria watching the first video. Both were very attentive to hear Nicola's story, laughing and looking somber during different parts of the video. After Nicola's story and before I could turn my recorder on, Nicola jumped out of her chair to give me a hug with tears in her eyes, "thank you, Kim – it's so good, it made me cry."

"That's true, what she said, it's so sad, it's very – like it's touch your heart, the story."
- Nicola

"The reality is sad really, but then life is -- you have to go on, go with the flow so--" – Clara

"It made me think it's the truth of what's going on in my life." - Jenny

Having watched the digital stories many times and sifted through every word spoken in the audio in putting the digital stories together, I felt I had thickened my skin by the time the second group's airing of digital stories came around. To my surprise, at the end of the workshop I felt heaviness in my chest, weight on my shoulders and forehead as I looked down at a page with scribbles in front of me. I was difficult to look up. I felt shame that participants in these workshops did not reflect the hope I had for change in PSW practices at the outset of this study in participants' narratives. I did not see hope in the digital stories. I felt hurt from the stories they had shared and through picturing negative interactions they described with family members, coworkers, LTC home leadership, and residents in my mind.

I sought to find change and here it was, but in a different form. There was steady movement, a disruption of seeing body and self. It all came together in this moment, a moment I would never experience again. Transformation occurred through a shift from hope, to despair of no hope and yet, hopefulness for realisations and new knowings. There was space for agency and change in the fullness of the moment. Despair in watching each of the stories was perhaps a

vehicle to hope. The moments of silence we observed after each story were full of conditioned fear. The silence was only broken when women confronted the stories that they tucked away at the end of each shift. As participants shared, there was no longer feeling shame about experiences they conveyed on the body in the first workshop. Clara, Nena, and Jenny were no longer alone. They were able to see, hear, and be present for one another. Through witnessing each story unfold on the screen, then, by listening to one another across the table, their bodies and stories of genderace were acknowledged.

Knowing her story of struggle and educational attainment, and the stories of women I spoke with through this study, I think the most heartbreaking statement to me was Nicola's statement about how she believes others perceive her as a PSW:

"...people think we are dumb and we don't have any opportunity that's why we go to this job. No, that's not true." – Nicola

In the digital stories compiled for this research, women chose to care because they wanted to help people. The perception held by Nicola, that others' felt they had no choice but to pursue this work, was a misconception that, in combination with the stresses of the job, made this particular labour of care narrative difficult to stomach. Maria and others describe themselves as "happy" in PSW care work, and the *but* only comes in when speaking about aspects of the job like LTC home politics with family members and administration.

Maria: It's sad first because it's truly worth it -- each and every video it's the reality of this kind of work that we do. We are there, we love our job and everything, we are there to help the residents or the patients and the workload, and dealing with the family member, and they expect so much from you. But at the same time, we're happy. Always, a lot of people say, "Wow, I don't have a heart to do that kind of job," but I just tell them, "Well, this is what somebody has to do it, right, somebody--" We can't be all working in the bank, we can't be all working in offices and stuff. Who's going to take care of the elderly? This is-
Nicola: Someone has to.
Maria: Yes, this is what I do and just -- it's a workload, it's too much, it's too heavy with the cut downs and but I don't know. [laughter]
Nicola: Yes. That's true, what she said, it's so sad, it's very – like it's touch your heart, the story. Then like she said, someone has to do that job too, okay. I'm happy to have a job especially in a hospital, that's what my dream. [laughs] So--
Kim: That's good.

Nicola: The other I have to add, it's good because you can show this clip over the program to someone and then people listening, and then they should understand—
Maria: They'll know that's it's not easy.
Nicola: It's not easy and then we are not born to do this, we have different knowledge and we are smart too.
Kim: Yes, of course.

I structured this chapter into two main sections to represent the telling of stories by PSWs: (1) Reflections on the body; and (2) Positioning and Re-Positioning the Labouring Body. In *reflections on the body* I re-represent women's stories through body maps described through their words, photos of their body maps, and slogans that emerged from Workshop 1. The second section on *positioning and re-positioning the labouring body* describes the postures and physical outlines of each body map women drew and the embodied stories behind this intentional positioning.

Reflections on the Body

Prior to and during the workshops, I fostered personal connections with women, not as an intentional step as a researcher, but as someone who grew up with the expectation that younger individuals will show respect for their elders by addressing women in a culturally appropriate way. Much like mam and sir is used in formal settings, in informal gatherings with women of known ethnic groups, I addressed women my senior in years as Auntie or Tita. Trying to describe what connection this creates is somewhat a struggle for me, but for now, I will liken it to the elimination of anonymous distance – as an Auntie or a Tita, your voice and actions are privileged in our relationship. As a tita, I understand it to mean that *I acknowledge and respect you as part of and important to my world*. In the knowing we created together through this study, it was of utmost importance that participants in this research, my Aunties and Titas, felt that stories they shared and their beings as racialised women, were of great worth to the change we

worked towards together and myself as an individual. I placed transcripts from the two groups for each workshop together here for readability. As a reminder, Maria and Nicola were participants who were recruited first and participated in each workshop ahead of the second group of three. The group of three was composed of Nena, Clara, and Jenny. As I became stronger in my facilitation techniques and more confident with how we could proceed through the study, I felt the second group's process better reflected the ways of engagement with the body I sought to facilitate.

Each of the sections that follow begin with each woman's body maps, position description, and personal slogan. My intentions for participant's slogans were to ask women to reflect on their bodies as a whole and synthesise their whole body into a few words or a statement. The following are participants' responses to, *"If you were to describe this picture, your body, your position the pictures you chose in a few words what types of things come to mind?"* Though, slogans are, "(e.g. a statement, a saying, a poem, a song, a prayer, something you say for yourself) that describes your philosophy of life or your current thinking about your life" according to Gastaldo et al. (2012, p. 28), I found that women often had more than a few words to say in summarising interpretations of their bodies. I highlight what I thought were important messages communicated through their bodies in a reflection that follows women's descriptions of their body maps. Here I present participants' interpretations of labours of care, leisure, and self care their first body map with their slogans.

Figure 1. Nicola - Body Map 1

Nicola (February 22nd) – Head forward, arms to the side of the body, after a shrug accompanied by a "sigh." Nicola describes that this position represents her feeling of being met with the demands of workload. She mentions this is often accompanied by the understanding that some colleagues do not appear interested in pulling their fair share of resident care.

Nicola's slogan (Body Map 1): *We are not guilty because our patient's okay. We try our best to comfort them, care them. So at the end of the day, I'm happy when I'm tired, knees giving pain, but still okay. [laughs] I think that's the reason we go the next day to work without calling sick. [laughter]*

Nicola: Okay, I'll start from the top of the head. [laughs] That's a lot I mean the time. All these remind me what I have to do. [laughs] Okay, the day start making breakfast for kids and me and lunch and then go, go, go.
Kim: [laughs] The skateboard.
Nicola: Then everything in my head, that's why it represent like that. Work time so I just believe there is strength in numbers so let's feel like on giver and then sometimes appreciation make me happy. [laughs] Then caution, no sitting time.
Kim: No sitting time. That's a good picture. [makes reference to the photo with the caution tape around the chair]
Nicola: [laughs] Those are just for the-- no sitting time actually yes. It's so hard to find the time to sit down when going to work 12 hours especially. I thought that 12 hours is going to be easier for me, but more work. Then I believe this one too, never doubt how strong you are.
Maria: It's a long day.
Nicola: It's a long day.
Maria: It's a long day.
Kim: I like that never doubt your strength.
Nicola: Then one pair of shoes one work for every activity. [laughter] Then just like a teamwork. I represent that as there needs to be teamwork. It's hard to present my family, in all my kids' activities and then drive them. [laughs]
Kim: You drive them everywhere.
Nicola: I had no idea how to put-- This is just like family time. Even in making phone call, helping them homework that kind of thing. I decided on all these. End of the day, the money [laughs] because the kid ask money sometimes they ask money for something and all of the bill payment, everything, the credit card that's where I put the money house money, groceries money, a car is money. [points to three photos with money] [laughter]
Nicola: I put it over like my relaxed hands.
Kim: Yes, okay.
Nicola: Lipsticks, cutex, whatever cosmetic.

Maria: The beautifying things for herself.
Nicola: Then here why I color red is just a stress, releasing. [shoulder] This I'm watching my drama in my own language and then releasing [into a] long sleep.
Kim: Wow, I like it. What's this?
Nicola: Pain, pain, pain. I don't want to put everywhere that on this like one is enough. [laughs]

Nicola expressed that creating a body map enabled her to better see **the many activities the body** engages in one day and the speed at which she feels each need to be completed (skateboard). The head begins daily planning, where all care activities circle the mind and are planned before being carried out. The head is connected to images representing time, teamwork, being a "giver," being busy at work (caution: no sitting time), and her children's activities. The heart is linked to support of children in their activities and being able to facilitate a variety of different activities with the support of colleagues and family members. Many of the connections between the head and the heart overlap. Indirectly, the heart is connected to celebrating strength and happiness through **appreciation of the body** in caring activities. Largely, the core of the body is dedicated to the care of others, while activities pertaining to care of the body are located at the extremities away from central focus.

Maria.

Figure 2. Maria - Body Map 1

*Maria (February 22*nd*) – Palms on temples, head forward to represent the feeling of "Agghhhh!" when Maria receives the shift changeover report that outlines who she is working with and what her shift work will entail.*

Maria's slogan (Body Map 1): *We know we work for our money. We leave work knowing that our patients are safe. We did the care we're supposed to and we go home and our conscience are clean and we're happy, we're satisfied.*

Maria: My body map is not finished. [laughs]
Kim: That's okay!
Maria: Mine is I like to start my-- because I work nights, right. Start my shift healthy and stuff. I make sure I have my coffee and so excited to go to work. Of course, I think about my daughter and my mom at home and stuff. Then what else I have there? In the middle of my shift I make sure everybody is good and what else?
Kim: What's that picture at the top with the globe where the kids are reaching?
Maria: Those one is-- so excited to go to work. [laughs] My patients are happy to see me [laughs] especially if I came from my long weekend off or my first day back to work. With the 12 hour shift which was two days and three days. I work every day. I basically don't have a day off because when I'm off at the hospital I'm at [the LTC home]. I work seven days a week. My life, to be honest, is more like work, is just work-- whenever I can. I-- when I go home I do stuff for myself as much as I can and I need to do my rest. The end of my shift just how I feel the stress, the life but then at the same time I'm thankful that I got a good job because I know a lot of people out there don't have a job. [points to photo of the sandwich] I want to eat a big burger. [laughter]
Kim: That [looks] very delicious.
Maria: I want to run like I find when-- I just want to share it my sister does a marathon in Ohio but she always encourages me to do. The thing with the marathon what I don't like is you have to train with other people. I just don't have that-- you meet up with them. I don't have the time because I want my own time, I want to--I enjoy running by myself, I just put the music on and then run. Then I'm okay. One time one of the workers say, "Was, that you I saw earlier? You went all the way to Markham and Sheppard?" Yes, that was me! [laughs] I run myself sometimes I do 10k by myself. I just run and then I rest, I walk and then I run. I feel by the time I get home I get all my stress out and I have a hot shower and go sleep and stop my night or days again because I sleep during the day and working at night. [laughs] Stress, when we go to work, we talk, it depends on who you work with. We share, we share with a coworker. Your coworker becomes your family. We always find that -- it's like when you look at our assignment oh, him? Her? No. [laughter]
Maria: It's true. It affects your whole shift. Knowing who you work with because you know there some people you work with you enjoy. It's like you don't even feel the--
Nicola: That's right, all the time pass.
Maria: You are tired because you work together but if you work with this person who is lazy and won't do their work. It makes it harder, it makes your shift longer. It's not unless you're dealing with this patient that's crying, they're screaming, they're climbing, they're trying to hit you.
Nicola: Yes, because some of us are never going to finish. It just like home but like I meant that you go home what it means like, okay, when you go home you got to do whatever. You cannot rest. You cannot take rest. The same thing at work, she giving me report, then says then I start. [laughs] They lie down was seven, the same thing, work never going to stop. Never finish,

because if the partner is not helpful, the partner is not with you, so then he or she try to cheat, like you know, like hiding. [laughs] It's so hard.

Maria: Yes, you don't see the whole worker for a shift. Now since your mom left we now we have eight patients.

Maria expresses that work is her top priority with all activities revolving around **caring for the body in preparation for work**. Whether it is staying healthy by preparing healthy meals, ensuring good rest, exercise, or rewarding self with a treat she discusses that her efforts in caring for the body are towards staving off illness to **maintain the labouring body**. She tells about needing solitude in caring for the body (quiet for sleep, solo running, etc.), but requiring coworkers for personal ("coworker becomes your family") and labour-related needs ("person who is lazy...makes your shift longer."). The "start of her day" is represented at the top of the body, which is coloured, smiling, and heart-full. **The body is drained** from colour towards the lower half of the body, where **stress acts on the body**, **the body appreciates the opportunity to labour**, and preparations for labour begin again.

Clara.

Figure 3. Clara - Body Map 1

***Clara** (March 11th) – Head slightly bent forward rests on the one hand she has to her forehead. Clara's other arm is across her body, hand holding her opposite hip. Clara describes this position as feeling overwhelmed by a lack of initiative by "hard-hearted" colleagues.*

Clara's slogan (Body Map 1): For now I feel like *I did my best and I can only give so much* I think that I tried and then -- It depends on the people who are if they cannot appreciate what I do for them, that's the only that's the best I could keep on offering them.

If the resident doesn't appreciate the care I give it's the best but I put myself everything to care for them for my family and for everybody. I try to balance everything so that's -- [laughter] yes. I did my best.

Clara: Yes, okay. My mind is always like on the circle or lots of things in my mind. That's why every time I have a migraine, headache like that that's why I put the red thing there.

Kim: Right here, okay.

Clara: It's always like -- my mind is always -- my head is always like the focus or I have to pay attention. Here on this side these are the people that I'm working with they're wicked! And they're fighting each other or using words like shut up or words that are very strong they're not really --

Jenny: Cooperative.

Clara: Yes, they're not really physically but sometimes it's worse when it's-- when there's verbally abusive. I just think that I'm working for the money and for my family.

Jenny: That's a good focus.

Clara: I'm not working for them I don't deal with them but I work because -- For example, when I do care they were like, "Why are you doing this?" Then I'm just focusing that I'm doing this for the resident also, it's not for them. I'm not working for them they're not giving me the money. I'm working for the resident.

So then because of sleep is my priority too and my family that's why it's [at] the center of my heart. I need to balance my myself with good nutrition and exercise and leisure time. These are my dreams to travel and these are what we do on our leisure time with the family. We go out, we eat, we just togetherness for us, togetherness.

My priority also is caring for the resident and caring for the family. This the dream that I --before I said that I went to school then that's my dream and I'm almost at the finish line. I'm almost retiring too but at least I have fulfilled something for myself. My finishing the school and then because it's for -- and that also to teach my son that even though you're old you can pursue your dream. And you can reach out your goals or whatever. That's why my son is always with me at school every time I go to school sometimes and he was so --my family is so supportive when I go -- when I trying to do my best for schooling and for the family so I'm very thankful for their support.

Nena: Yes, it's very lovely.

Clara talks about **the body engaging in competing mental activities** causing the body stress and strain. Here, Clara also describes **abuse of the body** during acts of labour and, like Maria, tells about **balancing the body to maintain the labouring body** through good sleep, nutrition, and leisure time. Clara values **acts that support the body by others** and **acts of the body to support others** in referring to family supporting the body's efforts at school and the body labouring to support family and residents. Clara describes that **the body dreams** and engages in labour to strive towards those dreams. While the head is consumed with acts the body needs to do, at the core of the body is the family. All other acts, needs, and hopes of the body are located at the body's periphery.

Nena.
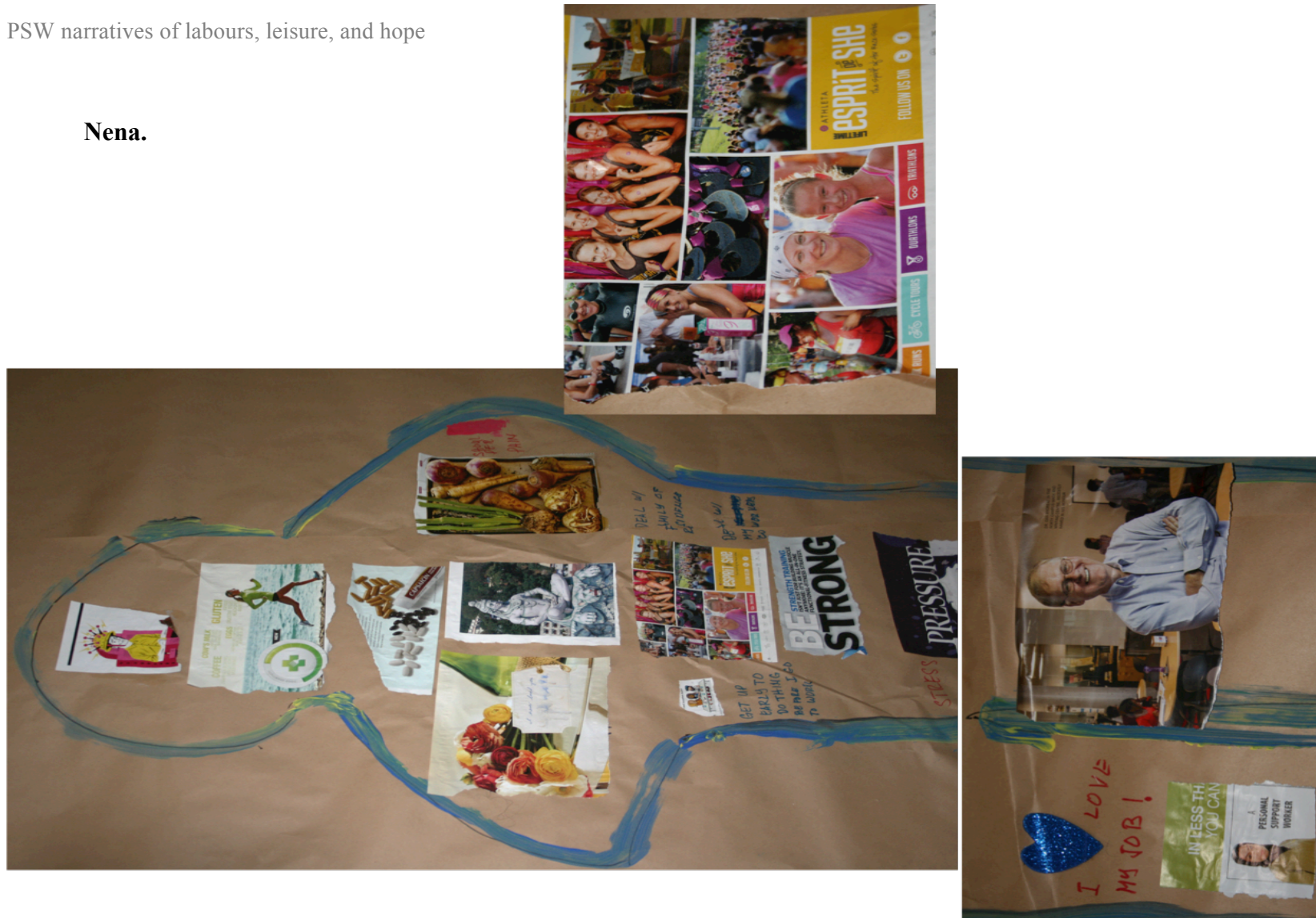
Figure 4. Nena - Body Map 1

Nena (March 11th) – Hands on hips, head forward. According to Nena, this position represents the upset feeling she gets when she is met with a resident's husband who waits for her and regularly demands how care should be handled with his wife.

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Nena's Slogan (Body Map 1): When you go to sleep I said, I did my best for today I did even though how difficult it is but *I did my job*. That's how I feel I did my job so even though it's hard that how I feel.

Nena: This one is represent on the top is my how do I see myself. Because of my residents that are demanding, so I just like all these spikes in my head it makes me in a bad mood. Because the husband is very demanding, the wife is already maybe 90 something but he still wants a physiotherapy and exercise the legs exercise the hands and the neck and things like that.
And their position is you have to be alert with this. You have to monitor when the pillow it's not in a proper place he goes to the nursing station and complain. If I forget to turn because she has to turn every two hours. So sometimes you forget because of so many inter -- distractions you have to prioritize.
He will go to the nursing station and complain, "I've been here for three hours or more than two hours my wife has not turn yet." What I can say so it makes me mad so that the nurse will come to me or "you have to turn" this before he goes. Now I have to watch the clock every time, "Oh it's two hours now, I have to go. I have to turn."
Then it's hard for me to find a helper, because this woman is huge it's very heavy to turn it's very hard. Sometimes my coworkers are busy so I have to wait a few minutes before they can come so it's very, very frustrating. Then I have to rush because it's going to be this thing is before supper, he must be in the bed.
So in one hour or 1 hour and 25 minutes I have to rush pull out my people to sit at their own table because it's suppertime. Some people are in the bed, you have to use the Hoyer, so it's a rush and it's really a pressure to me. I have to manage all these things I have --**.**
Then for these people that this medicine I have to put -- I have to take multivitamins for myself, to take care of myself and exercise and meditation that's how I put this-
Kim: What about this?
Nena: -and flowers is - I have flowers inside the home and it's therapeutic. It lifts up your spirit...
Jenny: Sure it does --
Nena: It takes away all this-
Jenny: Negative.
Nena: -yes, negative thinking that's blocks on your way. It's I'm touching them talking to them, "You, you're so beautiful, nice color. You're so --
Clara: You know what they say, "Take time to smell the roses."
Nena: Yes so I'm touching them and talking them so it's-- that's for myself to take up this stress. And then eat good food, things like that vegetable and balanced diet. Then go out with my friends and talking with them about what is bothering me and things like that. When you talk to your friends all these things that in your mind is just go away, they just go away and then you have --
I can see in my face that is less stress, it's smiling and then the stress just go away. What is this here? This is with -- go out with friends and things like that or if I have no time I have to call them and things like that. So they say, Nena, just do one day at a time and easy does it --
This is what they're saying to me, "How much you can do for one day?" Just take it easy." And I have to be strong and to deal with all this kind of stress. Besides work I have another problem that my family know about that so I don't need to mention that. Then I have to get up early because traveling from West to East takes so long so I have to get up early to do these things.

Before I leave and deal with the family of the resident this is I have not so it's-- Before I used to -- I changed my attitude now, before I used to hate this husband but now I changed my attitude. I have to be friendly and nice to him and it's getting better, he's smiling and well so --

Kim: So like this?

Nena: This one, [the photo of text that reads "I love my job"] I like my job, I like taking care of the people and you can learn from them too; what the experience in their life how of a hard time [they've had]. Because they said, before it's really tight before with the money and their life. They said, "Now it's much more easier." But before they said, "before we have to do everything plus that we don't have running water." We don't have what is this hot like heater now.

We don't have like so you will learn from them that they experience more difficult and hard than what we have right now. This is why I put this because if you do that job in, from your heart from your mind because I love my job.

Nena expresses that this body holds a lot of **anxiety in labouring for the bodies of others**. She explains that **the body is rushed** and requires **the support of other labouring bodies to support the labour tasks the body engages**. The **body is vigilant of time** (to perform care tasks), **others** (co-labouring bodies), **of the body itself** (preparing for and maintaining tasks of the body). **The body strives to be strong** and **the body adjusts its approach as needed** (relationship with a demanding family member) to make things easier on the body. **The body enjoys acts of care labour** for others ("I love my job") and the **body learns from this engagement** ("...you will learn from them that they experience more difficult and hard than what we have right now").

Jenny.
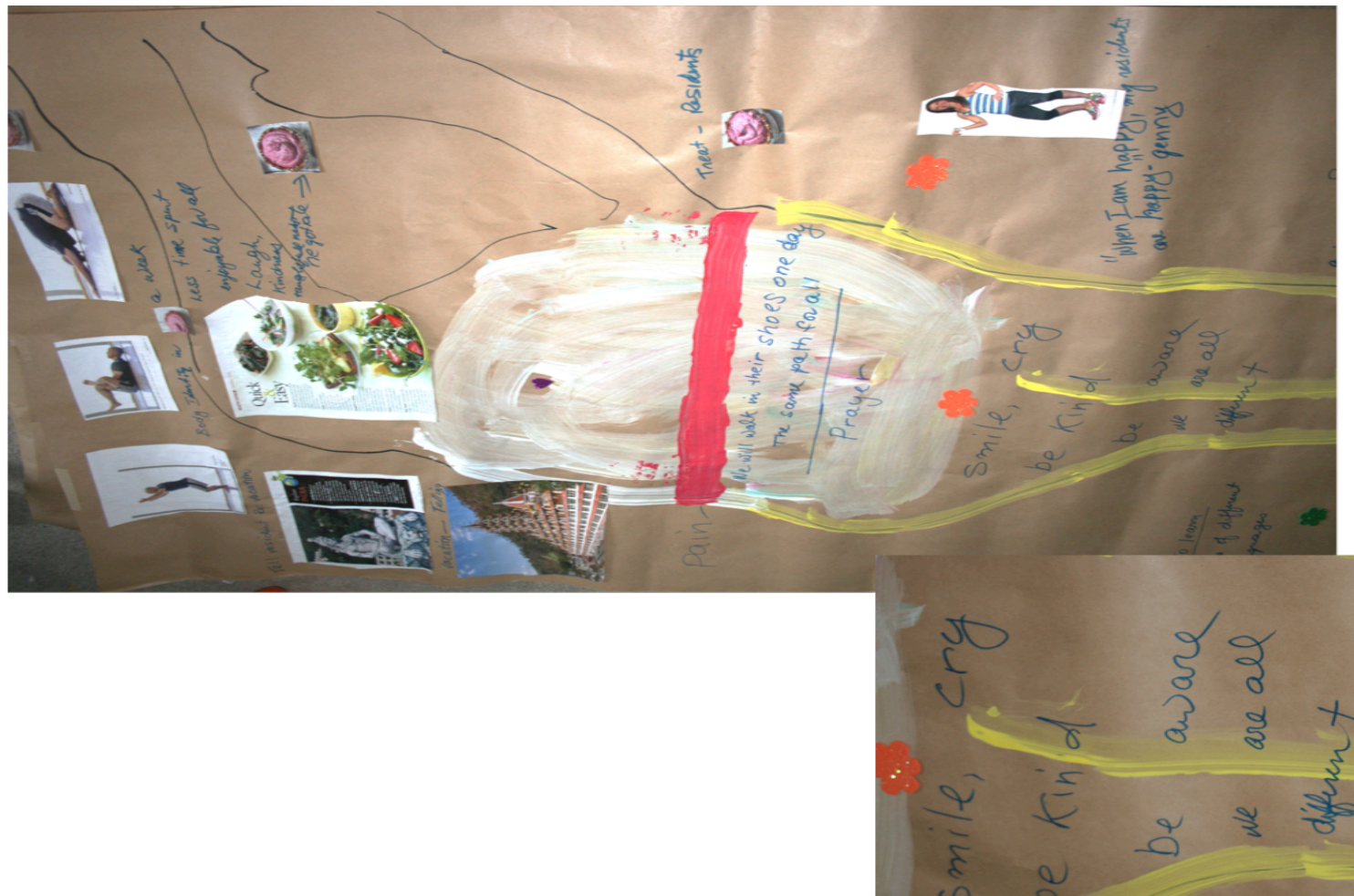
Figure 5. Jenny - Body Map 1

Jenny (March 11th) – A side view of Jenny with her back slightly bent forward at beside "giving care" to a resident. Jenny expresses that this position represents her most "difficult position" because of the back pain that ensues after heavy lifting and repetitive back-bending and strain that is required for resident personal care at bedside.

Jenny's slogan (Body Map 1): And I'm trying to fix my workplace will make life a little easier by if there is something that's difficult in my workplace I try to compromise and see how I can fix it. I think smiling and crying with your resident, be kind to them, be aware at all times, and remember we are all different human being. Have a kind heart for them. *One day we will walk in their shoes*.

Kim: Okay, Auntie Jenny
Jenny: In my heart when we talk about this and we discuss it I had -- I thought one day we will walk in these people shoes that we are caring for and I would like to have that good feeling. I would like people to treat me well so in 22 years of working in this field I'm trying to strategize because in the olden days we had a lifter that you had to pump.
Technology is so great now that it teaches us computer we used to chart everything right everything now we have a computer to document we have a lifter that is electronic and so the job got a little easier for us. Technically they're asking for more so I am learning how to cope with it I learned to treat my body well with yoga and exercise.
On my time off I go on vacation I come back I have -- I'm working we have residents who are doctors, who are lawyers, who are actors, who are engineers so when you come back you incorporate what you learn out there. You explain to them I have pain right now in my lower back so I'm learning how to cope with that, with how to fix your bed when you're doing care and adjust things.
When I find when I have a terrible situation in my job I talk about it and I get help. I come in some days I know my resident likes little treats, I bring little treats for them and talk and laugh with them. Some of them have memory loss, I try to do things at home quickly and fast that are healthy and that's how I do things around my family and adjust to my work.

Jenny has a keen awareness of the body (through a full career of work experience). She connects with the heart. The heart says that **the body will receive good if it does good to the bodies of others**. The body feels -- deeply -- that when the body of others are happy, then the body is happy. **The body navigates and adjusts** to the decreased physical workload and increased mental workload involved in care labour. **The body communicates** with other bodies to articulate its needs ("I have pain right now in my lower back so I'm learning how to cope with that"). **The body shares its knowledge** with others through caring relationships ("when you come back you incorporate what you learn out there"). **The body engages in tasks needed to care for the home in order to manage responsibilities of the labouring body** ("that's how I do things around my family and adjust to my work").

Women's first body maps represented different emotional and bodily sensations as the body engaged in care. Some of the main tensions held in the positioning of the first body included: exhaustion (i.e., *You cannot take rest* – Nicola, *You are tired because you work together but if you work with this person who is lazy and won't do their work, it makes it harder. It makes your shift longer* - Maria), frustration (i.e., *caution, no sitting time* – Nicola, *...spikes in my head* – Nena, *Negative thinking blocks in your way* - Nena), defensiveness/a need to protect the body and anger (*I'm working for the resident, not the family member, I'm working for my family* – Clara, *Residents and family are so demanding* - Nena), a sense of being overwhelmed (*lots of things in my mind* – Clara, *"the skateboard"* – Nicola, *I work seven days a week. My life to be honest is more like work. It's just work.*), and physical and emotional pain (*sometimes it's worse when they're verbally abusive* – Clara, *...knees giving pain* - Nicola). Bodily stories of care are complex and stories told through women's bodies were not only about tensions experienced in care.

Stories that shared glimmers of *hope* and *being with* also lived within the same tense bodies described earlier. I felt these uplifting moments were what drove the body to engage in caring in the first place and remain caring labour. Moving stories of the body lived together to fuel stories of hope. Women's first body maps expressed: feeling part of a community (i.e., *you can learn from them too, you will learn from [residents] that they experience more difficult and hard than what we have right now* – Nena), owning and advocating for PSW work (i.e., *from your heart from your mind, I love my job* – Nena, *So excited to go to work, my patients are happy to see me!* - Maria), heartfelt moments (i.e., *I bring little treats for them and talk and laugh with them [...] smiling and crying with your resident [...] have a kind heart for them* – Jenny), and strength (i.e., *never doubt how strong you are* – Nicola, *to teach my son that even though you're*

old you can pursue your dream - Clara). It is in these moments in care --in the same bodies that embodied tension -- that women's bodies were refueled, rejuvenated, and reminded women of the power of their caring. These kernels of hope and stories of *being with* appeared to be essential for the emergence of the antenarrative of labour I hoped to uncover.

Positioning and Re-Positioning the Labouring Body

In the first body maps, bodies were positioned in ways that storied different forms of angst, be it corporeally, emotionally, or cognitively. When asked to reposition for the second body outline, women's new outlines tell stories of openness, vulnerability, relaxation, and self-nourishing activity. This section will present the (re)positioning of each women's first and second body outline. Here, I focus on the juxtaposition between the first and the second outline, images of the second body map, my reflection on the telling of the second body map, and end with women's descriptions and slogans for the second body map to describe their visible/heard/cared for/acknowledged body in care.

Maria.

Maria's positioning (Body Map 1).

Kim: [...] Now, we're going to be thinking about a position that best represents our PSW work. I don't know, are you dancing, are you giving care, are you tired? Think about the position of your body when you're either giving care or thinking about the work that you have to do. Then we're going to trace your body in that position. [...] Think about for a moment about what position you would like to be traced on the paper and then we'll find a spot. We'll start there.
Maria: When you come to the work, we are just excited, and then someone gave report... Oh! Oh no! [makes disapproving sounds] [laughter] [...]
Nicola: Looking good.
Maria: Okay? Better?
Nicola: No.
Maria: You want me to move like that?
Nicola: Yes. That's good yes. And then, like maybe a hole [for the inside of the arm]. Yes, that's good. Maybe a hole like here?
Maria: Okay. Shadow—
Nicola: There you go.

Kim: Okay, good.
Maria: Do I get up now?
Kim: Yes, you can get up and... That looks good, I like it.
Maria: Looks like a ballerina.

Maria's re-positioning and description of the labouring body (Body Map 2).

Maria: This is my best; relaxed and under the sun and get drunk. [laughter] [...]Now, it's going to be more colorful. [...] Our life's going to be more colourful this time.
Kim: So, think about how you want yourself to be seen by others.
Maria: Happy, of course. Enjoying life, strong-- I want people to see me happy. Very strong, enjoying life. I want to retire early. I always tell who's retiring-- when are you retiring Nicola? Can I come with you? Can I retire with you? [crosstalk] Chelsea is so funny. One of the nurse who told her our Manager Shelly, I want to retire this year, this day, no more than that and that's it. Retire early. Freedom 55 she called it. Enjoy life while you can. [...]
Kim: Think about the activities you would do for yourself. Think about what your job *would allow* you to do. So, for example, you work so many shifts per pay period, if you could go to your work when you wanted, how often would you go to work?
Maria: I'll just go five days a week, like just one fulltime job, but I can't. One full time job will be good like everybody else, going to vacations.

> *Yikes. Though the employer-employee relationship is a real power differential, I use the words "would allow" in reference to powers an employer would have over one's ability to engage in labours of care. The employee structure was something I did not want to impose onto the making of the second body. This was an "oopsie" on my part.

Maria: Just a small house, comfy home [...] Party everywhere. [laughter] Party, party, party. Win the lottery. [laughs]
Kim: What else?
Nicola: What else? Party, party, party, healthy, help other people.
Kim: Party time? [laughter]
Nicola: Yes, a little bit drink, but not too much.
Maria: Nicola you don't even drink.
Nicola: Ya like on Sunday, me and my husband driving somewhere and then one of my friend called me and said, "What time is the LCBO closing?" I said, "I don't know. It's Sunday. It might be six o'clock." She really wanted to have a wine. Then I said, "Okay." So, what we did, we went over there, she and me finished one bottle and my husband said, "Okay. So, can you walk?" Usually when he drinks, I drive, [crosstalk] that day, he cannot drive. "Can you walk?" because we living [close] by and walk.
Maria: Part-time.
Nicola: More money you're thinking about?
Maria: No, but you already have a lot of savings.[...] Six to eight shifts is good enough if you work part-time. [laughter] I already had it all figured out. I always tell part-timers, "Do not get more than nine shift."
Nicola: That's right.

Maria: Nine and 10, it's less than $100 difference. If you have nine shifts, I always tell them that if you want your seniority, go as much as you can, but if you're moneywise, nine shift is enough.[...] Yes. I would like to volunteer. I always see myself as-- I always say, "God, if you let me win the lottery--" Back home we didn't have those recreation for old people for free. I would like to build a recreation for seniors to come and play the games, do arts, do whatever. I would hire a student, like a working student. I want that because we don't have that before. We don't have those kind of stuff back home. I always want that. "Please God, let me win the lottery." [laughs] We don't have those kind of programs. Me and my daughter used to volunteer on a run. You know the marathon?

Kim: Yes.

Maria: I don't know if you know about that work. Somewhere they have this-- you know downtown in the Queen's Park, these people that sells books and stuff? I forgot the term. We used to go there and then books are only 50 cents [crosstalk].

Kim: Yes. Like the sidewalk sales.

Maria: ... We used to, three times, three years in a row, we used to volunteer and back then as she grew up, she doesn't want to do things with mommy anymore. We used to watch a movie every week. "Do you want to watch this movie?" "Oh, I've watched it with my friend already."

Kim: I like your idea about the Day Center with the recreation.

Maria: Yes. I don't know what it is, but I always-- then my friend, my friend was Chinese. You know that Chinese, they always want money in their hand. She said, "Why you're not making money?" I said, "That's a whole thing. I don't want to make money. I want to give. I want to be able to help other people."

Kim: Yes. It's good.

Maria: I want that, but I don't have a land. I don't have money. I don't know. My only chance is winning the lottery. [laughs]

Maria's second body displays forms of self-care she would engage had she felt supported and secure in her body (i.e., **partying, traveling around the world, helping other people**). This body displays "ideal" circumstances in support of a stress-free lifestyle (i.e., **healthy, retire early, part-time work with six to eight shifts that would provide a substantive income**). Her body would live in a **"comfy home" so as to not overwhelm the body with cleaning responsibilities**. Maria discusses that the goals of this body would be more readily achieved if it had the **resources like land and money** - an idealised, social and economic status that her first body could only achieve if it won the lottery.

Maria's slogan (Body Map 2): Happy me.
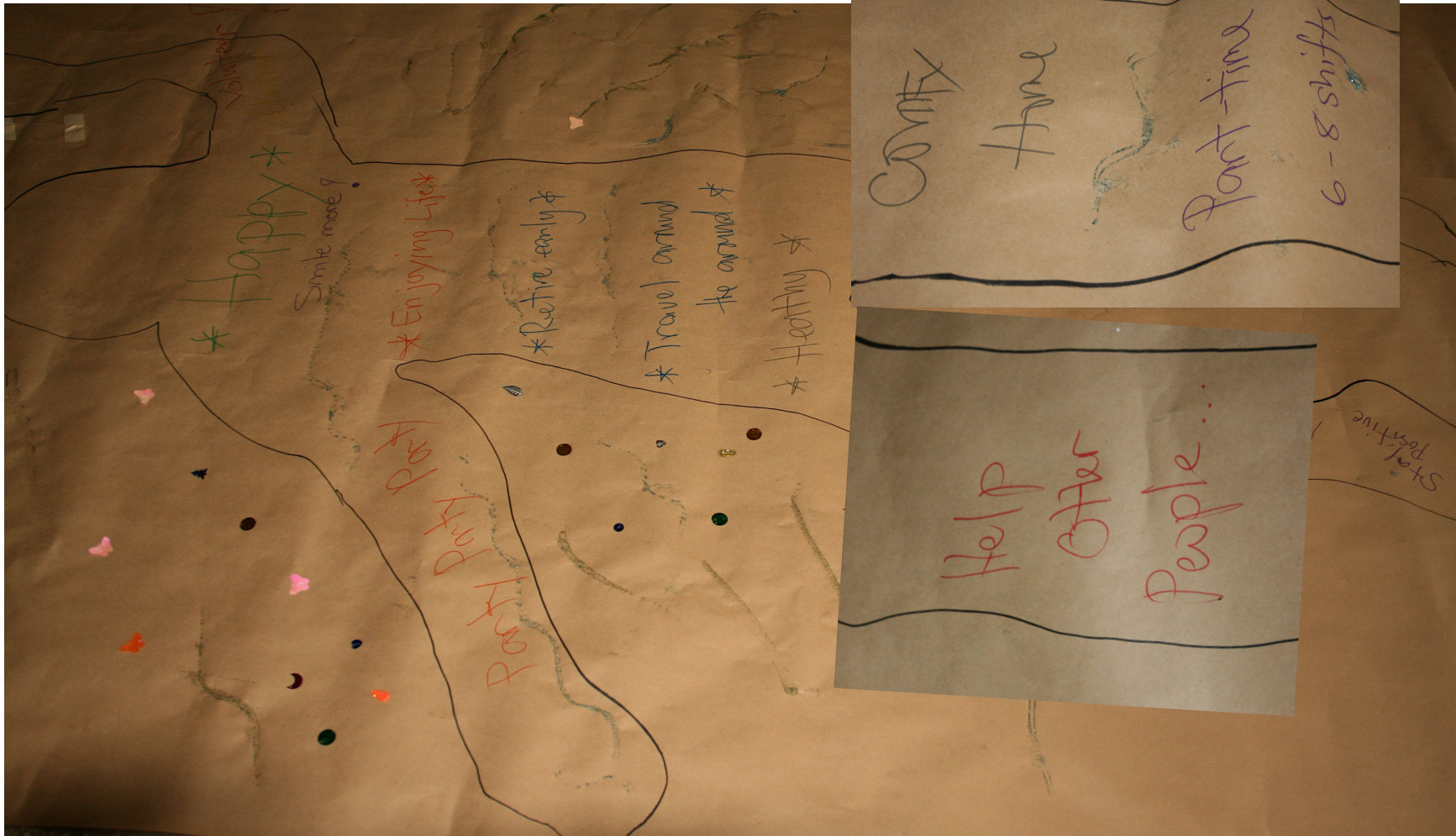
Figure 6. Maria - Body Map 2

Maria (February 22nd) – Lying on back, head forward. Legs are uncrossed. Right arm is to the side of the body, left arm slightly bent by the head.

Nicola.

Nicola's positioning (Body Map 1).

[Nicola shrugs shoulders and lets her arms fall to her side]

Nicola: How do you like that? That was easy.
Maria: Okay. My first, I be like when I go onto the unit, when you drawing... I was like, "This is my day, this is how I'm going to start?" [laughs].
Nicola: Who am I working with today? [laughs]. Oh him? Her?!
Kim: Why do you think you feel like that when you walk in?
Maria: The workload, the people you work with. Some, there's no teamwork.
Kim: Some there's no teamwork?
Nicola: They're not good team players.
Maria: Yes. You always end up doing more again, than the girl who obviously get paid the same.
Nicola: Some of them more complainers. They keep complaining for little thing--
Maria: Than doing the work.
Kim: They're more complainers than doing the work.
Nicola: Yes.
Kim: How about yours, over here?
Nicola: The same thing, like, ho. "Who I'm going to work with [laughs] -- today. Okay. Okay."
Kim: How does that make you feel in your body, when you think about it?
Maria: Exhausted already.
Kim: Exhausted already?
Maria: Yes, and not having started yet, you're already tired, you want to just to--
Nicola: And very stressed too.
Kim: Stress, yes. Where do you feel the stress? In your head?
Nicola: Stress in my head first.
Maria: The whole body.
Nicola: Then get it to the whole body later. It depends on -- sometimes, some assignment we have total, we see x number of patients, all of them are total care.

[Women continue chatting over several additions to their body maps.]

Nicola's re-positioning and description of the labouring body (Body Map 2).

Nicola: Go to Cuba. Just think about Cuba. [laughs] [...] I'm relaxing my hair, too.
Kim: You're resting?
Nicola: Yes. You see my pillow? That's my resting. [laughter]... I wish I could have a nice pillow or a soft pillow. [laughter] [...]
Nicola: Happy, happy.
Maria:
Kim: You can write down the words that express what you feel in this position. For example, how do you want to be seen by others?
Nicola: Yes, like perfect make up and then expensive handbag, a very expensive one.

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Nicola: I wish my hair is black.
Kim: Your hair is black.
Nicola: Because now it's grey.
Kim: No.
Nicola: Now, it's grey.
Maria: I am happy. Good life, we have to go shopping Nicola
Nicola: Yes.
Maria: But since you don't want to drive, long drive, we can go in the buses. Only 40 bucks.
Nicola: Yes, it's easy.
Maria: Whether we can talk and eat and--
Nicola: We drive on the bus because its so stressful driving on the highway.
Maria: Yes. We're going to ask a couple more people, so it's more fun. More fun with each other. I went a couple of times with my daughter to Buffalo.
Kim: You want to go with your daughter to Buffalo?
Maria: We went in the bus.
Kim: You went?
Maria: Yes. It's cheaper in the bus, like one of those-- it's only 40 bucks, because if you're driving and you're tired, it's okay if all of you drives and you take turns. That's very nice the thing for her hair, the pretty hair.
Nicola: Flower for my hair.
Maria: Yes. Bright, bright, bright, day bright light and everything.
Nicola: You know why I use pink? Because more girlish color.
Kim: Yes?
Nicola: Yes.
Maria: More what color?
Nicola: Girly girl.
Maria: Oh, girl.
Nicola: Girl is pink.
Kim: ... How do you want yourself to be seen by others?
Maria: I want-
Nicola: Happy.
Maria: -happy, colorful. I'm enjoying my life.
Nicola: Stress-free.
[...]
Nicola: You know if my friend said, "Oh, you look so fresh. Where did you buy that lipstick? That's nice. Your hair is nice." [...]
Maria: People see me happy. This time I'm writing inside Nicola. Enjoying life. I want to travel, retire early, travel around the world. My friend just text me this morning. She wants to-- her dream is she wants to go to Santorini on her 50th birthday next year. I said, "Make sure you don't bring your kids," because she has little kids, because she can't enjoy if people-- you bringing kids. It'd be just all ladies, no man either. [laughs]
Nicola: Big house.
Maria: I don't want a big house, too much to clean.
Nicola: Why? I'd like to have a big house.

Maria: Two bedroom is enough. If I have a guest, they can sleep in the living room. [laughs] that's Filipino
Kim: Yes, that's true.
Maria: We opened a big banig. [a banig is blanket people use for sleeping on and picnicking]
Kim: Yes. So, a house, what do you hope for?
Nicola: Healthy.
Nicola: If someone says, "Oh, your house is beautiful, so big, good."
Maria: Healthy.
Kim: I love your dreams. [...]

Beyond Nicola's yearning for rest, I see that Maria and Nicola are taking the "ideal" body quite literally in reproducing Western notions of freedom in beginning to think about their second body maps. Throughout each of the narratives that follow, I see capitalist materiality/reproductions of western aspirations/whiteness as a part of a colonial mentality as a means for gaining social capital. I say this not to fault or lay blame on participants' ways of expression apart from oppressive structure (I mean, who doesn't love vacations?), these are just ways of being that we are conditioned to want and need, through structuring of work-life, and expectations of who we should want to be.

In contrast to her first body map, Nicola is conscientious about how her **body appears to the world** in her second body map. She believes that her body is perceived at its most vibrant and successful when it is **"girly," has "perfect [black] hair and make-up," carries a very expensive handbag, and is living in a big house**. The second **body is stress free**. This **body is able to travel** and have **more time for family to support and witness "children's performance achievements."**

Nicola's Slogan (Body Map 2): Stress-free life.

Figure 7. Nicola - Body Map 2

***Nicola** (February 22nd) – Lying on side, legs together slightly bent, one arm supporting the resting head under a pillow (drawn), the other arm, bent at the elbow, is beside the torso on the floor.*

Jenny.

Jenny's position (Body Map 1).

Jenny: I think I'd like to go to my most difficult position.
Kim: Which is?
Jenny: My most difficult position-- if I don't position the bed appropriately, I have a lower back pain, right? I think-- I'm doing a resident and it's a very heavy resident I'm doing care. If that bed is not positioned right and I bend over in such a position that lower back pain starts.
Kim: Right.
Jenny: That's my worst time.
Kim: Yes, okay, that position looks maybe on the paper would look something more like this? [I stand and imitate the position Jenny is describing. Jenny has knee issues and after the first body map, I offered to be her stand in body for her second body map.]
Jenny: Yes.

Jenny's re-positioning and description of the labouring body (Body Map 2).

Jenny: I would love to be in a sitting position like this, this is where I do my yoga, or I do my mindfulness.
Kim: So I can do that. So I will be in a sitting position, so do you want your sitting position to be like this? Hold on, like this or like this?
Jenny: Like where I am, look at me.
Kim: So like this? Where is it-- where are your arms?
Jenny: On my knees.

Jenny: I have a sunshine image. I'm imagining the government is involved and we have more funding. I'm smiling all day, yes, I'm on top of the world. Everyone is listening, we have help for all people, yes. I respect me, I respect my residents and I have help for myself and my residents. I'm comfortable, I'm satisfied. I have residents that's satisfied and at peace. This means, I keep walking because the nursing home have more workers. We're able to stop and chat with a resident and understand them better. Wow, the government even give us an hour break. [laughter] More family are involved now.... Yes, because I had the resident-- at one point in my life I love yellow. I have a yellow uniform that I don't wear. [laughter] Because my ideas have changed now, I can't wear red, I can't wear yellow. One day I wore the yellow uniform and I went to work. This little lady looked at me and she says, "Yellow bird, you're here?" As she's seeing me for a long time. I said, "Yes." She kept calling me yellow bird and I thought this yellow uniform is cheering her up.
Kim: Something so small, right?
Jenny: Yes. I make her laugh, it made me laugh too.

> Jenny refers to **the body as a sunshine image**. **The body is smiling, comfortable, and satisfied**. **Tasks of the body are supported with government-supported funding, breaks, and resources**. **The body is listened to, supported by co-workers, and not rushed. Family of residents help the body by facilitating tasks of care labour. The body is respected and embodies rights.**

Jenny's Slogan (Body Map 2): We have respect for all. We have rights for everyone.
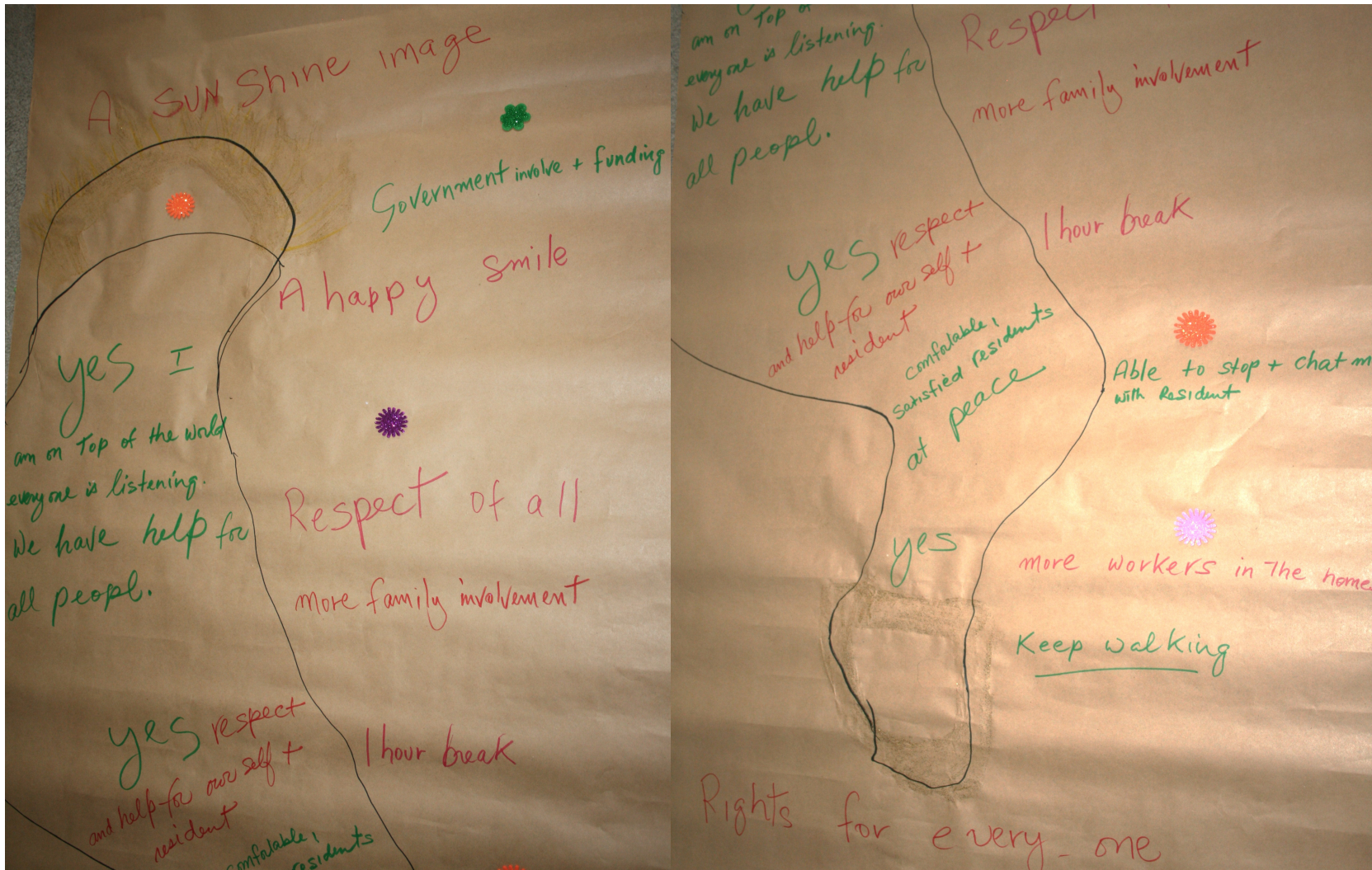
Figure 8. Jenny - Body Map 2

Jenny *(March 11th) – The body is sitting in chair, hands on lap. According to Jenny, the body is doing chair yoga and breathing.*

Clara.

Clara's positioning (Body Map 1).

Clara: [laughs] Oh, I don't know what kind of position because the night shift is different from the day and evening shift. We have everything [to do]. We do everything, almost everything and especially with the colleagues that I am working with. There is so much like-- [laughs] because I am the only one different. [laughter]
Kim: You're being very nice. [laughter] I can tell. [laughter] You're being very humble.
Clara: Because they are seniors too and their nose are so high and pointy. [laughter] I don't know what position. I'll just--[Makes a reversed "L" with her thumb and fingers and rests her right hand lightly on her forehead, as if to shield her eyes, left arm crosses her stomach and holds onto the belt loop on the right hip. Kim sighs]
Clara: Yes. [laughs]
[Women work separately in silence, referring to questions in participant handout]

Clara's re-positioning and description of the labouring body (Body Map 2).

Clara: Put my shoulder like, down [arms in front of the centre of the body, holding something]
Kim: Down.
Clara: Yes, instead of like this, relax. [laughs]
Kim: Yes, okay.

Clara: Clara is a loving and caring person, who wants to be portrayed as a loving person. Every time I chat with my niece [muah!] I always have a flying kiss, giving me kiss, that's why I put this, kissable lips.
Jenny: But Clara, you know every time you go into work, when people see you they smile, right?
Clara: Yes, that's why I put the smile with as a loving person and the glittery eyes. [laughter]
Jenny: Yes, googly eyes.
Clara: Twinkling and twinkling! At work I would like to have a dream of working together hand-in-hand and there's cooperation with the workers. With the team that I have joined in. I would like to have fun at work. Now it's so stressful because my supervisor is so much stressed in her life. Every time we move there's problems. We are like prisoners at night. That's why I put 'fun at work.' We don't have eating together. Only if the company will give us some food. But there is like a hard rock heart with these people.
Jenny: Hard-core, yes.
Clara: Yes, they're-- I don't know but that's what I said, I'm not working for them I'm working for myself and for the residents and for my family. But as a company, it would be better if we are working hand-in-hand and we have cooperation. There's fun at work. With the residents, I would like to have a caring hand, treat the resident as a family. At night we cannot do that because both of us has 50 residents, 45 residents. There's a team. We work two persons in each row it's like that. We have 50 residents. There's no caring, like as if you just want to finish the job. Now, I'd like to have one-in-one that's why I want to work one-in-one client centered care as we are supposed to.

But because at night it's different from the day. We cannot communicate with them because most of them are sleeping. Or if they are awake at night, they're wandering or they don't know where are they, where they are, because they just woke up. Maybe they're dreaming of their old days so it's hard to deal with them at night.

In the company, I hope they will appreciate our work, our accomplishment and we will be rewarded. Because now we don't even get a bottle of water sometimes. We are not like--there's so many occasions they will give us one pizza for each at night.

Jenny: But even so it's not that, the institution is very hot. The building is low and you're looking at that point in time your bottle is empty and your mouth is dry. It's hot and you haven't finished care and you're looking and you can't get a drink of water anywhere.

Clara: Nothing. That's why we're saying, we're working we get even water.

Jenny: That's so sad, yes.

Clara: Even a bottle of water. We have to supply it for ourselves. Most of the-- in the day shift, they bring their own spray because the resources are scarce, it's not enough. I don't know, yes. With the family, I would like to have more time with my family and more time for myself and that will achieve my goal. The flowers so I can smell the flowers [laughs].

Nena: That's very nice.

Clara describes the **body as a prisoner at night**. The loving and caring body portrayed in this map, tells of an alternative story: **the body wants to be cooperative and work hand in hand**. **The body longs for more time with family, to be fulfilled, to achieve, to be valued**. **The body expresses a need to have more time for itself and to have fun at work**. **The body wants to feel success and to be nourished (i.e., water, caring beauty in flowers)**

Clara's slogan: A peaceful person [laughs]. Contentment, accomplishment. If I will accomplish all those -- wishful thinking.

Figure 9. Clara - Body Map 2

Clara (March 11th) – The body is lying on its back, arms across torso, fingers interlocked holding flowers.

Nena.

Nena's positioning (Body Map 1).

Nena: For me, because I have residents which is very particular for every position of his wife every time--
Kim: Oh, I see.
Nena: --because this husband always come everyday. It's very hard to please him. It's very hard to please him.
Jenny: Perfect position. [laughs]
Nena: When I come and before report, he's already there, as in, "Oh my God." My mind is really upset because he wants his wife to be in bed at four o'clock. He's just waiting for me to--? He's very demanding. I'm frowning. [laughter] I'm upset. I said, "This man is really, it's just like he wants me to be a private nurse." I'm a little bit--
Kim: What does your body--?
Nena: I'm looking at him like that-- [imitates an annoyed look, then breaks into laughter]
Kim: Okay. So, hands on hips.
Nena: I'm so upset. I'm so upset!

Nena's re-positioning and description of the labouring body (Body Map 2).

[Women help Nena understand the concept behind second body map]
Clara: Your ideal.
Jenny: So we show our stress there, but we can be unstressed here.
Kim: But still doing the things that you need to do.
Jenny: Satisfactory.
Nena: I love to soak my foot, I'm so relaxed in it when I soak my foot. [crosstalk]
[...]
Clara: It's okay.
Nena: You're really good. I like to soak my foot and reading and things like I'm--
Clara: [Tagalog] Like that?
Nena: Square [to represent a book]. Oh no, my hands are supposed to be in my lap. Or I'm reading something like that.

[Women continue to work in silence, referring to the questions participant handouts]

Nena: Mine is really-- what is this? It's different.
Kim: They are all different, that's okay.
Nena: About how do you want yourself to be seen with others. With a little respect. Listen to our voice, if we say something because sometimes, the RN are not--the registered staff are not listening to us. They are just like, "Oh, she's just like that." We are the one who have direct contact with residents we know if there's a changes of the status, their condition. I would like them to hear our voice what we are saying and hard to see and recognize our hard work. That's what because we are only PSW so we're just like a very low position in a way. That's how they look at us.

Then hope -- hope it's in my mind. It's just a positive thoughts and inspired by the positive thoughts and feelings and happy and contented. That's my simple thought or whatever. [Hope] looks, that's my big smile. That's on my image. Looks happy and smiling. When you are happy, your muscles are relaxing and the thoughts are empty with the unkindly thoughts and free from destructive thoughts.

That's how I care myself. I read the book and soak my feet and it feels me relax really. When you are relaxed, the things that comes to your mind is, "Why are you so worried about this kind of thing?" Really it comes to my mind, "just think one day at a time and these things will goes fast" and satisfied with my job. The satisfied with my job and happy for my service to them, for these people that I work with.

Nena describes a **need for the body to be respected, listened to, and for opinions to matter**. **The body is knowledgeable** and Nena wants others to **recognize and appreciate the body's labour and knowledge**. Nena tells of **hope living in the head of the body** and describes that the **body's labour should be dignified and considered a higher position**. The **body is smiling and muscles are relaxed as it's empty of destructive thoughts**. **Activities the body engages (reading, soaking feet in a foot bath) further relax the body**. **The body appreciates itself and the work it does for others.**

Kim: How does this Nena feel? What are a few words to describe this Nena?
Nena's slogan: Okay. What how they describe? I just want to have a little respect for me and I will be satisfied and happy for myself when I do my job.
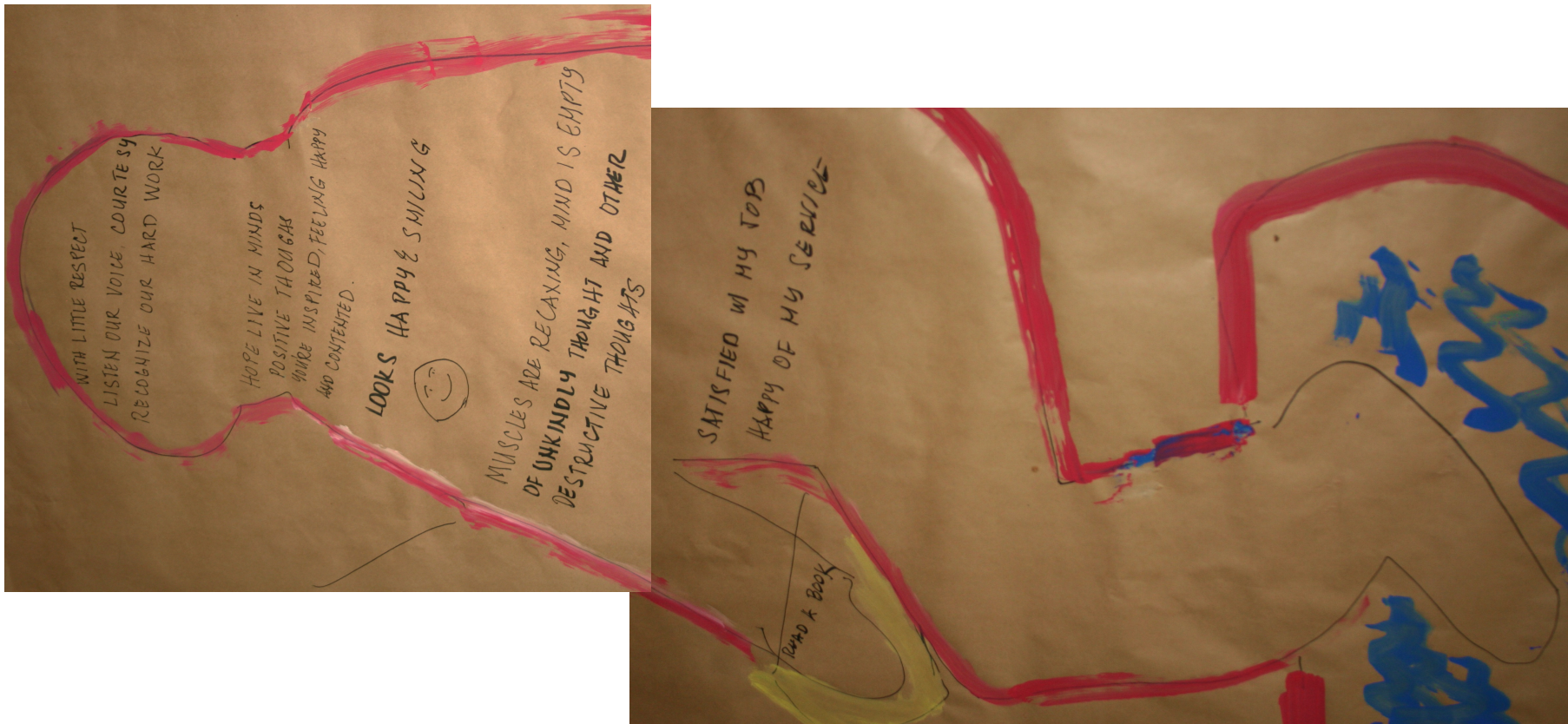
Figure 10. Nena - Body Map 2

Nena (March 11th) – The body is seated in a chair, feet are soaking in a bath, arms bent to holding a book, head is facing the book.

Summary of positing and repositioning embodied stories of genderace in care.

The first body map positions uncovered the following embodiments of genderace:

- Maria – excitement followed by apprehension and stress
- Nicola – stress of heavy workload, feelings of isolation (no teamwork)
- Jenny – difficult position, worst time, pain
- Clara – a diminutive position, shielding body core with arm and face with hand from work politics, tension
- Nena – mind is upset, feels demanded upon, hands on hips

These sentiments about the positioning of women's bodies expressed insecurity, conflict, strain, and stress on the body relative to women's descriptions of their bodies in the second body map.

In the second body map, women used the following words to describe their bodies:

- Maria – enjoying life, strong, life is colourful, happy
- Nicola – resting, perfect, pretty, feminine, stress-free, happy, expensive, perfect
- Jenny – yoga, mindfulness, sitting
- Clara – shoulders down, relaxed, holding flowers
- Nena – relaxed, reading

The second body map was an exercise to think beyond some of the structural limitations in place in settings of care and, in imagining the body apart from structures that define caring in LTC homes, creating the second body map became a space where the body could just *be.* Some of the other words/phrases that women used to describe their second body map included:

relaxed, celebrate, at peace, time with family, volunteer, friends, sunshine image, laughing, smiling, loving, a caring person, twinkling eyes, smelling flowers, appreciated at work, feeling accomplished, respected, having positive thoughts, caring for self, satisfied with my job, and happy [to serve] people I work with. Words that were the same or similar when describing both body maps were used in different ways. For example, in the first body map "I am strong" was used by Nena and Nicola and was expressed in a way that conveyed strength in the face of the stresses and strains presented on the first body map. In the second body map, being "strong"

simply meant feeling strong in addition to feeling *at peace, relaxed, appreciated, respected,* and so on. To me, I felt the other stories co-occuring in the body contextualised the expression of "strong." These embodiments of caring emphasised the potential of caring in ways the body chooses, (dare I say) free or protected from embodied experiences of the first body map. Descriptions from the second body map led me to reflect on how genderace lives in the body and is perceived on bodies engaged in genderacialised care.

Embodiments of genderacialisation: Acknowledging genderace as living in the body.

I reflect on how difficult it was for me to carry a conversation with women when discussing race directly with women in the workshops. When I brought up topics of race the room filled with silence and a tangible unknowing of how to articulate experiences of race. Typically, discussing race results in a discussion of anger of injustice faced by people of colour. However, in this context, it felt that women looked away when asked to identify feelings or experiences of racialisation. In both of the first workshops, where I asked women to think about the identities that represented their bodies to the rest of the world and, asked about race specifically, we broke eye contact. Women turned their heads away from me looked at their blank body outlines in silence. It was as if women were shielding themselves and their bodies from the discomfort elicited by my question. Why was this so? I think about how long I struggled, and continue to struggle, to articulate my stories of living racialisation. The embodiedness of race often remains ineffable due to a sub-conscious need to remain vigilant, perform, self-gaurd, and self-preserve against microaggression. Despite my best attempts to connect with women about how racialisation lived in their bodies throughout the workshops, I felt there was a barrier that prevented these narratives from being spoken.

The shield that one embodies to protect oneself from racialisation is tiring to endure. When I enter a situation where I crave acceptance and an ability to be myself, it is sometimes easier to remain silent, submit to stereotyping, and hear hurtful discourses. This may be similar to experiences of other women of colour. I knew that stories of racialisation would not be easily drawn out over the course of the short time women and I were in workshops together. So, rather than leaning into the discomfort through verbal discussion, which may have evoked distress, I trusted their bodies housed genderace and would, in some way, communicate and reflect systemic genderacialisation. And they did. After reflection, analysis, and more reflection, women's bodies *did* tell stories of genderace.

I see the body, or outsiders read on a body subject to genderacialisation, as largely contributing to some of the stories told through the second body map. If we were to look at words used to story the second body map (i.e., perfection, relaxation, expensive, colourful, having knowledge, having time, having money, "pink is girl") and the opposite of these words (imperfection, tension, cheap, colourless-ness, not having knowledge, time, or money, unfeminine) it appeared that this is how women sensed they were being perceived when they were not imagining themselves in this second body map — a space that existed apart from traditional structures that defined caring work. It felt like words that were absent in the second body map (imperfection, tension, cheap, colourless-ness, not having knowledge, time, or money, unfeminine) were the embodiments of genderace in settings of care that were not spoken forthrightly.

In the body studies literature on effects of race, gender, and class stratification on the body -- what this study describes as genderacialisation – authors describe how racialised women's bodies are subject to many of the perceptions described; perceptions that are further

maintained by the genderacialised nature of PSW care work. I still feel, at this time, I am

unable/do not have the resources to adequately fully articulate my own, let alone someone else's,

embodied experience of racialisation. However, to me, this is what differentiates the narratives of

genderace and genderacialision by non-white women. I am not to say these are sentiments (i.e.,

imperfection, feeling cheap, lacking knowledge or femininity) not felt by white women. What I

am saying is that oppressive histories of racialised women play a special role in how these

sentiments live in the core of racialised women's bodies and influence every which way we (I

say as a racialised woman) interact with the world — taking extra care to not reinforce, reflect,

or let the outside world know of the ways we have been genderacialised.

In this study, narratives of racialisation are still silenced and subverted. Colourblindness

in Canadian discourse and culture complicates our readiness to be able to hear and process

stories of genderace and fully appreciate experiences of racialisation. This was the importance of

being with and creating *hope* in seeking worth through labour within neoliberal and capitalist

systems. Culturally, there is no space for women to discuss stories of genderacialisation in

relation to systemic oppressions. And, when I asked women to provide perspectives on how

racialisation lives in their bodies, the experience for women was unfamiliar, jarring, and

uncomfortable. The system that structures existences in caring employment has carved within

each of us, citizens of a neoliberal, colourblind, and capitalist society, that connecting with self

means needing to reconcile failures of system *and* facing the cognitive disconnection individuals

need to make with their bodies (that have been systemically marginalised) to continue living and

thriving within a system that privileges certain bodies.

CHAPTER 7. The Labouring Body is Seeking *Worth*

But the strength of women lies in recognizing differences between us as creative, and in standing to those distortions which we inherited without blame, but which are now ours to alter. The angers of women can transform difference through insight into power. For anger between peers births changes, not destruction, and the discomfort and sense of loss it often causes is not fatal, but a sign of growth (Lorde, 2007, p. 131).

Spurred through struggle and anger, this activist narrative research had objectives to: deepen knowings of genderacialisation and story how genderacialisation occurs for PSWs working in LTC homes (addressed in Chapters 2 and 3); map stories of genderace by listening to racialised women's stories of current practices in care, leisure, and labours of care (addressed in Chapters 4 and 5); reveal how self-care, leisure, and care work are storied free from structure and to story genderace as it is navigated by PSWs in settings of caring (addressed in Chapter 6); and discuss with PSWs implications of stories and act to change structuring of care work (Chapters 7 and 8). The growth within this research story comes from knowing, through women's bodies, how *hope* and *being with* serve to sustain PSWs in seeking *worth* through the labouring body.

The next section discusses how my conceptualisation of hope evolved through the data collection process. First, I describe hope as it connects to labour and needed change in care practices. Second, I reflect on hope as a vehicle for revealing *worth* as an antenarrative of labour through a lens of genderace held in the body. Third, I describe the labouring body as seeking *worth* the antenarrative of labour within a genderacialised care structure that works to marginalise, silence, and oppress. In addition to the notion of *hope* as a vehicle for seeking worth through labour, I reemphasise *being with* as a relational concept highlighted by women through their stories.

What is Hope? Poetizing Genderace in the Body

Prior to data collection, hope was my way of hearing what participants expressed as wants for change. This study aimed to locate hope in the body not only because of the body's ability to hold stories of hope within but also for the potential for hope to create change through active resistance. When I spoke about hope at the inception of this study, I assumed people hoped for specific things, like acknowledgements of inequity towards social justice that would in turn, create an impetus for change: "[j]ustice constitutes an article of faith through deep feelings that move people to action" (Collins, 1998, p. 248). In the context of labours of care, I felt that the movement towards social justice for and by structurally marginalised groups was a natural hope that could be harnessed into actionable items for change. To me, hope was the vehicle for something deeper – hope enabled the labouring body to strive and struggle to reach or gain or acknowledge the body.

Hope is a concept I used to better understand how racialised women were thinking about and embodying wants for change within their current work circumstances. The absence of hope, in my mind, is despair and I felt that I was not in an ethical position to leave participants in a state of hopelessness. But here I was, challenged by my inability to locate hope in the body maps beyond material wants (especially in Maria and Nicola's body maps).

In the instance of the first group, hope and wants were conflated in Nicola and Maria's stories. Through reflection, my challenge was not only locating hope - it was about seeing the full picture of the body, then being able to articulate identity, bodily and emotive needs, then finally hope. Seeing the full body meant to story identity. Without the space to position and describe who one is, one is not able to fully articulate what change they hope for the body.

I struggled with the notion of hope in the traditional sense because I thought that hope (in the mistakenly assumed utopian sense) was a means, rather *the* means, for change in this context with racialised women as PSWs. I felt hope was needed. I wanted participants to have hope to stave off despair. What entered here was my issue of conceptualising and focusing on ideal care and care practices. Focused on the acts of care and not the body, I moved people away from locating identity in an embodied sense and asked them to think of the body only as it was relative to care.

Working through workshop 1 with the second group, I caught myself. I found that by letting individuals think through their identities, what ever that may look like to participants and absent of my probing and prompting, individuals were more expressive of identity through the body, which led to a new knowing of hope.

> **Guiding research question.**
> 4. How are hopes for labours of care, self-care, and leisure storied by PSWs working in LTC homes?
> • How are these hopes juxtaposed against body maps of current labours of care, self-care, and leisure practices?
> • How are these hopes juxtaposed against the structuring of care work through genderacialisation?

If I were to respond to the research question I developed for this study above, I would critique my use of the word hope and replace it with *wants* rooted in neo-liberalism. To respond to the first bullet point, I would say that the wants of the labouring body are structured in a Western, neoliberal, capitalist agenda and as such, the wants of the labouring body are juxtaposed in ways that will never equate to the current practices of care, self-care, and leisure. Here, I am referring to the Marxist notion of false consciousness and material determinism, where material gain of the working-class, through consumption, is an illusion designed to sustain productivity towards material gain of society's elite (Delgado & Stefancic, 2012; Eyerman,

1981). Keeping up with practices of care, in the ways PSWs are required to, while maintaining self-care through self-sustaining leisure practice is utopian. The politics of genderacialised care suggest that racialised women do not consider what the body needs until work is sorted and, as each person knows, work is never fully sorted. As a genderacialised body, the loop between feeling *worthy enough* for leisure and the actualisation of a rejuvenating leisure practice is a faulty circuit. Stories are socially and politically embodied and in relation to genderacialised care, feeling worthy in the body is tied to how the body can contribute to systemic aims for production.

Given the first part of this discussion, for the second bullet point, I think I am safe to assume that these wants rooted in neo-liberalism through genderacialisation are that much further from being realised. I am compelled to re-structure this question to the following:

4 (revised). When viewed through the lens of genderace and genderacialisation, how is hope expressed in stories of labours of care, self-care, and leisure practices?

I look now to know how hope becomes amidst practices of genderacialisation. To re-cap, my knowing of hope evolved over the course of my research to include: 1) hope as the antecedent for change, to 2) hope in relation to despair to, my final plateau, 3) the expression of hope in the body. Now, it is conceivable to me that hope arises from the recognition of one's own helplessness and the acknowledgement that any struggle against a conflated gendered, racialised, and classed system of hegemony is futile. It is, perhaps, through this insight one can begin to seek liberation amidst the structures of oppression (see discussion on Foucault's care for the self as a practice of freedom, later in this chapter).

In the blankness of the body outlines, one cannot unmake neoliberal nature, decolonise, decentre work, or make the body genderlessness, racelessness... but yet in the same breath, it can be done. The lack of traditional markers of identity (i.e., race, gender, class, etc.) on the body

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maps and in the digital stories were signifiers for the simultaneous becoming through

unbecoming; a practice of making, breaking, and re-making.

In the futility of struggle for equity what then is the role of resistance? The role of

resistance would be to *still* push (in the face of the structures that define bodies) for equity of

being in small scales that, over time and space, create the big waves of socially just change for

which we strive. One can only free oneself of the quicksand that envelopes their body by making

small pockets of space at a time: first by wriggling their toes, then feet, then by kicking their

legs, and finally by lying on their backs to shift the pressure (that is oppression) to free the body's

core. Only then, with the total realisation of the forces (powers) that exert pressures on each part

of our body, can we (society's collective) free our individual beings.

Speaking with participants and listening to their stories revealed hope as a vehicle to

knowing more about the antenarrative of the labouring body. Hope for the body can only exist

when the body is acknowledged. By acknowledging the body -- and one's right to exist in that

body – *hope*, for stronger teamwork, for a more colourful life, to be of help to others, to be

respected, to be valued, to have fun at work, to be listened to, to care differently, facilitates the

emergence of the antenarrative of labour. Thus, through recognitions of body and needs to be

heard and seen, the body can begin to tell a knowing of what the labouring body seeks through

hope.

Fragments of hope support listening and seeing the labouring body as seeking through

care work. With this new knowing, I move to describe my analysis process and, by poetizing,

begin to represent how an antenarrative of *worth* became from women's storying of their

labouring bodies. To reflect on how genderacialisation imparts and embeds marginalising

narratives on bodies, specifically labeled working bodies, I end this chapter by revisiting the

politics of genderacialised care with the knowing that the labouring body seeks worth through labours of care.

SEEKING *WORTH* THROUGH THE LABOURING BODY: AN ANTENARRATIVE OF PSW LABOURS OF CARE

labouring body under surveillance	**THE BODY SEEKS LIBERATION THROUGH LABOUR**
−	. . . through education towards labour.
to know through the body	. . . through consumption/financial capital from labour.
−	. . . from labour.
to appreciate	**THE LABOURING BODY IS**
−	. . . strong and grateful for labour.
to strive	. . . made a commodity.
−	. . . navigating and forgoing nourishment for labour.
to struggle	. . . faced with stress, struggles, and adjusts to accommodate it.
−	. . . engaging in mutual agreement and blame conflict from others.
to fragment and decentre identity	. . . sore, drained, abused, pressured, and coping to remain labouring.
	. . . insecure, being watched, sensing moral tension.
	. . . taken for granted and not valued.
−	. . . replaceable.
to silence	. . . isolated.
−	**THE LABOURING BODY DISRUPTS THE DISCOURSE OF (RE)PRODUCTIVE LABOUR**
to connect with	The labouring body is losing time.
−	Labouring bodies are not created equal.
to reconnect with the body	Labouring bodies are not protected and preserved.
−	The labouring body is demanded upon in ways beyond body care.
to despair	**THE BODY IS UNSETTLING AND REVALUATING WORK**
−	Struggling. "...you are controlled..."
to hope	Giving up. Defeated. Excluded. "...sometimes it's better to shut up."
−	Desiring to be heard, yearning to relate.
to be with through care	Repeat. "...work never going to stop. Never finish..."
	Sitting still. "realizing that what this life is all about"
−	Questioning and acknowledging PSW work. "I'm really not his slave. Right?"
to transform care	Hoping for change. "... if it changes in the nursing home, it's going to change my lifestyle."

EMBODYING HOPE IN STRUGGLE

Abusing   caring for
Dehumanisation   humanisation
Objectifying   subjectifying
    Commoditising   differentiating
    Not hearing   listening to
       Making invisible   being visible
          Disconnecting and isolating   connecting and communing
Worth: despair through labouring, acknowledging the body, and ***being with*** *others through care*

Commentary on analysis and connections to genderace.

I listened by noting how I felt genderacialisation was operating through the narratives and how genderace presented on the bodies. After the workshops were completed, I developed a narrative guided dialogical and embodied analysis approach for this improvisational critical narrative inquiry. I constructed my qualitative analysis based on some works on dialogism by Bakhtin (1981) and Mead (1934), who shared the notion that theorising by way of sharing of contextual and dynamic perspectives and then analysing dialogue provided insight into the subjective knowledge of society (Linell, 2009). I adopted this approach to acknowledge intersubjectivity in the textual representations (transcripts of stories told) of embodied knowings (brought out through body mapping and sharing after viewing the digital stories). After a textual analysis of interactive language (i.e., who is talking?; how does each person narrate themselves in relation to others?; what/why specific language was used in a given scenario; and what do beliefs held/actions/utterances by others imply about women or an activity?), I deepened my analysis by reflecting on writings that documented what it felt like to be in spaces of storytelling with women while they worked through body mapping and after watching digital stories.

My intention was to preserve particiant's voices in the final representation. With this aim and my desire to convey nuance, relationality, complexity, and depth in representations of collective and individual embodied stories I, first, moved through narrations of participants' body maps chronologically to review content as a whole. I then identified ebbs and flow in the conversations and fragmented the whole text by creating "bookmarks" or topic titles between conversations. Here I was attempting to maintain dialogue yet preserve individual perspectives. Specifically, I moved through transcripts of the workshops again and connected with the relationships participants made between their bodies, labour, and each other's stories. I then

identified which phase of the research process each narrative fragment was from by creating a

legend. I then returned to the "bookmarks" and used these headings to frame the analysis of the

third workshop, viewing of the digital stories. New headings were created for this last phase of

analysis as were needed. Finally, I went through my daily journal of reflections and moved

narrative fragments to align with an embodied analysis of my reflections. I journaled my

approach to this data and summarise it in the list below:

1) Review of temporally linear conversations/photos/slogans/reflections from each phase of body mapping and digital storytelling. *Hearing the whole.*
2) Revelation of dialogical narratives from engagement with body maps. *Fragmenting linear stories by topical titles to follow the ebbs and flows in conversation.*
3) Use identified narratives to re-review transcripts and process notes/reflections. *Sense making by seeing the whole through story fragments.*
4) Creation of legend for each phase of data collection and analysis (below). *Bookmarking narrative fragments.*
5) Pastiche of a collective narrative across research process (stanzas of poem in the section that follows). *Retrieving narrative fragments from other parts of the whole to create new story.*
6) Reflection on corporeal knowings to affirm/restructure story fragments. *Reflect on documented and felt bodily sensations while hearing/reading story and linguistic manifestations of body narratives, including pre-emergent body narratives.*
7) Representation of embodied stories (body maps, digital stories, and poetised representation of collective narrative).

In this approach codes were assigned to segments of the research process rather than the data

itself. I worked through eight aspects of this research process (outlined below) to connect with

embodied narratives that were revealed dialogically, through body mapping, or through

reflections in creating, then viewing digital stories. The following is a legend of symbols I used

to code narrative fragments that were pulled from various locations in our research process.

✪	Introductions and journey to PSW labours of care
★	Tracing I and body positioning
✤	Scanning I
✚	Tracing II and body positioning
❖	Scanning II
⭕	Comparing body maps 1 and 2
•	Digital storytelling
‽	Researcher reflections/observations

The "bookmarks" that materialised from body map and digital storytelling narratives were guideposts for deepening analysis, connecting with bodily knowings of genderace, and uncovering a pre-emergent body narrative. The representation positioned at the start of this section is a snapshot of the transformations and realisations that occurred through the body as a result of this research. I should note here that lines of the stanzas are not themes as they are not taken up in the same way across the two groups of participants, rather each line is an embodied expression of the dialogue stimulated by participants' engagement with symbols they placed onto their bodies.

To further address my first three research questions,

1. How do personal support care workers' stories told through body maps take-up, negotiate, or reconceptualize notions of labours of care, self-care, and leisure?
2. How do body maps reveal genderacialisation in the structuring of labours of care and navigations of current care practices by PSWs in LTC homes?
3. How do personal support care workers' stories take-up genderace?

I elaborate on the outline titled, "Seeking *worth* through the labouring body: An antenarrative of PSW labours of care" presented above through the poem that follows. As uncovered by my reflections, *hope, being with, and the struggle for worth* emerged from an acknowledgement of the body and was facilitative in hearing this bodily story as seeking through labouring. Through this analysis, *worth* was revealed as an antenarrative of **labour** in stories told by genderacialised women. Through the stories of individuals living a part of structures that oppress, the connection was revealed between *worth, being with* and genderace through **struggle** or acts of striving to be seen, heard, and acknowledged. In the following representation, I describe how labour is held antenarratively in labouring bodies as *worth*. Reflecting on invisibility through marginalisation, a thread running through the politics of genderacialised care, acts of struggle to **be worthy** within systems of stratified privilege is echoed in critical race feminism literature. Informed by all parts

of our research journey, story fragments felt through participants told stories in the poem over the next few pages, hold different narrative forms: grand narrative, counter-narrative, and, antenarrative – pre-emergent body narrative –. The stanzas of the poem describe how genderacialised women working as PSWs negotiate, reveal genderacialisation, and take up genderace on the body towards a knowing of how the body seeks to reconceptualise *being* and *worth* in relation to acts of caring apart from dominant structures – a knowing that is reflectively learned through communion with others.

THE BODY SEEKS LIBERATION

THROUGH LABOUR

... through education towards labour.

✪ **Maria:** Me, I really want to take computer science after my high school. You know back home, after high school, you continue right away. It's not like here. Sometimes people take a year off or something. But, my mom was already here, and she said that working as a -- they used to call it nursing aide -- if you finish nursing aide, you find a job right away.
That's how I went for one-year course back home, or one-year full-time course as a nursing aide. Then, when I came here, I was working -- I didn't work as a healthcare aide right away, because I was new, you're scared, you don't know. But I got lucky, because that time, the government, they were changing the nursing aide -- healthcare aide into a PSW program, and they were paying the agencies, all the healthcare facilities, to send all their staff to upgrade. I went to George Brown for free.
Nicola: Lucky you.

✪ **Nicola:** Back home, I had different career. I was a civil engineering assistant. Actually, here in Canada they call it technologist. After I got married, I moved from my country. I used to live in Philippines too [laughs]. That time I didn't work, I just raised my kids at home. My husband worked, so when we came to Canada, I went to -- first, we came to Winnipeg. I went to college and tried to update my certificate, diplomas, everything and then finally I figured out I had to go to school another two, three years to get this career back and then I find a way to get a job in a short period of time. Arriving to college, to take this course, PSW they call it. They call health care aid over there and then got hired to [a hospital]. Then my husband decided to move to Toronto, we came here. I had to go again to Centennial college to get the job in hospital theatre. Centennial again, same course in the same country, different provinces. [Laughter] I had the same certificate, two provinces.
Kim: When you came from your country to Winnipeg you went to school, and then for the same thing, and then you went to Toronto, which is a very expensive city to live in, and then do it again? That's incredible.

Nicola: Yes. I believe I was crying because the day my husband asked me, "If you want to go to hospital job you have to go to school or just choose a different career or stay at home."[laughs]

✪ **Clara:** Yes and I studied RPN. I just finished the course.
Kim: Oh, that's exciting.
Clara: And I passed!
Kim: Congratulations.
Clara: Thank you. I just got the result yesterday.

✤ **Clara:** This the dream that I --before I said that I went to school then that's my dream and I'm almost at the finish line. I'm almost retiring too but at least I have fulfilled something for myself. My finishing the school and then because it's for -- and that also to teach my son that even though you're old you can pursue your dream. And you can reach out your goals or whatever. That's why my son is always with me at school every time I go to school sometimes and he was so --my family is so supportive when I go -- when I trying to do my best for schooling and for the family so I'm very thankful for their support.

✪ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✤ Scanning I ✚Tracing II and body positioning
❖ Scanning II ✪ Comparing body maps 1 and 2 • Digital storytelling ❣ Researcher reflections/observations
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... through consumption/financial capital from labour.

✤ **Nicola:** I put it over like my relaxed hands.
Kim: Yes, okay.
Nicola: Lipsticks, cutex, whatever cosmetic.
Maria: The beautifying things for herself.
Nicola: Then here why I color red is just a stress, releasing. [shoulder] This I'm watching my drama in my own language and then releasing [into a] long sleep.

✚ **Maria:** This is my best; relaxed and under the sun and get drunk. [laughter]
Nicola: Go to Cuba. Just think about Cuba. [laughs]

✚ **Maria:** I'll just go five days a week, like just one fulltime job, but I can't. One full time job will be good like everybody else, going to vacations.

✚ **Kim:** how do you want to be seen by others?
Nicola: Yes, like perfect make up and then expensive handbag, a very expensive one.

... from labour.

✤ **Clara:** So then because of sleep is my priority too and my family that's why it's [at] the center of my heart. [...] These are my dreams to travel and these are what we do on our leisure time with the family. We go out, we eat, we just togetherness for us, togetherness.

✚ **Maria:** I want to retire early. I always tell who's retiring-- when are you retiring Nicola? Can I come with you? Can I retire with you? [crosstalk] Chelsea is so funny. One of the nurse who told her our Manager Shelly, "I want to retire this year, this day, no more than that and that's it." Retire early. Freedom 55 she called it. Enjoy life while you can.

THE LABOURING BODY IS ...

... is strong and grateful for labour.

✤ **Nicola:** Then I believe this one too, never doubt how strong you are.
Maria: It's a long day.
Nicola: It's a long day.
Maria: It's a long day.
Kim: I like that never doubt your strength.

✤ **Nena:** And I have to be strong and to deal with all this kind of stress. Besides work I have another problem that my family know about that so I don't need to mention that.

✚ **Kim:** So, think about how you want yourself to be seen by others.
Maria: Happy, of course. Enjoying life, strong-- I want people to see me happy. Very strong, enjoying life.

✤ **Nena:** This one, I like my job, I like taking care of the people and you can learn from them too; what the experience in their life how of a hard time [they've had]. Because they said, before it's really tight before with the money and their life. They said, "Now it's much more easier." But before they said, before we have to do everything plus that we don't have running water. We don't have what is this hot like heater now.
We don't have like so you will learn from them that they experience more difficult and hard than what we have right now. This is why I put this because if you do that job in, from your heart from your mind because I love my job.

✤ **Clara:** My priority also is caring for the resident and caring for the family.

✺ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✤ Scanning I ✚Tracing II and body positioning
✤ Scanning II ✺ Comparing body maps 1 and 2 • Digital storytelling ❢ Researcher reflections/observations

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✤ **Nena:** When you go to sleep I said, I did my best for today I did even though how difficult it is but *I did my job*. That's how I feel I did my job so even though it's hard that how I feel.

✤ **Maria:** Those one is-- so excited to go to work. [laughs] My patients are happy to see me [laughs] especially if I came from my long weekend off or my first day back to work. With the 12 hour shift which was two days and three days. I work every day. I basically don't have a day off because when I'm off at the hospital I'm at [the LTC home]. I work seven days a week. My life, to be honest, is more like work, is just work-- whenever I can. I-- when I go home I do stuff for myself as much as I can and I need to do my rest. The end of my shift just how I feel the stress, the life but then at the same time I'm thankful that I got a good job because I know a lot of people out there don't have a job.

... a commodity in labour.

✤ **Nicola:** Work time so I just believe there is strength in numbers so let's feel like on giver ... Then, caution, no sitting time. ... [laughs] Those are just for the--

no sitting time actually yes. It's so hard to find the time to sit down when going to work 12 hours especially. I thought that 12 hours is going to be easier for me, but more work.

★ **Maria:** Okay. Shadow—
Nicola: There you go.
Kim: Okay, good.
Maria: Do I get up now?
Kim: Yes, you can get up and... That looks good, I like it.
Maria: Looks like a ballerina.
❣ Maria compares her body outline to that of a performative dancer...

⊙ **Nicola:** We wish our will salary increase -
Maria: This is the kind of life we have [referring to the first body map].
Nicola: [looks to the second body map] - to good amount and then we don't have to go two jobs. Like, we just do eight, three hours for pay period and then the other rest of the time we spend with our family. Do what we have to do, you know?
Maria: Everything is so expensive now.
Nicola: Yes.
Maria: You know like – better. Your mom, She was only making how much dollar?

Kim: $2.65.
Nicola: Maybe that time it was good -
Kim: It was minimum wage at the time, yes.
Maria: Yes, but now, the minimum wage now is not even -- like everyday, the bread, the banana, everything is –
Nicola: Compared to other PSW, I think we're getting good money, compared to - - not compared to PSW a lot of pay, but the other agency people, getting only 16.
Maria: They only pay $12.-
Kim: Yes, agencies and community [PSWs] get less.
Maria: Yes. I used to do that. Five years but actually I didn't drive, so for me to get from one job to the next, I would have to get -- I was running all the time. Watching the child to catch the bus and make sure I get there on time. And they only give you so much time to get from one client to the next and the pay is just, is very little. It was 12 bucks, long time until now, it's still 12 bucks
Nicola: I think, until now some people are getting 12 -
Maria: I could not believe it's still $12.

✤ **Clara:** I just think that I'm working for the money and for my family.

✪ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✤ Scanning I ✚Tracing II and body positioning ❖ Scanning II ⊙ Comparing body maps 1 and 2 • Digital storytelling ❣ Researcher reflections/observations

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❖ **Maria's slogan:** *We know we work for our money. We leave work knowing that our patients are safe. We did the care we're supposed to and we go home and our conscience are clean and we're happy, we're satisfied.*

❖ **Clara:** I'm not working for them I don't deal with them but I work because -- For example, when I do care they were like, "Why are you doing this?" Then I'm just focusing that I'm doing this for the resident also, it's not for them. I'm not working for them they're not giving me the money. I'm working for the resident.

... is faced with stress and adjusts to accommodate it.

⭕ **Kim:** So when we think about the first body map, how do we feel?
Clara: Loaded.
Jenny: It was, yes, overloaded. It was stressful.

★❣ **Maria:** When you come to the work, we are just excited, and then someone gave report... Oh! Oh no! [makes disapproving sounds] [laughter]

★ [Nicola shrugs shoulders and lets her arms fall to her side]
Nicola: How do you like that? That was easy.
Maria: Okay. My first, I be like when I go onto the unit, when you drawing.. I was like, "This is my day, this is how I'm going to start?" [laughs].
Nicola: Who am I working with today? [laughs]. Oh him? Her?!
Kim: Why do you think you feel like that when you walk in?
Maria: The workload, the people you work with. Some, there's no teamwork.
Kim: Some there's no teamwork?
Nicola: They're not good team players.
Maria: Yes. You always end up doing more again, than the girl who obviously get paid the same.
Nicola: Some of them more complainers. They keep complaining for little thing--
Maria: Than doing the work.
Kim: They're more complainers than doing the work.
Nicola: Yes.

★❣ **Nicola:** The same thing, like, phew. "Who I'm going to work with [laughs] -- today. Okay. Okay."
Kim: How does that make you feel in your body, when you think about it?
Maria: Exhausted already.

Kim: Exhausted already?
Maria: Yes, and not having started yet, you're already tired, you want to just to--
Nicola: And very stressed too.
Kim: Stress, yes. Where do you feel the stress? In your head?
Nicola: Stress in my head first.
Maria: The whole body.
Nicola: Then get it to the whole body later. It depends on -- sometimes, some assignment we have total, we see *x* number of patients, all of them are total care.

❖ **Clara:** Yes, okay. My mind is always like on the circle or lots of things in my mind. That's why every time I have a migraine, headache like that that's why I put the red thing there.
Kim: Right here, okay.
Clara: It's always like -- my mind is always -- my head is always like the focus or I have to pay attention.

❖ **Nena:** Before I leave [work] and deal with the family of the resident this is I have not so it's-- Before I used to -- I changed my attitude now, before I used to hate this husband but now I changed my attitude. I have to be friendly and nice to him and it's getting better, he's smiling and well so –

⊕ Introductions and journey to PSW labours of care ★Tracing I and body positioning ❖ Scanning I ✚Tracing II and body positioning ❖ Scanning II ⭕ Comparing body maps 1 and 2 • Digital storytelling ❣ Researcher reflections/observations

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❖ **Clara:** ...Here on this side these are the people that I'm working with they're wicked! And they're fighting each other or using words like shut up or words that are very strong they're not really --

Jenny: Cooperative.

Clara: Yes, they're not really physically but sometimes it's worse when it's-- when there's verbally abusive.

❖ **Nena:** This one is represent on the top is my how do I see myself. Because of my residents that are demanding, so I just like all these spikes in my head it makes me in a bad mood. Because the husband is very demanding, the wife is already maybe 90 something but he still wants a physiotherapy and exercise the legs exercise the hands and the neck and things like that.

... engaging in mutual agreement with coworkers and blame conflict from family, administration, residents, and media.

⭕ **Maria:** Yes, it's different, if you come to our work you can see me sometimes-- I can -- in the hallway [imitates throwing a fit and yelling]. They call me crazy Maria at work. I was

like "ahh!" and then the nurses say, "Maria go in the backroom." Then I go there and [rattling] and [then] I'm done [laughs].

Nicola: Yes everyone has different personality, yes.

Maria: That's why in the daytime I always say -- at day time that I'm supposed to do two weeks night shift, two weeks days.

Kim: Right.

Maria: My [work] partner he can't do nights because he gets sick, not everybody can do night.

Nicola: Yes, we love to have all these?

Maria: Yes, he gets sick all the time when he works night and he can't and he can't sleep. He can't have enough rest then he gets sick, he goes sick home. We both agreed to I'm supposed to be late at night**.** Because she doesn't like -- there's kids and everything. Her [Nicola's] partner agreed to do the nights and she'll the days. That's why she will do mine -[crosstalk]

Nicola: Yes, definitely it's the agreement.

Maria: Yes, but when we got hired it's supposed to be two weeks, two weeks.

Nicola: Two weeks, yes.

Maria: I just can't do two weeks [of days]. It's the family. It's hard enough that we deal with patients, which is

difficult already plus the family that doesn't come everyday. When they [do] come and they see a little thing here, little thing and they already make a big deal. Like I always like to say, "You want to really write my name? Maria. M-A-R-I-A go report me to the manager, I really don't care." Because I know what I did is right. I didn't do anything bad or anything that I feel that -- but I got see the family member you cannot satisfy them no matter what you do, no matter what. You do more than what you're supposed to, they're not going to be happy. They have to find some faults.

❖ **Nicola:** Then one pair of shoes one work for every activity. [laughter] Then just like a teamwork. I represent that as there needs to be teamwork.

❖ **Nena:** And their position is you have to be alert with this. You have to monitor when the pillow it's not in a proper place he goes to the nursing station and complain. If I forget to turn because she has to turn every two hours. So sometimes you forget because of so many inter -- distractions you have to prioritize.

He will go to the nursing station and complain, "I've been here for three hours

⭕ Introductions and journey to PSW labours of care ★Tracing I and body positioning ❖ Scanning I ✚Tracing II and body positioning
❖ Scanning II ⭕ Comparing body maps 1 and 2 • Digital storytelling ❗ Researcher reflections/observations

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or more than two hours my wife has not turn yet." What I can say so it makes me mad so that the nurse will come to me or you have to turn this before he goes. Now I have to watch the clock every time, "Oh it's two hours now, I have to go. I have to turn."

... sore, drained, abused, pressured, and coping to remain labouring.

★❢ **Maria's body position I** – Palms on temples, head forward to represent the feeling of "Agghhhh!" when Maria receives the shift changeover report that outlines who she is working with and what her shift work will entail.

★❢ **Nicola's body position I** – Head forward, arms to the side of the body, after a shrug accompanied by a "sigh." Nicola describes that this position represents her feeling of being met with the demands of workload. She mentions this is often accompanied by the understanding that some colleagues do not appear interested in pulling their fair share of resident care.

★❢ **Nena's body position I**– Hands on hips, head forward. According to Nena,

this position represents the upset feeling she gets when she is met with a resident's husband who waits for her and regularly demands how care should be handled with his wife.

★ **Clara's body position I** – Head slightly bent forward rests on the one hand she has to her forehead. Clara's other arm is across her body, hand holding her opposite hip. Clara describes this position as feeling overwhelmed by a lack of initiative by "hard-hearted" colleagues.

★❢ **Jenny's body position I** – A side view of Jenny with her back slightly bent forward at beside "giving care" to a resident. Jenny expresses that this position represents her most "difficult position" because of the back pain that ensues after heavy lifting and repetitive back-bending and strain that is required for resident personal care at bedside.

★ **Clara:** I accomplish one day at a time

✪ **Clara:** I work night shift with the company.
Kim: Night shift. Okay.
Clara: It's tough with the colleagues that I am with. [laughs] But I'm coping.

★❢ **Nena:** For me, because I have residents which is very particular for every position of his wife every time--
Kim: Oh, I see.
Nena: --because this husband always come everyday. It's very hard to please him. It's very hard to please him.
Jenny: Perfect position. [laughs]
Nena: When I come and before report, he's already there, as in, "Oh my God." My mind is really upset because he wants his wife to be in bed at four o'clock. He's just waiting for me to--? He's very demanding. I'm frowning. [laughter] I'm upset. I said, "This man is really, it's just like he wants me to be a private nurse." I'm a little bit--
Kim: What does your body--?
Nena: I'm looking at him like that-- [imitates an annoyed look, then breaks into laughter]
Kim: Okay. So, hands on hips.
Nena: I'm so upset. I'm so upset!

✪ **Kim:** How did it feel to see yourself in this way? [referring to the body maps]
Maria: It feels great.
Kim: Yes?
Maria: Yes, it felt good. we can't do this type of work.
Nicola: Yes? [laughs]

✪ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✣ Scanning I ✚Tracing II and body positioning
❖ Scanning II ✪ Comparing body maps 1 and 2 • Digital storytelling ❢ Researcher reflections/observations

Maria: We can't say what we really want to say, how we feel -- because at work like I always had -- like if I'm mad at my coworker, like one time I report a coworker, okay. And then I said to the manager, "Okay, I want to speak to the director." The manager came to me and he said, "Maria, you want to speak to me?" I said, "No, I want to report to you what I needed to report to you." I don't want to see [my colleague] his face because I don't want to lose my job. I might say something now that I'm going to regret and he's going to put me outside the door." I said, " No." "Can I speak to him it is very serious but not right now. If he does his job what he's supposed to, what he's hired for maybe we're good." So director she needs to talk to me about everything**.**

❖ **Nicola's slogan:** *We are not guilty because our patient's okay. We try our best to comfort them, care them. So at the end of the day, I'm happy when I'm tired, knees giving pain, but still okay. [laughs] I think that's the reason we go the next day to work without calling sick. [laughter]*

❖ **Jenny:**... because in the olden days we had a lifter that you had to pump.

Technology is so great now that it teaches us computer we used to chart everything right everything now we have a computer to document we have a lifter that is electronic and so the job got a little easier for us. Technically they're asking for more so I am learning how to cope with it I learned to treat my body well with yoga and exercise.

On my time off I go on vacation I come back I have -- I'm working we have residents who are doctors, who are lawyers, who are actors, who are engineers so when you come back you incorporate what you learn out there. You explain to them I have pain right now in my lower back so I'm learning how to cope with that, with how to fix your bed when you're doing care and adjust things.

...insecure, being watched, sensing moral tension

• **Nena:** She and I worked nights. Maybe it was seven nights and we stopped. I don't know if you went on but I couldn't cope with it.

Jenny: If you do more a little bit [sic] more for the residents, they will stop you.

Kim: Why?

Jenny: They say, what are you doing? What are you--

Nena: Like you shouldn't. Let's say, she's a new person and they're are or-- she's not new it's just the way she does her work. It's too much detailed for her co-worker, like you shouldn't be doing all of that for your resident.

Clara: Because they're afraid that if you started it, it will be a routine--

Kim: For them.

Clara: It will be a work for us.

Jenny: You're going to do it every day.

Clara: For example, when the resident requests for a sandwich or -- they don't want-- sometimes they don't want and I feel guilty because they are hungry.

Jenny: Yes. You do.

Clara: And then they say if you started it, it will be a job, that you are obliged to give sandwich every night and sometimes they don't want it. It's sad.

• **Nena:** That's the thing that I feel really bad, frustrated. I have an issue in there too, like because of this husband, it's just like he-- I can feel he is picking on me. He comes before three o'clock and then he is just watching me; three o'clock, before there o'clock. Then after report, I have to make sure that I have to brush the teeth, comb the hair and

✿ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✤ Scanning I ✚Tracing II and body positioning
❖ Scanning II ✪ Comparing body maps 1 and 2 • Digital storytelling ❡ Researcher reflections/observations

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because he is-- everything, he can see every little thing. So because of this, I'm doing my job according to what they want but I don't talk to the husband because I'm upset of him but I'm doing my job [chuckles]. He complained to the DOC [director of care] that they want to change the primary nurse.

⭕ **Nicola:** Yes, you know.

Kim: Yes, so feeling secure, even in your -

Nicola: Yes, I think that's the other thing. People have two jobs because it's unsecure. Because we never know when we'll be asked to stop.

Maria: Yes, lose this one [job], at least, you have another one.

Nicola: Yes, you never know. That's what I'm thinking, like Maria is different situation. I have help with my husband, is what -- still, just thinking, if I get fired from hospital, I [would] have nothing. Then, I just keep going over there [to my other job] till, yes. [...]

...taken for granted

⭕ **Maria:** No matter -- like I said, some people, they don't work in the medical care, health care place, like they

will say, "How come you working on Christmas? How come you're working at night? How come you're working on the weekend?"

Nicola: It's 24 hours.

Maria: 24-hour care. You cannot tell the patient [or resident], "Okay, you guys stay here for a week. We're going to come back in a week or you can treat yourself**.**

Nicola: I'm going for my vacation. So you'll stay over there.

Maria: Yes, so we'll say, "It's 24-hour care and -"

Nicola: And then, *do what you have to do*. That's the important thing. Do what you have to do in your time period. Don't leave your part to do the other next. Like some kind of responsibility. You have like your job, you'll have some responsibilities. If I leave some to Maria, Maria has her own [workload] plus mine. That's not fair.

❖ **Clara:** ... At night we cannot do that [relationship with residents] because both of us has 50 residents, 45 residents. There's a team. We work two persons in each row it's like that. We have 50 residents. There's no caring, like as if you just want to finish the job. Now, I'd like to have one-in-one that's why I want to

work one-in-one client centered care as we are supposed to.

But because at night it's different from the day. We cannot communicate with them because most of them are sleeping. Or if they are awake at night, they're wandering or they don't know where are they, where they are, because they just woke up. Maybe they're dreaming of their old days so it's hard to deal with them at night.

In the company, I hope they will appreciate our work, our accomplishment and we will be rewarded. Because now we don't even get a bottle of water sometimes. We are not like--there's so many occasions they will give us one pizza for each at night.

Jenny: But even so it's not that, the institution is very hot. The building is low and you're looking at that point in time your bottle is empty and your mouth is dry. It's hot and you haven't finished care and you're looking and you can't get a drink of water anywhere.

Clara: Nothing. That's why we're saying, we're working we get even water.

Jenny: That's so sad, yes.

Clara: Even a bottle of water. We have to supply it for ourselves. Most of the-- in the day shift, they bring their own

✪ Introductions and journey to PSW labours of care ★Tracing I and body positioning ✤ Scanning I ✚Tracing II and body positioning
❖ Scanning II ⭕ Comparing body maps 1 and 2 • Digital storytelling ❣ Researcher reflections/observations

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spray because the resources are scarce, it's not enough. I don't know, yes.

❖ **Clara's slogan:** For now I feel like *I did my best and I can only give so much* I think that I tried and then -- It depends on the people who are if they cannot appreciate what I do for them, that's the only that's the best I could keep on offering them. If the resident doesn't appreciate the care I give it's the best but I put myself everything to care for them for my family and for everybody. I try to balance everything so that's -- [laughter] yes. I did my best.

...replaceable

❗ Another expression of *worth of the body* that was hinted at in the previous excerpt of transcript, Nicola and Maria discuss job security in their current positions. Both women work full-time jobs, but also have part-time jobs to ensure security through employment, "we never know when we'll be asked to stop." Job security is needed. The body makes compromises by working in fear of lost employment. Maria is a single mother, who also provides for and lives with her mother (who does not work)

and, as a result, is required work seven days a week. Genderace emerges on the labouring body as consumable and expendable.

⭕ **Maria:** Yes, and the thing here, usually back home, at the end of the day, we have something, it's called the Thirteenth Pay.
Kim: Thirteenth Pay, yes.
Maria: Yes, right. On that day, we have the extra pay -- here, you don't even get $5 bonus, not even Tim Horton card stuff. That's the bad thing about here. They do not do that. For us, that's how we feel and I'm sure you do too is for them, we are replaceable anytime. When you come, we have somebody at the door -
Nicola: Yes. We're just at the door. They just don't care.
Maria: -that's it, you don't care for your employee.
Kim: It is [a sign of] appreciation for you to get.

...isolated

• **Nena:** [pause] What do I think for that? Because-- [pause] it's just like when you have a problem, when you have an issue that comes out in your job

and everybody is against you or they are listening to these negative comments that they are on that side and they don't see you, it makes you feel bad and frustrated because they don't know. Only you know how you work, only you know how you perform your job to the best of your ability. It makes you feel bad, really and especially when people are talking about you or talking against you. It's just like you are alone and it's really-- they are bad. Then when the management will come in and the supervisor will come in and they are against you.

... navigating and forgoing nourishment for labour

❖ **Maria:** Mine is I like to start my-- because I work nights, right. Start my shift healthy and stuff. I make sure I have my coffee and so excited to go to work. Of course, I think about my daughter and my mom at home and stuff.

❖ **Maria:** I want to run like I find when-- I just want to share it my sister does a marathon in Ohio but she always encourages me to do. The thing with the marathon what I don't like is you have to train with other people. I just don't have

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that-- you meet up with them. I don't have the time because I want my own time, I want to--I enjoy running by myself, I just put the music on and then run. Then I'm okay. One time one of the workers say, "Was, that you I saw earlier? You went all the way to Markham and Sheppard?" Yes, that was me! [laughs] I run myself sometimes I do 10k by myself. I just run and then I rest, I walk and then I run. I feel by the time I get home I get all my stress out and I have a hot shower and go sleep and stop my night or days again because I sleep during the day and working at night. [laughs]

❖ **Nicola:** ... and then sometimes appreciation make me happy. [laughs]

❖ **Maria:** [points to photo of the sandwich] I want to eat a big burger [after my shift].
[laughter]
Kim: That [looks] very delicious.

❖ **Nicola:** Yes, because some of us are never going to finish. It just like home but like I meant that you go home what it means like, okay, when you go home you got to do whatever. You cannot rest. You cannot take rest. The same thing at work,

she giving me report, then says then I start. [laughs]

❖ **Nena:** I have to take multivitamins for myself, to take care of myself and exercise and meditation that's how I put this-and flowers is - I have flowers inside the home and it's therapeutic. It lifts up your spirit...
Jenny: Sure it does --
Nena: It takes away all this-
Jenny: Negative.
Nena: -yes, negative thinking that's blocks on your way. It's I'm touching them talking to them, "You, you're so beautiful, nice color. You're so --
Clara: You know what they say, "Take time to smell the roses."
Nena: Yes so I'm touching them and talking them so it's-- that's for myself to take up this stress. And then eat good food, things like that vegetable and balanced diet. Then go out with my friends and talking with them about what is bothering me and things like that. When you talk to your friends all these things that in your mind is just go away, they just go away and then you have --
I can see in my face that is less stress, it's smiling and then the stress just go away. What is this here? This is with -- go out with friends and things like that or if I

have no time I have to call them and things like that. So they say, Nena, just do one day at a time and easy does it -- This is what they're saying to me, "How much you can do for one day?" Just take it easy."

❖ **Clara:** I need to balance myself with good nutrition and exercise and leisure time.

❖ **Nena:** I have to get up early because traveling from West to East takes so long so I have to get up early to do these things.

❖ **Jenny:** I try to do things at home quickly and fast that are healthy and that's how I do things around my family and adjust to my work.

THE LABOURING BODY DISRUPTS THE DISCOURSE OF (RE)PRODUCTIVE LABOUR

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The labouring body is losing time.

⦾ **Jenny:** I think the home needs more employees, but they don't think so. They keep cutting back and cutting back, and we get a heavier and heavier load as we go along. It's been promises. Every manager that comes in there, they promise you, "Oh with funding we're going to help you," and they use the funding for other things, not for their promises.

Nena: They need to have a meeting for us and listen to our voice and our needs. Yes. They have to meet us, especially as PSWs. What is our concern? What is on our mind and things like that. So that they can hear what we have in our minds.

Jenny: We give up on rate of pay and all of that now because we see we're not going to get it. We know we're not going to get it, because we've been fighting for over 20 years to get a better pay. We know we're not going to get it. So just be honest with the employees and the residents and let them know what you're doing and that sort of thing.

Kim: So just be honest, listen, support, hire more employees to make things more manageable because the workload, and understand, and all of the other things that you have to deal with in addition to the [other] responsibilities you have at work.

Jenny: A simple thing like they take a half an hour out of our pay for lunch break, but if you look at it some days we don't get the half an hour. We can't, because we have emergencies on the floor.

Kim: So where do you get it back?

Jenny: You don't get it back.

Clara: That's your loss. In the day time, the other workers or staff, their start's supposed to be at 7:00, they come at 6:30 just to accomplish, because they have to put everybody on the table for breakfast so they have to come early.

Jenny: To organize themselves.

Nena: Ya to put [residents at the table] on time.

Clara: Well they start already at 6:30.

Jenny: Yes. Then we come in and we have to come before three o'clock to get started. Same thing you guys do.

Kim: So you're even coming over your hours to ensure that you're meeting all the responsibilities you have at work. So even if it means shifting the start time and the end time of a shift to accommodate for resident schedules?

Jenny: If you give half an hour to a resident shower, why should I give another half an hour to go and clean up the spa and get it organized for my resident to come and have a bath there? I'm spending another half an hour to clean the spa.

Clara: Because of the courtesy to another user.

Jenny: Yes. But there are wheelchairs and every thing packed in the spa. That's where I'm doing my care, but it's not ready for me.

Nena: Yes. Usually if you like for us in the evening, we have 10 people, and if you divide that eight hours for resident that you can give [care], it's--

Jenny: Half an hour for each resident. It's not enough.

Nena: Yes. Sometimes you spend more than half an hour for one resident. So you're taking that time from somebody. This other one, because you spend already more than supposed to be this hours that you give to this [resident], so you have only small time left. This residents that you're going to do next cannot have this time that you are supposed to give, because that time is limited, because for every hour, you have to do certain things.

✣ **Nicola:** Okay, I'll start from the top of the head. [laughs] That's a lot I mean the time. All these remind me what I

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have to do. [laughs] Okay, the day start making breakfast for kids and me and lunch and then go, go, go.

Kim: [laughs] The skateboard.

Nicola: Then everything in my head, that's why it represent like that.

❖ **Nena:** ...Then it's hard for me to find a helper, because this woman is huge it's very heavy to turn it's very hard. Sometimes my coworkers are busy so I have to wait a few minutes before they can come so it's very, very frustrating. Then I have to rush because it's going to be this thing is before supper, he must be in the bed. So in one hour or 1 hour and 25 minutes I have to rush pull out my people to sit at their own table because it's suppertime. Some people are in the bed, you have to use the Hoyer, so it's a rush and it's really a pressure to me. I have to manage all these things I have --**.** Then for these people that this medicine I have to put - I have to take multivitamins for myself, to take care of myself and exercise and meditation that's how I put this-

Labouring bodies are not created equal.

⊙ **Maria:** It's a good job. It's very -- it takes a lot of personality because not everybody can do.

Nicola: That's right.

Maria: Especially with personal care. Some people would see blood and they see something, the pain, stuff. I see nursing students see the blood and a guy, he fainted and everything because he couldn't take the smell, the blood.

Nicola: You have to have patience to do that stuff, yes.

Kim: Patience, yes.

Maria: Then, I always say, if that's what you really want, but you are young, go -- however, take up the end. Go nursing, go early. I don't discourage them to take this kind of job because it takes a lot of guts. It takes -- You have to have a very good heart to do this kind of job.

Nicola: Yes, you have to have a kind heart, understanding.

Maria: Yes. A lot of patience in that and if you want a more, much better job, even nursing now is not really -- I remember five years ago, nursing is going. You know hiring here and there and there. Now it's hard you [to] get in.

Nicola: Yes, that's right.

Maria: It is part time. Everything is casual now. It's casual, so part time.

Nicola: Yes, into that like whoever need to go to be a nurse, it's better to have like a PSW job couple of years or couple of months, and see how it works

⊙ **Nicola:** If [me not finishing my duties] happened every day, every shift, Maria go to complain about me, she'll say to me like, "No. Why you do like that?" Like you don't then, she gets more stressed, yes. [...]

Maria: Yes, patience for patients you take because like some people like to take it back, I can't. I can't be doing all and even the office. Someone will make me sleep when regulated and I said, "I can't do that. It's not my thing." Right, but my sister, she is an office girl. She loves to do paperwork and stuff but that's her thing.

Nicola: Yes.

Maria: I can't. I can't do this kind of [office] stuff. I like this place. The one-one, you interact with people.

Kim: Okay.

Nicola: Yes. Another thing they have to know [to work with people]. That's what I always say for that profession. Professional, a lot of the time, not -- some people they just come and just walk around. No, you have duties. When you come to the floor, you have duties.

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★ **Clara:** [laughs] Oh, I don't know what kind of position because the night shift is different from the day and evening shift. We have everything [to do]. We do everything, almost everything and especially with the colleagues that I am working with. There is so much like-- [laughs] because I am the only one [who works] different. [laughter]

Kim: You're being very nice. [laughter] I can tell. [laughter] You're being very humble.

Clara: Because they [my colleagues] are seniors too and their nose are so high and pointy. [laughter] I don't know what position. I'll just--[Makes a reversed "L" with her thumb and fingers and rests her right hand lightly on her forehead, as if to shield her eyes, left arm crosses her stomach and holds onto the belt loop on the right hip. Kim sighs]

⚪ **Nicola:** If you make your mind to be a PSW, you should have that passion and that kindness.

⚪ **Nicola:** No, and that they don't think about the next shift, they just call anytime, "I am sick." No, just please, just [laughs]. If you're sick, you just take care as soon as you get called because you know the place. It's so hard to get a

person [to cover]. Because everyone has two jobs -- strictly part-timers. [...]

✤ **Maria:** We always find that -- it's like when you look at our assignment oh, him? Her? No. [laughter] It's true. It affects your whole shift. Knowing who you work with because you know there some people you work with you enjoy. It's like you don't even feel the--

Nicola: That's right, all the time pass.

Maria: You are tired because you work together but if you work with this person who is lazy and won't do their work. It makes it harder, it makes your shift longer. It's not unless you're dealing with this patient that's crying, they're screaming, they're climbing, they're trying to hit you.

✤ **Jenny:** I come in some days I know my resident likes little treats, I bring little treats for them and talk and laugh with them, some of them have memory loss.

✤ **Nicola:** ...because if the partner is not helpful, the partner is not with you, so then he or she try to cheat, like you know, like hiding. [laughs] It's so hard.

Maria: Yes, you don't see the whole worker for a shift.

⚪ **Maria:** Yes, that's right.

Nicola: -experience and then you start from the beginning, then you know how you -

Maria: You can.

Nicola: -because this, you're working with people, you're working with a human being, so that's how I understand for that. How they're going to do everything. Then, you will treat because some nurses, I think -- you see some nurse students coming, they have no – [experience]

Maria: Yes, and actually they only do it for money.

Nicola: Yes.

Maria: Look at now, you can see them, they work with patients, they are just doing it for money. But in part time you don't see their care. You know why -

Nicola: No evaluation, no assessment just like here [by nurses]. Yes, just.

Maria: Yes. They do it for money but they make good money, yes.

Labouring bodies are not protected and preserved.

⚪ **Nicola:** The pay. Sometimes I feel like -- if they can give us some -- what they call stress relief like this [workshop]. Okay, so today we're just

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working. I know you're paying us but we just feel free to say anything, all your situation, just write down [laughs].

Kim: Write down.

Nicola: There is no wrong, right thing and -- whatever you want to say, you can say.

Maria: You are speaking the same language.

Nicola: Yes. Just like a – [relief]

Maria: I think there is something that I wish also on the world that we did -

Nicola: And the other thing we need is, we don't get any massage. We have to pay -- we have full type right now, so then we -- yes, benefits.

Maria: Our benefits don't have -- they only pay $7 for a visit and I have to -- one time in sunlight, even back home, you cannot go with $7 an hour for massage. I was so mad at them. But they said, it's not ours, it's your company, it's your hospital who choose this kind of --

Nicola: The other thing is there is --I have worked, the thing under my foot, I went to the doctor and the doctor gave me referral for my foot -

Maria: Foot care.

Nicola: Yes, foot care. I went there, $45 I paid, and then the girl check in my Sunlife products and said, "No, they're not doing." "Okay, this is not cosmetic.

This is what -- how I walk." That night I was siting in the corner, [because my foot was sore] $45, I have to go.

Maria: Benefits she had -

Nicola: Yes, kind of benefits and then my family, we all are in glasses, terrible really now [laughs] okay? But when you go twice, like we usually go somewhere by the plazas, okay, how much you have, then they come to the maximum. "$300. Okay, this glass is $300." "Excuse me, why? The kids, they're changing [glasses] every year." It's just 300 for two years, so everything goes like that, yes.

Maria: To me, they're -- the company like the hospital or whatever they are overworking us but underpaying. Like the benefits doesn't suit us. It's not enough -

Nicola: It's not good benefits we're having.

Maria: Yes, it's not good for our families, it's not good enough but our work is -- it's a lot of work.

Nicola: It's so true.

Kim: Yes, but I hear we're saying about overwork and underpay and then like a mental health, a day, to talk about things or benefits. These are all things that will keep you going, keep you doing things. Things like massages are essential

because you're lifting so much all the time.

Nicola: Yes, I talked to the place [insurance company] I bought the different [insurance] stuff, they said, get the doctor's referral and then they -- it will cover.

Maria: No, don't go there, I told you. [crosstalk]

Nicola: [...] That came out. It's the kind of thing -- yes, she's right. It doesn't matter part time or full time [sic]. It's better to have part time and more money and no plan. You can do whatever [laughs].

Maria: I think also, like now, a lot of part-timers who are single are asking us, "How much do you take home? You're full time." I said to them, "You don't have to take the benefit if you're single and you're healthy, you can go out."

⊞ **Kim:** Say, [a PSW] student becomes a passionate PSW who loves their job and is compassionate, how would you encourage that student to not burn themselves out?

Nicola: Find a good job in a good place at this -- like a hospital. Our pay is not good as what we expected but at least it's good. We have something like Maria said, "By the end of the day, thank God we have a good job." We work in a good

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company, good employer, not like the usual.

Maria: Don't stress yourself. I just tell them, "Don't stress yourself too much. If you're having a bad day, take a break. Talk to someone and talk to staff, yes. Don't take everything personally, because -

Nicola: Especially that's right. That's one important thing.

Maria: -the family and the patient

Nicola: The family or patient, don't take it serious because I always take that one. That's, this is the patient. It is the patient. That's not my family member, this is not my like my grandfather because when they're screaming, yelling at us. You know first thing, we get mad, you get hurt, everything. So just saying, "Okay" [to yourself].

Maria: One more thing, the nurses that worked for 30 years here they say, "Maria, don't forget. When you go home, you have your life."

Nicola: Leave them.

Maria: You have your own life. So don't take anything home. When you're here just do what you have to do here, then you go home." Sometimes it's hard, but we do.

Nicola: It's hard, yes.

Maria: when we think about them but -

Nicola: Being working long time, it's hard like --

Maria: that's how it is, I guess. [...]

★ **Jenny:** I think I'd like to go to my most difficult position.

Kim: Which is?

Jenny: My most difficult position-- if I don't position the bed appropriately, I have a lower back pain, right? I think-- I'm doing a resident and it's a very heavy resident I'm doing care. If that bed is not positioned right and I bend over in such a position that lower back pain starts.

Kim: Right.

Jenny: That's my worst time.

❖ **Kim:** What's this?

Nicola: Pain, pain, pain. I don't want to put everywhere that on this like one is enough. [laughs]

Kim: Right of course.

The labouring body is demanded upon in ways beyond body care.

⭕ **Kim:** So I'm hearing that time is very important to all of you because you also need time for your families, yourself, sleep, so important.

Clara: But then as you grow older you would have less sleep!

Jenny: So you'll have to cope with less sleep as you get older. [laughs]

Kim: I'll keep that in my mind and adjust accordingly! But I think what I'm seeing here, you're not asking for the moon?

Jenny: No.

Nena: No. We just asking for the right, for the just thing that is supposed to be given to us.

Jenny: Originally when you and I started it was 15 resident per PSW. When Mrs. Smith [the administrator] was there. 15 [residents], we started with. We are now at 11.

Clara: Yes. But then before, they're still moveable, or there's still people up doing things. Now there are more different diseases. The family, you have to deal with the family. Now more lawsuit from the family. [laughs]

Kim: The acuity has gone up a lot in long-term care.

Clara: Yes. Before, it's all caring and giving.

Nena: Now, they give us--

Jenny: Demands

Nena: -demands, the clothes to hang in every residence.

Jenny: We do laundry, we do housekeeping, everything.

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Nena: Yes, and-

Jenny: Yes.

Nena: -and we do the weights, and it's very hard. This weight is very time consuming. [...]

Jenny: It's a simple request. If a PSW ask a dietician to have a drink change for the resident, from a thickened drink to a regular fluid or honey-thickened, it takes almost three months to have it done in the nursing home, to change one drink.

Kim: So policies and procedures are slow?

Jenny: Very slow.

Clara: Because there are some rules that they have to follow and study. Because they cannot just change the thing. They're not--

Jenny: Three months, one drink?

Kim: You know the person best and their abilities, and what they're able to take and what not?

Nena: Yes.

Kim: So it's almost a trusting thing, too, right?

Clara: But sometimes it's also depends on the resident. Sometimes they have different-- like if their family is here, present, they perform well, they're doing well. But if they're not here, they're different, like they cannot do anything at all. So it depends.

✪ **Jenny:** I'm Jenny. I'm a PSW at [name of LTC home]. I think I'm working there a little over 22 years too. That's where I met Nena and Clara. I originally came to Canada I think when I was about 23. My kids are born here. I've been married for over 42 years. I'm now 62 and I'm actually enjoying my job. It's nice to see-- work with the seniors and you enjoy some of them. Some of them you have to cope with them. I've retired from a management position and I'm now working full time as a PSW. In my spare time I'm board of director for a non-charitable retiree building and I am a chair for my church council so I'm busy in my Sunday's it's like another working day. At the moment, I'm winding down in the next three years and enjoy it while I'm doing that.

✤ **Nicola:** It's hard to present my family, in all my kids' activities and then drive them. [laughs]

Kim: You drive them everywhere.

Nicola: I had no idea how to put-- This is just like family time. Even in making phone call, helping them homework that kind of thing. I decided on all these. End of the day, the money [laughs] because the kid ask money sometimes they ask money for something and all of the bill

payment, everything, the credit card that's where I put the money house money, groceries money, a car is money. [points to three photos with money] [laughter]

THE BODY IS UNSETTLING AND

REVALUATING WORK

Struggling. Desiring to be heard, yearning to relate.

❖ **Jenny:** Wow, the government even give us an hour break. [sarcastic laughter]

❖ **Clara:** We don't have eating together. Only if the company will give us some food. But there is like a hard rock heart with these people.

Jenny: Hard-core, yes.

❖ **Clara:** Now it's so stressful because my supervisor is so much stressed in her life. Every time we move there's problems.

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❖ **Nena:** ...if we say something because sometimes, the RN are not--the registered staff are not listening to us.

• **Kim:** How did watching that make you feel? All of your story.

Clara: The reality is sad really, but then life is -- you have to go on, go with the flow so--

Jenny: Even though you're doing the wrong things and it makes you feel guilty, you still have to do it because--

Nena: But you know I understand her because, if four of you and only you are persisting and three are -- you will not be here. These three will -- they are original [employees]--

Jenny: No. But, Nena, I always stand up to it and say, "This is who I am." And I never change it. I never change.

Nena: Yes, I understand you. If you're working by yourself evening, you can do what you want to do. Because you are there you are not joining with somebody. It's just like independent but for nights, they work in groups--

Kim: Because there're so many people.

Clara: --partners, they work with partners.

Jenny: Yes, they're limited people.

Clara: So, if you're only one, you want to do these right things and these three doesn't want you, you are influencing

them and you are controlled with them. You go with the flow. They will intimidate you.

Jenny: This is not good for you.

Clara: It's not. I know but it's hard.

Nena: But it's the system that is already there. It's the cancer that you cannot cure it.

Jenny: But the cancer is eating you up and it's not right.

• **Jenny:** There are low wages.

Kim: Wages, I think that-

Jenny: The break time, we don't get the break time.

Nena: The workload is really heavy. The workload is really heavy.

• **Clara:** Yes our voice we have to-

Nena: We don't have-

Clara: They should listen to our--

Jenny: They should come in and do some sort of talking to the PSW. Listen to them, because we need.

Nena: Because we are actually the front-liner and they don't listen to us.

• **Clara:** They have meetings but then we are not involved in the meetings. They don't ask us questions or they don't ask our opinion.

Kim: Yes, but you should also be given a space to say things without penalty.

Clara: That's why I said we are the front-liners. [crosstalk]

Kim: Because it sounds like there's fear in speaking out.

Jenny: For some you can't. You have to watch what you say around them, yes. Around management you can't, they don't agree with everything you say.

Giving up. Defeated. Excluded.

❖ **Nicola:** ... work never going to stop. Never finish...

✪ **Nena:** I start working there 1985 right after when I finished this-- before it was helper aide now it was changed to PSW. Since I started there I was so nervous to go in that kind of job. It's so scary and I have a-- with the help of-- I'm okay. I'm okay now. I'm married. One husband too. [laughter] Unluckily we don't have children. I'm traveling far. I'm in the west and I'm working here in the east. It's quite far but I'm just waiting for my retirement. That's all.

❖ **Clara:** We are like prisoners at night.

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❖ **Nena:** About how do you want yourself to be seen with others. With a little respect. Listen to our voice, if we say something because sometimes, the RN are not--the registered staff are not listening to us. They are just like, "Oh, she's just like that."

❖ **Nena:** That's what because we are only PSW so we're just like a very low position in a way. That's how they look at us.

• **Clara:** It's not right but -- like when I was talking to Ms. -- the management--
Nena: Sally.
Clara: Sometimes it's better to shut up.
Nena: Sally said?
Jenny: Yes, but I don't shut up. I just say it the way it is.
Kim: She said that to you? Your administrator said--
Clara: Yes. Because I was called by the administrator because there's a client, a resident told me that she don't want the morning the SW to come close to her or to be in the room where she is because apparently, she got hit -- I don't know. I told my supervisor. So my supervisor wrote it down. And then, I don't know

why I was called because I was just an instrument there.
I was just at the wrong time at the wrong place that the residents told me. So, you're supposed to advocate with the resident because she said that she got hit apparently. And instead when Sally talked to me and asked me to go the next day and the following week and then she was saying as if sometimes it's better to shut up your mouth. I said-- I was just, "Huh?" As if it's my fault that I was the one who was spreading the news that -- I was like in myself, where's the advocacy now for the resident. There's nothing there so--
Kim: That is so sad.

• **Jenny:** The staff is saying, those PSW are saying, "I want to do more for the resident but I can't."
Clara: Limited time. Limited time, limited resources, limited power.
Nena: The time, the time is limited.
[...]
Jenny: ... So things happened but if you can defend yourself, explain yourself exactly what happened and management wants to believe you. Well, if they don't -
Kim: What can you do about it?
Clara: But sometimes they believe the family rather than you.

Jenny: Yes, the family and the resident, they believe over you.
Kim: They're supposed to be advocates for everyone.
Jenny: Everyone but it doesn't happen that way.

• **Nena:** It's just like, "Oh my God, all my--" All that you invest, the good things and good jobs in there, is just nothing.

• **Jenny:** Yes. [and then the media say] It's the PSW not taking care of the resident.

• **Jenny:** Kim it's been four years now since one window in our institution is not open. For four years and there is no air exchange. Because new policy of the government is the nursing home is so low that the windows can't be opened. The resident is going to jump out. I don't think you've seen our nursing home.
Kim: No, I have seen.
Jenny: It's on the ground level. [crosstalk] Yes. Every time you ask them to open some place, to cross ventilate or something. They say no, the ministry said the windows can't be opened. People are getting sick in there and they are not seeing that. One staff come in with a

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cough, we all get it. All the residents get it.

Kim: Because everyone's breathing the same air.

• **Clara:** Just like now if you are-- if you say to somebody that you are working nursing home sometimes they're [looking at you strange]. What might they are doing- [they are asking themselves]

Nena: It's like the scary thing yes.

Kim: Really?

Nena: They don't look us as a [good worker].

Jenny: The nursing home is a blessed place, it's not scary it's not--

Clara: Is that the aim of the PSW has not been this. When the media show this kind of abuse these people are so they think [whatever].

• **Nena:** The family should have like a meeting for that this is how you-- this is not-- this is-- how do you say that. That this is not how you demand because people will run.

Clara: Actually they have a meeting every time [crosstalk].

Jenny: Yes the conferences but I don't know if they talk about it.

Clara: We are not involved in them. It's only the managers and the registered nurses.

Struggling. Giving up. Repeat.

Sitting still.

⭕ **Jenny:** I feel at ease. I think I challenged the world and I'm getting through. I've got it! [Jenny puts one fist into the air].

Kim; Yes, the world is yours! You've conquered it. [...]

[**Kim:** How then do we move from the first body map to the second body map? What has to happen in between to get from point A: stressed, overwhelmed, overworked, underpaid, to this body map [body map 2]?]

Clara: Realizing that what this life is all about like. What are you doing to yourself, abusing yourself. So when you realize you have to stop it and you have to do something to change.

Jenny: Make changes. We have to make changes. We have to set goals and plans and make them work for you. Change them in a positive way.

Clara: It's just because of just thinking of yourself on the second map. You're thinking your family on the side, but

firstly for your own. You see you have focus on your own.

❖ **Nena:** When you are relaxed, the things that comes to your mind is, "Why are you so worried about this kind of thing?" Really it comes to my mind, "just think one day at a time and these things will goes fast" and satisfied with my job.

❖ **Nena:** When you are happy, your muscles are relaxing and the thoughts are empty with the unkindly thoughts and free from destructive thoughts.

That's how I care myself. I read the book and soak my feet and it feels me relax really. [...]

• **Jenny:** You would think at that point in time that management would have said you also have to focus on the faculty of the resident. That's what he should have told the staff. When a resident says something, you think about the faculty of the resident before you use -- suppose now dementia just started and the residents says something and you repeat it and it's totally wrong? [Jenny is reflecting on how a coworker was accused of physical abuse against a resident]

[...]

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Kim: It sounds like this person, whoever is calling you in, doesn't have the capacity to address it in that way. It makes sense to us here because that's just how you relate to human beings. But--

Jenny: I just stand up to her. I say that. I say, when a complaint like that happen, I say "Well, you need to listen to the staff as well as the resident. If you think the resident is starting dementia, that's how you evaluate a situation. It can't always be the staff is wrong."

Clara: I know. That's why--

Kim: And you're not wrong for having said that.

Jenny: No.

Clara: And then she then told me sometimes to go direct to him. I said, "So where's the hierarchy then?" They are supposed to follow the rank before you go up--

Jenny: No. She shouldn't tell you that because she's telling us on the evening shift to go to your immediate supervisor, so why is she telling you to go to her?

• **Kim:** How did that make you feel to watch your own story?

Jenny: It made me think it's the truth of what's going on in my life. In the beginning, they won't tell us that but it just happens. [laughs] It just happens.

✚ I'm relaxing my hair, too.

Kim: You're resting?

Nicola: Yes. You see my pillow? That's my resting. [laughter]... I wish I could have a nice pillow or a soft pillow. [laughter] [...]

✚ **Clara:** Put my shoulder like, down [arms in front of the centre of the body, holding something]

Kim: Down.

Clara: Yes, instead of like this, relax. [laughs]

✚ **Jenny:** I would love to be in a sitting position like this, this is where I do my yoga, or I do my mindfulness.

✚ **Nena:** I love to soak my foot, I'm so relaxed in it when I soak my foot.

Questioning structure and acknowledging the weight of PSW work.

⭕ **Maria:** The first body map was more stress. More like -- I guess, because just like workload or offload, working more hours.

Nicola: That's the real life.

Maria: Real life.

Nicola: That's the real life. That's the experience in life now.

Maria : Fantasy life [laughs in reference to the second body map].

Nicola: This is the fantasy, better really meaning life. We wish [laughs]

Nicola: We wish life [laughs]

• **Jenny:** Every day of your life you're seeing your resident too, you see a gentleman who had memory lost or whatever. He was an engineer and I watch him move from stage to stage to stage. Now he can't stand up much anymore, he can't walk anymore. He doesn't have much memory. All he remembers is he says, "I don't know why every night you're trying to put me into this bed." Every night you're trying to get me to sleep, "Call me a cab, I'm going to Quebec." You know who that is. [laughter] I remember my residents [saying], "I don't know why you're always seeing me wherever I go." [laughter].

Kim: [commenting on the laughter] I think the fun piece is important because it's coping. You create a community. You said your coworkers are your family or your coworkers become your family. Creating that support system at work. Because when you're running from bed

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to bed, you alienate everyone else, you're just stuck in your own head. When do you form those relationships that are supposed to support you during those difficult times? [*Defeat*]

• **Jenny:** I think the nursing home has angels. Do you guys not see that? Nursing home has angels, and the people from outside don't see it. With what's going on now with society, they think these people that are working in the nursing are all bad people but they're not.

❖ **Clara's slogan:** A peaceful person [laughs]. Contentment. Accomplishment. If I will accomplish all those -- wishful thinking.

• **Clara:** Yes. No, because that was the one that is being publicized or being specified or--
Nena: See in the public media. [crosstalk]
Clara: In the news, it's always bad news. They don't see the good news.
jenny: Yes. One day, I called the Zoomer Channel, you know the radio station? And I was talking to her and she says, "It's unbelievable, ma'am. You do sound like you're working in a nursing home." I said, "I am." I said, "People

don't see the angels in the nursing home. They see bad people."
Nena: Because that's in the news, the one that is the reporter--
Jenny: Yes, but they don't see [crosstalk] nursing home have crisis and the government has to step in immediately because they do need funding. If you look at the way the situation is on the day shift, they have-- Yes, six and seven resident [sic] to one. In the evening shift, we have 10 and 11 resident [sic] to one. In the night shift, they have what?
Clara: 45 in two so 20--
Jenny: 45 into two so think about it. It's what? 40, 20, 22 to one. Think about that. You know?
Clara: Yes, they said that they are all sleeping, but still--
Jenny: No. Okay, if you look at it this way [crosstalk] if one PSW is on a wing in a night shift, and another resident go in another wing because she's in charge of two wings. The other resident wakes up and go and hit one. Do you think while she's doing care over here, she can manage over there?
Clara: No. Sometimes it's hard when one call bell run on the endpoint and another call bell, you don't know how.
Jenny: I was telling her, on the Zoomer Channel, I said, "You think it's

impossible?" I said, "If she's in one wing doing care on this site, which that care might be an emergency. The residents is spreading that feces all over so she's hustling to clean that resident and the other one is hitting that one there in another wing. How can she manage?" It's not that she allowed it to happen, it happened because there is not enough employees working.
Clara: The only one that is being publicized are the bad ones.
Nena: It's true.

• **Clara:** If you're reporting with the hitting thing, she doesn't want it—Don't [repeat] -- it's just within these four corners.
[...]
Kim: ... So then, from what I'm hearing, whose interests is this person looking out for?
Clara: Herself.
Jenny: Yes, because she's management.
Clara: She's just like--
Jenny: She wants it all to look good.
Clara: Yes. She doesn't want to write blah, blah, blah for the ministry to find out there's something wrong within the system.

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• **Nena:** This DOC said, "Why?" "Because I'm not happy, because she is not talking to me." [chuckles] They changed-- They want to change, they want to exchange from me, so I said, "I'm happy." In the other hand, I'm happy that I will have changed but in the other hand, I'm not happy because it looks bad on me that they think that I'm not a good worker. There's really one power of God that talks to this person in my wing, all of them [my coworkers], supported me because they [the family] want to exchange [me]-- I'm emotional now [laughs through tears].

Kim: It's okay.

Nena: I had to get from them [my coworker], one person and they get my one lady [with the husband]. They [my coworker] come to this husband, "Why you want to exchange? You want me to look after your wife? Nena is looking after your wife properly, why do you want exchange?" And the husband said, "Oh, I didn't say that, I didn't." He lied, he lied. "Oh, I didn't say that. I don't know what's going on. I just-- they just let me know that they will exchange." [...] They threatened me they will report to the ministry but I was off when they talk about this. Then this lady said, "So let the ministry come and check, how is

the skin of your wife? How is the--? if there's a bruise, if there's an open skin or whatever they [the ministry] can see. So let the ministry come." They supported me and things like that. "Only Nena is doing this very good job to this husband and wife." [...] [The DOC] looks and it was just like, "You know, Nena is the only one who looks after your wife very good and there is no bruises and there is no open skin and she reposition every two hours, so there's no reason to exchange. There's no reason. So, "Okay, okay, okay" this is what the husband said. Sometimes I can-- I said, "If you are doing really what is good, it will come, it will come up where it -"

Clara: And you are not working for him, you are working for the wife.

Jenny: Yes.

Clara: Our patient or our-- the resident is the wife not him.

Jenny: Sometimes you think they themself can do it at home, right? But they expect so much when the family comes to the nursing home. They don't realize we have 10 and 11 residents to take care of and we can't just focus on one.
[...]

Nena: But now, he's fine. As soon as Nena [speaking in the third person] come

in, Nena is thinking of brushing the teeth. Get her into bed, position her right. What happens if one of your resident is missing? You have no time to figure that out.

Kim: All of your energy-

Jenny: Is focused on this one.

Nena: This is why I hate it because I spend so much time for that lady and the other is less scary. But I spend so much time with her. They say they are paying, they say. But it's okay. Before she's so, I'm really not his slave. Right?

Hoping for change.

✚ **Maria:** Now, it's going to be more colorful. [...] Our life's going to be more colorful this time.

✚❗ **Jenny's body position II** – The body is sitting in chair, hands on lap. According to Jenny, the body is doing chair yoga and breathing.

✜ **Jenny:** When I find when I have a terrible situation in my job I talk about it and I get help.

✜ **Maria:** Stress, when we go to work, we talk, it depends on who you work

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with. We share, we share with a coworker. Your coworker becomes your family.

❖ **Jenny's slogan:** And I'm trying to fix my workplace will make life a little easier by if there is something that's difficult in my workplace I try to compromise and see how I can fix it.

❖ **Jenny:** I have a sunshine image. I'm imagining the government is involved and we have more funding. I'm smiling all day, yes, I'm on top of the world. Everyone is listening, we have help for all people, yes. I respect me, I respect my residents and I have help for myself and my residents. I'm comfortable, I'm satisfied. I have residents that's satisfied and at peace. This make me, I keep walking because the nursing home have more workers. We're able to stop and chat with a resident and understand them better. [*struggle*] More family are involved now.... Yes, because I had the resident-- at one point in my life I love yellow. I have a yellow uniform that I don't wear. [laughter] Because my ideas have changed now, I can't wear red, I can't wear yellow. One day I wore the yellow uniform and I went to work. This little lady looked at me and she says, "Yellow bird, you're here?" As she's

seeing me for a long time. I said, "Yes." She kept calling me yellow bird and I thought this yellow uniform is cheering her up.
Kim: Something so small, right?
Jenny: Yes. I make her laugh, it made me laugh too.

⭕ **Jenny:** I think I want it all. I want it to happen everywhere. I want it to happen in the nursing home for the changes to happen, and for my lifestyle to change when it happen too. I think if it changes in the nursing home, it's going to change my lifestyle.

❖ **Jenny's slogan:** We have respect for all. We have rights for everyone.

✚❓ **Clara's body position II** – The body is lying on its back, arms across torso, fingers interlocked holding flowers.

❖ **Clara:** Clara is a loving and caring person, who wants to be portrayed as a loving person. Every time I chat with my niece [muah!] I always have a flying kiss, giving me kiss, that's why I put this, kissable lips.

Jenny: But Clara, you know every time you go into work, when people see you they smile, right?
Clara: Yes, that's why I put the smile with as a loving person and the glittery eyes. [laughter]
Jenny: Yes, googly eyes.
Clara: Twinkling and twinkling! At work I would like to have a dream of working together hand-in-hand and there's cooperation with the workers. With the team that I have joined in. I would like to have fun at work. [*defeat*] That's why I put fun at work. [*struggle*]
Clara: Yes, they're-- I don't know but that's what I said, I'm not working for them I'm working for myself and for the residents and for my family. But as a company, it would be better if we are working hand-in-hand and we have cooperation. There's fun at work. With the residents, I would like to have a caring hand, treat the resident as a family. [*struggle, defeat*] With the family, I would like to have more time with my family and more time for myself and that will achieve my goal. The flowers so I can smell the flowers [laughs].
Nena: That's very nice.

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✚❓ **Nena's body position II** – The body is seated in a chair, feet are soaking in a bath, arms bent to holding a book, head is facing the book.

❖ **Nena:** Mine is really-- what is this? It's different.

Kim: They are all different, that's okay.

Nena: About how do you want yourself to be seen with others. With a little respect. Listen to our voice, [*struggle*] We are the one who have direct contact with residents we know if there's a changes of the status, their condition. I would like them to hear our voice what we are saying and hard to see and recognize our hard work. [*defeat*]

Then hope -- hope it's in my mind. It's just a positive thoughts and inspired by the positive thoughts and feelings and happy and contented. That's my simple thought or whatever. [Hope] looks, that's my big smile. That's on my image. Looks happy and smiling. [*Sitting still*]

The satisfied with my job and happy for my service to them, for these people that I work with.

❖ **Nena's slogan:** Okay. What how they describe? I just want to have a little respect for me and I will be satisfied and happy for myself when I do my job.

✚❓ **Maria's body position II** – Lying on back, head forward. Legs are uncrossed. Right arm is to the side of the body, left arm slightly bend by the head.

✚❓ **Nicola's body position II** – Lying on side, legs together slightly bent, one arm supporting the resting head under a pillow (drawn), the other arm, bent at the elbow, is beside the torso on the floor.

❖ **Jenny:** I think smiling and crying with your resident, be kind to them, be aware at all times, and remember we are all different human being. Have a kind heart for them. *One day we will walk in their shoes*.

❖ **Jenny:** In my heart when we talk about this and we discuss it I had -- I thought one day we will walk in these people shoes that we are caring for and I would like to have that good feeling. I would like people to treat me well so in 22 years of working in this field I'm trying to strategize...

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The Labouring Body Seeks...

At the onset of this study I was interested to know how racialised women tell stories of the body in systems of genderacialised care structured by capitalist production, the making of neoliberal nature, and invisibility through marginalisation. Women's stories revealed an antenarrative of the labouring body seeking worth through labours of care. There are three ways in which the labouring body seeks in relation to worth: the labouring body seeks worth within the system, the labouring body seeks to reclaim self-worth, and the labouring body seeks self-worth as interdependent and unamenable. Within the findings that follow, I describe the ways women's stories of worth reflect a number of genderacialised politics and together, how these narratives are situated in the literature.

Worth within the system.

The labouring body seeks worthiness of and in labour, appreciation, protection and preservation, and accommodations to shift work when necessary. The socioeconomic system functions by stimulating desires to be worthy and recognised within hierarchies of privilege – which may be conceptualised as some conglomerate of access, knowledge/power, and wealth – this naturalised desire to be worthy is propped up by illusions of attainment (i.e., privilege can be accumulated by hard work in systems of labour, education, politics, or some other means). Worth within the system, especially for racialised women, is an inherent desire due to the structuring of capitalist production, neoliberal nature, and invisibility through marginalisation discussed through the politics of genderacialised care.

Worthiness of and in labour through fair working conditions.

Genderace emerges on the labouring body as unheard and, quite literally, worth-less. Genderace emerges on the labouring body as consumable and expendable. Within a capitalist system, the collective compensation package is one way a company demonstrates how it values the worth of each individual labouring body. The labouring body compromises by opting out of self-care or working more to receive the care it requires. The body makes compromises by working in fear of lost employment.

"...we don't get the break time." – Jenny

This includes vacation, bereavement, and other leave time. Nicola and Maria talked about how much they would benefit from stress-relieving spaces and activities to reflect on care work without penalty. Women in this study talked about constantly sacrificing their own time before shifts or during break shifts to manage and meet the expectations of labour as a PSW. Labours in caring professions require time for reflection and decompression from the emotional and psychological challenges they are faced with on a day-to-day basis.

Nicola: I think vacation should be increased. Yes, that's what-
Maria: Yes. A lot of places, the maximum is four weeks... [For me] It's a long trip and it's very expensive. I am not going four weeks, I'm going for six weeks [laughs] and I don't care.
[...]
Nicola: Bereavement leave I think is not enough. [laughs]
Maria: The bereavement, it only -- It depends on the union you have with the QP.
Nicola: I think even like immediate member parents, child.
Maria: Parent is three days.
Nicola: Three days.
Maria: Only three days, that's it
Nicola: For me, I have to go back home and it's not-
Maria: [For] parents-
Nicola: That's the three days, I'm not [even] going to catch a flight. [laughs]
Kim: That's one way [travel].
Nicola: [The flight is] 24 hours, how can I go?

"...she don't know anything about the hospital pension." – Maria

Maria talks about fellow PSWs not being aware of the systems in place to save for

retirement. Many PSWs work multiple jobs and it is important for their future financial

security to understand how employers structure pension plans. Employers have a role to

play in the financial literacy of PSW employees. Disengagement from the financial

system, especially for racialised women, reproduces the politics of marginalisation

including the feminisation and racialisation of poverty.

Maria: The other things that maybe you can. You know when you start working at this
long term, because one of my co-worker at [a LTC home division], she's been there for
five years and she don't know anything about the hospital pension. Nobody mentioned.
She missed those five years that she did not contribute. I told her two weeks ago, that's
the only time she called them and there's nothing she can do about the years that she
missed, that she could have put money. But what I'm saying is I know there's a
recommended hours before you become eligible-
Kim: Yes, are you talking about HOOPP [Healthcare of Ontario Pension Plan]?
Maria: -but at least – Yes, HOOPP like that or hospital pension, or you know. I think HR
should contact the staff like, "Oh, just a reminder. You reach your hours. Do you want to
enroll or you don't?" It's your choice because some people when they enroll, who has
only one job in this country? Anyway, some people, when they contribute in one place,
they don't want to contribute in the other place. I contribute both. But they should tell the
staff because not all the staff are knowledgeable about this kind. But it's something that
you get you get when you retire.
You are working so many years and you don't even know anything. Some of the co-
worker, they don't like to share, "Oh, you can do this. You know you should do this, do
that." I like to tell people. Like our new staff, I tell them, "There is a credit union, you
guys apply, you can deposit money. There is a Canada savings bank, you can apply every
November and you put in 20 bucks, it will pay." Stuff like that. But I think the HR
management should remind. That's my own thing.

Women's stories about unsecure work, limited time for rest while at work, and a

lack of accessible information to financial literacy, especially for new Canadians, are

consistent with the literature on the precariousness of PSW care (discussed in Politic 5),

and the invisibility of stress and burnout (discussed in Politic 7), feminisation and

racialisation of poverty (discussed in Politic 1), respectively. For example, DeForge et al.

(2011) writes about the need for PSWs to balance resident care with workload tasks and a need to feel physically safe, emotionally safe, and safe in employment. Regarding limited time for rest, the ethic of care literature discusses a moral obligation to care when needed and in instances of PSW caring, care for others hinders one's ability to take the full hour break that is allotted. Reflecting on the need to include self in descriptions of care (Raghuram, 2009), it is crucial that LTC homes consider ways demands for care can be supported while PSWs take needed breaks. Research by Luisardi and Mitchell (2008) shows that women in the workforce have less financial literacy than men with less than 17% of their sample (of approximately 700 women) showing signs of financial retirement readiness. Facilitating support for employees also means that LTC homes should take care to provide PSWs with accessible information (via workshops, coaching sessions, etc.) to participate in benefit programs so PSWs are equipped with the financial literacy needed to invest in securing their financial futures. In silencing fears of work loss, inadequate work breaks, and insufficient knowledge of employee benefits, the body seeks worthiness of and in labour.

Appreciation and inclusion in decision-making.

Genderace emerges on the labouring body as grit that others can capitalize. Compromises the body makes are related to when colleagues "pull rank" and subsume responsibilities of others. The labouring body seeks knowing that PSW work matters.

"**They have meetings but then we are not involved in the meetings. They don't ask us questions or they don't ask our opinion." - Clara**

PSWs would benefit from the opportunity to tell management and decision makers how to make their job easier. In their current positions, PSWs in this study

expressed frustrations with not being heard, taken seriously, or told to be silent. The

opinions of PSWs matter in bettering resident care and the LTC home culture for PSWs.

**"But it's the system that is already there. It's the cancer that you cannot cure it." -
Nena**
"But the cancer is eating you up and it's not right." – Jenny

Here, Nena and Jenny are referring to the established hierarchy of coworker

politics. PSWs who have worked at the LTC home for many years have established

practices that were morally unsettling to some women in this particular discussion group.

For example, a resident asked Clara for a sandwich and after the interaction a fellow

coworker disciplined her because she could be perceived as setting an expectation for

care that could not be sustained by other PSWs. In the discussion, it appeared as though

this group of women had experienced their share of moral residue resulting from peers

and management, which according to the care literature is a quick way to burn out for

care workers.

In the quotes above, Clara, Nena, and Jenny discuss that there is no room for their

input in meetings or in decisions at work. Workplace politics make PSWs feel like their

decisions are not useful and sometimes are actually counter to the culture of task-focused

care. The unsupportive work culture that is described here reflects several politics of

genderacialised care. Specifically, I see connections between women's stories and politic

1 (reproductive workers are seen and not heard), 4 (ageism dismisses resident's voice and

PSWs are thereby dismissed for being advocates), 5 (poor work culture contributes to

precarious conditions and workplace stressors), and 7 (stress leads to burnout,

voicelessness, and invisibility). With increased standardisation of resident assessments

and surveillance, the undervaluing of PSW opinions is becoming a persistent theme in

LTC home care (DeForge, et al., 2011, Kontos, Miller, & Mitchell, 2009). More 'expert'

knowledge is valued over voices of PSWs who, often times, have the most contact with

residents. LTC home administration and care colleagues of PSWs need to hear their

opinions and appreciate the contributions made to resident care. PSWs express that the

labouring body seeks appreciation and inclusion in decision-making in feeling worth

within the system.

Protection and preservation of the body.

Genderace emerges on the body as "thick skin" that requires little attention to self

care from caring systems as workplaces are designed to revolve around support required

for residents/patients. PSWs are made vulnerable due to their working conditions and yet

are not attended to or supported by the LTC homes for which they work. Heavy

workloads and the abuse PSWs endure are normalised. Here, I refer to a lack of respect

for PSWs and their work in discussing how workloads and abuse towards PSWs are

overlooked. The body makes compromises by distancing itself from negative actions

involved in caring relationships that hurt the body. The labouring body needs protection

and preservation from the emotional and physical demands of care labour through fair

workloads and to be heard and respected by LTC home administration.

"Physically it's heavy." - Maria
"Yes, physically it's heavy. Then mentally sometimes stressed out yes at the end of
day."
- Nicola

This was a consistent sentiment over the course of discussions with participants.

During the day (7 am to 3 pm) the care staff to resident ratio is 1:6-7, evenings (3 pm to

11 pm) the ratio is 1:10-11, and nights (from 11 pm to 7 pm) the ratio can be as low as

1:20-22. Women talked about the physical pain they incurred from a career in care labour

and how it is also mentally and emotionally tolling work. PSWs need to be supported

through better staffing policies so resident care is not compromised and so PSWs can be

physically and mentally sustained throughout careers of caring.

Maria: And we get abused, all kinds of abuse and--
Nicola: Because people think we are dumb and we don't have any opportunity that's why we go to this job. No, that's not true.
Kim: I think that's a really key message. Definitely I think we take for granted our PSWs 100%, this is why it was important for me that pick up to this work. What other messages did you want people to see from seeing those stories? What other messages popped out to you?
Maria: For me, specifically is it's the abuse that we get from the patients. It's in every facilities [sic] wherever you work, long-term care, hospital. When patients get abused and even though they know patient [has dementia], they take the patient's side, but they don't listen to us. They don't believe that we're being abused. They always think that we are the one that's abusing the patients or the residents, and it happens a lot. The scary part, nowadays the family are just there waiting to sue the company or the hospital for money. It's happening a lot and that's scary.
Nicola: Yes, I will say the same thing but different way. Just for example, when you go to school, teacher teach you something and then we don't see what teacher has in her or his real life back in their house, okay. Whatever problem, she cannot show into the class. She has to smile and teach because that's what a student expect to learn over there and the parents of that student also expecting the teacher should be perfect, smile and be kind. The same like our job. Yes, I think this help to people to understand we also have life, we understand their situation too because we have mother, father, sister, brother, uncle, children, so we -- they also go through those situation, we understand, because we are not like robot over there, we are not a machine.
Kim: Yes. I appreciate that a lot and I'm hearing what you're saying in terms of the lawsuits. Some of the stuff that I cut out of the other videos was *the management always takes the patient's or resident's side, and [PSWs felt that] the patient always forgets the details of the story. They don't know what they left out, so it's not fair to us because our voices are just silenced* [repeating a participant's comment in the second participant group].
Nicola: That's right.
Kim: Yes, and I agree too, I think we only see one side of the coin, right, and this gets too--
Nicola: You don't see the other side. Then I know, managers, they just want to protect the company, and then me too, that's what we are almost silent. Every time we cannot say anything because we have to be nice, kind, respect to the people and then they have right to complain about us but we don't have right to complain.
Kim: In Nena's story, she says, "It's almost like we have to bow, bow, bow, and nobody can -- we can't say anything otherwise." It was really nice to see that your messages were coming together.
[Nicola and Maria nod in agreement]

"we get abused, all kinds of abuse... they don't listen to us. They don't believe that we're being abused. They always think that we are the one that's abusing the patients or the residents..." – Maria

"Yes, the family and the resident, they believe over you." - Jenny

Nicola supports this statement by saying, "...managers, they just want to protect the company, and then me too, that's [why] we are almost silent. Every time we cannot say anything because we have to be nice, kind, respect to the people and then they have right to complain about us but we don't have right to complain." I think the abuse that is being discussed by Nicola and Maria in their conversation speaks to the emotional, physical, and psychological abuse that is experienced by PSWs on a daily basis – not being believed, being silenced, not feeling safe to report moral misgivings, taking undue blame, among other challenges. Earlier, Nicola talks about needing to distance oneself from caring relationships in the sense that she "can't take anything personal" because it will hurt in ways she is not able to easily recover to "not call in sick" or face another shift of work.

The psychological abuse from administration is the erasure of PSW voices and experiences in effort to preserve the optics of the home. Nicola talks about the metaphor of the teacher, students only see one side, but do not know the complexities and politics outside the classroom walls. PSWs 'wear a mask' by taking on the identity defined by the home. There is a need for PSWs to 'smile', nod, and comply in service to preserve one's livelihood. In another example, Clara, after reporting to the administrator that a resident complained about someone acting roughly towards them during care was told, "sometimes its better to shut up" as the administrator made a zipping motion over their lips with their fingers.

Heavy workloads and abuse towards PSWs from residents, family members, and management create toxic work environments for PSWs. Banerjee and colleagues (2008) discuss that individuals who work in LTC homes endure violence everyday and that incidents of abuse are rarely reported. The antenarrative threads of the labouring body seeking protection and preservation of the body speaks to politics 4 (stigmatisation that creates distrust of LTC homes and blames PSWs), 5 (precarious conditions for PSWs and stressful workplace conditions), and 7 (normalisation of overworking and workplace abuse). PSWs express that the labouring body seeks protection and preservation in feeling worth within the system.

Accommodations to shift work and being short staffed.

Genderace emerges on the labouring body as cooperative and self-compromising. The labouring body compromises personal time. The labouring body seeks respect from colleagues with regards to their care duties as a team and time spent in the workplace. Respect for time for caring by everyone on the team ensures each PSW has the support that is needed to fulfill daily care responsibilities.

Maria: Because they expect you to do it next time. They said, "Oh, so if somebody calls in sick, they're not going to bother looking for someone."

Nicola: But that situation, yes. Some company, they do that one. Then like my place, I think some staff are abusing the system too. Just like what I was telling her, some people think, "Oh, I'm not going to work today because the weather is good." I'm not calling like, "Oh, I have my plans today." That's not nice, okay. You should understand that you can't and that people is very short, like you know, they're limited.

Maria: You have to go to work, do you work and do your work and you go enjoy. But no, they're doing that and it's not right like that. When somebody call in sick and do not want to -- Because once you do it, they're going to expect you to do that. "They were okay the last time, we split up and they can manage to take care of everybody with less staff."

Abuses cited in the previous section, are a result of short staffing according to Banerjee and colleagues (2008). Short staffing and PSW abuse contributes to high

turnover rates in LTC homes (Kozak, & Lukawiecki, 2001). LTC homes being short

staffed is linked to Politic 4 (ageism and stigmatisation of LTC homes that maintains

poor reputations, high staff-turnover, and low-wages in LTC homes), Politic 5 ('no-

replacement' policies that create precarious conditions for attending PSWs when staff

call in sick), Politic 6 (divisions of care that are maintained, make LTC homes a site for

low-wage, temporary, migrant workers), Politic 7 (despite this issue being a long-

standing one in LTC home, nothing has yet been done to attend to working short staff in

LTC homes). A perpetual overlooking of short staffing maintains high workloads, high

turnover, and PSW strain. LTC homes need to adopt policies that maintain an adequate

number of PSWs so staff, residents, and family members feel supported from shift-to

shift. The labouring body seeks accommodations to shift work and being short staffed in

feeling worth within the system.

To reclaim self-worth and self-care.

The notion that the labouring body seeks to reclaim self-worth is a counter

narrative that lends itself to the paradoxes discussed in ethics of care literature. For

example, the privileged unidirectionality of care (care for others, not for carer), the

illusion of the valuation of care (care as celebrated versus made a spectacle for discipline,

punishment, and the reinforcement of stigma), and the neoliberal agenda for care

(downloading responsibility to enable financially and culturally privileged individuals to

reap benefits of systems of caring) each structure the ability for some to privilege care for

self and others to navigate caring of self after the care of others. Compounded by the

limitations of resources, support, power, and time in caring institutions, genderace

complicates the ability to reclaim self-worth. By this I mean genderacialised structures

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permit little space if any for individuals to claim self worth; doing so would upset the current ways caring is engaged in LTC homes (i.e., task focused, health focused, and resident focused). Further, histories of oppression and colonialism have silenced racialised women, and until now, women and people of colour are hesitant to assert their power and voices to speak out against a lack of PSW self-care for fear of consequence. To reclaim self-worth, the labouring body seeks mutual agreement and support from leadership in conflict, stress relief and time to reflect, and to take back time.

Mutual agreement and support from leadership in conflict.

Genderace emerges on the body as a scapegoat to the inadequacies of care systems. The labouring body negotiates and receives undue blame from family members, management, and the media. The labouring body needs to have mutual agreements with coworkers and supportive family to ensure work shifts align with other life responsibilities (i.e., dependents, school, etc.).

"In the news, it's always bad news. They don't see the good news." – Clara

Clara's quote demonstrates that PSWs frequently encounter preconceptions about the labours of care PSWs engage. The public and other stakeholders need to know more about what PSWs do and the physical and emotional demands of PSW care. Individuals who take up care work as a PSW, more often than not, do care and take great pride in the work they engage – a message that should be acknowledged and shared broadly. Negative stories that are publicised in the media are evidence of a cracking system, not a group of people.

 "The staff is saying, those PSW are saying, 'I want to do more for the resident but I can't.'" - Jenny
"Limited time. Limited time, limited resources, limited power." – Clara

With supportive structures in place (spaces for PSW voices to be heard, for example), the

discourse of 'can'ts' in labour can shift to PSWs being able to wield more power in care,

to be heard, valued, and contribute to systemic shifts in LTC home care and institutional

culture.

The system appears to accept the way family members interact with PSWs. For

example, Nena is clearly distressed when she recalls being threatened with a call to the

ministry against her care. During our sessions it concerned me that frequent mentions of

interactions with a visiting husband has left such a negative impression on her to a point

where she felt under constant surveillance by one resident's husband. PSWs need neutral

spaces to voice concerns about interactions with coworkers and administration with

whom they work and family members and individuals visiting the home.

Maria: The family, I mean, the people in general, outside that doesn't do this kind of job
should all understand and they don't come to, especially if they have -- But I guess it –
You know what? We have -- I'm just going to example Mr. 951, because their daughter
works at the hospital. She's very nice, very, very nice girl and everything. She works in
the kitchen. When her dad come to our unit, she changed. I guess because it was her dad
that's in our unit and she would come. She's not thinking that she's not doing her work
properly. She would come and bring her dad-
Nicola: Separately.
Maria: -his food ahead of time. But when someone told her that, that, "That's not right,
you should bring it with everybody else. There's no favoritism or you treating him first
because he's your dad." Then she got upset and because I don't want that person to look
after my dad, and give him trouble too, the whole thing. But sometimes they have to
understand that when they think that we're abusing her dad. One thing she believes that
her dad still is treated and the other thing is she doesn't believe that her dad is -- you
know what I mean?
Because your dad was saying that, "Oh this guy grabbed me and pushed me." But that
guy wasn't anything -- didn't even touch him. But then she believes and then when we say
something about, "Oh, don't believe him, [he has dementia]," or you know what I mean? I
think family member or just people in generally out there.

What I think is being said here, between Maria and Nicola, is that people within the

organization who are not familiar with direct care work should also be made aware of the

day-to-day challenges of PSW labours of care. Maria and Nicola also highlight the

internal politics of LTC that staff are faced with including allegations of abuse, neglect,

and family members being discriminate about how specific PSWs engage in care with

residents.

Nicola: They should be educated that thing regarding like kind of this because I know
this. We are all human people. We don't understand sometimes that situation come to me,
I will be the same me or different me.
Maria: Yes, just people outside in general.
Nicola: Public should- understand.
Maria: Public, yes.

To ensure that each person has an understanding of the limited resources that PSWs have

access to, resources are needed for the general public including individuals who care for a

resident living in LTC homes. In addition to more support from leaders, needed public

awareness could challenge dominant messages shared in the media that stigmatise LTC

and PSWs. Women discussed having their roles be better understood, as PSWs are

humans who require understanding, compassion, and patience from residents, family

members, and fellow staff. The negative portrayal of LTC homes is linked directly to

Politic 4 (ageism and stigmatisation of LTC homes). Feelings of powerlessness and

PSWs wanting to do more for resident care, but feel unable to is a result of systemic

limitations (perpetually short-staffed, heavy workloads, cultures of abuse, silence, blame,

lack of leadership support) and constraints on time and material resources (Ostaszkiewicz

et al., 2016; Sharkey, 2008; Reason, Carthey, & de Leval, 2001). Politics 2 and 5 through

7 discuss the compounding conditions that structure the heavy workloads and cultures of

silence, abuse, and blame that reinforce a lack of support PSWs are faced with while

working LTC homes. PSWs look for support from colleagues and management staff in

times of conflict and when it is not available, which is most times, PSWs feel their work

and their say is not respected. The labouring body seeks mutual agreement and support

from leadership in time of conflict to re-claim worth and self-care.

To have stress relief and time to reflect.

Genderace emerges on the body as an inability to recognize and change self-

harming practices. The labouring body negotiates time to reflect and see how the body is

"abusing" itself. The body needs time and space to express its needs and wants.

Kim: ... So let's bring it back to you, because as you naturally do, you think about other people [laughs]. My last question for you today is what was it like for you to recognize your body in this way and to recognize yourself through the first body map and on the second body map?

Nicola: Yes, this [workshop] is great job. A Great time we spent [laughs] we have a great time.
Maria: Yes, they make up our nights [laughs].
Nicola: Yes, so like I said, we [should] have every sixth month or once a year, one thing [like this]. Okay, just start today or wherever sign up and come and do what you feel and just -- okay so we can open up [laughs].
Kim: It feels good right?
Maria: Yes. It feels good.
Nicola: Yes, it feels good. Relaxed.

Jenny: The first body map, I had problems with my lower back pain and arm pain. I figured in my second body map the way I can fix that, and with my help, I fixed it.
Kim: What was it like for you to acknowledge all of this today, to see it on paper? Because we think it all the time, we feel it all the time, but what is it like for you to see it on paper?
Jenny: I had a better way of expressing myself, and it actually is written somewhere, and somebody else will see it.
Clara: Be recognized for your hard work.
Nena: Yes, be recognized.
Clara: Yes, rewarded [laughs].
Nena: They need to recognize what we are doing. It's very, very complicated, and it's hard to manage. You have to speed up. You have to look at the time, how much you're going to spend in this, how much you're going to spend at that, to accomplish all these. So you're always in a speed. You're always on the go. But the second one is you realize that, "Oh, what I'm doing for myself is overwhelming, So I have to--" But the people that--
Jenny: Re-adjust?
Nena: Yes. You have to readjust. You have to relax your body. You have to see yourself. You have to feel yourself. How is your mind, your soul, and your body. All of these will

come when you are sitting down. When you are sitting down and relaxed, all of these things that you are doing will come to you, "this is too much for my body, and nobody is recognizing the work."

Engaging in PSW care is demanding on so many levels. Women describe the constant "go-go-go" pace PSWs are faced with in their work, which takes women away from being able to reflect on practices of care for self and residents. Paradoxically with the amount of surveillance that occurs in LTC home, there is little to no time to access self-reflection by PSWs in effort to reduce stress endured by LTC home care work. Within the task-centred context of LTC, there is little time to attend to PSWs personal stressors. Politics 1 and 3 (the genderacialised nature of reproductive work), 5 (labour force invisibility), 6 (care inequity through systemic deficiencies in caring systems), 7 (invisibility of stress and burnout), and 8 (self-care as self-indulgence or inaccessible for racialised women) describe the many ways PSWs are unable to access time for self and ability to reflect on the hazards of PSW practice.

Reflection in this study facilitated the ways in which women were involved in reconnecting with their bodies to realise they were overworking their bodies. Despite literature that suggests opportunities for self-reflection, stress management and strong social support lead to better care practitioner practices (Gray-Stanley & Muramatsu, 2011; Kowalski, et al., 2010; Rose, Madurai, Thomas, Duffy, & Oyebode, 2010), no such literature exists around self-care and self-reflection strategies for PSWs specifically. There is a need to investigate how strategies for stress relief can be integrated into the highly emotional and physical roles of PSW work. The labouring body seeks stress relief and time to reflect to reclaim self worth and self-care.

To take back time.

Genderace emerges on the body as willing and able to give its own time. The labouring body negotiates time for care for each resident and often sacrifices its own time to ensure needs of others are met. The labouring body needs adequate time allotted for all aspects of care.

"...staff are abusing the system too." - Nicola

Abuse by staff is mostly spoken about in this conversation when coworkers appear to be neglecting their duties or "hiding" during their shift. This is also true when PSWs call in sick as new regulations in some homes do not require staff to be replaced when a PSW calls in sick. Instead, the assigned "workload" or residents are re-distributed to the PSWs who do show up for work. Nena and Jenny have also described the practice of calling in sick and have said that their requests to change this practice have been dismissed by upper management. Reciprocal respect in care is needed for each care person to be accountable for his or her share of labour.

In one of my reflections, Maria tells me, when the recorder was off, that even if there are five "registered staff" [RPNs or RNs] and one of her [PSWs], each of the five will give her their share of the physical personal care. Even though the labours of care were to be equitable among staff despite their designation, nurses will look to her to complete their portion of the physical work. When I asked how she responded, she said that she "did what she was told." She described later on in the shift, that the nurses would ask her "what's wrong?" or why she "appeared tired" in a patronising way. Maria continues, "are you fucking kidding me? They dropped everything onto me and they have the nerve to care about me. Sorry. I can't talk. I'm too busy doing *your* work," she recalls

telling herself. This hierarchy is also observed in seniority of PSWs, when Nena says, "It's the cancer that you cannot cure it" and Jenny replies, **"**But the cancer is eating you up and it's not right."

This range of PSWs abuses is a result of a complex system of stratification. As I reflect on the politics of genderacialised care, I wonder how PSW education (politic 2) plays a role in defining PSW scope of duty and the ways not being a regulated profession contributes to the sense that it is okay to delegate undesirable 'dirty' work to PSWs (politic 4). Politics 1 (reproductive work), 7 (invisibility of stress and burnout in caring), and 8 (self-care) reinforce that to be worthy of time and rest, care work needs to reach a state of completion, when care work can never be finished). When PSWs dodge and hide caring work, they are looking to take back time for rest. In LTC homes, PSWs require support from colleagues and administration to ensure time for their own care is protected. Constructed neoliberal norms rooted in capitalist production need to shift to change the emphasis on work time as productive time only. The labouring body seeks to take back time to reclaim self worth and self-care.

Self-worth as interdependent and unamenable by *being with*.

Stratification of PSW care renders leisure and self care outside of work invisible and self-determination through care work nearly impossible (politic 8). The concept of interdependence is rooted in relational theories (Koggel & Orme, 2010). As identified through participants' body maps and digital stories, the notion that the labouring body seeks self-worth as interdependent and unamenable means:

- *to care in the ways the body chooses* (labours of care) by
- *acknowledging the body* (through body maps to locate kernels of hope)
- *and being with* (interdependence) *through care*.

I chose to use the word unamenable because amenable means open and responsive to suggestion. Given struggles of racialised women to find worth through the system -- and to be acknowledged as worthy -- in so many self-compromising ways, I felt *un*amenable was a word that could describe women's determination of worth as independent from the structures that label and denote worth. I felt that seeking self-worth as interdependent and unamenable could liberate one to collectively question the necessity of the 'mask' (Du Bois, 1903; Fanon, 1979; Goldberg, 1993, Montoya, 1994) worn to live in bodies of difference within neoliberal structures that marginalise and make invisible.

> One cannot care for the self without knowledge. The care for self is of course knowledge of self... but it is also the knowledge of a certain number of rules of conduct or of principles, which are at the same time truths and regulations. To care for self is to fit one's self out with these truths. That is where ethics is linked to the game of truth. (Foucault, 1987, p. 116).

Labour in relation to self-care, I reflect on one of Foucault's last works on *Ethic of Care for the Self as a Practice of Freedom* (1987). I will not begin to pretend that I am wholly understanding in my digestion of this interview, but in my readings of interpretations of Foucault's discussion of the practices of the self, I am led to understand that individuals can seek liberation from structures of power through practices of the self, an acknowledgement of rules and practices, and with the recognition that bodies are already governed. Linked to findings in the current study about acknowledgement of the body and stories of the body, interpretations of Foucault's writings on self-care describes that knowing self is to take care of self (Dilts, 2011):

> To identify what practices constitute free practices requires (as he sets out to do in The Care of the Self in particular) an account of how some practices can be understood as ones that allow access to a self that is not sovereign, but which, takes care of oneself 'as a way of , knowing oneself' [...] That is, the truth of a practice as

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> a, free ʿpractice requires precisely an account of the specific rules and practices of a specific milieu, of the truth games or regimes of veridiction that are in play, that is, as a subject that forms him or herself, but precisely by never appearing to be, beyond the mechanism of power' (p. 143)

That is, individuals must pursue practices of the self with the acknowledgement of bodies as subject to powers of constraint. Knowledge of the self and thus care for the self simply frees us as individuals from the futility of seeking liberation through practices of systems of power.

> That is, if we must accept some degree of the neo-liberal understanding of the subject, then we must think very seriously about the care of the self, about the kinds of individuals that we form ourselves into --never forgetting, however, that we are constrained, that *we are already* governable, or that we can succumb to something that forms and reforms us. We must take part in that work ethically rather than satisfactorily. Our work must be an ethical activity rather than a purely consumptive activity (p. 143). [...] These questions of the self, as practices of the self, might look very much like, investments in the self (education, medicine, exercise, disciplinary practices, etc.), but they are necessarily self-conscious of the rules of the truth game as a game, as a regime of veridiction under which they can be said to be true practices, and hence, contingent on the particular game one finds oneself in (Dilts, 2011, p. 144).

In this study, 'the game one finds oneself in' is the practices of labours of care. The 'investments in the self' (i.e., self-care, leisure, and time for self) are inherently part of the truth game that is (re)productive labour through care. The trick is, knowing that these practices are, and always will be, a part of these relations of power. Knowing oneself can articulate these investments of the self -- forays into exerting power within this truth game – but caring for self is the recognition of struggle that occurs from attempting to situate oneself in relation to these practices and, still, having and acknowledging one's *worth* despite acts and practices to mediate participation in labours of care.

Interdependence describes the power of communing that opposes isolating and hegemonic practices of care systems. The emerging antenarrative of this work sits apart

from the worth dictated by roles of care and a title within the system, self-worth as interdependent and self-determined rearranges power and listens to the body narrative of each person amongst a chorus of [others] in care. In other words, an ability to recognise one's own body, connect and care with others (interdependence), and articulate one's self-worth as unchanged by systemic forces that constrain the body is the pre-emergent body narrative that links *hope* and *being with* to *labours of care*. Despite the limitations of systems of care, these personal affordances move individuals, who labour in caring, to consider possibilities of care in ways the body choses.

To care in ways the body chooses.

Genderace emerges as a non-specialised reproductive worker. The labouring body negotiates other supportive labours of care with direct resident care. The labouring body needs to have its opinions valued and be supported in its aims for care. The idea of *to care in the ways the body chooses* speaks to misunderstanding PSWs face about their roles on a day to day basis. Women discuss their ability and desire to facilitate quality caring, however, people who do not understand PSW roles create hindrances to this care and subsequently de-value their roles as care persons (e.g., asking a women of colour for a special kitchen order, speaking to PSWs as if they were less intelligent, not describing PSW roles or being included in family orientation when residents move in), which is bound up in structures of genderacialisation. These misunderstanding are deeply cutting constant reminders that women of colour should 'know their place' in the system, which prevents PSWs from *caring in the ways the body chooses* without hindrance.

"...if you can propose people to get the education about that. "When your father, mother, loved one go to the hospital, what you are expecting from them and then what your role to do for them" – Nicola

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When my ma went into the hospital for knee replacement surgery, her good

friends and former coworkers brought her toiletries like body wash, powders, and hand

soaps. I myself wondered why this was, as I always came with food she liked. She said,

"what they use here is no good – I share with my roommate because her skin is sensitive

and no one comes to give her." I felt silly not knowing that was an issue, saw how little

things make a big difference in PSW care – especially when PSWs are often the target of

blame (and even legal action) when care is perceived to be "rough."

Jenny: Anybody who doesn't know about PSW work and expects to have a certain
expectation of what the work is, especially with family. They suggested also that maybe
**we create a tool for family members to explain to them before their family member
comes in, what they should be expecting.**
Clara: Yes, but sometimes, when they go on their orientation, isn't it that they have
expectations of what we are doing, the amount of care and everything?
Jenny: Yes, **we don't know all that's put out there to them.** If they do tell them,
"Look, this staff has 11 residents and they have eight hours. You have to spread your
time out among your eight hours and your 11 residents. Yes, they are supposed to--

Here Jenny extends Nicola's idea about describing the expectations placed on PSWs for

resident care to people who do not know about PSW work. Asking PSWs to be involved

in family orientation would give family members a better sense of the limited resources

each PSW has to work with at the various times throughout the day.

Nicola: Then if you can only, I don't know, it's not only the video clip to show to the
other people. Because your whatever research doing just, if you can propose people to get
the education about that. When your father, mother, loved one go to the hospital, what
you are expecting from them and then what your role to do for them. That's the first
thing.
Kim: Yes, I think that's a great idea because that helps them help you because you're not
having to now educate the family over and over, and over again.
Nicola: That's right.
Kim: They have those tools already, but yes-
Nicola: Just for your information, I see something because you used to bring your staff,
remember? To wash people and the powder, I think.
Maria: You used to bring a lot of them.
Kim: Really?

Nicola: -so now they stop. Cathy not doing it anymore, Cathy said "No, I'm going to do that." Because when we asked because now our unit is almost really now staying to go to nursing home.

[...]

Nicola: ALC, so mostly they're in for the bed. When your mom is in that situation, I don't think you expect everything from the hospital like the soap, kind of thing. Whatever she's leave what we had, only you, you know that. So you're going to buy that lotion, whatever brand. People are, "Okay, your mom it's better if you can buy body wash, powder, a little bit of something.

Maria: We used to buy it but we-

Nicola: Oh, so one lady went to outside get soap, you know little sachet packet from the hospital?

Maria: Yes.

Nicola: They [the family] did and show it to us. [They said to us, holding the soap in their hand from the hospital, looked at us and told us] "this is the soap" [like we didn't know that was soap].

[laughter] Yes, okay. Excuse me, I know that. It's cheaper. Yes, the cheapest one, they providing here. So why -- when I go home I told myself, "[Husband] Glen, you know what, when I go hospital, don't do that [to me]. I'm going to kill you." [laughter]

Nicola: Come on, this is your mother, father-

Maria: Even deodorant. One time I said, the daughter said – I said, "Could you bring something for your dad, it's really smelly and buy." She complained that her dad is not being washed because he smells. I said, "No, he's been washed but he has body odor-"

Nicola: You know some people, okay, you know body odor you cannot-

Maria: "-it can't come out." You need to bring something that your odor, "you guys supply that here." And we're like, "No".

Nicola: Yes, and in our unit, we almost don't get shave razor.

[...]

Nicola: But the patient complain, "you're rough." We're not rough, we're just shaving. Why can't those people buy nice thing. Soft [razor].

Kim: Yes, it's the expectation that everything is all-inclusive. [laughs]

Maria: Yes, like a hotel. [laughs]

Nicola: Like a hotel. [laughs]

Maria: This is hotel, they want food anytime, make that, "I want snack, right now." "Okay, sure, I'm going to cook." [said sarcastically followed by laughter]

Nicola: Yesterday someone call me, "Can you order Canada Dry, six o'clock in the evening." Canada Dry from *me*, sure I'm going to order [said sarcastically followed by laughter].

Maria: Yes, they're too much.

Nicola: Yes, they make you mad running.

[...]

Nicola: It's different. People [family members of residents/patients] when they migrated, they think, "Okay, it's Canada." We too, we came from the Philippines that time and then my husband was looking for someone, some friend in here. Then we found our friends in Toronto. Then he got a job opportunity in Winnipeg. We thought that it's Canada anyway. Most people don't get jobs and then he got job offer even if we not come here,

so then, "Okay, go to Winnipeg." Finally [we] found our friends over there. They say, "It's okay, you come here then you can move some there." We went there, that's how we got in Winnipeg. He got the job. [laughs]

Women working as PSWs in LTC homes described through their bodies in digital stories, body maps, photos, and reflective discussion how labour lived in the body. Hearing their narratives of labour, leisure, struggle, vulnerability, despair, invisibility, accomplishment, and celebration often created more questions than it did answers. What ended up being most paramount, however, was the space to connect and discuss stories that may have gone unheard otherwise – a perpetuation of marginalisation and invisibility narrative in communities of racialised individuals.

Returning to the politics of genderacialisation following analysis revealed that embodied counter narratives of seeking *worth in the system* and *reclaiming self-worth* were responsive to marginalisations that occurred for racialised women within the stratified system of healthcare in a context of capitalism. Women suggested that their digital stories and body maps should be geared to informing people about the labours of care. The resources women in this study suggested would highlight the work PSWs engage on a daily basis and the roles family members, residents, and co-workers have in supporting each other to better facilitate resident care. Nicola and Maria comment that coworkers, including registered practical nurses, also take advantage of PSWs.

Kim: Who should hear your stories?

Nicola and Maria: family, public, and people working within the institution.

Jenny: Government health service.
Kim: Yes, that's my next question. My question now is, who should see these? Who should see these? That's where I'm going. [laughs]
Clara: By the time they will increase, we're gone.
Kim: It's okay.
Nena: At least it's for the next generation.

Clara: Yes.
Jenny: That's how it will work.
Kim: Members of government. Who else do this should see this?
Jenny: Government.
Clara: The management.
Kim: Yes.
Nena: Coworkers.
Jenny: Coworkers.
Nena: The family too should know that.
Clara: Family.
Jenny: Family.

I believe a more intentional integration and streamlining of post- theories (i.e., post-identity) and language would have guided the latter half of this dissertation in ways that could have better supplemented knowings gleaned from the post- methods and representations used this study. Despite this, new knowings from this research on labour and genderace are rich and open the door for further unpacking how labouring bodies and genderace are connected. The antenarrative of labour described in this chapter have several implications for leisure and ways of conceptualising self-care both at home and in the workplace.

The Genderacialised Labouring Body Seeking Worth and Leisure

What does *the labouring body seeking worth* mean for leisure? I do not see leisure as equivalent to women's descriptions of seeking free time. Free time or time for rest was always in relation to the need to ready the body for care labour. Racialised women's leisure is more complex than is discussed in the leisure literature and leisure is dynamic and boundless in the lives of racialised women. Leisure looked like caring for the home and spending time with family, for example. Women talked about leisure in ways that enabled them to reconnect with their bodies, clear their minds, and ground themselves. In the context of care work, stress-relieving workshops that women desire may in some

ways be leisure, but it is also work to better know self. Leisure was a state of mind, a

space to be creative, oneself without a 'mask' or fear of repercussion, and a means to

temporarily be relieved of the stresses of care work. The final chapter of this dissertation

will discuss how the antenarrative of the *labouring body seeking worth* can mobilise

social justice by reframing understandings of how PSWs are valued in labours of care.

CHAPTER 8. Transformations and the Transformative Potential of Genderace/Embodied Stories of Genderacialisation

"...we are not a machine." – Nicola

This research unfolded knowing of genderacialised labours of care, leisure, *being with* and hope in unpredictable ways. This final chapter will serve to revisit learnings and transformations over the course of this inquiry as it pertains to the potential of knowing embodied stories of genderacialisation in care to transform care practices and contribute to theoretical and methodological bodies of literature.

Revisiting Objectives and Guiding Research Questions

Recognising the need to critique the structuring of systemic processes that oppress in order to move beyond it to imagine new cultures of care was an important starting point for this inquiry. This acknowledgment required me to think critically about the ways all aspects of labours of care continue to be contextualised by capitalism and neoliberalism that create ways of making invisibility through marginalisation from structures of dominance. This research project began with six research questions and five objectives. I summarise these knowings gained from this inquiry here.

To inform impacts of racialisation, gendering, and classing in care work and to deepen knowings of genderacialisation, I developed eight politics of genderacialised care to set the stage for knowing context of care systems that contribute to processes that stratify labouring body. By reviewing the literature, reflecting on personal experiences, and listening to women who participated in this study, I described how genderacialisation occurs for PSWs working in LTC homes. Thorough body maps, I learned how personal support care workers take-up, negotiate, and reconceptualise notions of labours of care, self-care, and leisure. It was clear that engagement in intra-corporal work (Hochschild,

1983), body work (Gimlin, 2007), and leisure were not distinct or isolated in stories told on the body maps. PSWs wanted to express and have others recognise that they loved their work; women felt they could make a difference in the lives of others by providing others what they needed. Body maps also told stories of being together through work, leisure, and tending to one's needs to rejuvenate. Tensions were heard when women expressed hope in struggles of labour, despair in labouring in care work they love, and a need for labour in attempting to liberate oneself from labour. Lastly women touch on the need for the dreams they held in their bodies to be realised through their labours of care.

To inform manifestations of genderacialisation, body maps further revealed that women were experiencing abusive, dehumanising, objectifying, isolating, and commoditising practices through the labours of care they engaged. Women felt unheard and invisible as PSWs, which spoke to the nature of power relations women as PSWs need to navigate in stratified care settings. Women navigated these expressions of genderacialisation in the face of struggle by rooting their hopes and sense of worth in reasons for engaging in care work (i.e., power to make a difference), in hopes held in the body, a tangible ability to care for families, and the knowing that the care work they do is in the best interests of residents.

An antenarrative of labouring through hope and being with in seeking worth uncovered stories of how women took up the embodied notion of genderace. *Being with* was an embodied way of connecting to others and supported the labouring body to *hope* in the face of genderacialised structures. *Worth* was the antenarrative that came through stories of labours of care. Moments of transformation occurred in our research process when women told stories of reclaiming self-worth and expressed a reconceptualisation of

worth in communion with others as interdependently conceptualised and unamenable by processes that work to oppress and subjugate.

The juxtaposition of the two body maps revealed women's hopes for the labouring body beyond processes of genderacialised care practices including feeling cared for, relating in humanising ways (such as the quote Nicola offered in the opening of this chapter), being treated as a capable individual by being listened to and acknowledged as present, able to contribute, and visible in caring relationships. Women also expressed seeking connection with coworkers ('like family') through labours of care. These hopes were juxtaposed against the current practices of care (storied by women in the first body map described in Chapter 6) to be manifestations of genderacialisation.

Women who participated in this study discussed implications of their personal stories of care labour as being able to facilitate knowing of PSW labour to recognise the efforts of the labouring body, develop knowings of PSW abilities within a very restrictive care environment, and the potential to influence care in the ways the labouring body chooses. Some influences women hoped to make through their stories in relation to recognizing worth of the labouring body and providing labouring bodies what is sought through care included:

- A recognition of worthiness of and in labour
- Appreciation
- Protection and preservation
- Accommodations to shift work and being short staffed
- Mutual agreement and support from leadership in conflict
- Stress relief and time to reflect
- The ability to take back time
- The ability to care in the body chooses

This list and potential for transformation of care practices were discussed in effort to inform sustainable labours of PSW care and in leisure to care for the body.

The last research question, yet to be addressed is:

5. What recommendations for change do PSWs recommend in light of their participation? To whom and how do we disseminate this information?

Women discussed wanting their digital stories to be shared broadly with family members of residents, individuals in administration in LTC homes, and the general public. PSWs who participated in this research said that more resources geared to the public would be helpful in articulating the types of care work PSWs engage, how PSWs can be supported, and how individuals can participate in care with PSWs to support residents living in LTC homes. Women felt that these efforts would eliminate uninformed requests and discipline that elicit negative feelings of individual worth in labours of care.

Implications and Learnings

From understandings of race, gender, class, and reproductive labour, this inquiry carved new territory and new language to convey processes that structure hidden and precarious labours of care. This new territory opens doors to a number of contributions to the existing literature that helped shape this research. For example, the invisibility and hypervisibility paradox of genderacialised labouring bodies, and structures that shape embodied narratives of genderace further expand the existing literature on working bodies. To my knowledge, this is the first study to develop digital stories from body maps to reveal *seeking worth* as an antenarrative in labouring bodies. Further, in line with the improvisation of narrative methods for this study, I used narratives from discussions on body mapping and following the airing of digital stories to deepen a reflective and embodied analysis to reveal the antenarrative of labour *(worth)*. Centralised around

stories of genderace, *acknowledging the body,* and *worth*, these new insights on labouring

bodies create more space to broaden theoretical, methodological, and practical learnings

towards transformations in care and how we approach knowings held in the body. I

further discuss theoretical, methodological, and practice implications of this research

here.

Theoretical and methodological implications.

Anticategorical intersectionality theory helped to question whether labels served

to help understand personal stories and whether layering social axes were useful for

reflecting complexity in social presentations of the body. Through this inquiry, this

example of intersectionality theory works to inspire others to think beyond fixed labels of

convenience and pre-scriptions. Understanding that personal narratives are complex,

dynamic, and shaped by processes of genderacialisation in contexts of care worked to

frame the ways stories can exist beyond fragmentations of prescribed identities.

Acknowledging processes of *genderacialisation* that aim to subjugate, and naming it as

such, liberates individuals to define selves away from loaded, pre-scribed labels of

difference. Considering the discussions of care work by racialised women who work as

PSWs in stratified environments like LTC homes, this study expands literature by

contributing the theoretical concept of genderacialisation to demonstrate how inequities

are structured and systemic, but are able to be uncovered with an intersectional lens.

Embodiments of genderacialisation or *genderace* are other theoretical

contributions that can be made to the literature. The findings of this study posit that

stories of marginalisation, difference, and seeking worth through labour live

intersectionally in the body and are connected to larger structures of oppression in care,

namely *politics of genderacialisation*. Genderace attempts to articulate language to name the stories that live in bodies of difference that is often left ineffable and silenced. Through critical narrative inquiry, the antenarrative that is revealed through this study, *the genderacialised labouring body seeks worth through hope and by being with,* reflects the politics of genderacialised care through stories of genderace. The following table (Table 2) summarises the connections between politics of genderacialisation (described in Chapter 2) and stories genderace (described in Chapter 7).

This research is an example of an improvised critical narrative inquiry and visual narrative methods and methodology. I see potential for this work to contribute to understanding how antenarratives can liberate researchers and participants from labels and assumptions in storying -- what is felt but as not easily articulated -- through alternative forms of textual and visual presentation. I hope this dissertation will show that there is great value to working across narrative understandings and approaches to deepen critical knowings of story before venturing into less-structured narrative antenarrative space. This work also challenges me to seek alternative ways of knowing through embodiment and representation (i.e., pastiche through storyboarding, narrative guided dialogical and embodied analysis) to make space for new, unveneered conceptualisations of personal story away from processes of subjugation. Expanding knowing through body map informed digital stories, to my knowledge, is new methodological territory in leisure studies. This body of work is a small collective of methodological pieces that I am proud to contribute to leisure studies.

Table 2. Connections between genderacialisation and stories of genderace

Politic of genderacialisation	Selected narratives from body maps and digital stories	Story of genderace/embodiments of genderacialisation
Politic 1 - the classed nature of PSW labour as reproductive labour structured in poverty	I work every day. I basically don't have a day off because when I'm off at the hospital I'm at [the LTC home]. I work seven days a week. My life, to be honest, is more like work, is just work-- whenever I can. I-- when I go home I do stuff for myself as much as I can and I need to do my rest. The end of my shift just how I feel the stress, the life but then at the same time I'm thankful that I got a good job because I know a lot of people out there don't have a job. - Maria	The genderacialised labouring body seeks worth within the system
Politic 2 - complex requirements to navigate systems of education towards PSW work	I went to college and tried to update my certificate, diplomas, everything and then finally I figured out I had to go to school another two, three years to get this career back and then I find a way to get a job in a short period of time.[...]Then my husband decided to move to Toronto, we came here. I had to go again to college to get the job in hospital theatre. College again, same course in the same country, different provinces. [Laughter] I had the same certificate, two provinces. Yes. I believe I was crying because the day my husband asked me, "If you want to go to hospital job you have to go to school or just choose a different career or stay at home."[laughs] - Nicola	
Politic 3 - the systemic undervaluing of health care workers of which racialised women are overrepresented in labours of PSW care	We wish our pay will increase to good amount and then we don't have to go two jobs. Like, we just do eight, three hours for pay period and then the other rest of the time we spend with our family. Do what we have to do, you know? - Nicola	
Politic 4 – ageism, stigmatization of LTC homes and PSW work	We try to make the home what we want for ourselves. Like some people will say, "I'll never go to a nursing home" What's wrong with a nursing home? It's supposed to be a healthy environment. What we want for ourselves is what we should give these people. – Jenny	

Politic 5 - stressed conditions and precariousness of PSW labour	With the residents, I would like to have a caring hand, treat the resident as a family. At night we cannot do that because both of us has 50 residents, 45 residents. There's a team. We work two persons in each row it's like that. We have 50 residents. There's no caring, like as if you just want to finish the job. Now, I'd like to have one-in-one that's why I want to work one-in-one client centered care as we are supposed to. - Clara	The genderacialised labouring body seeks to reclaim worth and self care
Politic 6 - divisions in care labour and the resulting transnationalisation of care work needed to manage demands for more care labour	I came here as a Nanny when I came in Canada. That's the only way to come here in an easy way because as an immigrant, it takes a while. When I came, I landed in Alberta and I worked as a nanny there. To come here and work as a nanny in a different country that you don't ever know is very hard if you don't have experience. At [their] home, I'm very shy to approach my employer. "Come on, the food is ready," and things like that, I'm really shy about that. Then after I got my papers, I said, "I don't want to be like this for the rest of my life." - Nena	
Politic 7 - the underwhelming response to address stress and burnout	It's the abuse that we get from the patients. It's in every facilities [sic] wherever you work, long-term care hospital. ... They take the patient's side, but they don't listen to us. They don't believe that we're being abused. They always think that we are the one that's abusing the patients or the residents, and it happens a lot. The scary part, nowadays the family are just there waiting to sue the company or the hospital for money. It's happening a lot and that's scary. - Maria The body is saying, "I'm painful," it's stressful. – Janet Yes, somebody needs to advocate for us – Clara	
Politic 8 - stratification of PSW care renders leisure and self care outside of work invisible and self-determination through care work nearly impossible	So then because of sleep is my priority too and my family that's why it's [at] the center of my heart. I need to balance myself with good nutrition and exercise and leisure time. – Clara Usually we have one hour [break], but we cannot spend one hour because of the job. – Nena	The genderacialised labouring body seeks self-worth as interdependent and unamenable by *being with*.

Practice implications for social justice.

> Transforming [invisibility] involves us in recognizing that our identity is
> not fixed but constantly reconstructed as we gather together aspects of our
> past and present stories that will help us to meet the future head-on. As we
> begin to tell our stories we might find out things about ourselves that we
> didn't know before; discover strengths and resources within that we did
> not know existed; enjoy feelings that we no longer have to deny or feel
> controlled by; acknowledge and welcome thoughts we might have
> previously feared; and behave in ways we now understand and can put to
> good use (Etherington, 2003, p. 34).

Silenced perspectives of racialised women who work in LTC homes are

privileged through a critical narrative approach. Estabrooks et al. (2014) called for special

consideration for gender, race, and class and, through this inquiry, I now see how

racialised women working within genderacialised care structures are silenced and silence

their own stories of genderace. Stories of genderace or women's embodiments of

genderacialisation reflected dominant discourses about racialised women (who perceived

others saw then as not women/feminine, unintelligent, and cheap). By listening to stories

told by racialised women, acknowledging taken-for-granted understandings in the day-to-

day lives of racialised women, and being critical of how personal agency is challenged in

contexts of care settings, women can collaboratively build capacity towards imagining

what well, just, and sustainable practices for working as PSWs in LTC homes would look

like.

> Evocative stories activate subjectivity and compel emotional responses.
> They long to be used rather than analyzed; to be told and retold rather than
> theorized and settled; to offer lessons for further conversation rather than
> debatable conclusions; and to substitute the companionship of intimate
> detail for the loneliness of abstracted facts (Ellis & Bochner, 2000, p. 744).

These evocative stories can help to acknowledge the masks that individuals of difference (especially racialised difference [Du Bois, 1903; Fanon, 1979; Goldberg, 1993, Montoya, 1994]) wear to navigate systemic marginalisation and invisibility. In this study, it was clear that masks (of cultural aptitude, consumption, and perfection) were worn to hide stories of genderace in care. Paradoxically, these oppressive masks protect the body from injury from microaggression. Creating safe spaces where individuals are free to unpack experiences around their bodies of difference is a starting point for how 'masks' can begin to be talked about towards revealing individuals behind the masks worn. Hearing stories by racialised women who work as PSWs fills an important gap in knowing about the ways self worth is sought in care, what the labouring body seeks to care for self, and a lack of opportunity for agency by individuals working in contexts of LTC care.

Care relationships, which support care systems to flourish and thrive in an evolving society, are supported by individuals who take up caring roles, yet care workers lack supports to maintain self-care and well-being, opportunities that are best understood from perspectives of individuals who are genderacialised and engaged in the labour of care in Canada's LTC homes. My hope is that the politics of genderacialised care serve as an important contribution to reckoning with how processes of subjugation occur in settings like care, but in other spheres of labour as well. Moreover, from this study and participant's recommendations I believe *hope, being with* and the antenarrative of *the labouring body seeking worth* (and the aspects of worth that the genderacialised labouring body seeks) can inform practice, policy, and social reform in care towards socially just and sustainable ways of caring. Specifically, I believe this research can facilitate:

- **Practice reform for self care** – by acknowledging the few opportunities women have for self care, LTC homes can work to integrate wellness programs towards relationship building, respite for the mind and body, showing appreciation and care for PSWs, and improving morale and resident care. This study demonstrated that in the few hours women and I were together, this creative time proved to be a valuable outlet for stress reduction.
- **Support for understanding PSWs roles** – PSWs are undervalued in their care roles and due to this, many do not take the time to learn about the ways PSWs can be supported by other members of the health care team, family members, and residents. In the movement towards a culture of relational caring, knowing more about PSWs can reduce power and value-laden assumptions behind requests for resident accommodation and the notion that PSWs are paid directly by residents and their families and are thus entitled to acts of submission and servitude.
- **Acknowledgement and reinforcement of worth** – dominant discourses of being worth-less have prevailed through the maintenance of reproductive work. *The labouring body seeks worth through hope and being with* as the antenarrative of labours of care demands an approach to listening to PSWs, hearing PSW perspectives in decision making, and telling PSWs of their worth in caring practices. This research can amplify PSW voices and open dialogue in effort to better value and listen to all involved in labours of care. Further, this work aims to bolster discussions towards better pay for caring work, for supporting PSWs in full-time employment, and in providing similar benefits that other members in the healthcare system have access to.
- **Reducing silences, exposing erasures, and hearing stories of hope for change** – This study was only a snapshot of how silences remain around race, gender, and class stratification in care. Through stories, this research aims to raise consciousness of colourblindness in Canada, and other oppressive structures that maintain stratification, towards the disruption of the processes that feminise and racialise poverty and social inequity. Voices of PSWs need not be taken for granted in everyday practice. PSWs have informed opinions that should be respected and listened to in a variety of ways including in: decisions around resident care, discussions about LTC home operations and employee relations, and choices about labours of care. Specifically, PSWs voices should directly inform the distribution of responsibility, workload, opportunities for respite, and the way challenging situations that have been faced in the past by PSWs are addressed and supported by all involved in care at the LTC home. PSWs stories in this study can be used to draw attention to the erasure of PSW voices to open dialogue around care, but also around the ways systems genderacialise individuals, which requires a careful consideration of the multiple and complex

politics involved in care by racialised women and special attention to histories and living stories of women of colour.

I believe that social justice is equitable and inclusive treatment that privileges individual' rights to agency, wellness, and fair visibility. Other social justice implications that I see in this inquiry involve:

- Illuminating inequity embedded into genderacialised labour of care systems, taken for granted assumptions of dominant care discourses, and expanding expectations for personal advocacy of care for the body for PSW care workers in LTC homes;
- acknowledging the body to reveal embodied stories of hope and relating in labour of care systems;
- recognising the need to *be with,* to limit isolating practices in care labour, and promote approaches that strengthen team work and community-building;
- acknowledging non-essentialised (not a one size-fits-all) approaches to relational caring, leisure, and personal wellness;
- reaffirming solidarity in collective tellings of stories with individuals with similar experiences; and
- making the politics of genderacialised care visible to continue to interrogate the ways personal agency can exist in stratified systems of care.

In reflecting on the role of empowerment in this study, I believe that to task someone with 'empowering' or to assume someone has ability to empower (as a researcher, for example), deems that person as powerful and acknowledges those in need of empowerment as power-less. Gutierrez (1990) suggests the following definition for empowerment: "empowerment is a process of increasing personal, interpersonal, or political power so that individuals, families, or communities can take action to improve their circumstances" (p. 149). Feminists suggest that one's positionality and identity works within the social, historical, and political context (de Lauretis, 1986) and through *conscientization*, "individuals come to understand the political dimensions of their [circumstances] and act accordingly" (Carr, 2003, p. 9). Critical reflective space plays an important role for women in supporting the possibility of reclaiming themselves and

women's sense of worth from genderacialised systems that usurp their power and reduce them to labouring bodies. In these spaces empowerment is connected to self-worth in a way that re-centres power around women of colour. Self-worth emphasises that women of colour are not worth-less and can re-write the way worth is denoted to the body. With regards to care work, critical and reflective space reminds PSWs (and others involved in LTC homes) that PSWs are strong, influential, and worthy of respect, care, and being heard.

Ownership and projection of voice in narrative inquiry, voices that are routinely silenced by marginalising and stressful experiences and are denied in caring work, is more useful in this inquiry than notions of empowerment. Through engaging in critical narrative work, women may have experienced through our research process that "[b]y writing stories [participants] become agents in [their] own lives" (Etherington, 2003, p. 20) in new ways. Potentially by reclaiming voice and locating agency through visual stories, participants have a sense of empowerment in the narrative process that I had a role in shaping. Is this, then, an empowerment of others? Is reclamation of voice empowerment? Self-empowerment? It is difficult for me to make assumptions about how participants may have articulated empowerment through the research process, if at all.

Critical reflections and research (re)considerations.

The movement of this inquiry beyond theories that critique structure (i.e., post-identity in conceptualising the embodied nature of genderace) required for the concepts I drew on to be more firmly grounded in the literature of post-theories. As I ventured away from explicit critique of structure to knowing through the pre-emergent body stories told by women through their body maps, I felt, more and more as I moved through the

research process, that this inquiry could benefit from new understandings of power

relations, relatings that are momentary and partial, and a fuller understanding of

knowing-unfolding-in the moment as discussed in Bahktin's work. Though I alluded to

some post- language and post-structural concepts (i.e., rhizomatic unfoldings,

fragmentation, and genderace) and took up approaches post- methods, analysis, and re-

presentation (i.e., improvisation, antenarrative, embodied analysis, poetizing, etc.), I felt

that my ability to effectuate post theories in this dissertation was lacking. For future

works related to this inquiry, I will read more closely into post-theories that will better

support my works that venture beyond structures of power.

Another limitation of this work was my ability to secure time and finances to

involve PSWs areas outside of the greater Toronto area. I think that involving racialised

women working as PSWs in rural settings or outside of Ontario may have offered

perspectives on the structuring of labours of care in different parts of the country that

would broaden the findings from this inquiry.

Third, with regards to my facilitation, I found that in order to hear rich and

involved stories by women working as PSWs, I had to structure workshops that were

very time consuming. Though I put my best effort forward in being accommodating to

very busy schedules, I felt that there was more I could do to be more ethically

conscientious of women's time and mental energy in gathering the same depth of data I

collected in this study. During my facilitation, and despite efforts to ensure all women in

the room identified as racialised women, it was evident that race remained an

uncomfortable topic to discuss. This suggests that more needs to be done around how

race is silenced by colourblindness in Canada. Rather than take up race directly through

discussion, I felt it was essential that women had other outlets to express race in different ways (embodied racialisation through body maps for example). In future research, this study can help facilitate a shift to a dialogue of change by unpacking what relational ways of caring (*being with*) and *hope* mean for PSWs. By acknowledging stories of genderace told by women in this study, change spaces can be created around a powerful collective of women who face similar challenges in LTC homes and, when invited to the table, their voices can further describe the ways self care can be supported and their worth can be realised in caring practices in LTC homes.

Lastly, my ability to accommodate the fullest extent of community engagement through a virtual gallery and virtual forum that I initially proposed was limited. The focus of this dissertation was to deepen knowings of genderacialisation and hear embodied stories on labours of care by PSWs and, to me, this was realised for the most part. I felt, though, that because I proposed to share stories more broadly as part of this project that this piece of the digital storytelling process was truncated somewhat. My next research priority is to develop the website where digital stories and photos of body maps will live. On this website, it would be very important to me and women who shared their stories through this research to have a space where more stories can be contributed and the general public can access and learn more about PSW labours of care.

Potential for Knowledge Sharing and Mobilisation

In the context of care in Canada, constructions and use of race, gender, and class as categories that fragment difference will continue to make invisible of experiences of care labour and leisure for PSWs care workers. Involving narratives of individuals working in PSWs roles with an understanding of processes that genderacialise is a gateway to

knowing various systemic negotiations and life navigations involved in labours of care through a first person account. Through this critical narrative inquiry and critiques presented in the politics of genderacialised care, it is my hope that we can continue to engage in meaningful conversations around how PSWs can be better supported and protected in LTC home work, by illuminating genderacialisation and other systemic discriminations still prevalent today (Al-Waqfi & Jain, 2007). I feel that there is great potential for knowledge translation through visual and art-based methods, workshops, virtual engagement of body maps, and digital stories engaged by this inquiry. Perhaps it is through stories from this project that Canadian silences and grand race, gender, and class discourses that dominate care systems can be seen and heard and ultimately, reduce essentialisations of women of colour involved in care work and the resulting marginalisation experienced. I take up more about my plan to pursue community-engaged work in the next section on future work and next steps.

Irresolutions, future work, and next steps.

From this study, I acknowledge a need to recognise some assumptions and irresolutions in considering *being with* and *hopes* to transform genderacialised labour and recognise worth within the system. Labour is structured in capitalism and living in a capitalist state like Canada limits opportunity for labour reform should it impact production. This work was very special to all involved and women expressed that it had made them think differently, for different reasons, about the care work they are engaged in. It is regrettable workshops like this could not be done with many, many more PSWs.

So long as we live on this earth and require sustenance for our bodies, relations of caring and activities that are rejuvenating for our bodies will always be needed. Every

individual requires connection to sustain life. For the future of caring and individuals engaged in labours of care, it is an imperative that we think about what the labouring body seeks so each person can thrive and feel worthy in being with others through care.

More research is needed with individuals engaged in community care as PSWs working in private residences often face greater time and resource restrictions, less employment protection from agencies with whom they work, and are paid less. Future research into politics surrounding genderacialisation in care in different areas of PSW work, like community care, is needed to bolster an understanding of different care structures as they relate to processes of genderacialisation. Further, more work needs to be done to centralise information on PSW employment so that statistics on staff 'turnover,' PSW training and education, and hours worked can be easily accessed.

Related to research ethics, a deeper look is required to support individuals, like PSWs, who are time-restricted but are very much needed in important research to inform and effect social change in care. As PSWs form an integral part of our health care system, a community of care researchers, policy makers, PSW educators, and leaders in PSW care are needed to listen to PSW stories from experiences in LTC home care to enact the policy and social reforms needed to attend to what PSW seek through labours of care.

The next steps for this narrative research with PSWs are fairly clear cut as per women's recommendations through this study: (1) sharing digital stories more broadly through an interactive, community engaged website, (2) working towards creating resources on PSW care so family members, individuals working in LTC homes, and the general public can best support PSWs through their everyday interactions and contribute to facilitating resident care with PSWs in LTC homes, and (3) develop ways more PSWs

can engage in creative outlets for self-care and personal reflection on care practices. In future research work, I hope to better articulate genderace through post-theories, embolden my ability to draw attention to processes that racialise, and work towards supporting relational caring in LTC homes inclusive of PSWs.

In this critical narrative inquiry and efforts to unpack antenarrative held in the body, I asked women of colour to attach their personal stories to genderacialised stratifications and personalise genderacialisation for privileged others. Insights gleaned from this very personal work will add to the literature by shedding light on how voices of racialised women have long been hidden and made invisible in stratified systems like those of care. As the backbone of health care (PHInternational, 2009), society would be amiss to continue to deny considerations made by LTC home PSWs towards more equitable and inclusive labours of care and leisure not only through basic employment privileges, but through fair and just treatment of the work racialised women engage in in Canada. I believe Freire's (1970) statement on consciousness-raising, "[t]o exist, humanly, is to *name* the world, to change it" (p. 69), touches on the different fronts this work with women of colour aimed to address. By naming genderacialisation, genderace is visible for all to see, in ways that not only critique how race, gender, and class are approached when looking at self, but also so that restorative journeys through hope and being with can reframe worth so it is accessed and (re-)written into everyday stories of the body in labours of care and leisure with others.

Postamble

The discussion of this document at my final dissertation defense was rich and insightful. Thank you again to my committee members who contributed to the dialogue that helped me experience my work in different ways. My intention for this postamble is to provide myself with a number of points to return to for future writings on this work.

First, I found the idea of the "machine" to be a salient metaphor throughout this project in several ways: (1) the workforce as a cog that is part of the neoliberal machine of production, (2) reproductive work as oiling the machine of capitalism, (3) dehumanising nature of caring work as the assembly line, or "bed and body work," and (4) PSWs as ancillary to skilled workers, and are often the least considered in the quickly moving trend of increased automation of care. Beyond caring, different ways women of colour take up different forms of reproductive work in relation to the body (i.e., garment factory workers, aesthetic workers, food services) is another future area of exploration related to the capitalist machine. This notion of the machine is an important one and should be given more consideration given the discussion of the structuring of care within a neoliberal and capitalist system.

My own reflections petered towards the end of this document. I could have cleared more space to connect with my body in the same way I asked participants to connect to theirs, perhaps better framing my experiences in relation to those of women who participated in this research. At the defense, I was reminded that my experiences of care were privileged in different ways in relation to the ways PSWs so intimately care for bodies of residents living in LTC homes. I recognize that women's stories of care are only a snapshot of living story and their living stories are far more complex than I could ever attempt to distill into a written document. The different ways privilege plays out in these experiences, and my perception of these experiences is something I should reflect on more closely.

Third, I will grow as a scholar by paying attention to and writing through emotions and an embodied voice. Emotions, to me, flag something more than a fleeting feeling in reaction to a person, an occurance, a place – emotions attempt to the signal the relating of the body to moment and thus, an unfolding story in the body. I will continue to think on, "What are ways that I could have better supported women in speaking about race? What work could have been done before hand to avoid silences around racialisation?" I will continue to attempt to translate embodied stories through different mediums like digital storytelling with special attention to image and video aesthetic (and doing the work to better my skills in these areas) to convey emotions and embodied story.

Lastly, I hope to be more conscious of the language I use for one social axis (i.e., colourblind) that may be unintentionally reproducing –isms in another (i.e., disablism/ablist). Again, my work to examine how bodies of differences are fragmented by identities may lend itself well to understanding how power is lost in antenarrative practice through the fragmenting of narrative in attempting to represent an uncoherent, complex story. In my practice of writing and attempting to assigning language to the ineffable, it will be worthwhile to re-examine how I have typified genderace and genderacialisation (with firm roots in humanism) as anticategorical and how intracategorical considerations may contribute to thickening the foundation of genderace.

References

Abt Associates for Centers for Medicare and Medicaid Services (2001). Report to congress: Appropriateness of minimum nursing staff ratios in nursing homes, phase one and phase two reports. Retrieved from http://www.allhealth.org/briefingmaterials/abt-nursestaffingratios%2812-01%29-999.pdf

Al-Waqfi, M. A. & Jain, H. C. (2007). Employment conditions of racial minorities in Canada: How bad is the problem of discrimination? In G. F. Johnson & R. Enomoto (Eds.), *Race, Racialization, and Antiracism in Canada and Beyond* (pp. 79-104). Toronto, ON: University of Toronto Press.

Alcock, P. (1993). *Understanding poverty in Canada.* Don Mills: Oxford University Press.

Alexandra, D. (2015). Are we listening yet? Participatory knowledge production through media practice: Encounters of political listening. In A. Gubrium, K. Harper, & Otañez, M. *Participatory visual and digital methods in action* (pp. 41-56). Left Coast Press: Walnut Creek, CA.

Alzheimer Society of Canada (2010). *Rising tide: The impact of dementia on Canadian society.* Toronto, ON: Author.

Anthony, R. M. (2012). A challenge to critical understandings of race. *Journal for the Theory of Social Behaviour, 43*(3), 260-282.

Arai, S. M. & Kivel, B. D. (2009). Critical race theory and social justice perspectives on whiteness, difference (s) and (anti) racism: A fourth wave of race research in leisure studies. *Journal of Leisure Research, 41*(4). 459-472.

Arat-Koç, S. (2001). *Caregivers Break the Silence*. A participatory action research on the abuse and violence, including the impact of family separation experienced by women in the live-in caregiver program. Toronto: INTERCEDE.

Arat-Koç, S. (2012). Invisibilized, Individualized, and Culturalized: Paradoxical invisibility and hyper-visibility of gender in policy making and policy discourse in neoliberal Canada." *Canadian Woman Studies/Les cahiers de la femme, 29*(3). 6-17.

Ariens, G. A., Van Mechelen, W., Bongers, P. M., Bouter, L. M., & Van Der Wal, G. (2000). Physical risk factors for neck pain. *Scandinavian journal of work, environment & health*, *26*(1). 7-19.

Ayo, N. (2012) Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health, 22*(1), 99-105.

Baines, C., Evans, P., & Naysmith, S. (1991). Caring: Its impact on the lives of women. In C. Baines, P. Evans, & S. Naysmith (Eds.). *Women's caring: Feminist perspectives on social welfare* (pp. 11-35). Toronto, ON: McClelland & Stewart Inc.

Bakan, A. and Stasuilus, D. (1997). *Not one of the family: Foreign Domestic Workers in Canada.* Toronto, ON: University of Toronto Press.

Bakhtin, M. (1981). *The Dialogic Imagination: Four Essays.* (M. Holquist, trans.). Austin: University of Texas Press.

Bakhtin, M. (1984). Rebelias and his world. Bloomington, IN: Indiana University Press.

Bakhtin, M. (1990). *Art and answerability: Early philosophical essays by M.M. Bakhtin*. M. Holquist & V. Liapunov (Eds.), (V. Liapunov & K. Brostrom, Trans.), TX: University of Texas Press. (Original work published in 1920)

Bakhtin, M. (1993). *Toward a philosophy of the act*. (Original work published in 1919-1921). V. Liapunov & M. Holquist (Eds.), (V. Liapunov, Trans.), TX: University of Texas Press.

Bamberg, M. (2004). Considering counter narratives. In: M. Bamberg & M. Andrews (Eds.). *Considering counter narratives: Narrating, resisting, making sense* (pp. 351-371). Amsterdam: John Benjamins.

Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S., & Szebehely, M. (2008). "Out of control": Violence against personal support workers in long-term care. *York University*. Retreived from: http://www.yorku.ca/mediar/special/out_of_control___english.pdf

Banton, M. (1978). *The idea of race.* Boulder: Westview Press.

Bauder, H. (2003). "Brain abuse", or the devaluation of immigrant labour in Canada. *Antipode*, *35*(4), 699-717.

Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Jennifer Blythe, Ren, Bourbonnais, Cameron, S., Doran, D. I., Kerr, M., McGillis Hall, L. M., Vezina, M., Butt, M., & Ryan, L. (2001). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system.* Toronto, ON: Canadian Health Services Research Foundation and The Change Foundation.

Barnes, M. (2012). *Care in everyday life: An ethic of care in practice.* UK: Policy Press.

Bhattacharya, S. (2012). Reflections on intersectionality: Bell Hooks. *Indian Journal of Dalit and Tribal Social Work (Insight Foundation)*, *1*(1), 61-90.

Bell, D. A. (1992). *Faces at the bottom of the well: The permanence of racism.* New York: Basic.

Benner, P. (1994). Caring as a way of knowing and not knowing. In S. S. Phillips & P. Benner (Eds.). *The crises of care: Affirming and restoring caring practices in the helping professions* (pp. 42-62). Washingtion, DC: Georgetown University Press.

Berbary, L. A. & Boles, J. C. (2014). Eight points for reflection: Revisiting scaffolding for improvisational humanist qualitative inquiry. *Leisure Sciences*, *0,* 1-19.

Berger, J. (1972). *Ways of seeing.* Penguin Books, London, UK.

Bernard, J., Phillips, M. & Chittenden, M. (2002). *Juggling work and care: The experiences of working carers of older adults*. Bristol: The Policy Press.

Berta, W., Laporte, A., Deber, R., Baumann, A., & Gamble, B. (2013).The evolving role of health care aides in the long-term care and home and community care sectors in Canada. *Human Resources for Health, 11*, 25. DOI: 10.1186/1478-4491-11-25

Bishop, R. (1996) Collaborative research stories: Whakawhanaungatanga. Palmerston North: Dunmore Press.

Bishop, R. (1999). Collaborative Storytelling: Meeting Indigenous Peoples' Desires for Self-Determination in Research. ERIC. Retrieved from: http://files.eric.ed.gov/fulltext/ED467396.pdf

Biurski, P. & Haglund, P. (2001). *Making sense together: The intersubjective approach to psychotherapy*. Lanham, Maryland: Rowman & Littlefield Publishers.

Bjorklund P. (2004). Invisibility, Moral knowledge and nursing Work in the Writings of Joan liaschenko and Patricia Rodney. *Nursing Ethics. 11*(2): 110 –121.

Bochner, A. P. (2000). Criteria against ourselves. *Qualitative Inquiry, 6*(2). 266-272.

Boje, D. M. (2001). *Narrative methods for organizational and communication research*. London: Sage.

Boje, D. M., Rosile, G. A., Durant, R. A. & Luhman, J. T. (2004). Enron spectacles: A critical dramaturgical analysis. *Organization Studies, 25*(5), 751–77.

Boje, D. M., Rosile, G. A., & Gardner, C. L. (2004). Antenarratives, narratives and anaemic stories. New Orleans: Academy of Management.

Boje, D.M. (2006). *Story organization: Story escape narrative prison*. London: Sage.

Boje, D. M. (2007). The antenarrative cultural turn in narrative studies. In M. Zachry & C. Thralls (Eds.). *Communicative practices in workplaces and the professions: cultural perspectives on the regulation of discourse and organizations* (pp. 219-238). Amityville, NY: Baywood Publishing.

Boje, D. M. (2011). Storytelling and the future of organizations: An antenarrative handbook. New York, NY: Taylor and Francis.

Boje (2012, Jan. 28) What is Antenarrative? [Blog post]. Retrieved from: https://business.nmsu.edu/~dboje/papers/what_is_antenarrative.htm

Boje, D. M. (2014). *Storytelling Organizational Practices: Managing in the Quantum Age*. London: Routledge.

Bordo, S. (2008). Gendered Bodies. In C. Malacrida & J. Low (Eds.). Sociology of the body (p. 110-115). Toronto, Ontario: Oxford University Press.

Bourdieu, P. (1979). Distinction: A Social critique of the judgement of taste. Cambridge, MA: Harvard University Press.

Bourdieu, P. (1986). *Distinction: A Social Critique of the Judgment of Taste*. London: Routledge.

Bourdieu, P. (1987). What makes a social class? on the theoretical and practical existence of groups. *Berkeley Journal of Sociology*, *32,* 1-17.

Bowling, A. (1999). Ageism in cardiology. British Medical Journal, *319*(7221). 1353-1355.

Boydell, Katherine M.; Volpe, Tiziana; Cox, Susan; Katz, Arlene; Dow, Reilly; Brunger, Fern; Parsons, Janet; Belliveau, George; Gladstone, Brenda M.; Zlotnik-Shaul, Randi; Cook, Sheila; Kamensek, Otto; Lafreneière, Darquise & Wong, Lisa (2012). Ethical challenges in arts-based health research. *The International Journal of the Creative Arts in Interdisciplinary Practice, 11,* Retreived from: http://www.ijcaip.com/archives/IJCAIP-11-paper1.pdf

Boyle, C. F., Levin, C., Hatefi, A., Madriz, S., & Santos, N. (2015). Achieving a "grand convergence" in global health: Modeling the technical inputs, costs, and impacts from 2016 to 2030. *PLoS ONE, 10*(10), e0140092, retrieved from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0140092

Brooker, D. (2004). *Person-centred dementia care*. London: Jessica Kingsley.

Brown, E. M. (1995). The tower of Babel: Bridging the divide between critical race theory and "mainstream" civil rights scholarship. *Yale Law Journal, 105,* 513-547.

Brown, W. (1997). The Impossibility of Women's Studies. *Differences: A Journal of Feminist Cultural Studies. 9*(3), 79–101.

Brown, P., & Warner-Smith, P. (2005). The Taylorisation of family time: an effective strategy in the struggle to 'manage'work and life?. *Annals of Leisure Research, 8*(2-3), 75-90.

Browne, C. V. & Braun, K. L. (2008). Globalization, Women's Migration, and the Long-Term-Care Workforce. *The Gerontologist*, *48*(1), 16-24.

Buckingham, D. (2009) 'Creative' visual methods in media research: Possibilities, problems and proposals. *Media, Culture & Society, 31*(4), 633–652.

Butler, R. (1969). Ageism: another form of bigotry. *The Gerontologist, 9*(3), 243–6.

Butler, R. N. (2006). *Forward* (pp. vii-viii). In N. Morrow-Howell, J. Hinterlong, J., & M. Sherraden. (Eds.). (2001). *Productive aging: Concepts and challenges*. JHU Press.

Calasanti, T. (2015). Combating ageism: How successful is successful aging?. *The Gerontologist*, *56*(6), 1093-1101.

Canadian Broadcasting Corporation (CBC). (2010, April 26). Ontario won't regulate personal care workers. *CBC news Toronto.* Retrieved from http://www.cbc.ca/news/canada/toronto/ontario-won-t-regulate-personal-care-workers-1.907601

CBC News. (2017, September 29). 'Why is it taking you so long to die?': Long-term care home treatment horrifies family - Incident this week marked 6th serious allegation of abuse against a city-run care home since 2015. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/ottawa/peter-d-clark-long-term-care-home-abuse-1.4314533

CBC News. (2017, October 1). Support workers in long-term care homes need more training, says expert - Mistreatment in long-term care homes a 'systemic' problem, says Council on Aging of Ottawa member. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/ottawa/long-term-care-stress-ottawa-1.4315684

CBC News. (2017, August 17). City councillor doesn't want high-profile incidents to tarnish entire long-term care system 'I don't want to leave the impression with the public that this is systemic in our homes,' Diane Deans says. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/ottawa/diane-deans-responds-garry-armstrong-long-term-care-1.4246837

CBC News. (2017, October 20). Support worker who punched patient gets 90 days in jail, Jie Xiao pleaded guilty in July to one count of assault. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/ottawa/jie-xiao-assault-guilty-sentencing-ottawa-1.4363754

CBC News. (2017, October 19). Wettlaufer inquiry commission comes to London today, Thursday's meeting in London, Ont. is the last of three community meetings ahead of the inquiry. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/london/london-ontario-wettlaufer-inquiry-meeting-1.4361262

CBC News. (2017, September 19). Is government ignoring PSWs and their patients?. Canadian Broadcasting Corporation. Retrieved from: http://www.cbc.ca/news/canada/ottawa/programs/ontariotoday/is-government-ignoring-psws-and-their-patients-1.4296858

Canadian Centre for Policy Alternatives. (2010). *Ontario's growing gap: The role of race and gender.* Ottawa, ON: Sheila Block.

Canadian Institute for Health Information (CIHI). (2011). *Health care in Canada 2011: A focus on seniors and aging*. Ottawa: CIHI.

Canadian Nurses Association (CNA). (1995). *Unregulated health care workers supporting nursing care delivery.* Policy statement. Ottawa.

Canadian Nurses Association (CNA). (2008). *Unregulated health care workers: A Canadian and global perspective.* Retrieved from: https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/18%20-%20unregulated_health_workers_04_2008_e.pdf?la=en

Canadian Practical Nurses Association (CPNA). (1999). *Facing forward: Current and future health care trends and issues and the implications for Canada's practical nurses.* Scarborough: CPNA.

Canadian Union of Public Employees (CUPE). (2009). *Residential long-term care in Canada: Our vision for better seniors' care - Part 3: Staffing and quality care.* Retrieved from http://www.cupe.ca/long-term-care/our-vision

Canadian Union of Public Employees (CUPE Ontario) & Ontario Council of Hospital Unions (OCHU). (2012, June). *Submission regarding Personal Support Worker (PSW) Educational Standards in Ontario (Submitted to the Ministry of Health and Long Term Care [MOHLTC] Ontario).* Retrieved from http://www.cupe.on.ca/a4917/Submission%20on%20Personal%20Support%20Worker%20educational%20standards%20in%20Ontario.pdf

Canadian Research Network for Care in the Community (CRNCC) & Personal Support Network of Ontario (PSNO)(2009). *Ontario personal support workers in home and community care: CRNCC/PSNO survey results.* Retrieved from: http://www.crncc.ca/knowledge/factsheets/pdf/InFocus-Ontario%20PSWs%20in%20Home%20and%20Community%20Care.pdf

Capra, F. (2002). *The hidden connections.* New York: Doubleday.

Carles, I. & Jubany-Baucells, O. (Eds.). (2010). *Genderace: The use of racial antidiscrimination laws – Gender and citizenship in a multicultural context.* (EU Seventh Framework Programme Grant 217237). EU: EU Seventh Framework Programme.

Carr, E. S. (2003). Rethinking Empowerment Theory Using a Feminist Lens: The Importance of Process. *Affilia, 18*(1), 8-20.

Carr, E. S. (2003). Rethinking empowerment theory using a feminist lens: The importance of process. *Affilia*, *18*(1), 8-20.

Carr, K. K. & Kazonowski, M. K. (1994). Factors affecting job satisfaction of nurses who work in long-term care. *Journal of Advanced Nursing. 19,* 878-883.

Chambers, C. A. (1986). *Women in the creation of the profession of social work. Social Service Review, 60*(1). 1-33.

Chappell, N. L., & Novak, M. (1992). The role of support in alleviating stress among nursing assistants. *The Gerontologist, 32*(3), 351-359.

Chase, S. E. (2005) 'Narrative Inquiry: Multiple Lenses, Approaches, Voices', in N. K. Denzin and Y. S. Lincoln (eds) Handbook of Qualitative Research, 3rd ed., pp. 651–79. Thousand Oaks, CA: Sage.

Cheek, J. (2008) Healthism: A new conservativism? *Qualitative Health Research, 18*(7), 974-982.

Chui, T. & Maheux, H. (July 2011). *Visible Minority Women (Component of Statistics Canada Catalogue no 89-503-X)*. Retrieved from http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11527-eng.htm

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, CA: Jossey Bass.

Clandinin, D. J. & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. J. Clandinin (Ed.), *Handbook of Narrative Inquiry: Mapping a Methodology* (pp. 35-76). Thousand Oaks, CA: SAGE Publications.

Clement, G. (1996). *Care, autonomy, and justice: Feminism and the ethic of care.* Boulder, CO: Westview.

Cloyes, K. G. (2002). Agonizing care: care ethics, agonistic feminism and a political theory of care. *Nursing Inquiry, 9*(3), 203-214.

College of Nurses. (2013) *Working With Unregulated Care Providers*. Retrieved from http://www.cno.org/Global/docs/prac/41014_workingucp.pdf

Collins P. H. (1991). *Black feminist thought*. New York, NY: Routledge, Chapman & Hall.

Collins, P. H. (1998). *Fighting words: Black women and the search for justice* (Vol. 7). U of Minnesota Press.

Condon, S. (2005). Sole Mothers… Sleep, Control and Leisure. *Annals of Leisure Research*, *8*(2-3), 91-104.

Connell, R. W. (1987). *Gender and power.* Cambridge: Polity.

Conrad, D. & Sinner, A. (2015). *Creating together: Participatory, community-based, and collaborative arts practices and scholarship across Canada.* Waterloo, Ontario: Wilfrid Laurier University Press.

Coyte, P. (2001). Current trends and future directions for the Canadian healthcare system. *Economic Affairs, 21*(4), 24-27.

Crawford, R. (2006). Health as meaningful social practice. *Health, 10*, 401-420.

Crawford, D. W., Jackson, E. L., & Godbey, G. (1991). A hierarchical model of leisure constraints. *Leisure Sciences*, *13*(4), 309-320.

Crawford, J. L., & Stodolska, M. (2008). Constraints experienced by elite athletes with disabilities in Kenya, with implications for the development of a new hierarchical model of constraints at the societal level. *Journal of Leisure Research*, *40*(1), 128.

Crawford, A. (2010). If "the body keeps score": Mapping the dissociated body in trauma narrative, intervention and theory. *University of Toronto Quarterly, 79*(2), 702-719. Retreived from: http://documents.mx/documents/mapping-the-ed-body-in-traumanarrative-and-intervention.html

Cregan, K. (2006). *The sociology of the body.* Thousand Oaks, CA: Sage.

Crenshaw, K. (1989) Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989,* 139–167.

Daly, T. & Szebehely, M. (2012). Unheard voices, unmapped terrain: Care work in long-term residential care for older people in Canada and Sweden. *International Journal of Social Welfare*, *21*, 139–148. DOI: 10.1111/j.1468-2397.2011.00806.x

Danna, K. & Griffin, R. W. (1999). Health and well-being in the workplace: A review and synthesis of the literature. *Journal of Management Research, 25*(3). 357-384.

Darder, R. Torres, H. and Gutierrez, H. (1997). Introduction. *Latinos and Education: A Critical Reader* (pp. x-xx). In A. Darder, R. Torres, H. Gutierrez (Eds.). New York: Routledge.

Deem, R. (1992). The sociology of gender and leisure in Britain—past progress and future prospects. *Loisir et Societe/Society and Leisure*, *15*(1), 20-38.

Deem, R. (1996). No time for a rest? An exploration of women's work, engendered leisure and holidays. *Time & Society*, *5*(1), 5-25.

Decuir, J., & Dixon, A. (2004). "So when it comes out, they aren't that surprised that it is there": Using critical race theory as a tool of analysis of race and racism in education. *Educational Researcher, 33*, 26-31.

DeForge, R., Van Wyk, P., Hall, J., & Salmoni, A. (2011). Afraid to care; unable to care: A critical ethnography within a long-term care home. *Journal of Aging Studies*, *25*(4), 415-426.

Dei, G. S. (2010). The intersections of race, class, and gender in the anti-racism discourse. In Zawilski, V. S. E., & Levine-Rasky, C. (Eds.). *Inequality in Canada: A reader on the intersections of gender, race, and class (2nd Ed.)*. Don Mills, Ont.: Oxford University Press.

de Jager, A., Tewson, A. Ludlow, B. & Boydell, K. M. (2016). Embodied ways of storying the self: A systematic review of body-mapping. *Forum: Qualitative Social Research, 17*(2).

de Lauretis, T. (1986). Feminist studies/critical studies: Issues, terms, and contexts. In *Feminist studies/critical studies* (pp. 1-19). UK: Palgrave Macmillan.

Delgado Bernal, D. (2002). Critical race theory, Latino critical theory, and critical raced-gendered epistemologies: Recognizing students of color as holders and creators of knowledge. *Qualitative Inquiry, 8*(1).105-126.

Delgado, R. (1989). Storytelling for oppositionists and others: A plea for narrative.

Michigan Law Review. *87*, 2411-2441.

Delgado, R. & Stefancic, J. (2012). *Critical race theory: An introduction (2ⁿᵈ ed.)*. NY, New York: New York University Press.

Deleuze, G. & Guattari, F. (1987). *A thousand plateaus*. B. Massumi (Trans.). Minneapolis: University of Minnesota Press.

Demello, M. (2013). *Body studies: An introduction.* New York, New York: Routledge.

Diamond, T. (1995). *Making gray gold: Narratives of nursing home care*. Chicago, IL: University of Chicago Press.

Dill, J. S., Morgan, J. C., & Konrad, T. R. (2010). Strengthening the long-term care workforce: The influence of the WIN A STEP UP workplace intervention on the turnover of direct care workers. *Journal of Applied Gerontology, 29*(2) 196-214.

Dillard, C. B. (2000). The substance of things hoped for, the evidence of things not seen: Examining an endarkened feminist epistemology in culturally engaged research. *International Journal of Qualitative Studies in Education, 13,* 661-681.

Dilts, A. (2010) From 'Entrepreneur of the Self' to 'Care of the Self': Neoliberal Governmentality and Foucault's Ethics. Western Political Science Association 2010 Annual Meeting Paper. Available at SSRN: https://ssrn.com/abstract=1580709

Dionigi, R. A. (2015). Stereotypes of aging: their effects on the health of older adults. *Journal of Geriatrics*. doi: 10.1155/2015/954027

Dirks, N. B., Eley, G., & Ortner, S. B. (1994). *Culture/power/history: A reader in contemporary social theory*. Princeton University Press.

Douglas, M. (1986). *How institutions think*. London: Routledge & Kegan Paul.

Doupe, M., St. John, P., Chateau, D., Strang, D., Smele, S., Bozat-Emre, S., & Dik, N. (2012). Profiling the multidimensional needs of new nursing home residents: Evidence to support planning. *Journal of the American Medical Directors Association, 13*(5), 487.e9-487.e17.

Dreher, T. (2009). Listening across difference: media and multiculturalism beyond the politics of voice. *Continuum: Journal of Media and Cultural Studies, 23*(4). 445-458.

Du Bois, W. E. B. (1903). *The Souls of Black Folk.* New York: Bantam Classic.

Duff, P., Wong, P., & Early, M. (2000). Learning language for work and life: The linguistic socialization of immigrant Canadians seeking careers in healthcare. *Canadian Modern Language Review*, *57*(1), 9-57.

Dufour, K. (2002). Art as activism, activism as art. *Review of Education, Pedagogy, and Cultural Studies, 24*(1-2). 157-167.

Dumont, J. C., Martin, J. P. & Spielvogel, G. (2007). *Women on the move: The neglected gender dimension of the brain drain*. (Discussion Paper Series IZA DP No. 2920). Bonn, Germany: Forschungsinstitut zur Zukunft der Arbeit Institute for the Study of Labor.

Dupuis, S. L., & Smale, B. J. (2000). Bittersweet journeys: Meanings of leisure in the institution-based caregiving context. *Journal of Leisure Research*, *32*(3), 303.

Dupuis, S. L. (2000). Institution-based caregiving as a container for leisure. *Leisure Sciences*, *22*(4), 259-280.

Dupuis, S. L., Gillies, J., Carson, J., Whyte, C., Genoe, R., Loiselle, L., & Sadler, L. (2012). Moving beyond patient and client approaches: Mobilizing 'authentic partnerships' in dementia care, support and services. *Dementia*, *11*(4), 427-452.

Dusche, M. (2004). Radical multiculturalism versus liberal pluralism. *Ethical Perspectives*, *11*(4). 238-249.

Ebersöhn, L. (2015). Body mapping: Life design with groups of youth in high risk and high need settings. In M. McMahon & W. Patton (Eds.), *Ideas for career practitioners: Celebrating excellence in career practice* (pp.82-89). Brisbane: Australian Academic Press.

Elias, N. (1978). The Civilizing Process: The history of manners. New York: Urizen Books.

Ellis, J., Boger, E., Latter, S., Kennedy, A., Jones, F., Foster, C., and Demain, S. (2017) Conceptualistion of the 'good' self-manager: A qualitative investigation of stakeholder views on the self-management of long-term health conditions. *Social Science & Medicine*, 176, 25-33.

Ellis, C., & Bochner, A. (2000). Autoethnography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd Ed., pp. 733-768). Thousand Oaks, CA: Sage.

Engels, F. (1968). *The condition of the working class in England.* Stanford: Stanford University Press.

Ely, M. (2007). Chapter 22 In-Forming Re-Presentations. In D. Jean Clandinin (Ed.), *Handbook of Narrative Inquiry: Mapping a Methodology* (pp. 567-599). Thousand Oaks, CA: SAGE Publications, Inc.

Eriksen, W., Bruusgaard, W. & Knardahl, S. (2003). Work factors as predictors of sickness absence: a three month prospective study of nurses' aides. *Occupational and Environmental Medicine, 60.* 271–278

Eriksen, W. & Bruusgaard, D. (2004). Do physical leisure time activities prevent fatigue? A 15 month prospective study of nurses' aides. *British Journal of Sports Medicine. 38*, 331-336. doi:10.1136/bjsm.2002.004390

Eriksen, W. (2006). Work factors as predictors of persistent fatigue: a prospective study of nurses' aides. *Occupational and Environmental Medicine. 63*(6), 428–434.doi: 10.1136/oem.2005.019729

Eriksen, W., Bjorvatn, B., Bruusgaard, D. & Knardahl, S. (2008). Work factors as predictors of poor sleep in nurses' aides. *International Archives of Occupational and Environmental Health, 81*(3). 301-310.

Espiritu, Y. (1993). *Asian American panethnicity: Bridging institutions and identities.* Philadelphia, PA: Temple University Press.

Essed, P. (2007). Multi-Identifications and transformations: Reaching beyond racial and ethnic reductionisms. In G. F. Johnson and R. Enomoto (Eds.). *Race, racialization, and antiracism in Canada and beyond* (pp. 233-252). Toronto: University of Toronto Press.

Estabrooks, C. A., Squires, J. E., Carleton, J. L., Cummings, G. G., & Norton, P. G. (2015). Who is looking after mom and dad? Unregulated workers in Canadian long-term care homes. *Canadian Journal on Aging, 31*(1), 47-59.

Estes, C. L. (1979). *The aging enterprise.* San Francisco, CA: Jossey-Bass Publishers.

Estes, C. & Portacolone, E. (2009). Maggie Kuhn: social theorist of radical gerontology. *International journal of sociology and social policy. 29*(1/2). 15-26.

Estes, C. L., & Binney, E. A. (1991). The biomedicalization of aging: Dangers and dilemmas. In M. Minkler & C. L. Estes (Eds.), Critical perspectives on aging: The political and moral economy of growing old (pp. 117–134). Amityville, NY: Baywood.

Evans, P. M. (1991). The sexual division of poverty: The consequences of gendered caring. In C. Baines, P. Evans, & S. Naysmith (Eds.). *Women's caring: Feminist perspectives on social welfare* (pp. 169-203). Toronto, ON: McClelland & Stewart Inc.

Evans-Winters, V.E. and Esposito, J. (2010). Other people's daughters: Critical race feminism and Black girls' education. *Journal of Educational Foundations, 24*(1-2). 11-24.

Eyerman, R. (1981). *False consciousness and ideology in Marxist theory*. Atlantic Hylands, NJ: Humanities Press.

Espinoza, L. and Harris, A. P. (1997). Afterword: Embracing the Tar-Baby - LatCrit theory and the sticky mess of race. *California Law Review*, *85*(5), 1585-1645.

Etherington, K. (2003). *Becoming a reflexive researcher: Using ourselves in research.* UK: Jessica Kingsley.

Fabian, J. (2008). *Ethnography as commentary: Writing from the virtual archive*. Durham, NC: Duke University Press.

Fanon, F. (1952). The fact of blackness. *Postcolonial Studies: An Anthology*, 15-32.

Fanon, F. (1967). *Black skin, white masks.* New York City, NY: Grove Press.

Farley, A. P. (2002). The poetics of colourlined space (pp. 97-158). In F. Valdes, J. M. Culp, A. P. Harris. (Eds.) *Crossroads, directions and a new critical race theory*. Temple University Press.

Ferdman, B. M. (1999). The color and culture of gender in organizations: Attending to race and ethnicity. In G. N. Powell (Ed.), *Handbook of gender and work* (pp. 17-34). Thousand Oaks, CA: Sage.

Fields, B. (1990). Slavery, race, and ideology in the United States of America. *New Left Review, 181,* 95-118.

Finch, J. and Groves, D. (Eds.). (1983). *A labour of love: Women, work, and caring*. London: Routledge and Kegan Paul.

Fineman, M. A. (2008). The vulnerable subject: Anchoring equality in the human condition. *Yale Journal of Law and Feminism. 20*(1), 1-23.

Fleras, A. (2012). *Unequal relations: Introduction to Race, Ethnic, and Aboriginal Dynamics* (7th Ed.). Toronto: Pearson.

Fleras, A. (2014). *Racisms in a multicultural Canada: Paradoxes, politics, and resistance.* Waterloo, ON: Wilfred Laurier Press.

Fleras, A. (2017). *Inequality Matters: Diversity and Exclusion in Canada*. Oxford University Press.

Floyd, M. F. (1998). Getting beyond marginality and ethnicity: The challenge for race and ethnic studies in leisure research. *Journal of Leisure Research, 301*(1), 3-22.

Forbes, D. A. and Neufeld, A. (2008). Looming Dementia Care Crisis: Canada Needs an Integrated Model of Continuing Care Now! *Canadian Journal of Nursing Research*, *40*(1), 9-16.

Foucault, M. (1972). *The archaeology of knowledge.* A. M. Sheridan Smith (Trans.). Pantheon Books.

Foucault, M. (1977). *Power/knowledge: Selected interviews & other writings 1972-1977*. New York: Vintage Books.

Foucault, M. (1978) *The History of Sexuality*. *Volume 1*. New York, NY: Random House.

Foucault, M. (1987). The Ethic of Care for the Self as a Practice of Freedom: An Interview with Michel Foucault on January 20, 1984 in The Final Foucault: Studies on Michel Foucault's Last Works. *Philosophy & social criticism*, *12*(2-3), 112-131.

Frances, H., Tator, C., Mattis, W., & Rees, T. (1998). *The colour of democracy: Racism in Canadian society* (2nd ed.). Toronto, ON: Nelson.

FreefromCare: Your nannies and caregivers agency (2016). Find Professional Nannies and Caregivers: Less Cost More Care. Retrieved from: http://www.freefromcare.ca/

Freire, P. (1970). Pedagogy of the oppressed. *New York: Continuum*.

Freund, C. (1990). The expressive body: A common ground for the sociology of emotions and health and illness. *Sociology of health and illness, 12*(1), 454-77.

Freund, C. (2006). Socially constructed embodiment: neurohoronomal connections as resources for theorizing about health inequalities. *Social theory and health. 4,* 85-108.

Frisken, F. & Wallace, M. (2000). *The Response of the Municipal Public Service Sector to the Challenge of Immigrant Settlement*. Citizenship and Immigration Canada, Ontario Region: Authors.

Gabriel, J. (1998). *Whitewash: Racialized politics and the media*. Psychology Press.

Gallop, J. (2002). *Anecdotal theory*. Durham: Duke University Press.

Garner, S. (2010). *Racisms: An Introduction.* Thousand Oaks, CA: SAGE Publications Inc.

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Gastaldo, D., Magalhães, L., Carrasco, C. and Davy, C. (2012). *Body-map storytelling as research: Methodological considerations for telling the stories of undocumented workers through body mapping.* Retrieved from: http://www.migrationhealth.ca/undocumented-workers-ontario/bodymapping

Gauntlett, D. & Holzwarth, P. (2006). Creative and visual methods for exploring identities. *Visual Studies, 21*(1), 82-91.

Gilleard, C. & Higgs, P. (2008). Aging, Alzheimer's and the Uncivilized body. In C. Malacrida & J. Low (Eds.). *Sociology of the Body: A Reader* (pp. 342-349). Don Mills, ON: Oxford.

Gillian, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge: Harvard University Press.

Gimlin, D. (2007). What is body work?: A review of the literature. *Sociology compass. 1*(1). 353-70.

Glenn, E. N. (1985). Racial ethnic women's labour: The intersection of race, gender and class oppression. *Review of Radical Political Economics, 17*(3), 86-108.

Glenn, E. N. (1987). Racial Ethnic Women's Labor: The Intersection of Race, Gender, and Class Oppression. In C. Bose, R. Feldberg, N. Sokoloff, E. N. Glenn (Eds.) *Hidden Aspects of Women's Work* (pp. 46-73). Westport, CT: Praeger.

Glenn, E. N. (1992). From servitude to service work: Historical continuities in the racial division of paid reproductive labour. *Signs, 18*(1), 1-43.

Glenn, E. N. (2000). Creating a caring society**.** *Utopian Visions: Engaged Sociologies for the 21st Century, Contemporary Sociology*. 29(1), 84-94.

Glenn, E. N. (2010). Forced to Care: Coercion and Caregiving in America. Cambridge, MA.: Harvard University Press.

Glenn, E. N. (2011). Constructing Citizenship: Exclusion, Subordination, and Resistance. *American Sociological Review 76,*1. 1–24. doi:10.1177/0003122411398443.

Goffman, N. (1963). *Behavior in public places*. New York: The Free Press.

Goldberg, D. T. (1993). *Racist culture: Philosophy and the politics of meaning*. Oxford: Wiley-Blackwell.

Goodall Jr, H. L. (2008). Twice betrayed by the truth: A narrative about the cultural similarities between the Cold War and the global war on terror. *Cultural Studies? Critical Methodologies*, *8*(3), 353-368.

Goodin, R. (1985). *Protecting the vulnerable.* Chicago: Chicago University Press.

Gough, B. & Deatrick, J. A. (2015). Qualitative health psychology research: Diversity, power and impact. *Health Psychology, 34* (4), 289-292.

Government of Canada. (2013). *Nurse aides, orderlies and patient service associates.* Retrieved from http://www.servicecanada.gc.ca/eng/qc/job_futures/statistics/3413.shtml

Government of Canada (2016). *Hourly Minimum Wages in Canada for Adult Workers (1975-1984)* Retrieved from: http://srv116.services.gc.ca/dimt-wid/sm-mw/rpt2.aspx?lang=eng&dec=2

Government of Ontario (2005). Ontario Job Futures. 3413*Nurse Aides, Orderlies and Patient Service Associates*. Retrieved from: http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413. Accessed December 13, 2005.

Government of Ontario. (2013). Ontario job futures. *Labour market information: 3413_Nurse aides*. Retrieved from: http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413.

Government of Ontario. (2011, with 2015 amendments). *Ontario's Long-Term Care Home Act* . Retrieved from: https://www.ontario.ca/laws/statute/07l08

Government of Ontario (2015, June 22). Ontario increasing wages for personal support workers: Province continuing to invest in home and community care (Health bulletin, Ministry of Health and Long-term Care). Retrieved from: http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20150622.aspx

Grabham E. (2006). Taxomonies of inequality: lawyers, maps, and the challenge of hybridity. (Trans. Grabham E. stimmt die Jahreszahl? Oder handelt es sich um. Original work published in 2006), *Social and Legal Studies*, *15*(1). 5-23.

Gramsci, A. (1971). *Selections from the Prison Notebooks*. Q. Hoare and G. N. Smith (Trans., Eds.). New York: International Publishers.

Green, L. (1998) Pornographizing, subordinating, silencing. In R. Post (Ed.). *Silencing: Practices of Cultural Regulation (pp.* 285–311). LA, CA: Getty Research Institute.

Gresham, M. L. (1976). The infantilization of the elderly: A developing concept. *Nursing Forum*, *15* (2). 195-210).

Gray-Stanley, J. A., & Muramatsu, N. (2011). Work stress, burnout, and social and personal resources among direct care workers. *Research in developmental disabilities*, *32*(3), 1065-1074.

Gubrium, J. F. (1975). *Living and dying at Murray Manor*. London, UK: Palgrave Macmillan.

Gubrium, A., Harper, K. & Otañez, M. (2015). Participatory visual and digital methods in action. Left Coast Press: Walnut Creek, CA.

Gubrium, A. & Harper, K. (2016). *Participatory visual and digital methods*. Routledge: NY, New York.

Gutierrez, L. M. (1990). Working with women of color: An empowerment perspective. *Social work*, *35*(2), 149-153.

Haight, B. K., Christ, M. A., & Dias J. K. (1994). Does nursing education promote ageism? *Journal of Advanced Nursing, 20*(2), p. 382–390.

Hall, S. (2001). The spectacle of the other. In S. Hall (Ed.). *Representation: Cultural representations and signifying practices* (pp. 325-379). London: Sage.

Hamington, M. (2004). *Embodied Care: Jane Addams, Maurice Merleau-Ponty and Feminist Ethics.* Chicago: University of Illinois Press.

Haney-López, I. F. (1994). The social construction of race: Some observations on illusion, fabrication, and choice. *Berkley Law Scholarship Repository, 29.* 1-63.

Hardingham, L. (2004). Integrity and moral residue: Nurses as participants in a moral community. *Nursing Philosophy, 5.* 127-134.

Harrington, C. (2008). Nursing Home Staffing Standards in State Statutes and Regulations. San Francisco: University of California. Retrieved from: www.pascenter.org/documents/Staffing_regulations_1_08.pdf

Hasson, H. & Arnetz, J. E. (2007). Nursing staff competence, work strain, stress and satisfaction in elderly care: A comparison of home-based care and nursing homes. *Journal of Clinical Nursing, 17.* 468-481.

Haug, F. (1987). *Female sexualization: A collective work of memory* (Vol. 25). Verso.

Hazan, H. (2002). The home over the hill: Towards a modern cosmology of institutionalization. *Journal of Aging Studies*, *16*(4), 323-344.

Haight, B. K., Christ, M. A., & Dias, J. K. (1994). Does nursing education promote ageism?. Journal of Advanced Nursing, 20(2), 382-390.

Held, V. (2006). *The Ethics of Care: Personal, political, and global.* New York: Oxford University Press.

Hessel, D. & Kuhn, M. (1977). *Maggie Kuhn on aging: A dialogue.* In Dieter Hessel (Ed). Philadelphia: The Westminster Press.

Health Association Nova Scotia (HANS). (2009). *Becoming a CCA.* Retrieved from: http://www.healthassociation.ns.ca/Generic.aspx?PAGE=Section+Our+Services/ Continuous+Care+Assistant+Section/Becoming+a+CCA&portalName=base

Health Association Nova Scotia. (2009). *Student Expectations.* Retrieved from http://www.novascotiacca.ca/Generic.aspx?PAGE=Student+Expectations&portal Name=ha

Health Canada (1999). *Canada's seniors.* Ottawa (ON): Division of Health and Aging Available: http://www.phac-aspc.gc.ca/seniors-aines/pubs/factoids/1999/pdf/entire_e.pdf

Health Professions Regulatory Advisory Council (HPRAC). (2006). *Regulation of Personal Support Workers.* Retrieved from http://www.hprac.org/en/reports/resources/PSW-FinalReportSept27-06.pdf

Hedblom, A. (2010). *Genderace glossary: Everyday racism.* Retrieved from: http://dev.ulb.ac.be/tef/glossaire/index.php?option=com_glossary&func=view&It emid=34&catid=13&term=Every-day+racism

Henderson, J. N. & Vesperi, M. D. (1995). *The culture of long term care: Nursing home ethnography.* Santa Barbara, CA: Praeger.

Henderson, K. A. & Allen, K. R. (1991). The ethic of care: Leisure possibilities and constraints for women. *Loisir et Société / Society and Leisure, 14*(1). 97-113.

Henderson, K. A. (1996). One size doesn't fit all: The meanings of women's leisure. *Journal of Leisure Research*, *28*(3), 139.

Hilfiker, D. (1985). *Healing the wounds: A physician looks at his work.* New York: Pantheon Books.

Hill, L. (2007). *Narrative portrait: The social construction of racial identity – Developing a racial identity.* In Healy & O'Brien (Eds.). *Race, Ethnicity, and Gender (2nd Ed.).* Thousand Oaks, CA: SAGE.

Hochschild, A. (1983). *The managed heart.* Berkeley: University of California Press.

Hondagneu-Sotelo, P. (2007). *Doméstica: Immigrant workers cleaning and caring in the shadows of affluence.* Oakland, CA: University of California Press.

hooks, b. (1989). *Feminist theory: From margin to center.* Boston, MA: South End Press.

Horna, J. L. A. (1987). The process of choosing leisure activities and preferences: A stream model. *Loisir et Société/Society and Leisure, 10*(2), 219-233.

Hubbard, J., & Mannell, R. C. (2001). Testing competing models of the leisure constraint negotiation process in a corporate employee recreation setting. *Leisure Sciences*, *23*(3), 145-163.

Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry, 75*(1). 3-18.

Hurd Clark, L. (2011). Facing age: Women growing older in antiaging culture. Lanham, MD: Rowman & Littlefield.

Huss, E. (2012). What we see and what we say: Combining visual and verbal information within social work research. *British Journal of Social Work, 42,* 1440–1459.

Hutchings, K. (2000). Towards a feminist international ethics (December special issue). *Review of International Studies*, *26*, 111–130.

Ikegami, Morris & Fries (1997). Low-care cases in long-term care settings: variation among nations. *Age & Ageing*, *26*. 67-71.

Ikemoto, L. (1995). Traces of the master narrative in the story of African America/Korean American conflict. How we constructed "Lost Angeles." In R. Delgado (Ed.), *Critical race theory: The cutting edge* (pp. 305-315). Philadelphia: Temple University Press.

Ikemoto, L. C. (2006). In the shadow of race: Women of color in health disparities policy. *University of California Davis Law Review, 39*. 1023-1060.

Inwood, J. F. and Yarbrough, R. A. (2009). Racialized places, racialized bodies: The impact of racialization on individual and place identities. *Geojournal, 75*. 299-301.

Iso-Ahola, S. E. & Mannell, R. C. (2005). Leisure and health. In J. T. Haworth & A. J. Veal (Eds.). *Work and Leisure* (pp. 184-199). New York: Routledge.

Jackson, M. (2002). *The politics of storytelling: Violence, transgression, and intersubjectivity*. Copenhagen, Denmark: Museum Tusculanum Press.

Jackson E. M. (1997) "Dimensions of Care in Five United States nursing Homes: Identifying Invisible Work in Care-Giving". International journal of nursing studies. 34 (3): 192–200.

James, C. A. (1997). Feminism and masculinity: Reconceptualizing the dichotomy of reason and emotion. *International Journal of Sociology and Social Policy. 17*(1/2), 129 – 152.

James, P. (2006). *Globalism, Nationalism, tribalism – bringing theory back in (vol 2)*. Thousand Oaks, CA: Sage.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Janes, N., Sidani, S., Cott, C., & Rappolt, S. (2008). Figuring out in the moment: A theory of unregulated care providers' knowledge utilization in dementia care settings. *Worldviews on Evidence-Based Nursing, 44*(1), 71-82.

Jean Baker Miller Training Institute (2012). *Relational-cultural theory.* Retrieved from http://www.jbmti.org/Our-Work/relational-cultural-theory

Jensen, L. D., Gonge, H., Jørs, E., Ryom, P., Foldspang, A., Christensen, M., Vesterdorf, A., & Bonde, J. P. (2006). Prevention of low back pain in female eldercare workers: randomized controlled work site trial. *Spine. 31*(16), 1761-1769 DOI: 10.1097/01.brs.0000227326.35149.38

Jensen, J. N., Holtermann, A., Clausen, T., Mortensen, O. S., Carneiro, I. G., & Andersen, L. L. (2012). The greatest risk for low-back pain among newly educated female health care workers; body weight or physical work load?. *BMC musculoskeletal disorders*, *13*(1), 87.

Johnston, B. (2001) Memory-work: The power of the mundane. In J. Small and J. Onyx (Eds.), *Memory-work: A Critique (Working Paper Series, 20/01)*. School of Management, University of Technology, Sydney, Australia.

Jordan, B. (1996). *A theory of poverty and social exclusion.* Oxford: Polity Press.

Jordan, J.V., Walker, M. & Hartling, L.M. (2004). *The complexity of connection: Writings from the stone center's jean baker miller training institute*. New York, NY: Guilford Press.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4),116-120.

Kane, R. L. & Kane, R. A. (2005). Ageism in healthcare and long-term care. *Generations. 29*(3), 49-54.

Karasek, R. & Theorell, T. (1990). *Healthy work: Stress, productivity, and the reconstruction of working life.* New York: Basic Books.

Kelly, J. R. (1983). *Leisure identities and interactions.* London: George Allen and Unwin.

Kemp, C. L., Ball, M. M., Perkins, M. M., Hollingsworth, C., & Lepore, M. J. (2009). "I get along with most of them": Direct care workers' relationships with residents' families in assisted living. *The Gerontologist, 49*(2), 224-235.

Kincheloe, J. L. & Steinberg, S. R. (1997). *Changing multiculturalism.* Philadelphia, Buckingham: Open University Press.

Kincheloe, J. L. & McLaren, P. (2005). Rethinking critical theory and qualitative research. In Y. S. Lincoln and N. K. Denzin (Eds.). *The Sage Handbook of Qualitative Research (3rd Ed.)*(pp. 303-342). Thousand Oaks, CA: Sage.

King, J. (1995). Culture-centered knowledge: Black studies, curriculum transformation, and social action. In J. Banks & C. M. Banks (Eds.). *Handbook of research on multicultural education* (pp. 265-290). New York: Macmillan.

King, C. R., & Springwood, C. F. (2001). *Beyond the cheers: Race as spectacle in college sport.* Albany, NY: SUNY Press.

Kittay, E. F. (1999). *Love's Labor: Essays on woman, equality, and dependency.* New York: Routledge.

Kittay, E. F. (2009). The moral harm of migrant care work: Realizing a global right to care. *Philosophical Topics. 37*(2), 53-73.

Kitwood, T. (1997). *Dementia care reconsidered: The person comes first.* Buckingham: Open University Press.

Kitzinger, C. & Wilkinson, S. (Eds.). (1996). *Representing the other: A feminism and psychology reader.* London: Sage.

Klitzing, S. W. (2004). Women who are homeless: Leisure and affiliation. *Therapeutic Recreation Journal*, *38*(4), 348.

Kofman, E. (2007). The knowledge economy, gender, and stratified migrations. *Studies in Social Justice, 1*(2), 122-135.

Koggel, C., & Orme, J. (2010). Care ethics: New theories and applications. *Ethics and social welfare, 4*(2). 109-114.

Kolawole, B. (2009). Ontario's internationally educated nurses and waste in human capital. *International Nursing Review, 56*(2), 184-190.

Kontos, P. C., Miller, K. L., & Mitchell, G. J. (2009). Neglecting the importance of the decision making and care regimes of personal support workers: A critique of standardization of care planning through the RAI/MDS. *The Gerontologist, 50*(3). 352 – 362.

Kontos, P. C., Miller, K. L., Mitchell, G. J., & Cott, C. A. (2010). Dementia care at the intersection of regulation and reflexivity: A critical realist perspective. *Journal of Gerontology: Social Sciences,* doi: 10.1093/geronb/gbq022.

Kowalski, C., Driller, E., Ernstmann, N., Alich, S., Karbach, U., Ommen, O., ... & Pfaff, H. (2010). Associations between emotional exhaustion, social capital, workload, and latitude in decision-making among professionals working with people with disabilities. *Research in developmental disabilities*, *31*(2), 470-479.

Kozak, J. and T. Lukawiecki (2001). Abuse and Neglect in Long-Term Care: A Resident's Perspective. *Family Violence Prevention Unit*. Health Canada: Ottawa

Kravits, K., McAllister-Black, R., Grant, M., & Kirk, C. (2010). Self-care strategies for nurses: A psycho-educational intervention for stress reduction and the prevention of burnout. *Applied nursing research. 23*(3), 130-138.

Kuhn, M. (1986). Finding common ground. In C.W. Mahoney, Estes, C.L. and Heumann, J.E. (Eds), *Wingspread Conference on Disability and Aging*, Institute for Health & Aging University CA, San Francisco, CA and World Institute on Disability, Racine, WI, San Francisco, CA and Berkeley, CA.

Ladson-Billings, G. (1998) Just what *is* critical race theory and what's it doing in a *nice* field like education? *Qualitative Studies in Education. 11*(1), 7-24.

Ladson-Billings, G. & Donner, J. (2008). The moral activist role of critical race theory scholarship. In Denzin & Y. Lincoln (Eds.). *The landscape of qualitative research* (pp. 371-402). Los Angeles, CA: Sage.

Lambert, J. (2006, 2010). *Digital storytelling: Capturing lives, creating community*. Berkeley, CA: Digital Diner Press.

Landa, J. Á. G. (2008). Narrating Narrating: Twisting the Twice-Told Tale. In J. Pier and J. Á. G. Landa (Eds.). *Theorizing Narrativity*. (pp. 419–52). Berlin: Walter de Gruyter.

Landsbergis, P. A. (1988). Occupational stress among health care workers: A test of the job demands-control model. *Journal of Organizational Behavior, 9*(3), 217-239.

Lawrence, T. B. & Maitlis, S. (2012). Care and possibility: Enacting an ethic of care through narrative practice. *Academy of Management Review, 37*(4). 641-663.

Lawrence (III), C. (2012). Listening for stories in all the right places: Narrative and racial formation theory. *Law & Society Review, 46*(2). 247-258.

Lee, J. and Lutz, J. (2005). Introduction: Toward a critical literacy of racisms, anti-racisms, and racialization. In J. Lee and J. Lutz (Eds.). *Situating "race" and racisms in space, time, and theory: Critical essays for activists and scholars*. (pp. 3-29). Montreal, QC: McGill-Queens University Press.

Leidner, R. (1999). Emotional labor in service work. *The Annals of the American Academy of Political and Social Science, 561*(1). 81-95.

Leininger, M. (1984). *Care: The essence of nursing and health.* Detroit, MI: Wayne State Press.

Lenskyj, H. (1988). Measured time: women, sport and leisure. *Leisure Studies, 7*(5)*,* 233-240.

Leininger, M. (1994). *Transcultural nursing: Concepts, theories and practices.* New York: McGraw-Hill.

Leung, C. B. (2009). Collaborative narration in preadolescent girl talk: A Saturday luncheon conversation among three friends. *Journal of Pragmatics*, *41*(7), 1341-1357.

Li, P. S. (1988). *Ethnic inequality in a class society.* Toronto: Wall and Thompson.

Li, P. S. (1992). Race and gender as bases of class fractions and their effects on earnings. *Canadian Review of Sociology and Anthropology, 29*, 488-510.

Li, P. S. (2000). *Cultural Diversity in Canada: The social construction of racial differences.* Department of Justice Canada, Strategic Issues Series rp02-8e. Retrieved from: http://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/rp02_8-dr02_8/rp02_8.pdf

Lilly, M. B. (2008). Medical versus social work-places: constructing and compensating the personal support worker across health care settings in Ontario, Canada. *Gender, Place and Culture*, *15*(3), 285-299.

Lincoln, Y. S. and Denzin, N. K. (1994). The fifth moment. In N. K. Denzin and Y. S. Lincoln (Eds.) . *Handbook of qualitative research* (pp. 575-586)*.* Thousand Oaks, CA: Sage.

Linell, P. (2009). *Rethinking language, mind and world dialogically: Interactional and contextual theories of human sense-making*. Greenwich, CT: Information Age Publishing.

Lipsky, L. D. & Burke, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others.* San Francisco, CA: Berrett-Koehler Publishers.

Lopez, S. (2006). Emotional labour and organized emotional care. *Work and Occupations. 33*(2), 133-160.

Lopez, K. J. & Dupuis, S. L. (2014). Exploring meanings and experiences of wellness from residents living in long-term care homes. *World Leisure Journal, 56*(2). 141-150.

Lorde, A. (1988). *A burst of light: Essays*. Ithica, NY: Firebrand Books.

Low, J. & Malacrida, C. (Eds.). (2008). *Sociology of the body: a reader*. Oxford University Press, USA.

LTC Task Force on Resident Care and Safety Ontario. (May 2012). *An action plan to address abuse and neglect in long-term care homes.* Retrieved from: http://longtermcaretaskforce.ca/images/uploads/LTCFTReportEnglish.pdf

Ludlow, B. (2014). Witnessing: Creating visual research memos about patient experiences of body mapping in a dialysis unit. *American Journal of Kidney Diseases, 64*(5), xiii-xiv.

Lusardi, A., & Mitchell, O. S. (2008). *Planning and financial literacy: How do women fare?* (No. w13750). National Bureau of Economic Research.

MacCormack, C. P., and Draper, A. (1987). Social and cognitive aspects of female sexuality in Jamaica. In P. Caplan (Ed.). *The Cultural Construction of Sexuality: Sexuality in Jamaica* (pp. 143–165). Tavistock, London: Routledge.

MacGregor, H. N. (2009). Mapping the body: Tracing the personal and the political dimensions of HIV/AIDS in Khayelitsha, South Africa. *Anthropology & Medicine*, *16*(1), 85-95.

MacGregor, H. N. & Mills, E. (2011). Framing rights and responsibilities: Accounts of women with a history of AIDS activism. *Bio Med Central International Health & Human Rights, 11*(S7), 1-11. Retreived from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3287463/

MacKinnon Williams. (2010). *Effectively utilizing BC LPNs and care aides: Follow-up report*. Vancouver, BC: MacKinnon Williams.

MacKinnon, C. A. (1982). Feminism, Marxism, method and the state: An agenda for theory. *Signs: A Journal of Culture, Women, and Society, 7*(3). 515-544.

Malenfant, E. C., Lebel, A. & Martel, L. (2010). *Projections of the diversity of the Canadian Population, 2006-2031*. Statistics Canada catalogue no. 91-551-X. Retrieved from http://www.statcan.gc.ca/pub/91-551-x/91-551-x2010001-eng.pdf

Marable, M. (2002). The political and theoretical contexts of the changing racial terrain. *Souls: A Critical Journal of Black Politics, Culture, and Society*, 4(3). 1-16.

Markula, P., & Friend, L. A. (2005). Remember when . . . Memory work as an interpretive methodology for sport management. *Journal of Sport Management, 19*(4), 442–463.

Martin, J. (1989). Transforming moral education. In M. M. Brabeck (Ed.). Who Cares? Theory, research, and educational implications of ethic of care (pp. 183-96). New York: Praeger.

Martin, C. (2007). Feminism, the self, and narrative ethics. *Macalester Journal of Philosophy*, *16*(1), 7-14.

Matsuda, M. (1991). Voices of America: Accent, anti-discrimination law and a jurisprudence for the last reconstruction. *Yale Law Journal. 100.* 1329-1407.

Martin, P. Y. (2003). "Said and done" versus "saying and doing" gendering practices, practicing gender at work. *Gender & Society, 17*(3). 342-366. DOI: 10.1177/0891243203251716

Marx, K. & Engels, F. (1967). *The communist manifesto.* Introduction by A.J.P. Taylor. Harmondsworth, UK: Penguin Books.

May, L. (1996). *The socially responsive self.* Chicago: University of Chicago Press.

McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society, 30*(3). 1771-1800.

McDowell, L. (2011). *Working bodies: Interactive service employment and workplace identities*. UK: John Wiley & Sons.

McGregor, M. J., Tate, R. B., Ronald, L. A., McGrail, K. M., Cox, M. B., Berta, W., & Broemeling, A. (2010). Trends in long-term care staffing by facility ownership in British Columbia, 1996-2006. *Health Reports, Statistics Canada. 21*(4). Catalogue no. 82-003-XPE.

McIntosh, P. (1988). White privilege: Unpacking the invisible knapsack. Retrieved May 2015 from:

http://people.westminstercollege.edu/faculty/jsibbett/readings/White_Privilege.pd
f.

McQueen A. (2000). Nurse–Patient Relationships and Partnership in Hospital Care.
Journal of clinical nursing, 9(5). 723–731.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective.
Psychiatric Rehabilitation Journal, *25*(2), 134-14.

Mead, G. H., (1934). Social psychology and behaviourism. In Morris, C. W. (Ed.). *Mind,
self & society from the standpoint of a social behaviorist* (pp. 1-8). Chicago, Ill:
University of Chicago Press.

MetLife Mature Market Institute, National Alliance for Caregiving, & The National
Center on Women and Aging. (1999, November). *The Metlife juggling act study:
Balancing caregiving with work and the costs involved*. Brandeis University:
Metropolitan Life Insurance Company.

Meyers, D. T. (2004). Narrative and moral life. In C. Calhoun (Ed.).
Setting the Moral Compass: Essays by Women Philosophers. New York: Oxford.

Miles, R. (1989). *Racism*. London, England: Routledge.

Miller, W. B. (1958). Lower-class culture as a generating milieu of gang delinquency.
Journal of Social Issues, 15. 15-19.

Miller, E. A., Tyler, D. A., Rozanova, J., & Mor, V. (2012). National newspaper
portrayal of US nursing homes: Periodic treatment of topic and tone. *The Milbank
Quarterly*, *90*(4), 725-761.

Minister of Justice Canada (2015). *Canadian Multiculturalism Act*. Retrieved from
http://laws-lois.justice.gc.ca/PDF/C-18.7.pdf

Ministry of Health and Long-Term Care (MOHLTC) and the Seniors Health Research
Transfer Network (SHRTN). (2008). What we heard: Long-term care quality
consultation (A common vision of quality in Ontario long-term care homes).
Retrieved from:
http://www.health.gov.on.ca/en/common/ministry/publications/reports/quality_co
nsultation_08/quality_consultation_08.pdf

Ministry of Health and Long-Term Care (2017, September 28). *Ontario partnering with
the Michener Institute to launch personal support worker registry - Registry will
improve transparency for patients and families*. Queens Printer for Ontario.
Retrieved October 24, 2017, from:
https://news.ontario.ca/mohltc/en/2017/09/ontario-partnering-with-the-michener-
institute-to-launch-personal-support-worker-registry.html

Ministry of Health and Long-Term Care (2015, June 22). *Ontario increasing wages for Personal Support Workers - Province continuing to invest in home and community care.* Ottawa, ON: Queens Printer for Ontario. Retrieved from: http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20150622.aspx

Ministry of Health and Long-Term Care. (2017, September 28) Ontario Partnering with the Michener Institute to Launch Personal Support Worker Registry - Registry Will Improve Transparency for Patients and Families. Queens Printer for Ontario. Retrieved October 24, 2017, from: https://news.ontario.ca/mohltc/en/2017/09/ontario-partnering-with-the-michener-institute-to-launch-personal-support-worker-registry.html

Mitchell, L. M. (2006). Body and illness: Considering Visayan Filipino children's perspectives within local and global relationships of inequality. *Medical Anthropology, 25*(4), 331-373.

Mitchell, G., Dupuis, S., Kontos, P., Jonas-Simpson, C., & Gray, J. (2017, in review). The dehumanizing patterns of modernity and the therapeutic culture for persons with dementia: A complex and intersectional alternative view by Collective Disruption. *Ageing and Society*. Submitted August 2017

Montoya, M. (1994). Mascaras, trenzas, y grenas: Un/masking the self while un/braiding Latina stories and legal discourse. *Chicano-Latino Law Review, 15*, 1-37.

Mooers, C. (2003, June). Missing bodies: visibility and invisibility in the bourgeois public sphere. In *CPSA Annual Conference* (pp. 1-32). *Edmonton, AB*.

Morgan, D. G., Stewart, N. J., D'Arcy, C., Forbes, D., & Lawson, J. (2005) Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units. *Journal of Psychiatric and Mental Health Nursing, 12*(3). 152-161.

Morrow, M., Hankivsky, O., and Varcoe, C. (2001). Women and violence: The effects of dismantling the welfare state. *Critical Social Policy, 24*(3). 358–384

Mowatt, R. (2009). The king of the damned: Reading lynching as leisure. *Policy Futures in Education*, *7*(2), 185-199.

Mowatt, R. A., French, B. H., & Malebranche, D. A. (2013). Black/Female/Body 'hypervisibility' and 'invisibility': A Black Feminist augmentation of feminist leisure research. *Journal of Leisure Research, 45*(5), 644-660.

Nash, C. (2003). Cultural geography: Anti-racist geographies. *Progress in Human Geography, 27*(5), 637–648.

National Association of Career Colleges (NACC). (2014) *Personal Support Worker.* Retrieved from http://nacc.ca/about-nacc/nacc-curriculum/personal-support-worker/

National Association of Career Colleges (NACC). (2014). *Personal support worker.* Retrieved from: http://nacc.ca/about-nacc/nacc-curriculum/personal-support-worker/

National Association of Certified Caregivers/Personal Support Workers (NACCPSW) (2013). *CPSW Information*. Retrieved from: http://www.naccpsw.org/cpsw-information/

Neville, S. (2008). Older people with delirium: Worthless and childlike. *International Journal of Nursing Practice*, *14*(6), 463-469.

Noddings, N. (2002). *Starting at home: Caring and social policy.* Berkeley: University of California Press.

Nolan, M. R., Davis, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'person-centred' care: A new vision for gerontological nursing. *International Journal of Older People Nursing, 13(*s1). 45-53.

Norrick, N. R. (1997). Twice-told tales: Collaborative narration of familiar stories. *Language in Society*, *26*(2), 199-220.

Norris, J., Sawyer, R. D., & Lund, D. (2012). *Duoethnography: Dialogic methods for social, health, and educational research*. Walnut Creek, CA: Left Coast Press.

O'Brien, E. & Armato, M. P. (2007). Building Connections with Antiracism and Feminism. In J. F. Healy & E. O'Brien (Eds.) *Race, Ethnicity, and Gender (2nd Ed.).* Thousand Oaks, CA: SAGE.

Omi, M. and Winant, H. (2013). The theoretical status of the concept of race. In W. Crichlow (Ed.). *Race, Identity, and Representation in Education*. (pp. 3-12). New York: Routledge.

Omi, M. and Winant, H. (1994). *Racial formation in the United States: From the 1960s to the 1990s*. New York: Routledge.

Ontario Ministry of Health and Long-Term Care. (15 June, 2015). Ontario increasing wages for personal support workers: province continuing to invest in home and community care. *Health Bulletin*. Retrieved from http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20150622.aspx

Onyx, J. & Small, J. (2001). Memory-work: The method. *Qualitative Inquiry, 7*(6). 773-786.

Organisation for Economic Cooperation and Development (OECD) (2005). Long Term Care for Older People. Paris: OECD.

Ortega, M. (2013). Photographic representation of racialized bodies: Afro-Mexicans, the visible, and the invisible. *Critical Philosophy of Race, 1*(2). 163-189.

Ostaszkiewicz, J., O'connell, B., & Dunning, T. (2016). 'We just do the dirty work': dealing with incontinence, courtesy stigma and the low occupational status of carework in long-term aged care facilities. *Journal of clinical nursing, 25*(17-18), 2528-2541.

Otañez, M & Guerrero, A. (2016). Digital storytelling and the viral hepatitis project (pp. 57-70). In A. Gubrium K. Harper, & M. Otañez (Eds.). *Participatory and Digital Methods in Action.* NY, New York: Routledge.

Palmer, P. M. (1983). White Women/Black Women: The dualism of female identity and experience in the United States. *Feminist Studies*, *9*(1). 151-170.

Personal Support Network of Ontario (PSNO)(2014). *What can a psw do?Role of personal support workers and areas of ability*. Retrieved from http://www.psno.ca/uploads/1/0/1/9/10197937/what_can_a_psw_do_fs_2014.pdf

PHI national (2009, November 20). *Home health aides sing "I'm Your Aide, NOT Your Maid"* [Video file]. Retrieved from: https://www.youtube.com/watch?v=GikWopiQkdg

Phillips, A. (1999). *Which Equalities Matter?* Polity Press: Cambridge.

Pinnegar, S. & Daynes, J., G., (2007). Locating narrative inquiry historically: Thematics in the turn to narrative. In Clandinin, D. J. (Ed.). *Handbook of narrative inquiry: Mapping a methodology* (pp. 1-34). Thousand Oaks, CA: Sage.

Puka, B. (1990). The liberation of caring: A different voice for Gillian's 'different voice.' *Hypatia, 5*(1), 58-82.

Purdie-Vaughns, V. and Eibach, R. P. (2008) Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate-group identities. *Sex Roles.* DOI 10.1007/s11199-008-9424-4.

Pratt, G. (1997). Stereotypes and ambivalence: the construction of domestic workers in Vancouver, British Columbia. *Gender, Place and Culture: A Journal of Feminist Geography*, *4*(2), 159-178.

Prosser, J. (2009). Seeing red: Poetry and metaphor as response to representational challenges in critical narrative research. *International Journal of Qualitative Studies in Education, 22,* 607-622.

Pyke, K. D. & Johnson, D. L. (2003). Asian American women and racialized femininities: "Doing" gender across cultural worlds. *Gender and Society,11*(3). *34-53.*

Pyper, W. (2004, November). *Perspectives on labour and income: Employment trends in nursing, 5*(11). Retrieved from http://www.statcan.gc.ca/pub/75-001-x/11104/7611-eng.htm

Raghuram, P. (2009). Caring about 'brain drain' migration in a postcolonial world. *Geoforum, 40,* 25-33. DOI: 10.10.1016/j.geoforum.2008.03.005

Ramazanoglu, C. (1993). Introduction. In C. Ramazanoglu (Ed.). *Up against Foucault: Explorations of some tensions between Foucault and feminism* (pp. 1-25). London, UK: Routledge.

Rattansi, A. (2005). The uses of racialisation: Time-spaces and subject objects of the raced body. In K. Murji & J. Solomos (Eds.). *Racialisation: Studies in theory and practice.* pp. 271-302. Oxford, NY: Oxford University Press.

Reason, J. T., Carthey, J., & de Leval, M. R. (2001). Diagnosing "vulnerable system syndrome": An essential prerequisite to effective risk management. *Quality in Health Care, 10.* ii21–ii25.

Registered Nurses Association of Ontario (RNAO). (1996). *Replacement of registered nurses by less prepared providers.* RNAO and ONA Joint Statement. Retrieved from www.rnao.org/policy/less_prepared_providers.asp.

Reynolds, A. L. and Pope, R. L. (1991). The complexities of diversity: Exploring multiple oppressions. *Journal of Counseling and Development, 70.* 174-180.

Ribas, V., Dill, J. S., & Cohen, P. N. (2012). Mobility for care workers: Job changes and wages for nurse aides. *Social Science and Medicine, 75,* 2183-2190.

Rice, C. (2009). Imagining the other? Ethical challenges of researching and writing women's embodied lives. *Feminism & Psychology, 19*(2), 245-266.

Robb, C., Chen, H., & Haley, W. E. (2002). Ageism in mental health care: A critical review. *Journal of Clinical Geropsychology, 8,*1–12. doi:10.1023/A:1013013322947

Robinson, F. (2011). *The ethics of care: A feminist approach to human security.* Philadelphia, PA: Temple University Press.

Rodgers, G., Gore, C., and Figueiredo (Eds.). (1995). *Social exclusion: Rhetoric, reality, responses.* Geneva: International Labour Office.

Ronquillo, T. M. (2008). *Normalizing knowledge and practices: Interrogating the representation of the ethnic other in human behavior and the social environment (hbse) textbooks.* Ann Arbor, MI: ProQuest.

Rose, J., Madurai, T., Thomas, K., Duffy, B., & Oyebode, J. (2010). Reciprocity and burnout in direct care staff. *Clinical psychology & psychotherapy, 17*(6), 455-462.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging.* New York: Pantheon Books.

Rummery, K. & Fine, M. (2012). Care: A critical review of theory, policy and practice. *Social Policy & Administration, 46*(3). 321-343.

Ryan, M. (2007). Toward a definition of narrative. In D. Herman (Ed.), *The Cambridge Companion to Narrative* (Cambridge Companions to Literature, pp. 22-36). Cambridge: Cambridge University Press. doi:10.1017/CCOL0521856965.002

Sawchuk, R. (2007, May 14). *Comparison of curricula for training of home care/special care aides in Saskatchewan for Saskatchewan association of licensed practical nurses.* SK: Home Care/Special Care Aide Sector Partnership Steering Committee.

Schaie, K. W. (1988). Ageism in psychological research. *American Psychologist, 43*(3), 179.

Schwandt, T. A. (1996). Farewell to criteriology. *Qualitative Inquiry, 2*(1). 58-72.

Schwandt, T. A. (2014). *The Sage dictionary of qualitative inquiry*. Sage Publications.

Sharma, R. D. (2012). *Poverty in Canada.* Don Mills, ON: Oxford University Press.

Sharkey, S. (2008). People caring for people. Impacting the quality of life and care of residents of long-term care homes: A report of the independent review of staf!ng and care standards for long-term care homes in Ontario. Available from: http://www.health.gov.on.ca/english/public/ pub/ministry_reports/staff_care_standards/staff_care_standards.pdf

Shannon, C. S., & Shaw, S. M. (2005). " If the Dishes Don't Get Done Today, They'll Get Done Tomorrow": A Breast Cancer Experience as a Catalyst for Changes to Women's Leisure. *Journal of Leisure Research*, *37*(2), 195.

Shaw, S. M. (2001). Conceptualizing resistance: Women's leisure as political practice. *Journal of leisure research, 33*(2). 186-201.

Shilling, C. (2012). *The body and social theory.* Thousand Oaks, CA: Sage.

Shinan-Altman, S & Cohen, M. (2009). Nursing aides' attitudes to elder abuse in nursing homes: The effect of work stressors and burnout. *The Gerontologist. 49*(5), 674-684. doi: 10.1093/geront/gnp093

Skloot, R. (2010). *The immortal life of Henrietta Lacks.* New York: Crown Publishers.

Skovholt, T. M. & Trotter-Mathison, M. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (2nd ed). New York: Routledge.

Slote, M. A. (2008). *The ethics of care and empathy.* New York: Routledge.

Smith, M. (2003). Regulation of PSW. In M. Smith. *Commitment to care: A plan for long-term care in Ontario* (Ontario Ministry of Health and Long-Term Care in HPRAC, April 2004. CAT #7610-2241610). Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/ltc_04/mo hltc_rep04.aspx

Solomon, J. (2002). "Living with X": A body mapping journey in time of HIV and AIDS. Facilitator's Guide. *Psychosocial Wellbeing Series*. Johannesburg: REPSSI.

Solórzano, D.G. (1998). Critical race theory, racial and gender microagressions, and the experiences of Chicana and Chicano scholars. *International of Qualitative Studies in Education, 11*. 121-136.

Solórzano, D.G., & Yosso, T. (2001). Critical race and LatCrit theory and method: Counter-storytelling. *Qualitative Studies in Education*, *14*(4), 471-495.

Sparkes, A. C. & Smith, B. (2008). Narrative constructionist inquiry. In J. A. Holstein & J. F. Gubrium. *Handbook of Constructionist Research* (pp. 295-314). New York: Gilford Press.

Speller, B. & Stolee, P. (2015). Client safety in assisted living: Perspectives from clients, personal support workers and administrative staff in Toronto, Canada. *Health and Social Care in the Community*, *23*(2), 131–1.

Stacey, C. L. (2005). Finding dignity in dirty work: The constraints and rewards of low-wage home care labour. *Sociology of Health & Illness*, *27*(6), 831-854.

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion fatigue and satisfaction test. In C. R. Figley (Ed.). *Treating compassion fatigue* (pp. 107-119). New York: Brunner Mazel.

Statistics Canada (2003). *Ethnic diversity survey: Portrait of a multicultural society* (Statistique Canada Statistics Canada Catalogue no. 89-593-XIE-i). Retrieved from: http://www.statcan.gc.ca/pub/89-593-x/89-593-x2003001-eng.pdf

Statistics Canada (2004). *Women in Canada: Work chapter updates 2003* (Statistique Canada Statistics Canada Catalogue no. 89F0133XIE). Retrieved from: http://www.statcan.gc.ca/pub/89f0133x/89f0133x2003000-eng.pdf

Statistics Canada (2007). *Residential care facilities 2005/2006* (Statistique Canada Statistics Canada Catalogue no. 83-237-X). Retrieved from: http://www.statcan.gc.ca/pub/83-237-x/83-237-x2008001-eng.pdf

Statistics Canada. No date. Table *206-0091 Low income measures (LIMs) by income source and household size in current dollars and 2015 constant dollars, annual* (table). CANSIM (database). Last updated July 26, 2017. http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2060091 (accessed August 8, 2017).

St. Elizabeth Health Care. (2008, May). *People caring for people: Impacting the quality of life and care of residents in long-term care homes – A report on the independent review of staffing and care standards for long-term care homes in Ontario.* Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/staff_care_standards/staff_care_standards.pdf

Statistics Canada. (2004). Employment trends in nursing. *Perspectives on Labour and Income. 5*(11) Ottawa, ON: Wendy Pyper. Retrieved from http://www.statcan.gc.ca/pub/75-001-x/11104/7611-eng.htm

Statistics Canada (2005, March, 22). Study: Canada's visible minority population in 2017. *The Daily*. Retrieved from: http://www.statcan.gc.ca/daily-quotidien/050322/dq050322b-eng.htm

Statistics Canada (2015a). *Days lost per worker by industry and sex (Males)*(Statistique Canada Statistics Canada CANSIM, table 279-0030). Retrieved from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/labor61b-eng.htm

Statistics Canada (2015b). Days lost per worker by industry and sex (Females) (Statistique Canada Statistics Canada CANSIM, table 279-0030). Retrieved from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/labor61c-eng.htm

Statistics Canada (2015c). *Days lost per worker by industry and sex* (Both sexes) (Statistique Canada Statistics Canada CANSIM, table 279-0030). Retrieved from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/labor61a-eng.htm

Statistics Canada. (2017). Table 206-0091 Low income measures (LIMs) by income source and household size in current dollars and 2015 constant dollars, annual (table). CANSIM (database). Last updated July 26, 2017. http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2060091 (accessed August 8, 2017).

Sitzman, K., & Eichelberger, L. W. (2004). *Understanding the work of nurse theorists: A creative beginning*. Sudbury, Mass: Jones and Bartlett Publishers.

Stone, R. I. (2001). Research on frontline workers in long-term care. *Generations, 25*(1), 49-57.

Stormann, W. F. (1984). The Promised Leisure: An Illusion. *Quest*, *36*(2), 147-152.

Synnott, A. (1993). The body social: Symbolism. *Self, and Society (London and New York: Routledge, 1993)*, *149*(154), 1336-1371.

Tator, C., Henry, F., Mattis, W. and Rees, T. (1998). *The colour of democracy: Racism in Canadian society*. Toronto, ON: Harcourt Brace.

Teelucksingh, C., & Galabuzi, G. E. (2005). Working Precariously: The impact of race and immigrants status on employment opportunities and outcomes in Canada. In T. D. Gupta (Ed.). *Race and racialization: Essential readings* (pp. 202-208). Toronto: Canadian Scholars Press.

Thompson, C. J., Stem, B. B. & Arnould, E. J. (1998). Writing the differences: Poststructuralist, pluralism, retextualization, and the construction of reflexive ethnographic narratives in consumption and market research. *Consumption, Markets and Culture, 2*(2), 105-231.

Titon, J. (1980). The life story. *Journal of American Folklore*, *93*(369). 276-292.

Toles, M. & Barroso, J. (2014). Introduction to qualitative health research. In G. LoBiondo-Wood & J. Haber (Eds.), *Nursing research: Methods and critical appraisal for evidence-based practice* (8th ed., pp. 95-108). St. Louis, MI: Mosby, Elsevier.

Tolson, D., Rolland, Y., Andrieu, S., Aquino, JP., Beard, J., Benetos, A., Berrut, G., et al. (2011). International association of gerontology and geriatrics: A global agenda for clinical research and quality of care in nursing homes. *Journal of the American Medical Directors Association, 12*. 184-189.

Todaro-Franceschi, V. (2013). *Compassion fatigue and burnout in nursing: Enhancing Professional quality of life*. New York: Springer.

Tronto, J. C. (1993). *Moral boundaries: A political argument for an Ethic of Care.* New York: Routledge.

Tronto, J. C. (2013). *Caring democracy. Markets, equality, and justice.* New York, NY: New York University Press.

Turner, T (1980). The social skin. In J. Cherfas & R. Lewin. *Not work alone: A cross-cultural view of activities superfluous to survival* (pp. 112-140). Beverly Hills, CA: Sage Publications.

Twigg, J. (2000). Carework as bodywork. *Aging and society. 20,* 389-411.

Tyson, C. J. (2007). At the intersection of race and history: The unique relationship between the Davis Intent Requirement and crack laws. *Harvard Law Journal. Paper 177, 50*(2). 345-396.

United Nations Development Fund for Women (UNIFEM). (2005). Briefing Sheet: Migrant women in search of decent jobs. *UNIFEM, September*. Retrieved from http://www. unifem.org/materials/fact_sheets.php?StoryID=302.

Ungerson, C. (1983). Why do women care? In J. Finch and D. Groves (Eds.). *A labour of love: Women, work, and caring.* London: Routledge and Keagan Paul.

Valdes, F. (1997). Poised at the cusp: LatCrit theory, outsider jurisprudence, and Latina/o self-empowerment. *Harvard Latino Law Review, 2*(1), 1–59.

Veal, A. J. (2015). Human rights, leisure and leisure studies. *Quest. 36*(2), 249-272.

Veenhoven, R. (2000). Wellbeing in the welfare state level not higher, distribution not more equitable. *Journal of comparative policy analysis**. 2,* 91-125.

Vickers, M. H. (2005). Illness, work, and organization: Postmodern perspectives, antenarratives, and chaos narratives for the reinstatement of voice. *Journal of Critical Postmodern Organization Science, 3*(2), 74 – 88.

Villanueva, A. (1993). *Planet, with Mother, May I?* Tempe, AZ: Bilingual Press.

Võ, L. T., & Sciachitano, M. (2000). Introduction: Moving beyond" exotics, whores, and nimble fingers": Asian American women in a new era of globalization and resistance. *Frontiers: A Journal of Women Studies*, 1-19.

Walker, M. U. (1989). Moral understandings: Alternative "epistemology" for a feminist ethics. *Hypatia, 4*(2). 15-28.

Wallace, R. W., & Brubaker, T. H. (1984). Long term care with short term workers: An examination of nursing home aide turnover. *Journal of Applied Gerontology. 3*(1), 50-58.

Walker, M. & Rosen, W.B. (2004). *How connections heal: Stories from relational-cultural therapy.* New York, NY: The Guilford Press.

Walker, G. J., & Virden, R. J. (2005). Constraints on outdoor recreation. In E. L. Jackson (Ed.), *Constraints to leisure*, (pp. 201-219). State College, PA: Venture.

Watkins, M. & Shulman, H. (2008). *Toward psychologies of liberation: Critical theory and practice in psychology and the human sciences.* New York, NY: Palgrave Macmillan.

Waxman, C. I. (1977). *Stigma of poverty.* New York: Pergamon Press.

Webster, G. & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

Whitbourne, S. K., Culgin, S., & Cassidy, E. (1995). Evaluation of infantilizing intonation and content of speech directed at the aged. *The International Journal of Aging and Human Development*, *41*(2), 109-116.

White-Means, S. I., & Chang, C. F. (1994). Informal caregivers' leisure time and stress. *Journal of Family and Economic Issues*, *15*(2). 117-136.

Wilpert, C. (2003). Racism, discrimination and citizenship: The need for anti-discrimination legislation in the Federal Republic of Germany. In Z. Layton-Henry & C. Wilpert (Eds.). *Challenging racism and discrimination in Britain and Germany*. Basingstoke: Palgrave Macmillan.

Wilson, G. (2001). Conceptual frameworks and emancipatory research in social gerontology. *Ageing & Society*, *21*(4), 471-487.

Winddance Twine, F. (2000). Racial ideologies and racial methodologies. In F. Winddance Twine and J. W. Warren. (Eds.). *Racing research, Researching race: Methodological dilemmas in critical race studies.* (pp. 1-34). New York: New York University Press.

Wing, A. K. (Ed.). (2003). *Critical race feminism: A reader (2nd ed.).* New York: New York University Press.

Women & Health Care Reform. (2009). *Hidden health care work and women*. Toronto, ON: Women & Health Care Reform.

Yosso, T.J. and Solórzano, D.G. (2005). Conceptualizing a Critical Race Theory in Sociology. In, M. Romero & E. Margolis (Eds.), *The Blackwell Companion to Social Inequalities*, (pp. 117-146). Oxford, UK: Blackwell Publishing.

Yosso, T. J. (2005) Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race, Ethnicity, and Education, 8*(1). 69-91.

Zarzour, K. (2017, September 29). Personal support workers 'furious' at province's plans for registry - New data for caregivers will be 'colossal waste of money,' association president says. YorkRegion.com. Retrieved October 25, 2017, https://www.yorkregion.com/news-story/7584393-personal-support-workers-furious-at-province-s-plans-for-registry/

Zeytinoglu, I. U., Denton, M., Plenderleith, J., & Chowhan, J. (2015). Associations between workers' health, and non-standard hours and insecurity: the case of home care workers in Ontario, Canada. *The International Journal of Human Resource Management*, *26*(19), 2503-2522.

Zlomislic, D. (2016, October 6). *Report revealed major gaps in Ontario personal support worker registry.* The Toronto Star. Retrieved October 25, 2017, from: https://www.thestar.com/news/canada/2016/10/06/report-revealed-major-gaps-in-ontario-personal-support-worker-registry.html

Appendix A – Participant Information Package

STORY-BASED ART WORKSHOPS

A look at
LABOUR, LEISURE, & CARE OF
PERSONAL SUPPORT WORKERS

PARTICIPANT INFORMATION

A LOOK AT LABOUR, LEISURE, AND CARE OF PERSONAL SUPPORT WORKERS

This booklet will give you information you need to make an informed choice about participating in this study.

Background and Project Information

This study was developed from a need to better understand women's stories of care work in care settings. The literature documents that a majority of personal support workers (PSWs) are women of colour, who may experience:

- financial and time constraints that create barriers in tending to self-care and participating in traditional forms of leisure
- a lack of opportunity for career advancement and further training in care work
- fewer resources available for care of aging parents and children
- work overload, work underload, or shift inconsistency

Understanding these challenges, this study seeks to learn more about the realities of PSWs to frame recommendations and hopes for a better care structure for PSW care. It is necessary that PSW stories direct recommendations for better care experiences for PSWs working in long-term care homes.

Creating Art and Telling Stories

Both storytelling and art are means to communicate important messages in powerful ways. Seeing images are impactful and influential. Using art and digital methods, this study will highlight stories by PSWs. Stories aim to uncover how day-to-day demands for care by women of colour with aims to improve policies and practices for PSWs. Body mapping and digital storytelling are two ways we will explore and capture PSW stories that will be used in this study. You do not have to have any experience with these methods, creating art, or using computers.

Body map

Body maps are life-sized outlines of participants' bodies. Based on responses to reflective questions, images, words, symbols, or slogans are drawn, painted, or written on the life-sized body outline.
Example:

- http://www.migrationhealth.ca/sites/default/files/Body-map_storytelling_as_reseach_LQ.pdf

Digital story

Digital stories are 3 to 5 minute stories that bring together the audio recordings of your voice, digital images, and body maps to create impactful videos and communicate important messages.
Examples:

- *https://www.youtube.com/watch?v=2V_OLABwQjQ*
- *https://www.youtube.com/watch?v=vsuHabO2TYA*

How much time will I need to commit to this study? What activities are involved?

Participants will be asked to participate in three phases (see Table 1, below).

☐ *Phase 1* involves a brief meeting to discuss your involvement in the workshops and to answer any questions you may have before the first in-person meeting. Workshop meeting times will be confirmed at this time. When you contacted the facilitator to inquire about your participation, you would have set up a time to chat with her. The first meeting to create your body maps will be done in a group setting. A light lunch will be provided. Participants will be guided through a series of activities to create body maps. Participants will be asked to trace their bodies and then, paint, draw, or cut and paste images on to the tracing in response to questions.

☐ *Phase 2* involves working with the body maps created at the previous workshop to create an outline for your digital story. Photos and quotes from our conversations will be available for you to use to create your digital story. The facilitator will use your outline to create a personalised digital story. Once your digital story is ready, you will be asked to review your video and recommend changes so it is to your liking.

☐ *Phase 3* will involve a gathering of all participants to view and discuss digital stories. At this meeting participants will talk about what they learned. Participants will also be asked how body maps and digital stories can be used to communicate important recommendations for making experiences of care work better for PSWs.

Table 1: Time Commitment and Activities

Phase	Activity	Time/Location
1	Introductory meeting (Individual)	0.5 hour, at your convenience Skype/call
	Body Maps (Group) (A light lunch will be provided)	4.5 hours, Date TBD Location TBD
2	Digital Story (Group)	3.0 hours, Date TBD Location TBD
	Digital Story Editing (Individual)	1.0 hour, at your convenience Skype/call
3	Showcasing Videos and Developing Recommendations (Group)	1.5 hours, Date TBD Location TBD
	All meetings	*10.5 hours*

What will I be asked?
You will be asked reflective questions during the body mapping and digital storytelling phases to think about your work as PSW in ways you may not have considered before. This study is mostly interested in capturing your stories of PSW work. The questions will focus on your day-to-day experiences as a PSW and how your feelings translate through drawings on a tracing you make of your body. For a

full list of questions please refer to the attached list at the end of this information package.

Where will the in-person workshops be located?

This will be determined once availability is given by PSWs.

How will I communicate with the facilitator?

Participants will be asked about their preferred method of communication. A phone number is needed for the purpose of communicating if meeting time is cancelled or changed. Participants will be contacted via phone or Skype for two meetings. Emails will be sent for workshop reminders and for the communication of confidential links to digital stories. Computer use is not necessary for communication, but access to a computer will be required for reviewing your digital story. If you do not have access to a personal computer, your facilitator can help arrange for you to view your story on a public computer or her own personal computer at your convenience, if desired. For the purpose of sending remuneration and/or reimbursement participants will need to provide a mailing address.

Please note, when information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you.

If you prefer not to participate using this online method, please contact one of the researchers so you can participate using an alternative method such as telephone call.

What are my rights? What are the risks of participating?

You have the right to withdraw participation at any point in the study. You have the right to refuse answering questions you do not feel comfortable answering. If you withdraw your participation, your artwork, audio recordings, video, or digital images will not be used in any part of the study.

The workshop sessions will be audio recorded and photos will be taken. Your identity will be kept confidential. Your name will not be published on any report produced from this study and digital images will not be included if your face is captured. Brief videos of your art and you engaged in the workshop also be taken. Your face will not be included in any video or photos. Due to the group nature of these workshops, your anonymity cannot be guaranteed but all participants will be required to sign a consent form indicating they will not talk about who is involved and what is discussed outside of group conversations.

There are minimal risks to participating in this study. As this study examines stories of PSW labours of care, there might be a possibility of encountering negative stories associated with PSW care work. Discussing negative stories may be upsetting.

Should you find yourself feeling uncomfortable with the stories shared, please notify the facilitator immediately. Counseling contact information is provided below should you require additional support.

Resources for mental wellness:

- *The Girlfriend Club (free)* - http://www.eventbrite.ca/o/about-3239325656
- *Canadian Mental Health Association* - http://toronto.cmha.ca/mental-health/find-help/
- *Women's College Hospital* - http://www.womenscollegehospital.ca/programs-and-services/mental-health/groups

Table 2: Remuneration and Reimbursement

Activity	Time/Location	Remuneration *	Reimbursement**
Introductory meeting (Individual)	0.5 hour Skype/call at your convenience	$12.50	--
Body Map (Group)	4.5 hours	$125.00	Travel: up to $15 Care: up to $40
Digital Story (Group)	3.0 hours	$75.00	Travel: up to $15 Care: up to $40
Digital Story Editing (Individual)	1.0 hour Skype/call at your convenience	$25.00	--
Showcasing Videos and Developing Recommendations (Group)	1.5 hours	$37.50	Travel: up to $15 Care: up to $20
All meetings	*10.5 hours*	*$275.00*	*Travel: up to $45 Care: up to $100*

Remuneration

To thank you for your participation, you will receive remuneration following the completion of each session. Should you choose to end your participation, you will receive remuneration for your participation up to and including the session you chose to end your participation. A breakdown of remuneration is shown in Table 2.

*The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

How can I be reimbursed for some costs associated with participating?

**If you choose to claim your transportation and care costs, please keep your receipts (i.e., TTC transit transfer). Reimbursements are available for meetings specified in the above table. If you have any questions, please ask Kimberly Lopez which receipts are acceptable for proof of payment. Reimbursements are not available without proof of payment. Reimbursements will be distributed at the following meeting or mailed to you should you choose to withdraw your ongoing participation. A breakdown of available reimbursement is shown in Table 2.

How will I provide my consent?

You will be asked to sign a consent form once, for all sessions, at the beginning of the first in-person workshop. Though you may agree to participate in some or all of the phases of this study during that time, you may choose to withdraw your consent at any time. Your verbal consent is ongoing. If you consent to participate, you are agreeing to have digital images taken of you or your art, conversations audio recorded, and video taped during some parts of your participation.

You may choose to sign and bring the consent form attached to this information package with you when you arrive at the first workshop, alternatively consent forms will be available on site.

How will my body maps and digital stories be used/shared?

During workshops 1 and 2, Kimberly and another graduate student will take digital images and video of your body maps for use in your digital stories. Digital images of your body maps and your digital stories will be stored on a secure University of Waterloo server until a website is ready to permanently host images from the project. You will be notified when your images are placed online. Though posted digital images and videos will not identify you, once placed online, anyone can access digital images and digital stories.

Do you know someone who would be interested in participating in this study?
If so, please feel free to pass on this information and tell them to contact Kimberly at the information below.

Contact information

Facilitator and Researcher
Kimberly Lopez, PhD Candidate
Dept. of Recreation & Leisure Studies, University of Waterloo, Waterloo, ON N2L 3G1
kjlopez@uwaterloo.ca | Skype: kjlopez_office | Mobile: 647-671-5836

Doctoral Research Advisor
Sherry Dupuis, PhD
Dept. of Recreation & Leisure Studies, University of Waterloo, Waterloo, ON N2L 3G1
sldupuis@uwaterloo.ca | 519-888-4567, Ext. 36188

List of Questions and Probes

Phase 1

Workshop 1

Introductory activity – Tracing and meeting the body

- Tell us about this position that best represents your care work as a PSW.
- What does this body position tell us about you?
- Tell us your story about becoming a PSW.
- What does a typical week look like for you?

Adding to body maps and telling about self in labour, leisure, and care (Body map 1)

- If people were to describe your identity, what would it look like on your body? (RQ1)
    - How is your body involved in communicating your identity to others?
    - How is your identity celebrated?
    - How do you negotiate your identity in your care work?
    - How does your body feel if care work gets in the way of how you want others to see you?
    - What symbols or images represent your identity?
- How do you care for your body as a PSW? (RQ2)
    - How does caring for your body feel?
    - How does not being able to care for your body feel?
    - What does caring for your body look like?
    - What symbols or images represent how you care or do not care for your body?
- How does your body engage in leisure as a PSW? (RQ2)
    - How does your body feel when you deprive yourself from time for yourself?
    - How does it feel in your body when you have time for yourself?
    - What symbols or images represent your leisure?
- Think about negotiations or compromises you make in/for your caring work? (RQ3)
    - How do those negotiations or compromises feel in your body?
    - What symbols or images represent how you accommodate care work?
- Think about who or what else is involved in your care experience. (RQ2, RQ3)
    - How do others play a role in your experience of care?
    - Who is affected by your care?
    - How is your body supported/not supported in caring work?
    - What symbols or images represent your relationships with others in care?
- When you think about your care work, where do you feel it in your body? (RQ2, RQ3)
    - How does caring work affect your body?
    - Where do you feel the tolls of care work?

- o Where in your body do you feel the benefits of your caring work?
- o What symbols or images represent your how your care work makes you feel?

Personal slogan (Body map 1)

What would the personal slogan of this body be?

Body scanning

What are your bodies telling us about...
- How identity is taken up? How our identities are involved in care work?
- How you care for yourselves?
- Your leisure?
- The way we negotiate or compromise for caring work?
- Others involved or affected by our caring work?
- How care work makes us feel?

Retracing the body and telling new stories (Body map 2)

- How do you want yourself to be seen by others? What images, symbols, or words represent how you want others to see you?
- What do you hope for? Where does hope live in your body? What does hope feel like? What images, symbols, or words represent hope?
- Where does care for self live in your body? What does it look like? Feel like? How does it feel in your body when you feel supported? What does it look like? What images, symbols, or words represent care for self?
- Think about how you would change the way you engage in care work. How would you care for others while caring for yourself at work? What would need to change? What images, symbols, or words represent how you would change care to make sure you were caring for yourself while caring for others?
- If you could engage in leisure the way you wanted to at work, what would that leisure look like? Outside of care work? What images, symbols, or words represent how you would engage in leisure?

New Personal Slogan (Body map 2)

What would the personal slogan of this body be?

Tellings of two bodily representations (Body maps 1 and 2)

- What do you see? How do the bodies differ? What changes are needed to realize our organic, hopeful, happy selves in the second body map?
- How do the bodies illustrate hopes for the future of PSW care?
- What would you like people to learn from your story about PSW care work? About self-care as a PSW? About leisure as a PSW?
- How does it feel to acknowledge your body in this way?
- What was new for you? What was surprising? What did you find challenging?

Phase 2

Workshop 2

- What should people know about what care work is like for PSWs?
- How does your body map reflect these messages?
- How would you express what care work is like for PSWs through your digital story?
- What symbols or words could be used to reflect these ideas?

Interview 2

- What were your overall impressions of your digital story?
- How did it make you feel? Was it representative of your storyboard?
- What excites you about your story? What surprises you? What stood out for you?
- What messages do you think your digital story tells to the world? What messages do you want your digital story to communicate? Do you think your digital story, as-is, does this?
- If not, what changes would you recommend I make to your digital story? Are there any other changes you would like to see/hear? Music? Text? Images? Photos? Parts of your body map? Video?

Phase 3

Workshop 3

- What are your impressions of your digital stories? What stood out for you? How did they make you feel? What were some of the things you were seeing and hearing?
- What were the main insights you gained from engaging in this process? If you were to think about the messages you hope your work to communicate to others, what would those messages be?
- Which parts of your story should others hear? Who should hear your stories? What are the best ways to share your stories?
- How can PSW care work change to realize the hopes you talk about in your second body map? What has to happen to make these changes? What supports do you need to make these changes?

Appendix B – Recruitment Poster

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PARTICIPANTS NEEDED FOR RESEARCH IN:
LABOUR, LEISURE, AND CARE OF
PERSONAL SUPPORT WORKERS

Volunteers are needed to take part in a study about *the role identities play in care work*. Participants must:
- be a personal support worker (post-PSW education/training)
- identify as a woman of colour/visible minority/racialised woman (e.g., Asian, S.E. Asian, E. Asian, African, Caribbean, descent)
- have worked in long-term care home(s) for at least 1 year

As **one of six** participants in this study, you would be asked to:
- discuss your experiences of working as a PSW
- create artistic representations of your stories
- develop recommendations for wellness for PSWs

Participation would involve **10.5 hours** of your time:

- Phone/Skype sessions (one 30 minute and one 1.0 hour meeting)
- In-person story-based art workshops (one 4.5 hour, one 3.0 hour, and one 1.5 hour meeting)

In appreciation for your time, you will receive $275.00 in remuneration for 10.5 hours of your time. In addition, reimbursement funding is available for transportation and family care. Please contact Kimberly for more information.

For more information or to volunteer for this study, please contact:
Kimberly Lopez
Department of Recreation & Leisure Studies
Aging, Health, & Well-being Program
at Email: *kjlopez@uwaterloo.ca*
Skype: kjlopez_office | Mobile: 647-671-5836
This study (ORE #21954) has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee.

Social Sciences and Humanities
Research Council of Canada

Conseil de recherches en
sciences humaines du Canada

Canada

Appendix C – Phone script for participant recruitment in LTC homes

Hello,

My name is Kimberly and I am a doctoral student at the University of Waterloo wanting to speak with PSWs who work in LTC homes. Would it be possible to speak with this home's administrator?

[If/when administrator is speaking]
Hello, my name is Kimberly and I hope to speak with PSWs who work in LTC homes in effort to better understand the structure and experience of PSW care work. Do you have two minutes to chat with me today about an opportunity for PSWs who work at your home?

[If no, ask:] Is there a better time for us to chat?
[If yes, proceed.]

Great, thanks for your time. In particular, I am looking at how women and individuals of colour talk about care work in their lives. I will be guiding participants to use art-based methods to create body maps and digital stories reflective of PSWs day-to-day care experiences. No experience with any of these methods is needed.

This study will help inform how care experiences are structured for PSWs in an effort to work towards sustainable care practices in LTC homes. This study will not be linked in anyway to your home.

The study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee

What I would like your help with is spreading the word about this study.

Would you feel comfortable hanging a poster inviting PSWs to participate in your communication area?

[If agrees to hang poster, arrange the best time to drop off the poster.]
Would you feel comfortable sending an email to your PSW staff with the poster?

[If agrees to send email, send an email template:]
At what email address is the best to reach you and send the email template?

Do you have any questions about this study? Thank you very much for your time and I look forward to meeting with you about the poster and being in touch with you about the email.
[End call]

Appendix D – Informational Email to Administrators

Email script for participant recruitment in LTC homes (via LTC administration)

Dear staff member,

I wanted to pass along an opportunity to participate in a study about care work experiences of women working as PSWs in LTC homes. The facilitator of this study will guide participants to use art-based methods to create art and digital stories reflective of your day-to-day care stories as PSWs. Specifically, she is looking at how women who are also individuals of colour talk about care work in their lives. No art or video experience is needed. This study will help inform how care experiences are structured for PSWs in effort to work towards sustainable care practices in LTC homes.

Participants should:
- be a personal support worker (post-PSW education/training)
- identify as a woman of colour/visible minority/racialised woman (e.g., Asian, S.E. Asian, E. Asian, African, Caribbean, descent)
- have worked in long-term care home(s) for at least 1 year

As **one of six** participants in this study, you would be asked to:
- discuss your experiences of working as a PSW
- create artistic representations of your stories
- develop recommendations for wellness for PSWs

Participation would involve **10.5 hours** of time (spread over a number of sessions):
- Phone/Skype sessions (one 30 minute and one 1.0 hour meeting)
- In-person story-based art workshops (one 4.5 hour, one 3.0 hour, and one 1.5 hour meeting)

The workshops will take place locally at [location TBD] and meeting times will be determined by participants.

In appreciation for your time, you will receive $275.00 in remuneration for 10.5 hours of your time. In addition, reimbursement funding is available for transportation and family care. Please contact Kimberly for more information by February 15, 2017.

For more information or to volunteer for this study, please contact:
Kimberly Lopez at Email: kjlopez@uwaterloo.ca | Skype: kjlopez_office | Mobile: 647-671-5836

Kimberly will send you an information package and set up a date to meet with you if you are interested in participating.

Appendix E – Consent Forms

ACKNOLWEDGEMENT OF INFORMATION

Date

Title of Project: Genderacialised politics of care and PSWs: Stories of LTC home care labours, leisures, and hopes

Organizers*: Kimberly Lopez, PhD Candidate*
    University of Waterloo, Department of Recreation and Leisure Studies
    Faculty of Applied Health Sciences

This session focuses on (*insert focus of session*) and will be facilitated by Kimberly Lopez, a PhD Candidate at the University of Waterloo.

I agree to participate in a study being conducted by Kimberly Lopez, a PhD student in the University of Waterloo's Department of Recreation and Leisure Studies who is working under the supervision of Dr. Sherry Dupuis and Dr. Susan Arai. I have made this decision based on the information I have received in the information package and my initial meeting with Kimberly. I have had the opportunity to ask questions and request any additional details I wanted about this study.

As a participant in this study, I realize that in Phase I, I will be asked to take part in a call/Skype conversation with the facilitator, followed by a group story-based group art workshop with a discussion group component. In phase II, I will be asked to participate in a story-based art workshop where I will be asked compile information to create a video. Following the group workshop, Kimberly will contact me by phone or Skype to provide feedback on my video and any revisions needed. Phase III, I will be asked to attend an airing of the videos created from the story-based art workshops and participate in discussion. As a participant in this study, I am aware that I may decline to answer any question that I prefer not to answer in any of the phases.

I am also aware that I have the option of allowing my participation to be tape recorded, videotaped, and photographed to develop content for the final video and promote open discussion. All information that I provide will be held in confidence, and I will not be identified in the thesis or summary report unless I provide consent to do so. I understand that photographs or videos published from this report will not include my face unless I give my permission. I was informed that I may withdraw my consent at any time by notifying Kimberly right away.

Participation in each session is voluntary and involves a total of 10.5 hours of input to and discussion of the issues associated with PSW labour, leisure, and care. There are minimal risks to your participation in this session. You may decline answering any questions you feel you do not wish to answer and may decline contributing to the session in other ways if you so wish. All information you provide will be considered confidential and grouped with responses from other participants. No faculty members will be present during the session and your name will not be identified with the input you give to this session. The information collected from this session will be retained for 15 years in a secure location and final products will be posted on a website on the Internet. Once audio files are transcribed the copies of the voice files will be permanently deleted.

Given the group format of this session we will ask you to keep in confidence information that identifies or could potentially identify a participant and/or his/her/their comments. If you have any questions about participation in this project, please feel free to discuss these with the facilitator, or later, by contacting professor Sherry Dupuis at 519-888-4567, Ext. 36188. If you are interested in

receiving a copy of the executive summary of the session outcomes, please contact Kimberly Lopez at *kjlopez@uwaterloo.ca.*

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#21954). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact:

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PARTICIPATION AGREEMENT & CONSENT (MULTI-PHASIC STUDY)

Though I provide my consent to all workshops and meetings here, at this time, I understand that verbal consent is ongoing and I may withdraw my participation at any time. I understand that the facilitator will begin each session by asking for my agreement to participate.

I agree to participate in Phase One of this study
[A call/Skype conversation with the facilitator (30 minutes), followed by a group story-based group art workshop with a discussion group component (4.5 hours).]

YES   NO   (Please circle your choice)

I also agree to participate in Phase Two
[A story-based group art workshop (3.0 hours) where I will be asked compile information to create a video. Following the group workshop, Kimberly will contact me by phone or Skype so I can provide feedback on the video on any revisions needed (1.0 hour).]

YES   NO   (Please circle your choice)

I also agree to participate in Phase Three
[Attend an airing of the videos created from the story-based art workshops and participate in discussion to improve the experience of PSW labour (1.5 hours).]

YES   NO   (Please circle your choice)

As a participant in this study, I agree to being videotaped, have digital images taken, and audio recorded for the purpose of video creation as well as a means of better understanding the care experiences of personal support care workers. I agree to allow video, audio, and/or digital images in which I appear to be used in teaching, scientific presentations and/or publications with the understanding that I will not be identified by name or face without my consent. I am aware that I may withdraw this consent at any time without penalty, at which point, the videotape and/or photographs and/or audio recording will be erased.

YES   NO   (Please circle your choice)

Participant Name: _____(Please print)

Participant Signature: _____

Witness Name: _____

Witness Signature: _____

Date: _____

Appendix F – Participant Information Package

STORY-BASED ART WORKSHOPS

A look at
LABOUR, LEISURE, & CARE OF
PERSONAL SUPPORT WORKERS

FACILITATION GUIDE

Appendix F(i) – Introductory Meeting Script and Procedure

Facilitator: Kimberly Lopez **Length of time: 1.0 hour**
Date: TBD **Location: Phone call/Skype**
Room specifications: N/A **Room contact information: N/A**
Participants in attendance:

Introductory Meeting Set-up (15 minutes)	• Note book and pen, computer (if Skype is needed) • Participant contact information sheet, participant information package
Script	

Script

Hello _____,

Thank you for your interest in this study on PSW labour, leisure, and care. My name is Kim and I am a graduate student at the University of Waterloo interested in role identity plays in the wellness of PSWs and care in which PSWs participate. In this meeting/telephone call, I hoped we could talk more about your participation in this study on labour, leisure, and care of PSWs. We arranged this time previously, but is now still a good time for you to discuss these details?
[If yes, proceed. If no, ask, "what is a better time for you to be reached?"]

During our chat today, I will not be audio recording our conversation, but I will be making notes about some of the questions you may have so I can best address your concerns. It was my intention to touch base with each participant before meeting in person to get a sense of what questions you may have.

Please feel free to ask me any questions you may have as we go through the information package that was mailed/emailed to you. This study is a part of my research as a doctoral student, but also serves to better understand and improve the PSW care experience by understanding how care work is structured. I hoped we could take a few minutes to review the different sections of the information package to ensure you understood the details of the study.

[review "Background and Project Information" section]

Do you have any questions about this section?

[review "Creating Art and Telling Stories" section]
Do you have any questions about this section?

[review "Time Commitments and Activities" section]
Do you have any questions about this section?

[review "Location" section]
Do you have any questions about this section?

[review "Communication" section]
Do you have any questions about this section?

How would you prefer we communicate with one another? Phone? Email?
To confirm, to reach you by phone, the best number to reach you is _____.
In case there is a change in our group meeting times, I will call all participants. In case I need to share updated information with you about your work, do you have access to email at home? If so, what is the best email address to reach you? Do you have access to a computer or other device that enables video?

[review "Your Rights" section]
Do you have any questions about this section?

[review "Consent"]
Do you have any questions about this section?

[review "Remuneration and Reimbursement section]

This study asks for 10.5 hours of your time. We will be providing each participant with $25 for each hour for a total of $275.00 for all 10.5 hours. Should you choose to leave this study, which is entirely your decision, you will receive $25 for each hour you contribute to this research.

There is also an opportunity for you to claim your travel expenses to and from the workshops. To do this, please bring in receipts from your travel to the next meeting we have together. At the last meeting I will provide a self-addressed stamped envelope so you can send me the receipts from your travel.

You will receive remuneration following the completion of each session. Should you choose to end your participation, you will receive remuneration for your participation up to and including the session you choose to end your participation.

Are there child or family care responsibilities that you will need to make arrangements for as a result of your participation in this study?

[If yes, describe, "reimbursement is available for care expenses up to $40 for the 4.5 and 3.0 hour sessions. To take advantage of this reimbursement, you would have to provide some sort of documentation of care (i.e., a note from babysitter indicating the amount, or movie ticket receipts) at the next meeting"]

Do you have any questions about this remuneration and reimbursement for this study?

It is your choice to participate in this research and you may ask questions about the study at anytime or choose to not answer questions you are uncomfortable answering. Please be aware that anyone choosing to participate must give their permission to allow:
- comments to be noted and audio recorded (with no personal identifiers)
- digital images taken and videotaped (with no personal identifiers)
- photographs/videos of art to be used in teaching, presentations, and reports

Your name will not be used or tied to your art or comments unless you consent to doing so. Would you like to have your real name identified? If not, you can choose another name for yourself that will be linked to your artwork and video. If you change your mind and no longer wish to participate, I will not use your contributions in the project. Once the project is completed, I will photograph your art and you may keep the originals.

If you have any questions during meetings or between meetings, I will do my best to answer them for you. If you have

any questions about your participation after the program is over, please contact me (Kimberly). Do you have any other questions?

Are you still interested in participating in the workshops and meetings to help people understand the life stories of PSWs? If so, I will leave you with my contact information so you may reach me if you have questions or concerns about your participation. If you choose not to participate, that is okay too. There are no risks for you choosing not to participate.

[review "Contact Information and Resources" section]

[If a location and date is predetermined say:] Our first group workshop is on _____[date]. Information about location including travel directions is included in your information booklet.

[If a location and date is not predetermined say:] We will be determining a date shortly. Can you please confirm your availability with me for the next 3 weeks?

I look forward to meeting and working with you in person! As any research requires your consent to participate, please ensure that you have read the consent forms in your information packet. I will have copies of these forms at our first group meeting. Feel free to reach out if you have any questions about these forms in the meantime.

[review "Consent forms" section]

Thank you for taking the time to chat with me. You will receive remuneration for this time at our first meeting or, should you change your mind about participating between now and then, I will send your cheque in the mail.

Do you have any final questions?
[If no, proceed. If yes, field questions]

Thank you so much for your time today. I look forward to working with you in person. Take care and have a good day/night. [End call]

Appendix F(ii) – Body Mapping Workshop – Facilitation Script

Facilitator: Kimberly Lopez   **Length of time: 4.5 hours**
Date: TBD   **Location: TBD**
Room specifications: TBD   **Room contact information: TBD**
Participants in attendance: TBD

Body Mapping Workshop Set-up (1.5 hours)	• Ready AV: audio recorder, camera, ipad, AAA batteries, camera memory cards, back up battery, USBs, and charger. • Paperwork: Folder for consent forms, cheques, attendance sheet, participant information package • Set up eight chairs in a circle, in front of chairs place consent forms, pens, markers, information packages, note pad, post-it notes, and name plates • In a radial formation, place drop cloth, mural paper (lengths of 6 feet) behind each chair • At the end of each mural place paint, paint brushes, water containers, markers, paper, folded aprons • In the middle of the circle of chairs place magazines, scissors, glue, masking tape.
Welcome and consent (10 minutes) Materials: • Consent forms • Pens • Extra participant packages • Audio recorder • Camera	Good morning/afternoon. My name is Kim and I will be facilitating this session today. I am excited to be here today with you because I think this work is very important for others to understand stories of PSW work and care. In particular, I am interested in how women, who are racialised, sometimes described visible minorities, talk about their experiences as a PSW. Researchers and policy makers are interested in this area because more often than not, it is women who take on caring roles in the workforce and at home. Also, it's often women of colour who are involved in direct care responsibilities. What might be gained in learning about how care work effects PSWs? As you are well aware, all of this caring work can sometimes take a toll on how women are able to care for themselves and even how much time women in care work are able to engage in activities that nurture self. So we want to hear your stories of what this all means for how care work can be better for PSWs, especially for women and people of colour.

	Before we begin, I hoped to make sure there weren't any outstanding questions about the information package. What questions do you have? [Field questions] If you agree to continue to work with me for the duration of this study, I will need your written consent. This workshop involves creating art that represents the experiences you hold in your body that you may or may not have thought about before. I will be using an audio recorder to record your comments. I will transcribe the discussion, take digital images, and record video for you to use later. Your confidentiality is very important. I promise to remove any information that identifies you, including removing your name and cropping out your faces from digital images. As we are working together in this group, it is important that we do not share personal information about one another to anyone. Do we all agree to maintain a confidential space? This is intended to be a relaxed, creative space, where we can learn a little bit more about one another, free of judgment. If you agree with all that I've said, please ensure you've signed a consent form before we begin. [Pass around consent forms and pens] To ensure confidentiality, I will be assigning pseudonyms and you are free to pick another name that will stand-in for your real name in documentation. On your nameplate, please write your real name that we will use in this group and choose another name that I will use for my records. You can write this name on a piece of paper beside your given name and hand it to me. I will record your pseudonym you submit to ensure your information stays private. I promise that we will introduce ourselves in just a moment. [Participants fill out a name plate]

Overview of meeting and *"Tracing and Meeting the body"* introductory activity (40 minutes) Materials: • iPad with example body maps • Markers, pencils, pens, and paint • Magazines, scissors, glue • Aprons, paint brushes, paint and water containers • Mural paper • Post it notes and note pads • Name plates • Audio recorder • Camera • Questions printed in large font for reference	Now we begin the fun part. Today we will be creating body maps by using paper, paint, markers, and other materials to express how we feel about care work. This is one of two body maps we will create today. These are some examples of body maps used in different projects. [Pass around iPad with images]. You can see that the body maps are life-sized reflections of your body and on it there are drawings of symbols or words. First, to introduce ourselves, we will start by tracing our bodies onto paper. This tracing is called a shadow. You will see that there are pieces of mural paper and markers and pencils for you to trace your body. You can't do this part on your own, so you'll have to find a partner to help you do this. Please remove your shoes or any excessive clothing/accessories you may have on (e.g. bulky jacket, hat, purse, etc). Then, I will be asking you some questions and you can decide how you wish to represent how you feel by drawing it on your shadow. You can take some time to think about how you feel before drawing or painting on your shadow. There are note pads, post it notes, and pens available for you to jot down words or phrases to help you if you choose. Now, we'll start by finding a partner to create an outline or a shadow of our bodies. Once you've found a partner, find a spot with mural paper. You can bring your nameplate to your paper. Before you start tracing your body, think about how you feel when you get ready for work and when you are providing care as PSW. What body position reflects how you feel? Find a partner and trace a shadow of your body in that position onto the paper. This is just an outline for now, we will be adding details to this shadow later. [Take digital images and video during this time] Once you are done, use your body map to introduce yourself to our group. I will come around with the audio recorder so we can capture your description. As you introduce yourself, think about the following questions: • Tell us about this position and how it best represents your care work as a PSW.

	• What does this body position tell us about you? • Tell us your story about becoming a PSW. • What does a typical week look like for you? [Everyone walks around to each tracing as participants introduce themselves and their tracing. Kim records and each participant describes their tracing]
Adding to body maps and telling about self in labour, leisure, and care (65 minutes) Materials: • Questions printed in large font for reference • Music	The next step involves reflecting on the feelings in our body and where in our body those feelings occur. We will start to think about your present experience of being a PSW. You may use any of the materials available: magazines, glue, paper, paint, or markers. Think about the following questions and the areas in your body where these questions are taken up. For example, the first question asks you to think about your identity: • how does your body communicate your identity? • how does this representation make you feel in your body? • where do you feel your identity in your body? You may want to jot down a short list of symbols you hope to include to describe this. It is okay if you don't finish your body map to the level you imagined it would be complete. It usually takes many hours to finish a full map. Perhaps think about a few elements for each question you can focus on and really express those few elements fully. Take a few minutes to jot down your thoughts before you begin to map on your shadow. Written words are okay too, so if you get stuck on how to visually represent a feeling on your body, you can use words, emotions, or signs. There are no wrong answers here so feel free to express the words, shapes, symbols, and colours that come to mind. Please feel free to be honest, in both the positive and negative. There are beautiful things we can use to represent some of the ideas we are thinking about, which is fine, but I understand that not everything are rainbows and butterflies and these feelings should also be given space to be heard. Please use the next hour to consider and then map your responses to the following questions. After an hour, we will discuss your maps.

[Take digital images and video during this time]

- If people were to describe your identity, what would it look like on your body? (RQ1)
  - How is your body involved in communicating your identity to others?
  - How is your identity celebrated?
  - How do you negotiate your identity in your care work?
  - How does your body feel if care work gets in the way of how you want others to see you?
  - What symbols or images represent your identity?
- How do you care for your body as a PSW? (RQ2)
  - How does caring for your body feel?
  - How does not being able to care for your body feel?
  - What does caring for your body look like?
  - What symbols or images represent how you care or do not care for your body?
- How does your body engage in leisure as a PSW? (RQ2)
  - How does your body feel when you deprive yourself from time for yourself?
  - How does it feel in your body when you have time for yourself?
  - What symbols or images represent your leisure?
- Think about negotiations or compromises you make in/for your caring work? (RQ3)
  - How do those negotiations or compromises feel in your body?
  - What symbols or images represent how you accommodate care work?
- Think about who or what else is involved in your care experience. (RQ2, RQ3)
  - How do others play a role in your experience of care?
  - Who is affected by your care?
  - How is your body supported/not supported in caring work?
  - What symbols or images represent your relationships with others in care?
- When you think about your care work, where do you feel it in your body? (RQ2, RQ3)
  - How does caring work affect your body?
  - Where do you feel the tolls of care work?
  - Where in your body do you feel the benefits of your caring work?
  - What symbols or images represent your how your care work makes you feel?

	[Give 30 minute and 10 minute time notices] [Take digital images and video during this time]
Personal slogan (10 minutes) Materials: • Post it notes and pens	Look at your body map. Think about what story this map tells. What would the personal slogan of this body be? Take 10 minutes to think about a short, memorable phrase to describe this PSW body. Think about where you would place your slogan on your body. [Take digital images and video during this time]
"Body scanning" **and interpreting stories of the body in labour, leisure, and care** (30 minutes)	Scan your body map. What do you see? Scan your neighbours' body maps. What do you see? [Audio record during this time] What are your bodies telling us about... • How identity is taken up? How our identities are involved in care work? • How you care for yourselves? • Your leisure? • The way we negotiate or compromise for caring work? • Others involved or affected by our caring work? • How care work makes us feel?
Re-tracing Bodies and Telling New Stories (65 minutes) Materials: • Markers, pencils, pens, and paint • Magazines,	Trace a new shadow of your body. This time think about a posture that represents how you feel when you are most yourself, happy, and hopeful. Please use the next hour to consider and then map your responses to the following questions. [Audio record during this time] • How do you want yourself to be seen by others? What images, symbols, or words represent how you want others to see you? • What do you hope for? Where does hope live in your body? What does hope feel like? What

scissors, glue • Aprons, paint brushes, paint and water containers • Mural paper • Post it notes and note pads • Name plates • Audio recorder • Camera • Questions printed in large font for reference	images, symbols, or words represent hope? • Where does care for self live in your body? What does it look like? Feel like? How does it feel in your body when you feel supported? What does it look like? What images, symbols, or words represent care for self? • Think about how you would change the way you engage in care work. How would you care for others while caring for yourself at work? What would need to change? What images, symbols, or words represent how you would change care to make sure you were caring for yourself while caring for others? • If you could engage in leisure the way you wanted to at work, what would that leisure look like? Outside of care work? What images, symbols, or words represent how you would engage in leisure?
New personal slogan (10 minutes) Materials: Post it notes, pens	Look at your body map. Think about what story this map tells. What would the personal slogan of this body be? Take 10 minutes to think about a short, memorable phrase to describe this new body. Think about where you would place your slogan on your body and add it to your body. [Take digital images and video during this time]
Tellings of two bodily representations (30 minutes)	Now that we've completed two body maps, let's discuss: [Audio record during this time] • What do you see? How do the bodies differ? What changes are needed to realize our organic, hopeful, happy selves in the second body map? • How do the bodies illustrate hopes for the future of PSW care? • What would you like people to learn from your story about PSW care work? About self-care as a PSW? About leisure as a PSW?

	Think back to your body maps. Tell us about how you experienced the body mapping exercise. - How does it feel to acknowledge your body in this way? - What was new for you? What was surprising? What did you find challenging?
Wrap up and next steps (10 minutes) Materials: - Meeting reminder flyer - Remuneration cheques	Thank you for sharing your time and your knowledge with me. We have done a lot today and your maps will continue to be useful in the next phase of this study. You will get to keep your maps at the end of this project. In the meantime, I will transcribe the recordings and compile the digital images and video. In the next part of our work together, we will be doing a storyboarding activity. We will put together your maps, digital images, videos, and the audio from our discussion to make a short movie. If you would like to claim your transportation or childcare for this session, please give me your receipts or bring them to our next meeting and I will reimburse you at our next meeting. Thank you again and I look forward to seeing you on [insert date] at [time]! [Distribute remuneration and meeting reminder flyer]
Take-down and filing checklist	File and store: - Audio files from voice recorder - Digital images taken of body maps - Digital images and videos from camera - All AV equipment - Participants' note pads and name plates - Paperwork – attendance list, remuneration and reimbursement list, consent forms, information booklets, and contact information - Participants' body maps - All art materials
Begin documenting personal observations, reflections, and experiences.	

Appendix F(iii) – Digital Storytelling Workshop – Facilitation Script

Facilitator: Kimberly Lopez **Length of time: 3.0 hours**
Date: TBD **Location: TBD**
Room specifications: TBD **Room contact information: TBD**
Participants in attendance: TBD

Digital Storytelling Workshop - Set-up (60 minutes)	Set-up and ready: • AV: audio recorder, camera, iPad, AAA batteries, camera memory cards, back up battery, USBs, personal computer, and chargers. • Paperwork: Folder for consent forms, cheques, attendance sheet, remuneration and reimbursement list, and participants' contact information • Set up eight chairs in a circle, information packages, note pad, post-it notes, and name plates • Along the walls, put up body maps, selected sections of transcript from participants introductions, digital images, • At the end of each mural place paint, paint brushes, water containers, markers, paper, folded aprons • In the middle of the circle of chairs place magazines, scissors, glue, masking tape.
Welcome, consent, and introduction to digital storytelling (20 minutes) Materials: • Consent forms • Pens • Extra participant packages • Audio recorder	Welcome back! Before we begin, I hoped to make sure there weren't any outstanding questions about the project. What questions do you have? [Field questions] I will need to make sure your consent is current and that you've indicated you agree to participate today. Please take note that you are free to withdraw your participation at anytime. This workshop involves reflecting on art created at our last meeting and reviewing the transcripts from our discussion. The purpose of this study is to explore day to day stories of PSWs to understand and improve the structuring of care work. Again for this meeting, I will be using an audio recorder to record your comments. I will transcribe

• Outline of study progress
 • Digital stories
	the discussion, take digital images, and record video for use later. Your confidentiality is very important. I promise to remove any information that identifies you, including removing your name and cropping out your faces from digital images. As we are working together in this group, it is important that we do not share personal information about one another to anyone. Do we all agree to maintain a confidential space?
	
	 This is intended to be a relaxed, creative space, where we can learn a little bit more about one another, free of judgment. If you agree with all that I've said, I will ensure your consent forms are up to date and begin audio recording.
	
	 [Start audio recorder]
	
	 Today we are working together, in the second phase of this project, for three hours and in this time we will bring together the audio recordings of your voices, your digital images, and your body maps to create digital stories. The video recordings from our last meeting will be used to introduce each of your digital stories.
	
	 So what are digital stories? Digital stories are 3 to 5 minute videos that communicate an impactful message. I've brought an example to share with you [show digital story example]. Digital stories have 7 stages and we will be focusing on these two stages (in bold below) today.
	     • Orientation and introduction to seven steps of digital storytelling (Right now)
	        o Showing examples of digital stories and a discussion of the process
	     • Script writing (Body maps, last meeting)
	        o Crafting a script, participants come with stories in mind or a draft story
	     • **Story circle**
	        o **Presenting rough drafts of story, creates space to talk about difficult parts of story**
	     • **Voiceover**
	        o **Select aspects of story, photos, artifacts, participants create story boards where the "visual, oral, and textual – mesh with each other" (p. 28)**

	• Rough edit (next meeting)
	    o Use software to create a rough edit
	• Final edit
	    o Use software to create a final edit
	• Workshop airing
	    o Screening digital stories as a research collective, celebrating the group's accomplishments (Lambert, 2010)
	• Public airing
	    o Inviting groups to screen and dialogue about the short stories
	
	But first, we need to create an outline of what types of things we want to include in each of our digital stories.

Storyboarding (Story circle) (30 minutes) Materials: • Note pads, pens • Audio recorder • Dot stickers • Post it notes • Markers • Printed digital images • Copies of individual and group transcripts • Computer • Camera • Audio recorder	Let's start with the slogans we created at our last meeting. What do each of these slogans represent? Would any body like to share their slogan? When you think of your slogan, what songs come to mind? Digital stories often have a sound track. Pick two types of music to represent your two body maps. If you have specific songs in mind, even better! Write these two songs or the type of music you would like beside your slogan on your body map. [15 minutes] In our last meeting, we talked about your body maps and the differences between them. There were some key ideas you talked about when describing your body maps. We discussed: How your bodies represented: • How identity is taken up. How our identities are involved in care work. • The way we negotiate or compromise for caring work. • How care work makes your feel.

• Music list	• Others involved or affected by our caring work.
	• How you care for yourselves.
	• Your leisure.
	
	Based on our discussions:
	   • What should people know about what care work is like for PSWs?
	   • How does your body map reflect these messages?
	   • How would you express what care work is like for PSWs through your digital story?
	   • What symbols or words could be used to reflect these ideas?
	
	[Discuss]
	
	Consider:
	
	What parts of your body map are most meaningful to you? To learn as much as we can from your body maps, I hoped that we could use the next 10 minutes to place a dot beside the parts of your body map you wanted to emphasize in your digital story.

Storyboarding (Voiceover) (120 minutes) Materials: • Highlighters • Pens, post it notes, markers • Transcripts • Digital images • Paper	Now, as you can see there are your body maps, text, and images posted on the wall. Starting with your body maps, order your dots. Place a post it note beside each dot and move through your body maps indicating what order you would like that aspect of your body map to appear in your video. We can do this by attaching a small post it note with a number on it. Next, go through your text. This conversation is transcribed from our last meeting. Use a highlighter to indicate what text will go with the images on your body map. Place a number beside your highlighted text to correspond with the number or numbers of your body map. I will use the text to clip audio from the voice recordings from the last meeting and place them with images from your body map. If you feel audio is needed, we can record you talking more about your body maps. You can see I've also placed some group dialogue here. Feel free to highlight text from that discussion as well.

	Finally, go through your digital images, choose which ones are most meaningful to your story. Number photos to go with the numbers on your text and your body map.
	[Show an example]
	It will be my job to bring these four elements (your songs, your digital images, your body maps, and your voices) together.
	[Video record and take digital images at this time, support where help is needed]
	[Give 1 hour, 30 minute, and 10 minute time notices, then bring group back together]
	[If there's time, we can do some sharing about our storyboarding process]
Wrap up and next steps (10 minutes) Materials: • Meeting reminder flyer • Remuneration and reimbursement cheques	Thank you for sharing your time and your knowledge with me. We have done a lot to outline our personal story for each of your digital stories. In the meantime, I will transcribe the recordings of today's session and compile the digital images and video. In the next part of our work together, we will refine our digital stories individually. Before you leave today, please let me know of a time that works for you to chat about your video. I will need a month to put together the material in the order you indicated through storyboarding activity. At our next meeting together, we will premiere all of the digital stories and have a short discussion about who should see your videos. If you would like to claim your transportation or childcare for this session, please give me your receipts or bring them to our next meeting and I will reimburse you at our next meeting. Thank you again and I look speaking with you about your digital stories in about a month!

	[Distribute remuneration, reimbursements, and meeting reminder flyer]
Take-down and filing checklist	File and store: • Audio files from voice recorder • Take digital images of storyboards • Digital images and videos from camera • All AV equipment • Participants' note pads and name plates • Paperwork – attendance list, remuneration and reimbursement list, consent forms, information booklets, music list, and contact information • Art data – Participants' numbered body maps, digital images, and transcripts • All art materials

Appendix F(iv) – Digital Story Editing Interview – Facilitation Script

Facilitator: Kimberly Lopez   **Length of time: 1.0 hour**
Date: TBD   **Location: Phone call/Skype**
Room specifications: N/A   **Room contact information: N/A**
Participants in attendance: TBD

Set-up and preparation (30 minutes)	• Ready video and story board summary • Ready consent forms • Computer, audio recorder • Paperwork – attendance list, remuneration and reimbursement list, consent forms, and contact information • Information package
Introduction and consent **(10 minutes)**	**Script** Hello _____, Thank you for agreeing to meet with me to discuss your video. In this meeting/telephone call, I hoped we could talk more about your digital story on labour, leisure, and care of PSWs. We arranged this time previously, but is now still a good time for you to discuss these details? [If yes, proceed. If no, ask, "what is a better time for you to be reached?"] During our chat today, I will be audio recording our conversation and making notes about some of the questions you may have so I can best address your concerns. Do you agree for this meeting to be recorded?

	[If yes, start the recorder] The purpose of this study is to explore day to day stories of PSWs to understand and improve the structuring of care work. Please be aware that you are able to withdraw your participation at anytime by simply asking me to stop our discussion. Also, you may choose to refuse to answer any question you don't feel comfortably answering. It was my intention to touch base with each participant after the storyboard workshop to get a sense of how they felt about their digital story. As we reflect on your digital story, please feel free to ask me any questions you may have. As you know, this study is a part of my research as a doctoral student, but also serves to better understand and improve the PSW care experience by understanding how care work is structured and your contributions are very valued. I have a few questions for you that will guide us through this meeting, but feel free to add any additional comments. Do you have any questions?
Overall Impressions **(10 minutes)**	At our last meeting, we discussed what digital story telling was all about and we took time to go through your photos, transcriptions of audio, and body maps. We started off our meeting talking about the personal slogans for each of the body maps and what music reflected each body map. Then you placed the different pieces into order. After our group meeting, I put the pieces you selected together. First, what were your overall impressions of your digital story? How did it make you feel? Was it representative of your storyboard?
Reflection **(10 minutes)**	What excites you about your story? What surprises you? What stood out for you?
Messages	What messages do you think your digital story tells to the world? What messages do you want

(10 minutes)	your digital story to communicate? Do you think your digital story, as-is, does this?
Changes to be made **(15 minutes)**	If not, what changes would you recommend I make to your digital story? Are there any other changes you would like to see/hear? Music? Text? Images? Photos? Parts of your body map? Video?
Closure **(5 minutes)**	It is your choice if you would like to review your digital story again before we meet again. Would you like to see your digital story again before it airs to the group? [If yes, "I will incorporate the changes you recommended and will send it to you as soon as it is ready. Feel free to reply to me by email"] Is there anything we didn't cover that you would like to add before we end our meeting today? A note that remuneration for our discussion today will be sent by mail. At our next meeting together, we will premiere all of the digital stories and have a short discussion about who should see your videos. A gentle reminder that we will be meeting together for the last time on [date] at [time]. I look forward to seeing you there! [End call]
Filing checklist	File and store: • Audio files from voice recorder • All AV equipment • Participants' note pads and name plates • Paperwork – attendance list, remuneration and reimbursement list, consent forms, and contact information

Appendix F(v) – Airing Digital Stories and Recommendations – Facilitation Script

Facilitator: Kimberly Lopez　　　　　　　　　　**Length of time: 1.5 hours**
Date: TBD　　　　　　　　　　　　　　　　　**Location: TBD**
Room specifications: N/A　　　　　　　　　　**Room contact information: N/A**
Participants in attendance: TBD

Set-up and preparation **(60 minutes)** Materials: • Computer • Chargers • Access to projector and screen • Digital stories on USB	• Set up chairs, in a semi-circle around screen. • Place AV equipment on table (computer, audio recorder, camera) • Digital stories on USB backup and accessible server
Introduction and consent **(10 minutes)**	Welcome back! This is our last meeting together. Before we begin, I hoped to make sure there weren't any outstanding questions about the information package or where we are in our research process. What questions do you have? [Field questions] Just as we have for previous meetings, I will need to make sure your consent is current and that you've indicated you agree to participate today. Please take note that you are free to withdraw your participation at anytime. This workshop involves watching the digital stories we created and having a discussion about your impressions and where you feel your stories would be most useful.

	Again for this meeting, I will be using an audio recorder to record your comments. I will transcribe the discussion, take digital images, and record video for use later. Your confidentiality is very important. I promise to remove any information that identifies you, including removing your name and cropping out your faces from digital images. As we will be engaged in a group discussion, it is important that we do not share personal information about one another to anyone. Do we all agree to maintain a confidential space? The purpose of this study is to explore day to day stories of PSWs to understand and improve the structuring of care work. Please be aware that you are able to withdraw your participation at anytime by simply asking me to stop our discussion. Also, you may choose to refuse to answer any question you don't feel comfortable answering.
Watching Digital Stories **(30 minutes)**	Over the last few meetings together, you created body maps, told stories, selected parts of visual and verbal story that were meaningful to you and crafted digital stories from the art you created. This meeting today will culminate our time together. Please sit back, relax, and enjoy the digital stories you created! Please feel free to jot down what you are moved by, what you are excited by and what you were surprised by from watching the digital stories. • Participants watch digital stories [Photos/video can be taken at this time]
Post-viewing discussion and developing recommendations **(40 minutes)**	[Ask participants to move their chairs to form a circle] • What are your impressions of your digital stories? What stood out for you? How did they make you feel? What were some of the things you were seeing and hearing? • What were the main insights you gained from engaging in this process? If you were to think about the messages you hope your work to communicate to others, what would those messages be?

	• Which parts of your story should others hear? Who should hear your stories? What are the best ways to share your stories? • How can PSW care work change to realize the hopes you talk about in your second body map? What has to happen to make these changes? What supports do you need to make these changes?
Closure **(10 minutes)**	Thank you for sharing your time and your knowledge with me. We have spent a fair bit of time together unpacking what care work looks like from your perspective as women of colour working as PSWs. I will send each of you a copy of your stories and when these digital stories are made available on a website, I will share that website with you. You will get to keep your maps at the end of this project and I will mail each of them to you, if you so choose. In the meantime, I will work to write up the work we did together. Thank you for participating in the workshops and for meeting with me individually. It has been a pleasure working with you and I wish you all the best in your work, leisure, and in finding time to care for self. If anyone would like to claim transportation costs for this session, or there are outstanding receipts for reimbursement, I will give you a self-addressed stamped envelope and you can mail your receipts to me. I will send a cheque in the mail. [Distribute all remaining remuneration and collect receipts for reimbursement, if any. Please note which participants would like to keep their body maps. Distribute self-addressed stamped envelopes for participants to send receipts for reimbursement for last session.]

AGENDA
February 22, 2017 | 9:30 am - 2:00 pm (Maria and Nicola)
March 11, 2017 | 9:30 am - 2:00 pm (Nena, Clara, & Jenny)

Introductions (45 minutes)

Map 1: Identity, care, and leisure
(65 minutes)

Map 1: Personal slogan
(10 minutes)

Map 1: Body scanning
(45 minutes) **and *Lunch***

Map 2: Telling new stories
(65 minutes)

Final Discussion (30 minutes)

Wrap-up and thank you
(10 minutes)

Introductions (45 minutes)

Tell us about this position and how it best represents your care work as a PSW.

What does this body position tell us about you?

Tell us your story about becoming a PSW.

What does a typical week look like for you?

Map 1: Identity, care, and leisure
(10 minutes/question)

If people were to describe your identity, what would it look like on your body?

How do you care for your body as a PSW?

How does your body engage in leisure as a PSW?

Think about negotiations or compromises you make in/for your caring work. Where do you feel this in your body?

Think about who or what else is involved in your care experience.

When you think about your care work, where do you feel it in your body?

Map 1: Personal slogan (10 minutes)

Think about what story this map tells.
What would the personal slogan of this body be?
Think about a short, memorable phrase to describe this
PSW body. Place your slogan on your body.

Map 1: Body scanning

What are your bodies telling us about...

How identity is taken up? How our identities are involved in care work?

How you care for yourselves?

Your leisure?

The way we negotiate or compromise for caring work? Others are affected by our caring work?

How care work makes us feel?

Map 2: Telling new stories (10 minutes/question)

How do you want yourself to be seen by others? What images, symbols, or words represent how you want others to see you?

What do you hope for? Where does hope live in your body? What does hope feel like? What images, symbols, or words represent hope?

Where does care for self live in your body? What does it look like? Feel like? How does it feel in your body when you feel supported? What does it look like? What images, symbols, or words represent care for self?

How would you care for others while caring for yourself at work? What would need to change? What images, symbols, or words represent how you would change care to make sure you were caring for yourself while caring for others?

If you could engage in leisure the way you wanted to at work, ***what would that leisure look like***? Outside of care work? What images, symbols, or words represent how you would engage in leisure?

Look at your body map. Think about what story this map tells. ***What would the personal slogan of this body be?*** Think about a short, memorable phrase to describe this new body. Place your slogan on your body and add it to your body.

Final Discussion (30 minutes)

Now that we've completed two body maps, let's discuss:

What do you see? How do the bodies differ? What changes are needed to realize our hopeful, happy selves in the second body map?

How do the bodies illustrate hopes for the future of PSW care?

What would you like people to learn from your story about PSW care work? About self-care as a PSW? About leisure as a PSW?

Think back to your body maps. Tell us about how you experienced the body mapping exercise.

How does it feel to acknowledge your body in this way?

What was new for you? What was surprising? What did you find challenging?

Thank you for your participation!

Please see Kim to set up a date for Workshop 2: Digital Storytelling.

AGENDA

March 9, 2017 | 9:30 am - 12:30 pm (Nicola)
March 16, 2017 | 9:00 am - 12:00 pm (Maria)
March 23, 2017 | 10:30 am - 1:30 pm (Nena)
March 24, 2017 | 10:00 am - 1:00 pm (Clara)
March 24, 2017 | 2:30 pm - 5:30 pm (Jenny)

Introduction to digital stories
(10 minutes)

Personal slogans
(10 minutes)

Anthems
(10 minutes)

Storyboarding (80 minutes)

Voiceover (60 minutes)

Wrap-up and thank you
(10 minutes)

Personal slogans
(10 minutes)

Think about what story these maps tell.
What would the personal slogan of these bodies be?
Think about a short, memorable phrase to describe this PSW body.
For body map 1 – think of a phrase or a few words to describe this map.
Write it on a sticky note and attach to your body map.

For body map 2 – think of a phrase or a few words to describe this map.
Write it on a sticky note and attach to your body map.

Anthems/Music
(10 minutes)

Digital stories often have a sound track. Pick two types of music to represent your two body maps.

If you have specific songs in mind, even better! Write these two songs or the type of music you would like on a sticky note beside your slogan on your body map.

Storyboarding
(80 minutes)

Our conversation was transcribed from our last meeting. Please go through text and choose which conversation pieces are most meaningful to you about PSW labour, your leisure, and care. You choose the order of the text. You don't have to use all of the text.

Next, go through your digital images, choose which ones are most meaningful to your story. Put a dot on the photos you would like to see as part of your digital story.

Match the photos you selected with the text you selected. You can choose more than one photo for each conversation piece if you like.

Keep in mind

- What should people know about what care work is like for PSWs?
- How does your body map reflect these messages?
- How will you express what care work is like for PSWs through your digital story?
- What symbols or words could be used to reflect these ideas?

Voiceover
(60 minutes)

Finally, we will read the stories we created. We will need clear audio for the digital stories!

Thank you for your participation!

Please see Kim to set up a date for Workshop 3: Airing Stories and Recommendations