

The Emotional Labour of Frontline Care Work

by

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ABSTRACT

Using a symbolic interactionist approach grounded in the theory of emotion management, this study is a qualitative exploration of emotion in the context of frontline care work. For the purposes of this study, a frontline care worker is defined as a worker paid to provide in-person health or support services directly to an adult client, whether in home or in an institution, and includes a variety of job titles such as care aide, companion, support worker, and nurse. Following in-depth semi-structured interviews, participant talk underwent computer-aided qualitative coding, summarization, and reiterative thematic analysis. In the findings I describe the ways that workers manage their emotions, explore the experiences and consequences of emotional labour among workers, identify three important feeling rules in care work, and expose a number of structural influences that shape workers' experience of emotional labour.

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CHAPTER 1

INTRODUCTION

Canadians report feeling a great deal of pride towards the national health care system (Sinha 2015), suggesting that collectively we are proud of our capacity to take care of each other. Women continue to provide unpaid care work within the context of family (Chappell and Funk 2011; Funk 2012; Funk, Stajduhar, and Cloutier-Fisher 2011), but more than 80 per cent of Canadian women are employed in the formal labour market (Fields, Bourbeau, and Patterson 2018). Because women today have less time to provide unpaid care, families must increasingly outsource care to paid workers (Lan 2011). This social trend is reflected by the fact that many of the job titles held by the participants in this study, such as paid companion, care aide, and support worker, were unheard of as recently as 50 years ago. This social trend is also reflected by the fact the health and social care is among the largest employment sectors in the country (Statistics Canada 2011) and is also the fastest growing employment sector in Canada with an increase of almost 14,000 jobs in 2017 (Fields et al. 2018). The emotional expectations involved caring labour are fundamentally different than in many other occupations (England 2005; Theodosius 2008). Work in health and social care involves attention, concern, long-term relationships, and acting for the benefit of another person, rather than relatively impersonal customer interactions involved in selling a product for the purpose of making a profit.

Frontline care includes the supportive, assisting, and domestic work of cooking, cleaning, helping with personal hygiene, giving medication, and providing transportation and companionship; these ancillary frontline jobs represent as much as 65% of the health care labour force (Armstrong, Laxer, and Armstrong 2014). This research attempts to add to the body of knowledge about all frontline carers, particularly those working in a non-professional capacity.

Specifically, the goal of this study was to explore the emotional experiences of frontline care workers in order to (i) identify how various contextual and structural influences shape emotional labour in care work; and, (ii) consider emotional commonalities in care work across a variety of job titles and workplaces. For the purposes of this study, a frontline care worker is defined as any paid worker providing in-person health or support services directly to an adult client, whether in the home or in an institutional setting. There are many job titles in frontline care, such as home care and home support workers, home helpers, care aides, nurses, companions, and paid caregivers. An assumption that drives this research is that the emotional experiences of workers have consequences that relate both directly and indirectly to the experiences of those receiving formal care and support.

Care is a broad concept, linking formal systems of work with the informal institution of family, and encompasses multiple facets of meaning that relate feelings, thoughts and actions. Care is the act of providing “what is necessary for the health, welfare, maintenance, and protection of someone or something” (Oxford Dictionary Online, n.d), requiring that someone notice that there is a need, followed by ‘caring’ enough to act on that need. Care includes cognitive aspects such as attention or interest, and emotional aspects such as affection or concern. Unpaid carers often understand care and caregiving to be an intrinsic feature of family and loving relationships (DeVault 1999; England 2005; Erickson 2005; Funk et al. 2010; Lang et al. 2014), while paid carers tend to focus on the material tasks that they perform, on emotions less intense than love such as concern and kindness, and on their competency in both areas (Bailey et al. 2015; Lopez 2006; Miller et al. 2008). Ultimately, care is “a mix of different forms of labour that involves hands, hearts and minds” (Bolton and Wibberley 2014:684). Care is an

extensive concept; to narrow the focus to a manageable size this study concentrates on the emotional experiences of those who do the work of care.

There are a number of emotional characteristics expected of people who hold the role of carer. In the private sphere, for example, a stereotypically good mother is loving, thoughtful and selfless. In the public sphere, care workers are expected to be empathetic and supportive, and to put aside their own needs for the needs of their charges (Grant, Morales, and Sallaz 2009; Miller et al. 2008; Salmela 2014; Theodosius 2008). The emotional connection between carer and cared-for emerged as a dominant theme in a concept analysis of care in professional nursing (Hermanns and Mastel-Smith 2012), and studies with a focus on non-professional care work commonly describe the importance of emotional connections between workers and clients (Dodson and Zincavage 2007; Novek 2013; Outcalt 2013; Wiles 2003). As described through the employment webpage of a private care agency, carers must be kind, patient, friendly and attentive (Comforts of Home-Care Inc. 2015). As such, care work requires skill and expertise in managing personal feelings while also attending to, understanding, and managing the physical and emotional needs of the care recipient.

And yet, frontline care jobs are low prestige, low pay, and often precarious—part-time, on call, and with no benefits or security (Daly and Armstrong 2016). Indeed, the work of care has a relatively low status in society more broadly: care is linked to women’s labour in the home, is understood and perceived to require little or no skill and involves the dirty work of “dealing with leaky bodies and unsettled minds” (Bolton and Wibberley 2014:686). Despite Canadian’s pride in the health care system, the actual work of care work continues to be held in rather low esteem. This is also demonstrated by a relative lack of research devoted to the experiences of this category of the labour force. The status of care is important for understanding emotional

experience, as status is the basic building blocks that inform expectations around what workers should and should not do, and what they should and should not feel.

In this study, emotion is understood through a sociological lens. That is, emotion does not arise out of biological triggers, unbidden and uncontrollable. Rather, emotion arises based on a person's interpretations of their situation and their understanding of their status relative to others (Hochschild 2003). For example, a person may feel insulted because they believe that their status is threatened through slander or the denigrating actions of another. But if a person does not perceive or interpret words or actions as discrediting, for example perhaps the other person is merely a child, they are unlikely to feel insulted. In other words, the majority of emotion is not instinctual. Emotion operates through social mechanisms such as cultural and gender socialization, and through people's interpretations of their social relationships (Kemper 2014; Shott 1979; Thoits 1989; Turner and Stets 2005). According to Turner (2014), emotions are aroused in two basic ways: through a person's self-evaluation of meeting (or not meeting) expectations, and through interaction and feedback from others.

Importantly, emotion is not contained only within the body of an individual as a sensation, emotion is also external and shared between actors through the give-and-take of action and reaction. Emotion is a key element of micro-interaction and communication (Collins 2014); the output of emotional expression gives the other person information, while the emotional input from that other person is then interpreted (or misinterpreted). Emotional acumen or emotional literacy, that is, the ability to appropriately interpret the emotional expressions of others, is an important ability for care workers (Thoits 1989). At the same time, the ability to manage one's own emotional response is also important; workers are commonly expected to show attention

and concern, and ideally are capable of exhibiting whatever emotional appearance is appropriate to the situation (England 2005; Theodosius 2006; Wharton 2009).

Another key feature of care is that it is intrinsically relational. Unlike many forms of paid work, carers are often tasked with duties that are highly intimate, and which may be perceived as a violation if undertaken without supportive rituals (Goffman 1971), and the emotional exchanges that allow such intrusions to occur. Also, care relationships may endure for years, developing into deeply held feelings of concern and affection on the part of both the worker and the client (and social ties may easily extend to other members of the family). Emotion cannot be removed from the highly interpersonal and relational work of frontline care.

For much of my adult life I have worked as an unpaid carer; along with mothering, I was the primary family carer for my father-in-law who was struggling with early onset Alzheimer's disease. In terms of paid labour I have worked in the frontlines of care, performing support work for older adults in long-term residential care, and in the community where I worked with older people who required additional supports due to various disabilities. My personal experiences have taught me the value of emotional control, not only controlling how to show feeling, but learning how to control the experience of feelings. I learned that it is vital for carers to be able to interpret the emotional cues of the people they are charged with caring for, otherwise instrumental tasks turn into cruelties and interaction becomes harmful rather than supportive. Emotional acumen becomes even more crucial if other forms of communication are lacking, as when a person has disabilities interfering with speech or cognition. I also came to understand that emotional ability does not come 'naturally,' but is a skill learned and improved with effort, reflection and practice. My goal with this research was to learn more about my own assumptions

and understandings of care and emotion, and to add to the sociological body of knowledge of care and emotion more broadly.

I grounded this research in an interpretive and constructivist epistemology (Creswell 2013) and a symbolic interactionist approach (Goffman 1959; Mead 1934). From this perspective, emotion is highly subjective but is not a lone experience. Emotion arises out of the context of a person's life experiences and through their situated interactions with others (Hochschild 2003; Stets and Turner 2014; Thoits 1989). Because of these features of human emotional experience, I chose qualitative interviews as the most appropriate method for understanding and interpreting feeling, facilitating greater richness and depth of information from participants (Warren 2001). I then analyzed transcriptions through preliminary coding within the qualitative analysis software package NVivo 11, followed by the creation of interpretive memos and case summaries which I used for reiterative thematic synthesis. My personal experience may be misconstrued by some as a problem of bias. However, as a qualitative researcher, I understand my personal experience to be of significant benefit to the quality of analysis, improving my potential for interpreting the data in ways that would resonate with participants (Lincoln and Guba 2013).

This thesis is comprised of six chapters, including this introduction. Chapter two outlines the theoretical underpinnings of this research, including sociological approaches to emotion and an overview of research on emotion and care, while chapter three discusses my methodological approaches and choices. Chapters four and five form the findings: chapter four provides context by exploring the meaning of care as constructed and interpreted by participants, and how the structural features of care organize and impinge on care relationships and influence the emotional work undergone by carers. The structural features addressed in this chapter include the

care plan, organizational systems, and a contrast between working in institutional settings and in private homes. Chapter five delves into the micro-interactions within worker-client relationships and explores emotion management as experienced by participants. This chapter also describes three important feeling rules of frontline care identified as “don’t take it personally”, “be respectful”, and “treat them like family but don’t get too attached”. This study concludes in chapter six, in which I discuss the findings in light of the current literature, discuss limitations and possible future directions for research, and policy issues that could support (and improve) the emotional experience of people who put so much effort into the work of care.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

This chapter is structured around a discussion of theoretical approaches to emotion, care, and care work, and provides a background on how sociology approaches emotion as a public and social action rather than as a private event hidden within the body. Particular attention is paid to the theory of emotion management, including its sociological foundations, criticisms, and contemporary discussions about its utility as an analytical tool for investigations in the work of care. The theoretical discussion is followed by a brief overview of emotion and emotion management in the frontlines of care.

THEORETICAL FRAMEWORK

Emotions

Research in emotion, particularly in relation to labour, is not new to sociology. Durkheim argued that group membership and common activity engender feelings of belonging and solidarity, while Marx argued that relations of production create feelings of anger and alienation (Grant, Morales, and Sallaz 2009; Heaney 2011; Kemper 1984). However, a sociology of emotions, energized by the work of Arlie Hochschild, did not really appear until the latter half of the 20th century (Heaney 2011; Turner and Stets 2005). Emotions have a biological element in that basic reactions such as anger, fear, or surprise seem to arise naturally, such as a feeling of fear when sensing a threat, or a feeling of pleasure on eating a good meal (Thoits 1989). Basic emotions are evoked when there is little need (or little time) to interpret or think about a given situation. Yet sociologists argue that much of human emotion is shaped by how people interpret and express what they feel (Hochschild 2003/1973; Scheff 2009), and the majority of human

emotions are tied to interpretations of social life and relationships (Kemper 2014; Shott 1979; Thoits 1989; Turner and Stets 2005). For example, feelings of admiration, pride, and guilt are not ‘basic’; you cannot feel jealousy, nor can you feel shame, in the absence of a social context.

A great deal of emotional interpretation takes place through taking on the role of the other, which is when we make inferences about what another person might be thinking, and reciprocally see ourselves through that imaginary perspective (Mead 1934). At the same time, we are aware that others are doing the same about us, and we put on a front to manage the other’s impression of us based on what we think they think about us (Goffman 1959). The other person may be an individual or a group of people who we are attempting to interpret in real time as we actively interact with them, but the other may also be imagined in terms of an abstract self-judgment: what would mom think? Or what would ‘people’ think? (Mead 1934). Arlie Hochschild (2003/1973) extended these sociological concepts to include emotions in addition to thoughts, arguing that role taking also involves interpreting what we think others feel about us, which in turn helps us understand our own feelings. The emotional layer of perception, in a reciprocal fashion, helps us determine how we ourselves feel about a given situation, and how we feel about ourselves.

Two domains of emotion that result from role taking are defined as reflexive and empathic emotions (Shott 1979). Reflexive emotions are those that we feel when we consider how the self appears to others, and include feelings of guilt, shame, envy, and pride. Empathic emotions are those that we feel when we consider how another is feeling, or imagine what we might feel in the same situation. As explained by Peggy Thoits (1989), empathic emotions help us understand how the other person is feeling, and give us clues about how to respond appropriately; reciprocally, the emotions of one person become the object of the other’s

response. An ability to recognize and understand the emotions of others, while at the same time recognizing, understanding and managing one's own emotions, can be a significantly important skill in relationships of care (Stone 2002) . Similarly, a lack of emotional acumen can be a detriment in care relationships. Emotional support-giving attempts may succeed or fail depending on the worker's capacity (and willingness) to perceive, make sense of, and respond to emotional signals.

One of the ways these attempts to role-take manifest is explained by Goffman's concept of impression management (1956, 1959, 1963). He argues that individuals act to hide stigma and avoid emotions involving shame. For Goffman, shame is a broad emotional category that includes reflexive feelings ranging in degree from trivial embarrassment (such as laughing at oneself), through disgrace, to abject humiliation. Shame is also generative, in that it is linked to and can lead to other emotions such as anger, doubt, disgust, anxiety, and fear (Scheff 2009; Theodosius 2008; Turner 2014). Any variation of a shame emotion occurs when seeing the self negatively through the eyes of others, even if only slightly, and even if only in anticipation or in imagination (Dodson and Zinbarg 2007; Shott 1979). Evidence of shame can be seen in averted or lowered eyes, blushing, stammering or giggling, or aggression and anger. Scholars in emotion have identified shame as a significant and compelling emotion, shaping much of human interaction (Scheff 2009); people act to avoid shame, and when they experience shame they work to avoid, change, or disguise their feelings (Hochschild 1979).

Relatedly, I draw on Goffman's conception of rituals as supportive interchanges (1971). Rituals are the everyday micro-acts of civility and respect (hellos, pleases, and thank-yous) that form a central organizing feature of society through encouraging and affirming connectedness, and leading to more dialogue and interaction. These rituals are directly involved in shows of

gratitude, appreciation, and respect. When these rituals of civility are violated, shame for one or both actors ensues, and remediation in the form of apology (or restitution of some kind) is needed if the interaction is to continue without conflict. Emotion is directly implicated as a crucial piece of these micro-acts and everyday interactions (Hochschild 2003).

It is important to note that a sociological perspective of emotion insists that society and culture are inextricably linked to our feelings. We interpret emotion based on cultural scripts, and our expectations of how a person ought to feel in a given situation. Culture also provides meaning and language allowing people to understand and describe their feelings. Further, we understand the emotions of others (and determine our responses) based on our interpretations of their emotional signals. Culture strongly influences how people understand and govern their personal emotional experience.

Emotion Management

Arlie Hochschild is credited with invigorating a sociological enquiry into emotion, and her work developing the theory of emotion management, or emotion work, is built directly on Goffman's theorizing of impression management. Her book "The Managed Heart" investigates how people manage the impressions others have of them, through controlling their emotional expressions and appearance (Hochschild 2003). Through analysis of service staff in the airline industry, she shows how external display and internal feeling need not match. Her analysis investigates the ways that we work on emotions to feel what we think is appropriate for the situation, or at least to project the appropriate emotional appearance even if we do not really feel it. Everyday talk is full of examples of emotion work, such as 'I psyched myself up', or 'I forced myself to stay calm', or 'I tried not to cry'. Sometimes our emotional performances are highly

managed as we self-consciously try to project a specific persona or align ourselves with a given role. Other performances feel simple and natural, such as when our feelings easily align with our identity and expectations for the situation. For emotional performances that align with expectations, emotion management operates invisibly and automatically and generally goes unnoticed. Emotion management is thus detectable only when automatic emotion work fails, as that is when people must consciously put effort into their emotional expression and feeling (Salmela 2014).

Surface acting and deep acting

Drawing on a theatrical metaphor, Hochschild (2003) proposes that people control their emotions through a process of surface acting and deep acting. Surface acting is the outward, managed presentation of self. It is acting calm when you are feeling upset, or putting a smile on your face when you would rather not. In the context of the workplace, surface acting allows workers to do their job and also acts as a protective barrier between how people must behave while at work versus who they perceive themselves to ‘really’ be. Surface acting is common in strongly hierarchical social systems such as workplaces (Turner 2014; Wharton 2014). Those in dominant positions have some freedom to express a negative opinion of others, while those in subordinate positions are expected to show deference and respect towards their superiors even in situations that would otherwise incur feelings of anger or contempt. Those working in a social context, such as people in retail, food services, or the health care industry, are also expected to show respect towards their customers and clients. The need to put on a consistent display that is at odds with internal feeling can be exhausting (Hochschild 1979). A person who is tired is apt to make errors, and an emotionally exhausted worker may allow an inappropriate emotional display to slip out (England 2005). For example, a worker may forget to hide their feelings of contempt

for their boss or may be unsuccessful at acting politely when interacting with a rude customer. Such emotional ‘slips’ can result in social conflict and significant personal consequence, ranging from a raised eyebrow to an escalation in an emotionally charged interaction, up to a formal reprimand or even getting fired.

Deep acting goes beyond merely putting on the correct display, rather it involves living with the appropriate emotion so that the inner world of feeling matches the outer world of appearance. Deep acting is a focused emotional regulation strategy involving any combination of suppressing or eliciting felt emotion (Wharton 2014). “In deep acting display is a natural result of working on feeling; the actor does not try to seem happy or sad but rather expresses ... a real feeling that has been self-induced” (Hochschild 2003:35). For example, a care worker who is interacting with a ‘difficult’ client may draw on empathetic emotions, allowing them to transform angry feelings about the ‘difficult’ behaviors to feelings of sympathy and concern. Deep acting has advantages over surface acting, as ‘faking’ a feeling becomes unnecessary, and slips of showing inappropriate feeling do not happen. However, when deep acting fails a worker must fall back on their surface acting skills.

Feeling rules

Social life is guided by social norms, which are shared understandings about how you ought or ought not behave. Norms allow us to understand the social world and give us direction for how to act in a given situation. Breaking a norm can have negative consequences, ranging from internal feelings of uneasiness to external social sanctions such as shunning or even imprisonment. Goffman (1956) divides behavioral norms into the broad groups of substantive rules and ceremonial rules. Substantive rules are typically formalized into codes of law, mores or ethics. Ceremonial rules are the guides for behavior where the expression of self or the

appreciation of others is primary, are highly interpersonal and tend to be part of the cultural fabric of living.

Hochschild focused on the emotional content within ceremonial rules, describing feeling rules which outline not only how we and others ought to behave, but also how we and others ought to feel. Feeling rules, or emotional norms, are cultural scripts “according to which feelings may be judged appropriate to accompanying events” (Hochschild 2003:59). Feeling rules are rarely overtly described, becoming visible only when they are broken, as others respond by teasing, scolding or shaming. They are highly visible during early socialization, as children learn the norms of everyday manners. Emotion work is tied directly to feeling rules, as people shape their feelings according to what they believe they *should* feel.

Emotions in the workplace: emotional labour

The difference between publicly expressed emotion versus privately felt emotion is central to Hochschild’s conception of emotion work. The public-private dichotomy also informs her distinction between emotion management and emotional labour (Theodosius 2008). Emotion management takes place in the private sphere of home and everyday interaction, while emotional labour takes place in the public sphere of work. For Hochschild, emotional labour is a corporate commodity controlled by the employer, with direct implications for profit. Jobs that call for emotional labour have three common characteristics:

“First, they require face-to-face or voice-to-voice contact with the public.

Second, they require the worker to produce an emotional state in another person - gratitude or fear, for example. Third, they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees” (Hochschild 2003:147).

In the workplace, many emotional processes are employer-directed “and are embedded in job requirements and performance expectations” (Wharton 2014:343). Hochschild’s main concern is the degree of governance employers exert over the emotional presentations of their employees, and the outcomes of such externally imposed emotional control (Salmela 2014). Workers accept external control to comply with workplace expectation, and also because they “come to believe in, and identify with, the organizations’ emotional mandates” (Wilkins and Pace 2014:397) At its most extreme, control of emotion by outside forces rather than by the self can result in exploitation of the worker, in denial of authentic feeling, and in self-alienation (Hochschild 2003). For Hochschild, the separation of public and private is primary.

Emotional dissonance and alienation

Hochschild (2003) identifies the conditions that produce emotion management as a misalignment between emotional experience and emotional expectation, and she refers to this gap as emotional dissonance. To relieve dissonance, people may engage in cognitive reappraisal, reconsidering their interpretations of the situation to bring their understanding closer into alignment with their feeling. For example, a bride might expect to feel excitement and joy on her wedding day, but when the day arrives finds herself feeling nervous, disappointed and let down. In this situation, she is apt to work hard to cheer herself up, to feel the happiness that she thinks she should. As part of the cheering-up process, she may tell herself that her expectations were unrealistic, which helps reduce her distress over the misalignment of experience and expectation.

However, cognitive reappraisal of a situation is less useful in work situations where emotional expectation is not open for debate. Workers may regularly show emotions they do not really feel (such as compassion or empathy) or suppress an emotion they are feeling (particularly anger and frustration). Intentional differences between emotional appearance and feeling may not

necessarily be experienced as a problem, and in some cases may be easily accepted by the individual (Bolton and Boyd 2003). However, when emotional appearance becomes “harder to deliver, the worker may withdraw emotional labor and offer instead a thin crust of display ... the penalty becomes a sense of being phony or insincere” (Hochschild 2003:21). Repeated surface acting can lead to emotional alienation, which is a sense that there is an impassable divide between feeling and expression.

While alienation is not an inevitable outcome of surface acting, research provides many examples of emotional distress experienced by employees as they attempt to conform to the emotional requirements of their job. Surface work can result in the ‘burnout’ commonly experienced by workers in a number of emotionally intensive service areas, such as health care, social services, education or criminal justice (Hochschild 2003/1973; Maeve 1997). Workers report high levels of burnout when deep acting fails and they must instead engage in surface acting for long periods of time (Wharton 2009; Wilkins and Pace 2014). The negative effects of emotional alienation include stress, job dissatisfaction, absenteeism, and changing careers (Salmela 2014). Organizational systems, workload, management styles, and emotional support networks may alternatively support the worker or contribute to emotional exhaustion.

Theorizing Emotion Management in Care

The concept of emotional labour as analytically distinct from emotion management is not without critics. Bolton and Boyd (2003) argue that Hochschild paints employees as emotionally crippled rather than exercising choice in their emotional interactions with clients. Further, they find the dichotomy between public emotional labour and private emotion work as overly simplistic, since many feeling rules in the workplace are not necessarily commercially motivated.

They contend that Hochschild fails to distinguish “between emotion management as part of the capitalist labour process, emotion management due to professional norms of conduct, or emotion management during normal social interaction in the workplace” (Bolton and Boyd 2003:293). Cranford and Miller (2013) further criticize Hochschild’s dichotomous view in the context of care work, pointing out that emotional labour does not fit well in the context of care, which may involve long-term personal relationships rather than short-term and relatively impersonal interactions as in some other service sectors. Further, they point out that health labour is often state-funded rather than part of the profit-seeking market system of production and wealth acquisition. Indeed, Canada’s health care system is a mixture of private and public interests, and care work is often undertaken through state-run health systems where economics forces are mitigated by social values and political policy. While it is outside the scope of this research to explore these ideas, it is likely that capitalism and profit-seeking may become increasingly important factors for care work in the face of modern globalization (Armstrong et al. 2014).

Nevertheless, dichotomizing emotional control between the commercial sector and everywhere else certainly creates a problem for studying emotion and care work. Is the worker kind to her client because her employer demands it, because of her own expectations of her work role, or because she is expressing ‘genuine’ concern? Care is an activity where personal identity and work roles are blurred (Aronson and Neysmith 1996), and the task of teasing apart emotional labour as distinct from other forms of emotion management becomes difficult. Below, I describe the work of two scholars who have attempted to address these issues, both with a focus on emotion in nursing.

Bolton and Theodosius: emotion management in nursing

Sharon Bolton is highly critical of Hochschild's public-private dichotomy of emotion management and emotional labour, and she abandons the concept of emotional labour altogether. She developed her own typology of emotion management and identified four types of emotion management in nursing: pecuniary, prescriptive, presentational and philanthropic (Bolton 2000, 2005; Bolton and Boyd 2003):

- Pecuniary emotion management—explicitly imposed feeling rules based on profit-seeking.
- Prescriptive emotion management—feeling rules based on organizational roles and status, exemplified by a professional code of ethics in nursing. Prescriptive feeling rules are both explicit and implicit and are imposed through workplace and educational socialization.
- Presentational emotion management—feeling rules based on everyday manners and etiquette imposed through basic socialization.
- Philanthropic emotion management—the individual gives a 'little extra', based on empathy or benevolence.

In analysis, however, determining individual motivations is highly problematic. Is the nurse smiling at her patient because her employer demands it, or because nurses are morally bound to be pleasant, or because she is being polite, or because she thinks her patient could use a little boost? Bolton's re-conception of emotion management is taken up by some (Cranford and Miller 2013) and contested by others (Brook 2009; Salmela 2014).

Catherine Theodosius (2008) also criticized Hochschild's theory as problematic in an analysis of care work, however, she did not abandon the concept of emotional labour. Instead,

she created a typology of the emotional labour she found in her study of nursing. Similar to Bolton, she found that nursing emotional labour involves employer and organizational demands, and is also influenced by the moral imperatives of care as formalized in nursing ethics.

Theodosius arrived at three types of nursing emotional labour which she terms therapeutic, instrumental and collegial:

- Therapeutic emotional labour —performed for the benefit of the patient, involving empathy and listening. Also used to develop trust and establish a relationship between the nurse and patient.
- Instrumental emotional labour—undertaken to encourage cooperation from the patient, facilitating the embodied tasks of health care.
- Collegial emotional labour—encompasses interaction amongst nurses and other members of the health care team and is not directly implicated in nurse-patient relationships.

Theodosius' conception of therapeutic emotional labour is similar to Bolton's conception of philanthropic emotion management, in that emotions are based on empathy, and emotional control is undertaken for the benefit of the patient. Therapeutic emotional labour also encompasses many aspects of Bolton's concept of prescriptive emotional management, in that this type of emotional labour is a moral responsibility and a fundamental aspect of nursing work (Theodosius 2008). For both Bolton and Theodosius, the professional code of ethics in nursing is highly salient. A nurse who perceives that her client is anxious or upset and "engages in a reassuring conversation with the patient is a case in point. The nurse's compassionate support of the patient complies with her professional feeling rules" (Salmela 2014:139). If therapeutic

emotional labour is not done, or is done clumsily and inexpertly, the nurse runs the risk of appearing cold or uncaring, violating ethical expectations.

Importantly, therapeutic emotional labour involves the ubiquitous feeling rule ‘don’t take it personally’, where normally unacceptable social behavior in a patient or client is excused due to their illness, their pain, their personality, their age and so on. This feeling rule allows nurses to banish feelings of anger or resentment at mistreatment or ‘bad’ behaviour, and encourages nurses to act with benevolence towards a patient regardless of how they are being treated by that patient. However, emotional labour that is therapeutic and benevolent in intent is not only undertaken by nurses, and the feeling rule ‘don’t take it personally’ is not exclusive to nursing (Cranford and Miller 2013; Dupuis, Wiersma, and Loisel 2012; Hochschild 2003; Matousová and Tollarová 2014). Care workers of all kinds strive to help their clients feel better, both emotionally and physically. The argument that this kind of emotional labour is embedded in an explicit code of ethics appears to miss the fact that the ethics of nursing are in turn embedded in broad social norms regarding care more generally.

Instrumental emotional labour is emotional presentation undertaken to gain compliance and cooperation from the client (Theodosius 2008). The goal is to facilitate the bodywork involved in health care, some of which may be uncomfortable or even painful for the patient. Instrumental emotional labour uses techniques such as distracting, teasing, cajoling, or reassuring, and draws on empathy to understand and respond to the emotional status of the patient. Rather than being solely for the benefit of the client, however, such manipulation of the emotions of the other is also for the benefit of the nurse, allowing her to complete her tasks more efficiently. Instrumental emotional labour seems to differ from therapeutic emotional labour primarily in purpose rather than in performance. According to Theodosius, if this type of

emotional labour is withheld, worse than merely appearing cold, the nurse will likely appear unkind, cruel or even abusive. Instrumental emotional labour is undertaken with the intent to ease direct physical interaction, while therapeutic emotional labour is undertaken with the intent of creating and maintaining a positive relationship. Both types of emotional labour appear to relate to all frontline care work.

Collegial emotional labour is the emotion management undertaken amongst co-workers, which Theodosius refers to as ‘the health care team’ (2008). Collegial emotional labour is much more fluid and negotiable than therapeutic or instrumental emotional labour, and depends on the nuances of status, social identity, personal identity, and personality. The feeling rules that apply to collegial emotional labour are highly variable and may take place in formal team interaction, in corridors and behind the scenes, or in front of a patient or family member. Work-related status is a key factor in collegial emotional labour: those in lower status positions often need to do more emotional labour than those in higher status positions, particularly in terms of suppressing anger. The importance of relative status in the workplace has been noted by researchers exploring emotion in other industries as well (Piper and Monin, Nanette 2006). However, according to Theodosius, nurses have a specific purpose within the hierarchy of care as “conduits for communication” amongst the health care team, and the main purpose of collegial emotional labour is to facilitate care (2008:178). Despite this assertion, however, she notes that emotional labour among co-workers is not exclusively altruistic and for the sake of the patient. In particular, Theodosius explores the relationship between nurses and doctors, where nurses engage in emotion management to protect the self and to negotiate or contest relative status. The concept of collegial emotional labour appears to focus on the relationships between professional

health care providers. Unfortunately, the emotional labour of non-professional workers is completely invisible in Theodosius' analysis.

Finally, Theodosius synthesizes the three types of emotional labour to describe the processes of emotional labour itself. She identifies reflexive emotional processes as a key feature of emotional labour in nursing, finding that much of the emotional labour involves processes that draw on self-identity. Whether nurses engage in surface acting or deep acting reflects not only how much they identify with their work role, but also “the degree to which individuals wish to share their self with those they are interacting with” (2008:213). This issue of self-identity interacting with work, and emotional expression influenced by factors such as self-confidence or relational familiarity, serves to emphasize the problems that arise when simplifying emotion management into an either-or of public versus private.

Bolton and Theodosius generally agree that Hochschild's dichotomous distinction between public emotional labour and private emotional management is overly simplistic when applied to care work. Based solely on an examination of care in nursing, both theorists identify more complex versions of emotion management for care work. However, Bolton's typology depends on identifying individual motivations, which is highly problematic. Theodosius' typology depends less on motivation, and more on the situational context. However, the three dominant situational contexts she identifies are exclusively relevant to nursing, concentrating only on emotional exchanges between nurses and patients, and nurses and doctors. And yet, emotion management in the context of care is often undertaken by non-professional workers who rarely interact with doctors, and whose clients and customers are not always imagined as 'patients'. Further, Theodosius' typologies are built exclusively from data in one highly specific

institutional health care context — an acute care hospital. Neither approach effectively theorizes emotional management undertaken in all care contexts, and by all frontline workers.

Hochschild herself acknowledges that the analytical distinction of emotion in the workplace versus everywhere else needs further theorizing. She identifies a third realm of emotion management as ‘marketized domesticity’. “If those in the realm of work follow the feeling rules of a company, and those at home rely on the feeling rules of kin, those in marketized domestic life draw on complex mixes of both work and family cultures” (2003:204). Essentially, Hochschild acknowledges that care is the liminal field where work and family overlap and intertwine (Daly and Armstrong 2016). It appears that the theorizing of Bolton and Theodosius overcorrect for the useful simplicity of Hochschild’s initial analysis.

Emotional Labour and the Status of Frontline Care Work

While it is clear that nurses (historically female) are generally subordinate to doctors (historically male), the bulk of personal and social care performed in today’s health care industry has been downloaded from the nursing profession to an array of non-professional frontline workers with titles such as support worker, aide, attendant, or assistant (Armstrong, Armstrong, and Scott-Dixon 2008; Denton, Zeytinoglu, and Davies 2002). These ancillary support roles continue to be dominated by female workers and hold a much lower status than their nursing counterparts. Frontline workers are routinely subject to exploitative work conditions, including high rates of part-time work without union benefits or protections, and working under conditions of casual or temporary employment, split shifts, and irregular schedules (Armstrong et al. 2014). This condition is a reflection of the low esteem frontline care appears to hold in our society, and the devaluation of women’s work more broadly.

In addition to holding a low position in the workplace hierarchy as part of a feminized labour sector, frontline workers tend to be women who are also from a lower class and a marginalized ethnic background (Armstrong 2014; Bourgeault et al. 2010). Although the ethnic mix of the frontline care labour force in Canada is somewhat unclear because of the statistical categorization of occupations, the evidence strongly suggests that immigrant women represent a disproportionately large segment of workers (Armstrong et al. 2008; Cranford and Miller 2013; Denton et al. 2002; Novek 2013). This factor adds an extra layer of complexity to understandings of status in the workplace, as racialization may further depress the social status of many frontline workers.

According to Wharton (2014), feelings of anger among workers in low-prestige jobs correlates with perceptions of mistreatment, while workers in high-prestige jobs tend to feel anger through perceptions of disrespect. As mentioned previously, Theodosius (2008) explores surface acting among nurses possessing a certain level of professional prestige, but who find themselves suppressing anger over being treated disrespectfully by doctors. As part of her analysis, she identifies the key importance of reflexive shame-anger spirals in such situations of status inequality. Shame-anger spirals are feelings of shame and humiliation one moment, followed by anger and indignation the next, and so on repeatedly (Scheff 2009). However, Theodosius neglects to analyze the relationships between nurses and their subordinates, such as nurses' aides, orderlies, student nurses, cleaning staff, food services staff and so on. Given their relative status as compared to nurses, ancillary or support workers also may be expected to experience such shame-anger spirals in their relationships with co-workers. Indeed, this sense of emotional distancing specifically in the context of work, and "may be particularly important for

those in the most structurally disadvantaged positions, and whose dignity is most at stake” (Wharton 2014:343).

In terms of structural position, a recent study analyzing power and social position from a Foucauldian perspective found that health care assistants caring for older adults with dementia were more likely to feel undervalued and disregarded rather than empowered (Scales Kezia et al. 2017). Indeed, it is generally acknowledged that frontline care work is ‘subordinate’ and ‘ancillary’ (Armstrong et al. 2008; Denton et al. 2002; Dodson and Zincavage 2007; Stacey 2011; Stone 2002). And yet there is ambivalence over who holds social power *within* care relationships. In discussing the ‘peculiarities’ of interaction in institutional settings, Goffman noted that care workers “may be obliged to render to patients services such as changing socks, tying shoelaces or trimming fingernails, which outside the hospital generally convey elaborate deference ... [yet] the attendant at the same time exerts certain kinds of power and moral superiority over his charges” (1956:498–99). Care workers are required to impose their will in a number of situations, such as when administering medications, and their authority is particularly conspicuous among older adults with dementia or cognitive decline (Dupuis et al. 2012). Conceptions of older adults as vulnerable to victimization are a key feature in the literature on elder abuse (see for example Walsh and Yon 2012). Clearly, the power dynamics that occur between the carer and the cared-for are complex.

Another complexity is that an individual’s social power also depends on the social setting; there is an important power differential between those caring for patients in institutional settings and those providing care for clients in their own homes (Stacey 2011). Decades of research indicates that deference, or being appropriately respectful, is a fundamental requirement for people who work in the home (Parreñas 2000; Rollins 1985; Romero 1990). The similarities

that can be drawn between home support work and domestic service, doing tasks such as cooking, cleaning, and laundry, helps to further underscore the power and status disparities between professionals and non-professionals in health care (Dodson and Zinavage 2007). The association between care work and femininity, with the added factor that the care may be taking place in the private sphere of the home, means that the activities of frontline care workers tend to go unseen and unrecognized and are further devalued (Armstrong et al. 2008; Bolton and Wibberley 2014; Lilly 2008; Outcalt 2013; Stacey 2011). It also provides another layer of understanding regarding the historical (and ongoing) economic exploitation of women, immigrants and racialized groups in both domestic labour and frontline care (Dodson and Zinavage 2007).

This thesis is grounded in the sociological approach to emotion as an embodied activity that is perceived, evoked and understood based on social context. The reflexive process of role-taking helps us understand how we feel about ourselves, how we feel about a given situation, and provides the information that we use in ensuing interaction, acting variously to support or disrupt those feelings through impression management (Goffman 1959). The theory of emotion management indicates that we interpret and manage emotions as we interpret and determine our actions in relationships (Hochschild 2003). Emotional labour is an analytically distinct form of emotion management that occurs in the context of public relationships and work; the feeling rules associated with emotional labour are more circumscribed by external control than are private interactions. Care involves complex relationships with implications for the emotional experience of carers and has been explored in some depth in relation to nursing. The literature review that follows describes the research findings regarding emotion management and

emotional labour in care work, including what is known about the emotional experience of non-professional frontline care workers.

LITERATURE REVIEW

This review of the literature begins with an exploration of the meanings infused in the concept of care, the gendered nature of care, and a tendency within the literature to oversimplify issues of care alongside analytical dichotomies. The review then explores the perspectives of family, clients, and workers in regards to care relationships, discusses the emotions commonly known to be involved in care, and explores the issues of involvement and distance as an emotional protection for the worker.

Care is a strongly gendered concept, and the working world of paid care is similarly gendered. Both formal and informal care systems are influenced by diffuse yet persistent beliefs about the social roles of men and women (Aronson 1992; Hooyman and Gonyea 1999). Women are expected to be nurturing and kind, and “people assume that women typically occupy social roles related to caring for others” (Diekman and Goodfriend 2006:369). Jobs that emphasize social relationships often require workers to possess personal character traits such as ‘warm’ and ‘compassionate’; traits that are conceived of as innately feminine (Clow, Ricciardelli, and Bartfay 2014). Despite the near-equality of women’s participation in many segments of the general labour force in Canada, gendered discourses continue to associate femininity with jobs that relate to family and love, and associate masculinity with jobs that relate to power and rationality. These gendered associations may discourage men from care work while simultaneously encouraging women to take on the ‘natural’ activities of being nurturing and supportive. One private home care agency in Winnipeg, for instance, advertises their services

with a strong reliance on such role expectations: “Our caregivers give the same care and concern as a 'Good Daughter' would, caring for her parents” (Comforts of Home-Care Inc. 2015). The assumption implicit in this statement, and thousands like it, is that an ideal carer is female.

Not surprisingly, then, it is primarily women who do the work of care. In the informal setting, unpaid family caregivers around the world are predominantly women (Columbo et al. 2011; Pyper 2010; Sinha 2013), and women worldwide spend double the amount of time providing unpaid care as compared to men (Budlender 2008). However, women’s increasing labour force participation has impacted the time and social resources they have available for informal care work (Hooyman and Gonyea 1999; Pyper 2010; Silverstein and Giarrusso 2010). This situation puts pressure on formal care systems and is often referred to as the ‘care crisis’ (Harper 2014; Throne 2011). Women also overwhelmingly dominate in the work of paid care. In Canada, women make up the majority of the entire health labour force, whether professional or non-professional (Status of Women Canada 2012). Supplementary social support is perhaps one of the most strongly feminized segments of the health labour force. In Canada, women account for about 80 percent of frontline workers in long-term care, and about 90 percent of workers in home care (Armstrong et al. 2008; Estabrooks et al. 2015).

The material division of which gender does the work of care is, perhaps, the simplest dualism that arises in most discussions about care work. However, an inclination to view the world in terms of simple dualisms also informs a multitude of analytical divides on the topic of care, such as social versus medical, informal versus formal, public versus private, and non-profit versus for-profit. This tendency also influences how emotion is understood in the paid care context. For example, emotion is seen as ‘genuine’ and holds greater import in the private sphere of informal family care as opposed to the public sphere of paid care work (England 2005;

Hochschild 2004). There is also a divide between physical support and emotional support, as policies surrounding health care and direct care consistently focus on physical tasks or time-based efficiencies, and tend to be dismissive of the emotional work involved in creating and maintaining quality care relationships, if emotion or relationships are mentioned at all (Cancian 2002; Denton et al. 2002; Hayes and Moore 2017; Stone 2002). Nevertheless, care scholars argue that relational work is inextricable from conceptions of care (Cranford and Miller 2013; Daly and Armstrong 2016; Gray 2012; Rivas 2011).

A major theme arising from a family and client perspective of care is the fundamental importance of long-term relationships: (dis)continuity of care is a key factor that directly influences their positive or negative perception of care quality (Funk et al. 2010; Lang et al. 2014; Sims-Gould and Martin-Matthews 2010b; Wiles 2003). Health care professionals similarly assert that care interactions based on trust and mutual understanding are essential for the health and well-being of patients (Bondi 2008; Stajduhar et al. 2011; Theodosius 2008). Frontline workers also focus on relationships, particularly when describing the positive aspects of their jobs: multiple studies have found that it is not uncommon for workers to report working outside of paid hours to allow more time for emotional and relational care, or to provide practical support that is not part of their official duties (Bourgeault et al. 2010; Denton et al. 2002; Lang et al. 2014; Wiles 2003). Reciprocity in the form of mutual exchanges of care and affection are highly rewarding for workers (Brown and Korczynski 2017; Rivas 2011), and relationships between workers and clients can develop to the point where paid caregivers become a surrogate family member or ‘fictive kin’ through their caregiving role (Outcalt 2013; Stacey 2011). Indeed, support workers may be encouraged to think of their charges as their own parents or grandparents, and the use of family-like metaphors in reference to care relationships has been

noted over and over again (Berdes and Eckert 2007; Daly and Armstrong 2016; Funk, Waskiewich, and Stajduhar 2014; Lan 2011; Sims-Gould and Martin-Matthews 2010a).

A family model of care has benefits for organizations and systems which reap the material benefits of paying employees for family-like work that is devalued to minimum wage rates (Boris and Klein 2006). Even better from a systems perspective, in a family model of care, labour may sometimes be provided for free and outside of paid working hours. There may also be ‘obvious’ benefits for clients who want to be treated ‘like family’. However, disability activists and scholars repeatedly point out that not everyone wants to be treated like family; there are inherent potentials for oppression when care is understood as being based on sympathy and caretaking (Caldwell and Heller 2003; Diedrich 2004). Further, care relationships should not be exclusively characterized as a cooperative alliance. Instead, people should acknowledge that care relationships can be, and often are, adversarial and violent (Kelly 2017; Kelly and Chapman 2015).

Despite these scholarly contentions, care workers of all types indicate that their job requires a number of emotional characteristics, such as patience, compassion, understanding, and responsiveness (Bourgeault et al. 2010; Miller et al. 2008). These emotions are not directly associated with organizational expectations of public emotional labour, rather they are associated with generalized social expectations of private emotion management. These same emotions are also associated with maternalism and a ‘family feeling’ achieved through everyday domesticity, such as providing comfort, preparing meals, and simply spending time talking (DeVault 1999; Ruddick 2009). For example, having a simple conversation with a frontline worker may be the only regular interaction a client has with another person (Gray 2012). Everyday and basic social

interaction is a highly important positive feature of frontline support work for clients who otherwise are experiencing social isolation.

The majority of studies of emotion and emotional labour in care work focus on the experience of nursing or focus on specific organizational contexts. Interestingly, one study argued that the professionalization of front-line work results in more bureaucratization (more time filling out forms and complying with systemic red tape) and less direct contact between worker and client (Black and Rubinstein 2005). Further, professionals are formally taught to keep an emotional distance (Stoltz et al. 2006; Theodosius 2008), while non-professionals generally do not have that educational background and instead rely on intuition and life experience (Black and Rubinstein 2005).

In terms of non-professional frontline care work, an ethnographic study conducted in three long-term care facilities in the US found that workers cope with emotional challenges more easily when in the context of a family model of care, developing ‘meaningful’ relationships and having the freedom to express ‘natural’ emotional reactions (Lopez 2006). A mixed-methods Ph.D. thesis that focused on long-term care in the UK found that a family model of care encourages the negotiation of the emotional roles of both residents and staff, with positive results for both parties (Luff 2008). Both of these studies suggest that emotional experience is improved when workers and clients follow family-like emotional norms, rather than organizationally imposed feeling rules. Clare Stacey (2011) finds that burnout associated with emotional labour among frontline carers is reduced by the emotional rewards of care, which foster job satisfaction, a positive sense of self, and dignity. In her qualitative study of home care nursing aides in the United States, she concludes that “these relational aspects of the job are just as important as

monetary compensation, for it is through connections to clients that aides ... achieve a sense of dignity at work” (Stacey 2011:158)

In contrast, Lisa Dodson and Rebekah Zincavage (2007) conclude that a family model of care is exploitative of frontline workers, stating that “our research uncovers the tension experienced by care workers as they manage their work as both a job and as a commitment to care for fictive family members” (p. 906). This tension appears to be a key emotional feature in a family model of care; workers are expected to ‘care like a daughter’ or think of their client as they would their own grandmother and at the same time are encouraged to avoid getting too attached (Matousová and Tollarová 2014; Stone 2002). For example, maintaining some emotional distance is necessary to ensure some personal well-being in the emotionally charged environment of palliative care (Funk, Peters, and Roger 2017), however, this distance cannot be so large that carers appear to be indifferent or cruel (Brown and Korczynski 2017; Theodosius 2008). Care, then, is a balancing act of closeness and distance, attachment and detachment (Bondi 2008; Funk, Peters, et al. 2017). The notion that care should feel ‘like family’ for clients while at the same time be approached in a ‘professional’ manner by workers exposes the fact that care combines the spheres of family and work.

Care relationships can be rewarding or problematic, and this may be most apparent when emotional labour is devalued or goes unrecognized (Cranford and Miller 2013; Stacey 2011). Nurses are trained to develop caring relationships while maintaining a ‘professional’ distance between themselves and their patients (Stoltz et al. 2006), however, few frontline workers receive similar training (Black and Rubinstein 2005). The process of emotion management in nursing has been explored through numerous studies and books, however, conceptualizations and interpretations of emotion by frontline workers remain relatively scarce. This thesis attempts to

address that gap in the knowledge, with a sociological perspective that also encompasses broader social and structural factors influencing individual experience.

CHAPTER 3

METHODOLOGY

The aim of this study is to add to the body of knowledge about frontline caregivers.

Specifically, the study focuses on the emotional experiences of caregivers and asks the following questions:

- (1) how do conceptualizations of their ‘work role’ and ‘social role’ shape their emotional experiences
- (2) how do the structural and situational features of work and workplaces influence their emotional experiences, and
- (3) how do frontline care workers interpret their own emotions and emotional responses to others?

My study draws primarily on the theory of symbolic interaction. The research questions signify the foundations of an interpretive and constructivist epistemology, acknowledging that the meanings and understandings of frontline carers are influenced by normative expectations embedded in their social and work roles. Reflecting the macro-sociological foundation of my inquiry, I also explore how institutional and social structures influence the emotional experience of workers.

THE STUDY DESIGN

This thesis follows an inductive approach to research that informed by the theoretical concepts of emotion work and emotional labour. As Patton (2015) indicates, “While the inductive nature of qualitative inquiry emphasizes the importance of being open to whatever one can learn, some way of organizing the complexity of experience is virtually a prerequisite for

perception itself” (2015:359). I chose semi-structured open-ended interviews as a data collection strategy to help uncover experiences of emotional labour which may be unrecognized by the participants themselves (Hochschild 2003/1973; Salmela 2014), allowing for the exploration of “the unseen or the hidden dimensions of the self” (Marvasti 2003:22). Open-ended interviews also allow for elaboration, permitting conversations that might connect participants’ stories and emotional experiences to broader cultural meanings and social structures (Rubin and Rubin 2005).

Initially, I explored the option of video interviews, so that embodied nuances of emotional expression could be captured. However, I abandoned this approach primarily because of the complexities and cost of acquiring and organizing video equipment. Instead, I made sure to be open and observant of physical cues during the interviews and wrote my observations as field notes written immediately following the interview. These notes were incorporated into the overall analysis whenever applicable. Interviews were recorded and transcribed, then imported into NVivo 11 for coding, followed by summarization, synthesis and reiterative comparison between themes and cases.

Recruitment

This research was approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba. The ethics certificate and renewal certificate are attached in Appendix A. To recruit participants, I used an online classified ad, hung posters in public locations and distributed an invitation to participate through email lists with the Centre on Aging at the University of Manitoba, of which I am a student member. Recruitment materials are available in Appendix B. An ad in the job section of a free online classified service (Kijiji.ca) brought in four

participants. Another four participants contacted me through an invitation distributed to the email list at the Centre on Aging; off note, all of these four participants received the invitation after it was forwarded to them from an employer or supervisor. Finally, one participant was invited from my social network. Paper posters were put up in libraries, grocery stores and retirement residences throughout the city, but earned no responses.

During the informed consent process, participants were asked to read and sign a consent form as approved by the university research ethics board, attached in Appendix C. A few participants were relative novices in communicating in English and had some trouble with the formal legalese of the consent form. For these participants, we read through the form together or I read the form out loud and rephrased concepts to ensure understanding.

Participants

Originally, I intended to confine participants to people working in private homes of their clients, employed either by public home care or by private care agencies. Academic discourses commonly divide care into separate analytical spheres, such as formal or informal, public or private, institutional or community (Armstrong et al. 2008; England 2005; Stone 2002). I was planning to abide by the analytical distinction between working in institutions versus working in the community, however, the act of care straddles all of these areas, and frontline workers commonly cross such theoretical divides. The complexities I faced are eloquently elaborated upon by two of my participants, and I will allow them to state my case:

Gloria: I've always had two or three jobs. Right now I've got a couple, you know. But I've always had, even when I worked full time, I always had a part-time job too somewhere, in a group home or a nursing home or working privately or whatever. I've done palliative care too, and now I'm using that experience to volunteer at one of the hospitals. Same thing. Volunteering is work too, you know. (laughter)

Michelle: The thing when I go to the nursing home, I have relatives there, and one of my relatives is also a client. I work there for the agency, and I also work there with my private clients. For a while, I was also volunteering. So. Yeah. (laughter) I've worn many hats there. So sometimes I go pffffff. You know. Okay, what am I doing right now? And of course, there's different rules depending on your hat.

On reflection and with some further reading, I realized that participants in this study need not be restricted to those with one work location or one job title. In working towards the development of a generalized theory of care, Stone (2002) examined data collected from a variety of professional and non-professional health workers, including nurses, care aides, therapists, social workers and case managers, because she wanted to explore common meanings of care that are not context specific. While I am not claiming to develop a generalized theory, I too wanted to explore commonalities regarding the emotional effort involved in care. While striving to recognize commonalities in the emotional labour of a variety of different frontline care workers, I also acknowledge differences in location and work arrangements. As Rubin and Rubin note, “reality is complex; to accurately portray that complexity, you need to gather contradictory or overlapping perceptions and nuanced understandings that different individuals hold” (2005:67).

To be eligible to participate in this study, respondents were required to be working in frontline care for at least one year. Frontline care is defined broadly as employed to provide direct physical, emotional or social support for one or more adult clients. Additionally, participants had to be 18 years of age or older, be able to talk with me in English, and be able to meet with me in Winnipeg. Of nine study participants, two were male and seven were female. Four of the women were newcomers to Canada and may be further classified as visible minorities. Four participants (two men and two women) had full-time employment and worked in a consistent setting. Of these, two worked directly for the regional health authority while the other two worked within the self- and family-managed care program. In Manitoba, self- and

family-managed care is a quasi-partnership between the public health authority and individuals, whereby hiring, training and other aspects of employment administration are handled directly by the client or a family member, and the worker's wages are funded through the health authority. Four participants had full-time employment; two were employed directly by the public health system and two were working under the auspices of the self- and family-managed care program. Three participants worked a combination of part-time shifts with multiple employers, picked up casual shifts here and there, and one also had a few clients as a self-employed care provider. Two participants worked exclusively casual shifts on an 'on-call' or 'temp' basis. To help sort out the various contexts under which participants do their work, I have outlined participant characteristics in Table 1 on the following page.

Data Collection

Participants were interviewed in a variety of locations according to their preference, including the participant's home or workplace, public libraries, coffee shops and fast-food restaurants. Interviews lasted about an hour and 40 minutes and were recorded on my smartphone. For participant privacy, my phone is password protected, and the audio files were further protected through encryption. The semi-structured interviews were open-ended, with broad and general questions about feelings and experiences, such as "Speaking generally, how you feel about the work you do?" or "Can you tell me about a client that you have worked with for a long time?" These questions were designed to lead participants into talking about their feelings and care relationships, and to give participants the opportunity to fully describe the complexities of the situations surrounding their experience. Generalized prompts were prepared, such as 'tell me more,' or 'how did that make you feel?', and I used conversational techniques of repeating information to clarify my understanding. In addition, I occasionally asked pointed

Table #1 Participant Characteristics										
Name ¹	Age	Hours	Job Title(s)	Years in Current Position	Years of Related Work Experience	Employer	Work location	# of clients	Birth Country	Year Arrived
Brent	43	Full Time	support worker	13	16	Client/Employer self-managed care program	Private home	1	Canada	n/a
Chiara	27	Casual	care aide	>1	6	commercial agency	Private homes	varies	Philippines	2009
Craig	40	Full Time	nurse	>1	10	WRHA ² - community health	Private homes and clinic	varies	Canada	n/a
Daisy	49	Full Time	home care attendant	2	2	WRHA ² - home care	Private homes and seniors housing	18	Korea	2004
Gloria	64	Casual	recreation therapist	>1	40+	WRHA ² - PCH ³	PCH ³	varies	Canada	n/a
		Part Time	companion	5		commercial agency	Private home	1		
		Volunteer	friendly visitor	3		---	Hospital	varies		
Jessie	53	Part Time	care aide	1	35+	WRHA ² - home care	Seniors housing	45	Canada	n/a
		Part Time		2		commercial agency	Private home	1		
Marjorie	47	Full Time	caregiver	3	3	Client/Employer family-managed care program	Private home	1	Congo	2010
Michelle	55	Part Time	home support and companion	7	7	self-employed	Private homes and PCH ³	5	Canada	n/a
				7		commercial agency				
Serena	30	Casual	care aide	2	2	commercial agency	Private homes, PCH, and hospital	varies	Ethiopia	2013

1. All participants are identified by a pseudonym, aside from Gloria who requested that I use her real name.
2. WRHA refers to the Winnipeg Regional Health Authority, the public healthcare authority in Winnipeg and the surrounding area
3. PCH refers to Personal Care Home, congregate residential care for adults, sometimes referred to as a nursing home, accredited and funded through public health

questions in response to the talk of the participant, eliciting as much detailed information as possible related to my overall research question. When relevant, I include my input in the interview conversation in the findings section (chapters four and five). The interview guide is attached in Appendix D.

As I just mentioned, the average interview lasted one hour and 40 minutes; in fact, two interviews lasted two hours and one interview stretched to almost three hours. I found that it was sometimes myself pushing to end the interviews, with participants often having more to say: “*Craig: Can I tell you one more story?*” However, I would become tired from the effort of active listening, of being self-aware, and of engaging in purposeful emotional labour. Indeed, this is also in some ways a limitation, in that I underestimated how much people wanted to talk about their troubles. In the informed consent process, I initially told participants that the interviews would take about an hour. However, after conducting the first few interviews, I told the remaining participants that the length of the interview was really in their control, and that some interviews had gone on as long as two hours. In the future, I will be more careful in how I make such time estimates.

In addition to using emotional labour during the interviews, I was also carefully and purposefully observant of non-verbal emotional communication such as body language, gestures and hand signals, and recorded my observations in field notes written immediately following the interview. It is interesting to note that transcribing is itself an interpretive and analytical process, and it is helpful for student researchers to undertake this process themselves (Davidson 2009; Tilley 2003). Interpretation starts from the moment that talk is put into type. With this in mind, I transcribed each interview as soon as possible. I transcribed the interviews using the freeware transcription software Express Scribe, and transcribed ‘verbatim’, indicating pauses in the flow

of speech and changes in tempo and tonality in hopes of capturing emotional nuance. I did not note background noises or overlapping speech, however, physical actions and emotional cues through body language are included in the transcriptions, based on a combination of field notes and memory.

During transcription, I performed preliminary anonymizing by removing proper names of participants and other people mentioned during the interview, such as clients, family members, co-workers and private employers. All participants are referred to by the use of a pseudonym, aside from Gloria who requested that I use her proper name. The transcripts average just over 11,000 words in length and each took about 7 hours to prepare (about four hours of typing per hour of audio). I then read through each transcript while listening to the audio at normal speed to check for errors and omissions. I went through the transcripts a third time to correct any obvious grammatical errors occasionally made in every day speech or by non-native speakers of English, such as verb form, subject/verb agreement, and the use of articles, prepositions and pronouns. These corrections were directly requested by two participants as part of the informed consent process when they were asked to agree to having the interview recorded. I do not claim to be a grammarian, so it is likely that some errors remain that I didn't notice. To improve readability, I also removed extraneous words and repeated phrases that act as a means of gathering one's thoughts or as habits of speech (such as um, so, like, I mean, that is, yeah). However, such words were not omitted when I understood them to communicate emphasis, or as emotional cues indicating shame or unresolved emotions.

ANALYTIC STRATEGY AND RIGOR

All transcripts and field notes were imported into NVivo 11 (Starter Edition) as raw data. As a student researcher, I decided that it was important to learn as much as possible through the

thesis process, and gaining familiarity with a qualitative data handling application seemed appropriate. A common analytical procedure in qualitative research is to organize data by concept labels called ‘codes’ and assigning data that conceptually fits the code in a process called ‘coding’ (Coffey and Atkinson 1996). NVivo refers to concept labels as ‘nodes’, and refers to the practice of assigning data to a node as ‘coding’. My process for coding was inductive yet also informed by my knowledge of previous scholarship. For example, I had a pre-established node for ‘Don’t Take It Personally’, which has been repeatedly identified as a common feeling rule for care workers (Bailey et al. 2015; Stone 2002; Theodosius 2008). A few early nodes were based directly on interview questions, such as “What would you say are the most difficult parts of your job?”, which I later assigned to nodes based on the emotional content of the answer. In the early stages of analysis I tended to identify concepts that, while interesting, did not inform the research question and set these codes aside as ‘off topic’. In the later stages of analysis, I organized the concept codes into themes through summarization and constant comparison.

The unit of analysis was at minimum a phrase, but more often was multiple sentences or a paragraph, and I found that contextual content in the narratives was also contained within the span of multiple paragraphs. As I tried to uncover emotional themes embedded in the narratives, I found that some of the longer passages were temporally or logically out of order. Participants might pause and correct themselves, digress from the story and then come back to it, change their mind about the meanings and details of events, or jump back and forth in time to clarify emerging thoughts or ideas. Michelle, working as a private companion through a for-profit care agency, provides a brief example of participants constructing their memories out loud:

Michelle: I didn’t even know who she was. And she acted like she didn’t know who I was. But I’m trying to think (pause). Did I not have my name tag on?

Another rebellious move. (laughter) Did I not have my tag? You know what, maybe I didn't. Or no! I must have. I was still using (pause) hmm. But anyway, she acted like she didn't know who I was. (questioning tone of voice, long pause) Then we talked on the phone the other day for some reason, or no, I saw her in the office. And she said 'Oh, was that you I saw by the elevators?' I didn't even know who she was. I didn't know she worked for the same agency, and I thought that was really weird. But no, that was the only time. No, that's wrong. I did see, this past summer, that's right, I did see one of my bosses.

Although the construction of these narratives was interesting, I was not particularly concerned about ways that participants went about constructing their stories. In instances such as these, I performed a micro-analysis of select narratives. First I reorganized the more convoluted and lengthy narratives, reducing my confusion and improving my chances of making sense of what the participants were telling me. In qualitative analysis, writing summaries is a method which preserves meaning, helps significantly in reducing the volume of data, and improves understanding and interpretation (Welsh 2002). Rather than data corruption, or data destruction, qualitative researchers contend that such methods are respectful of participants' ways of organizing meaning (Riessman 2001). I copied and pasted the narratives into a Microsoft Word document where I sorted out the meanings and storyline. To illustrate, Michelle's above passage was rearranged as presented below, integrated with a brief and preliminary analytical commentary:

***Michelle:** I didn't even know who she was. And she acted like she didn't know who I was. I may not have had my name tag on -- another rebellious move. (laughter) You know what, maybe I didn't. [change of subject indicating perhaps the name tag is irrelevant to her overall story, or perhaps she just can't recall. Note that Michelle portrays not wearing a nametag as 'rebellion' – a power move and feelings of resistance/defiance?] But anyway, she acted like she didn't know who I was. Then I saw her in the office and she said 'Oh, was that you I saw by the elevators?' I didn't even know who she was. I didn't know she worked for the same agency, and I thought that was really weird. Aside from this past summer, when I did see one of my bosses, that was the only time.*

After rearranging such passages, I then imported these documents back into NVivo as data to be coded and analyzed while the original passages contained in the transcription were left un-coded.

As I advanced through the transcripts I was continually revising the node structure, asking new questions of the data and performing electronic data searches relating to my new understandings. “One of the problems with this, though, is that every time the researcher asks a question of the data ... it is tempting to re-code this as a subset” (Welsh 2002:8). I fell victim to this temptation. I realized that I had created so many nodes that I was beginning to make coding errors. At this point I stopped coding, and instead worked to clean up the coding system and review the data to check for coding consistency. The nodes from this early stage of analysis in NVivo are attached in Appendix E.

I found that textual analysis was somewhat complicated by my focus on emotions, which are embodied experiences that people may have trouble putting into words (Theodosius 2008). Additionally, the process of emotion management is largely hidden and unconscious and participants may not even try to put it directly into words, instead telling a story to explain an emotional experience (Hochschild 2003; Kemper 1981; Thoits 1989). As a result, nodes were predominantly populated by long narrative passages describing situations, feelings, thoughts, and actions, without an explicit explanation of the process of emotion management. While I expected this as a practical matter of analysis, I did not understand how to use the data analysis software to keep track of my interpretations. I made note of the meaning I was extracting from the data in annotations; however, annotations are not searchable and do not ‘travel’ with the data into nodes. I later learned that memos, a different NVivo tool, are easily searchable in data queries and can be linked to data sources and nodes, so I manually went through the annotations and created memos.

At this point, I began to recognize the limitations of a hierarchical nested node format, which I believe was holding me back from conceptualizing the thematic relationships emerging from the data. I tried to create a networked node system through the NVivo 'collections and sets' tool but stepped back before fully exploring this aspect of the software program. I was becoming extremely frustrated with learning how to fit my analytical insights with the organizational processes of the software. The strength of computer software lies in sorting data, searching for key words, organizing semi-quantitative information such as word counts and frequencies, and analyzing highly-organized data from questionnaires (Weitzman 2000). However, the emotional meaning of my participants' words emerged not in key words or phrases themselves, but in stories and contextual clues. NVivo does not help with drawing inferences or interpreting the meaning held in narrative passages. Rather than acting as a tool to increase my productivity, the software was creating a significant volume of additional work. According to Welsh, "it is important that researchers do not reify either electronic or manual methods and instead combine the best features of each" (2002:9), and I decided that I might proceed more quickly if I moved to manual methods. I wrote case summaries to refine my focus, and developed a Microsoft Word document collecting both the nodes and the memos which I then began to sort into themes. In the process of creating the summaries and the thematic data document, I was able to put aside a lot of extraneous data that did not inform the research questions.

An overview of case summaries, including reference to the themes I had developed at that point, is included in Appendix F. It may be noted that I was using directed content analysis (Hsieh and Shannon 2005) for the three themes of emotional labour in nursing found by Theodosius (2008): that is, 'instrumental', 'therapeutic' and 'organizational/collegial' emotional labour. Theodosius' category 'organizational/collegial' emotional labour refers to that among

nurses and doctors, or between nurses. For the purposes of this study, I found the term to be inappropriate; frontline workers rarely interact with nurses, and even more rarely with doctors, and when they do the relationship could hardly be termed ‘collegial’. Further, the work of participants occurs in the home as well as in institutional/organizational settings. I broke ‘organizational/collegial’ emotional labour into two codes. One code captures situations of working alongside other workers of a similar status, which I termed ‘emotion management with co-workers’. The second code captures situations of working in a subordinate work status, which I termed ‘emotional labour with supervisors and employers.’

The categories of ‘instrumental’ and ‘therapeutic’ emotional labour also proved to be problematic. In Theodosius’ conception, ‘instrumental’ emotional labour is undertaken to encourage cooperation with the nurse as she performs the physical tasks of care, while ‘therapeutic’ emotional labour is motivated by the nurse’s desire to be psychologically and emotionally supportive (2008). Both forms of emotional labour were found among many participants, however, the analytical division between the two relies on knowing the motivation of the actor, and distinct motivations did not clearly arise in the data from frontline workers. The carers in this study predominantly reported holding both motivations concurrently and did not engage in emotional labour in an either-or fashion. After wrestling with the problem for some time, I arrived at the conclusion that it was necessary to discard the labels ‘instrumental’ and ‘therapeutic’ altogether. This difference in thematic coding is likely due to the parameters of the participant pool and the broad context of care work in this study; respondents had multiple job titles other than nurse and worked in multiple settings other than in a hospital. Importantly, the primary form of care undertaken by participants in this study is also substantively different, involving chronic care among older adults rather than acute care among adults of any age. Taken

together, this suggests that social support and care for older adults involves different emotional features than the professionalized and medicalized work of caring for acute patients in a hospital.

The thematic difference between emotional labour among frontline care workers and that among hospital nurses is discussed as a finding in the final chapter of this thesis. From this stage, analysis proceeded in a relatively straightforward fashion; I continued to synthesize the findings through reiterative re-organizing and memo writing, and through drafting and re-drafting the findings chapters of this thesis. Finally, I created an executive summary of the findings for participants, included in appendix G.

I suggest that novice qualitative researchers may find analysis more difficult if they are also learning to use analysis software. For example, I did not fully understand the structural logic programmed into the software, nor how to access or use the variety of tools provided by NVivo. As a result, I repeatedly lost track of theoretical connections, interpretations, and insights. In a variety of analytical situations, I found myself repeating the same work over and over again. While experienced researchers should be able to bend a software package to their own approach (Weitzman 2000), I was unable to make the software mesh with my emerging analytical insights. It might have been better for me to use the online training courses offered by NVivo. I chose not to go this route, in part because of the cost, but primarily because the infrequent scheduling of the training meant I would have had to pause my analysis. In hindsight, it would have taken significantly less time to understand how to use the software upfront. I highly recommend that students take some training in whatever program they choose, before plunging into computer-assisted qualitative analysis.

ASSUMPTIONS AND TRUSTWORTHINESS

Uncovering the emotion management of participants involved a great deal of subjective interpretation on my part, and the emotional experiences of the participants are understood and explained through the veil of my own perspective. My academic training supplies the theoretical basis that I use in this research: a symbolic interactionist approach holds that our understanding of the world is socially constructed, people are agentic, and we create meaning through interaction. Feminist theories emphasize power and status, drawing attention to structural forces and social categorizations (such as race, sexuality, gender, disability, and age) that create and maintain inequity. My perspective is fundamentally grounded in the theory of emotion management developed by Arlie Hochschild, which conceives of emotion as socially constructed and profoundly important in interaction, as explained in chapter two of this thesis. My interest in researching care work among an older adult clientele is also driven by my personal history, as outlined in the introduction. Although I have only relatively recently learned about the theory of emotion management, I have been consciously and purposefully managing my emotions for many years. Through learning about the theory of emotion management I was able to reflect on it in my own experience, and then use that experience to enhance my ability to recognize and understand emotion management in others.

My experience and personal connection to care work may be seen by some as a problem of bias; however, social researchers acknowledge that humans always hold assumptions and bias, whether they are aware of it or not (Creswell 2013; Denzin and Lincoln 2002; Lincoln and Guba 2013). Rather than striving for objectivity, qualitative researchers are as transparent and open as possible about their assumptions, as well as their epistemological and ontological stance, and Morse (2015) argues that clarification of bias contributes to assessing the rigor of qualitative

research. My perspective influences the research questions I have chosen and the design of the study, and I believe it has helped me in my interactions with participants during the interviews. Holding some common ground with participants increased my chances of gaining rapport in the interview and improved my capacity to interpret meanings in ways that the participants would agree with. Such efforts “require some base of prior experience/construction commonality” (Lincoln and Guba 2013:53). During the interviews, a few participants commented that I must have done similar work because I seemed to understand, as exemplified by the following passage from Brent, a disability support worker:

***Brent:** Yeah. [smile] You know exactly what I’m taking about, don’t you?*

***Lisette:** [laugh and nod] I had dishwasher issues, but that’s okay. [B & L both laughing] ...*

***Brent:** There’s a few things, you know, that you can’t tell someone that hasn’t worked in this industry. They just won’t understand.*

My standpoint also strongly influences my interpretation of the data. For example, I know what it is like to do peri-care (washing the genital and anal area of the body). I use my knowledge of this, and multiple other care activities and interactions, to better interpret the emotions of participants.

I hope to show that the analysis is trustworthy and rigorous. In describing the findings I include thick description and long passages of participant data. The goal of this technique is to allow readers to assess my interpretations for themselves (Lincoln and Guba 2013), which in turn contributes to trustworthiness and rigor in the findings. In describing the methodology, I have tried to be transparent and reflective regarding the research process and the analytical choices I have made to arrive at the themes, which I present as findings in Chapter 4 and Chapter 5 of this thesis. In sum, this qualitative study analyzes data collected via nine semi-structured interviews with frontline care workers. Participant demographics are presented in Table 1. Analysis of the

interviews proceeded through preliminary coding in NVivo 11, narrative summaries and case summaries, interpretive memos, reiterative thematic synthesis, and the writing (and-re-writing) of this thesis.

CHAPTER 4

THE EMOTIONAL FIELD OF FRONTLINE CARE

I have borrowed the title for this chapter from the book “Emotional Labour in Health Care: The Unmanaged Heart of Nursing” (Theodosius 2008). Theodosius used the title “The Emotional Field” for her chapter focussing on her methodological approach to studying emotions. I am using the term field from a particularly sociological perspective which proposes that interaction is structured by the social context (field) in which that interaction takes place, while at the same time allowing for human agency (Martin 2003). Care is a field where multiple social institutions (such as health care systems, the family, labour markets, economics, education etc.), structure the perceptions, actions, and motivations of individuals. People hold generally common understandings of their relative position within the field of care, however within these generalities there is a great deal of room for interpretation. Also, unexpected individual actions may disrupt the expectations of a few, but may also disrupt the field itself, changing general expectations. It is within such disruptions, when expectations do not match experience, that emotion management occurs (Hochschild 2003). In this chapter I seek to understand and describe how some of the structures and forces within the field of care influence the emotional experiences of frontline care workers, and how workers themselves may influence the field of care.

Generalized ideas of what makes an ideal carer, in combination with personal conceptualizations of what it means to care, influence the emotional experience of frontline workers. Expectations may not match events, and such situations require emotion management to return feelings back into alignment with expectations. The field of care incorporates moral understandings of care that are defined by normative expectations, the structural status of care

work in the labour market, and the situated social space of working among families in private homes or in the hierarchies of health institutions. Findings presented in the following sections respond to the questions (1) how do conceptualizations of their ‘work role’ and ‘social role’ shape the emotional experiences of frontline workers, and (2) how do the structural and situational features of work and workplaces influence their emotional experiences.

This chapter is broken up into two broad themes. The first theme, the meaning of care, examines how frontline carers construct and interpret care. It explores the stereotypes of care as women’s work, as well as how cultural norms influence the emotional labour of care workers in my study. I focus on the tensions between care as a private labour of love versus care as a public labour for money, and the resulting complex relationship between the emotional and material rewards of care work.

The second theme of this chapter examines three structural and organizational features of care: (1) the care plan, which is a record keeping method and a common feature in the workplaces of frontline care; (2) participant stories that highlight how organizational structures variously support, or do not support, their emotional experience; and (3) the differences between working alone in private home versus in semi-public and public situations such as retirement and long-term care residences.

MEANING OF CARE

Emotion, from a symbolic interactionist perspective, is best understood through the filter of human perception and interpretation. People understand their social world, and also their inner private world of identity and feeling, through ascribing meaning to sensations, interactions, and events (Shott 1979). What it means to care and to be a care worker is important contextually:

these meanings form the milieu within which workers follow suitable feeling rules. This section explores how study participants ascribe meaning to their role of care worker. As will be shown, participants describe themselves as being ‘naturally’ suited to caring, as genuinely caring, and as loving to care. These meanings define the ways that participants work to shape their emotion.

Caring Identities—We Are Naturally Suited to Care

Understandings of good quality care are imbued the moral imperative that carers ought to be driven by a personal desire to help others (Bolton 2000; Miller et al. 2008; Stacey 2011). The basic assumption of this perspective is that it is the ‘nature’ of certain types of people to want to care, and that care work is a vocation and a labour of love (Cancian 2002; Rivas 2011). This theme arises in the talk of all study participants.

Gloria: You’re either a natural at it or you’re not.

Jessie: Me, it’s just like second nature. You know, it’s my life. I’ve lived with it since I was 17 years old looking after people like this.

Chiara: I always believe a person in home care should be special.

Craig: To me, it is more than just a job, and it should be considered more than just a job. If it’s just a job to you, then I don’t know if it’s really the right career for you.

Caring identities are imbricated with other ‘natural’ identities, such as that of being female. Gender is important in assessing emotional labour, as women are held accountable for their emotional performances in ways that men are not (Erickson, 2005). As mentioned in the literature review, the ideal care worker is imagined as a woman, however, workers may resist or reinforce this ideal. A small piece of resistance is found in the present data by two participants who react to clients’ use of the term ‘girls’ when referring to care workers in general:

Michelle: My client said “I really appreciate you ‘girls’ coming in and helping me out and everything you do.” Pffff. [emphasis on girls, eye roll, sardonic tone of voice]

Daisy: Sometimes my clients, when they complain, they are reminded of a previous bad experience with a worker, and then they complain that we are all like that. 'You girls are all blah blah blah.' (sigh) It's like that.

The diminutive term 'girls' suggests that care workers are children rather than mature adult women. The scoffing, sighing and eye-rolling in both excerpts are examples of role-distancing (Goffman 2006), indicating that both Michelle and Daisy resist being cast in the role of 'girl.' However, the narratives from the other female participants reproduce the dominant ideal of care as women's work; indeed, four participants refer to themselves and their co-workers as 'the girls.' Research suggests that the ideal of women as carers not only reinforces and reproduces the subordinate status of care work, it may also create conditions where male carers are the objects of ambivalent sexism because of the incongruity of their role (Clow et al. 2014). Interestingly, the male participants in this study, Brent and Craig, rarely bring up gender at all and when they do they are careful; both mainly identify other workers by their job title rather than their gender.

Another 'natural' identity that overlays with that of carer is ethnicity. Women of color are often depicted as naturally suited for care work, more so than white women (Dodson and Zinbarg 2007; Noveck 2013; Wilkins and Pace 2014). These scholarly assertions are echoed in the talk of participants in my study, many of whom characterize Filipino culture in particular as more caring than other cultures. Jessie, a non-Filipino participant, states: "*The Filipinos are wonderful caregivers. Absolutely wonderful caregivers.*" However, other racial and ethnic backgrounds do not appear positively in the talk of participants, unless the participant is themselves a member of a racialized minority group, showing typical in-group versus out-group attitudes. In such cases, participants tend to frame their ethnic and cultural heritage as infused with an affinity for working with older adults. For example, Serena, a temp care aide originally from Ethiopia who arrived in Canada two years prior to the interview, says that caring for older

adults aligns with her cultural values: *“I like more working with the elderly than the kids ... the way our culture is, they call people a blessing, and when you do something for the elderly they will bless you more.”* Indeed, participants of all backgrounds tend to assert that care work aligns with their personal identity as well as the values of their particular culture.

However, in a diverse country such as Canada, ethnicity and culture may also create barriers for workers seeking to find shared meanings of care with their clients. All four newcomer participants spoke about their English language competency, indicating that a lack of fluency creates feelings of shame, self-doubt, anger and fear. These emotions arise through seeing ourselves through the eyes of others, which is referred to in sociology as the looking-glass self (Scheff 2011). Marjorie, a newcomer from the Congo, provides an example of self-appraisal based on the imagined attitudes of others. Marjorie has a great deal of informal care experience and expresses no self-doubt as to her skills and competencies in the physical tasks of care. However, she was initially ‘scared’ to work for her client/employer:

Marjorie: I am very experienced for this job. But I was scared. The one problem was my English. Yes, I said, oh, my conversation is not good. I was scared.

I interpret her fear to be associated with potential feelings of shame and the resulting stigmatization should her lack of English proficiency be exposed. Marjorie repeatedly mentioned that her communication skills made her afraid to talk to people, and she was hesitant to place herself in a position where she might be expected to talk in English. She was worried that I would misunderstand her and she was also concerned that her lack of English fluency would be exposed to a wider audience: *“For my conversation, you are going to check and make sure it makes sense, right? You are going to fix my grammar?”* Marjorie and one other participant specifically asked that I transcribe their words carefully and correct any grammatical errors so they would not appear unknowledgeable or incapable of talking properly. Such anticipation of

being seen as not ‘normal’ or ‘less than’ indicates fear of exposing stigma. Indeed, social theorists assert that one of the most powerful motivators of human behaviour is acting to avoid shame (Scheff 2009; Shott 1979; Turner 2014). Participants asked me to be a team member, to collude with them in presenting a non-stigmatizing joint front to avoid shame (Goffman 1963).

Participants work with all types of clients, some of whom show overt racism, and frontline workers may be fearful of potential anger or aggression from clients if they show poor language skills. To act despite the anticipation of shame, embarrassment or contempt, requires managing those feelings and eliciting courage (Kemper 2014). Daisy, another newcomer participant, does not mention fear regarding her language skills, yet she also struggles with communication. Interestingly, she is explicit about her efforts to conform to a specific Canadian cultural behavioral norm that involves non-verbal emotional communication. She talks about consciously using eye contact, a sign of honesty and openness in Canadian culture, but an action which holds much different emotional meaning in her culture:

Daisy: [recovering from telling a story that had brought her to tears] Why is my English so bad? (sigh) Even though I’m a smart woman, I’ve taken many many training sessions and education. It makes me very frustrated. And sad. Sorry, I cannot look at your eyes. (sigh) In my home culture I cannot.

Lisette: Huh! (sound of surprise) But you have specifically said to me that you do eye contact with your clients, especially when they’re not happy. (Daisy is nodding) So eye contact is intentional, but it’s not always natural or comfortable for you?

Daisy: Yeah. It’s not normal. It’s not okay in my culture, but I know it is expected in Canada. But right now I am having strong feelings. So, that’s why I don’t look at your eyes. I don’t like eye contact.

As part of the emotional and relational aspect of her work, Daisy reassures clients by looking them in the eye. Daisy is fully aware that she and her client have been socialized in different cultures with different feeling rules. She also understands that the onus is on her to align her emotional expression with that of her client and not the other way around. However, the act of

showing the emotional display expected in mainstream Canadian culture goes against her internalized expectations, and she must manage her emotional reactions at breaking what is to her a social taboo. At this point in the interview, Daisy's feelings are quite raw; she had just finished sharing a story about feeling deeply ashamed and angry. In that moment, the effort of bringing her feelings under control appeared to be significant, and she was unable to perform the additional emotional work that it would take to look me in the eye, showing the effort it takes to provide an emotional display that is at odds with inner feeling.

To further illustrate the emotional effort required of people who must adapt to norms that do not align with those stemming from their primary cultural socialization, I include a quote from Serena, who arrived in Canada two years prior to her interview. Throughout her interview she indicates concern about her lack of language fluency, and comments directly on how she works to achieve cultural competency. She indicates that she finds it challenging simply to understand other people:

Lisette: What would you say are the most difficult parts of your job?

Serena: Understanding people. The other people you work with, and the client. That's not easy. You're always handling so many different behaviours, so many different kinds of people. Especially when you work as a temp, it's always changing. It's always different people. It's very hard.

This passage is interesting because, as Serena indicates, it is not just language where understanding is important, but there are “*so many different behaviors.*” There are undoubtedly many other hidden and unrecognized emotional challenges faced by newcomer care workers as they try to manage language barriers as well as cultural behavioral differences. In Serena's case, this is exacerbated by the fact that her position of temporary worker means that she is not given the opportunity to develop relationships and learn the meanings of her clients' individual and idiosyncratic behaviors.

Cultural variations and language difficulties are highly pertinent in understanding emotional labour, as these differences require additional effort to bring the self into alignment with unfamiliar feeling rules and norms, making the work of care emotionally challenging. And yet, newcomers represent a disproportionate share of the frontline care labour market generally (Armstrong et al. 2014). It is unlikely that newcomers are ‘naturally’ more caring than are Canadian born people, rather it is more likely that Canadian-born people have more opportunities for jobs with higher pay and higher status. While participants tend to say that caring is part of who they are, they reveal that the emotional labour involved in care is not necessarily ‘natural.’ Another aspect of the notion that care is a natural vocation for some people, is that quality care involves authentic emotion. The next section explores the tension between care as a private labour of love versus a public labour for material gain.

Purchased Intimacy—We Genuinely Care

In the work of care, a clash between a public life of wage earning and a private life of family and emotion is noted repeatedly in the literature (Aronson and Neysmith 1996; Dodson and Zinavage 2007; England 2005; Outcalt 2013; Rivas 2011). When care is available for purchase there is always the potential that workers may be regarded as emotionally inauthentic (Dodson and Zinavage 2007). This tension between money and emotional authenticity imbues the talk of all participants, and participants frequently present themselves as being ‘caring’ in contrast to ‘uncaring’ others. For example, Serena, a care aide working for a temp agency, suggests that workers should genuinely care about people rather than approaching their job only as a source of income:

Serena: Some people, some workers, they don't do what they should, and some they do what they should but they aren't nice. Like, are they working for money or are they really helping people out, you know?

Serena interprets the fact that some workers will not complete all their assigned tasks, such as bathing or turning the body to avoid bedsores, as being uncaring. Alternatively, she notes that some workers complete all the required tasks but are rough or unkind. In either situation, she questions their moral investment in care work. In contrast, she characterizes herself as kind and respectful, while also accomplishing all of the tasks required of her position.

Marjorie, a private caregiver who arrived in Canada from Congo in 2010, provides an example of claiming a strong personal and cultural affinity for caring and a distancing of the monetary aspect of care as a job. In particular, she asserts that care as practiced in her home country holds a particularly high value because it is unsullied by money and the working world.

Marjorie: I know what is going on with the job, I have experience. Like I helped my husband's grandma. She was 82, and she was sick in the head. That's the same as this job, I take care. In our country, it's never like you see here, where people work in home care. That doesn't happen, it's just family. You have that responsibility; you take care of your family.

In drawing on her cultural background Marjorie reinforces her caring identity. While talking about her experience she also explains that care in her home country is not a public issue in the way it is in Canada. Interestingly, Marjorie works in a context which is almost indistinguishable from informal care apart from the fact that she is paid: she has exceptionally close emotional bonds with the family that she works for and speaks of them using kinship terms. This aspect of Marjorie's story is explored in detail in the following chapter.

Participants provide evidence of their authenticity by describing the little extra things they do for their clients and the genuine effort they put into their work. For example, many participants report giving gifts to their clients, including personal time such as running errands, staying for a few minutes extra or arriving early. Participants also combine gifts of personal time

with material items such as bringing in homemade baked goods as treats or spending their own money to purchase items for the client. Participants spoke of doing such favours for their clients as a sign of quality care, personalized attention and concern, and genuine emotional connection. Gloria, a frontline worker with over 40 years of experience in multiple care contexts and roles, explains that quality care is simply not suited to the constraints of time and bureaucratic efficiency. To really care, you must be responsive to the situation and, if necessary, stay past official working hours.

Gloria: I'm not there like (looks at her watch), 'oh, it's eight o'clock, gotta go, sorry!' (rueful laugh). You know? That's not me. But there are staff that do that. That's not a compassionate care worker.

Here, Gloria is engaging in social comparison as a way of evaluating her role performance and generating self-esteem. When a worker gives time or brings in material gifts, it is viewed as an emotional expression that they 'really' care. In her passage, Gloria is charging others as less generous and potentially enhancing my assessment of her. Of interest, Gloria and others also spoke about spending considerable time outside of work in invisible emotional effort, thinking about their client, planning outings, or worrying about a client's welfare. By contrasting her personal attitude with workers who follow the clock, Gloria simultaneously critiques the system of care work which delimits pay for time, and also symbolically asserts and affirms her caring identity.

In interaction, giving is just as important as receiving, and clients may feel that it is important for them to their show appreciation to a worker who 'really' cares (Marmot & Wilkinson, 2005; Stone, 2002). In her capacity as a self-employed worker, Michelle provides an excellent example of how workers may handle the dilemma of accepting tips intended as a sign of appreciation, but which Michelle knows may be construed by others as 'taking advantage':

Michelle: One of my first private clients, she offered me fifteen dollars an hour, and I thought, oh that's wonderful! And that's still what I charge, you know, five, six, seven years later. Another private lady, she was just like, it's easier to pay you twenty. You know, most people have twenties, not just tens and fives, right? (Lisette is nodding) At first she'd usually give me a twenty and I'd give her five dollars back. The odd time she'd be 'oh, keep the change, keep the change' and eventually it was always always 'keep the change'. But she never really said 'I'm just going to pay you twenty dollars an hour.' So I talked to her daughter (laugh). You know, I didn't want the family to think I'm taking advantage or anything of the sort. And the daughter said 'Oh, yeah take it.' So that was that. But then (laugh) usually I'm with her for more than an hour too, that's the thing. (laugh) Yeah, you know.

Michelle works very hard to ensure that she does not appear predatory and greedy. She checks in with other involved people to get their approval of any increases in her wage or accepting gifts of money. It is also noteworthy that Michelle exhibits a great deal of emotion management within this brief portion of the interview. Her nervous laughter reveals that she felt doubt about how I might interpret her having taken extra money from her client. Her laughter towards the end of the passage exemplifies a technique of deep acting, banishing feelings of shame by evoking amusement (Scheff 2009). At the close of the passage, Michelle states “*I'm with her for more than an hour too, that's the thing.*” In giving more time she balances the situation through reciprocity, engaging in what exchange theorists call ‘distributive justice’ (Goffman 1971:115–16). She is also asserting her identity as a kind, just, and caring worker and explaining that she gave extra time as proof of the authenticity of her emotions.

While the practical tasks of care are highly variable and dependent on a client’s individual need, participants associate good care with attentiveness, kindness and respect. This discloses the feeling rule that care workers should do the work because of genuine affection, as well as having an intrinsically caring nature. To prove their motivation to care is genuine and therefore high quality, workers often provide extra emotional labour: essentially workers provide emotional labour for free. Relatedly, economics, efficiency, time and money are portrayed as

disreputable signs of low quality care. And yet, participants care not only as an expression of self-identity, but also a means of earning an income. In the field of care, the overlap between the public world of work and the intimate world of family-like emotion is evident. This is also played out in the tension between the relational rewards of caring and the precarious and low-wage material rewards of care work, as addressed in the next section.

Emotional and Material Rewards of Care Work—We Love to Care but the Pay is Demeaning

Participant responses support the feeling rule that they should “love to care” for others. An important compensation for caring are the valuable intrinsic emotional rewards that are not present in other types of jobs. Indeed, over half of the participants in this study speak about the relational rewards inherent in providing care. For example, Gloria, speaking in the context of her work as a private caregiver working for a for-profit agency, indicates that she enjoys interacting with people, and the work allows her to express important aspects of her self-identity:

Gloria: I think (long pause) well, it's the enjoyment I get. The socialization. That's the part of me that needs to be fulfilled. The compassionate part, that part needs to be fulfilled. The spiritual part of me that gets fulfilled.

However, there is no guarantee that care work is always emotionally rewarding. The data from my participants suggest that care work is sometimes mundane, boring, and lacking in relational rewards. These responses are more characteristic of temporary or part-time workers, as well as workers who work on a tight schedule of specific tasks with multiple clients. For example, Jessie holds a position as a part-time care aide working with multiple clients living in a single retirement residence. She describes her work as ruled primarily by time:

Jessie: If I don't have the time, that's what I tell them. "I'm sorry honey, I'm really busy right now." But generally (laugh) I walk fast, I get around the building pretty quickly. Um. I don't like to take the elevator so I'll take the stairs. And, you know, you learn your run. You'll think, okay, well this one's in

room 15 and this next one's way across the building, and so (pause) ... we adjust our runs to what works. Yeah. So, generally it works out pretty good.

Lisette: So, how many clients do you have?

Jessie: Um. (pause) I think 37.

Lisette: In a week?

Jessie: No, in a day.

Lisette: In a day?(incredulous tone)

Jessie: (nodding) Some of them it's a supper run, take them to supper and then take them back up from supper. I may go back to that same client at eight o'clock to give meds, or I may go back at nine-thirty to put them to bed.

In an eight-hour shift Jessie has a maximum of 13 minutes with each client. This does not include the time it takes her to travel between clients nor does it account for multiple visits for different tasks with the same client. Clearly, she has found ways to increase her efficiency by saving time (Bolton and Wibberley 2014). Elsewhere in her interview, Jessie indicates that the need for “efficiency” often promotes tension because she would prefer to spend more time with clients, particularly when they feel ill, experience extra or new difficulties, or are simply having an off day and feeling low. Frontline care which is rationalized to fit within the constraints of timetables and bureaucratic efficiency contains very few emotional rewards.

It is within relationship and interaction that many of the emotional rewards are found. However, the data shows that care is not always appreciated; clients can be abusive, rude, or may simply feel entitled and fail to acknowledge the humanity of the worker. For example, Brent has been working full time with a single client for 13 years, however Brent characterizes his relationship with his client as a business-like affiliation lacking any features of camaraderie and friendship:

Brent: When I first started there was more of a camaraderie, but it's become more like a background noise. You know, I've been there for a while and the shine comes off after a while (laugh). You distance yourself from it in a sense. Like, I'm there to do my job, and I do it relatively well, and I know inside and

out what he wants throughout the day. So the conversation, even on a transactional level, has gone down quite a bit.

Over time, Brent and his client have less and less communication with each other, perhaps both a symptom and cause of the distance between the two. Vocalization itself would add to the relationship: the words and sounds made by one are heard by both, giving rise to shared understanding and shared emotion (Mead 1934:64). The act of vocalizing increases the probability of moving from a mere identification of each other as objects, to identification *with* each other as belonging to a relationship. Brent's work does not involve relational conversation nor relation rewards, as is typified by other participants. Instead, his work has become routinized and rationalized with a focus only on tasks.

Clearly frontline carers do not always receive relational and emotional rewards from their work. Additionally, they very rarely enjoy their Pay, as illustrated in the following quotes:

***Gloria:** I think what we do is just total care. I call it total care. They don't pay me total money for it of course (laugh). Like I'm getting 11 dollars [an hour].*

***Michelle:** I just got a raise. I'm now at the top of the pay scale at my company. The top, which is \$11.75. I feel embarrassed to even say this. I feel like it makes no sense. My raise was eight cents. Eight cents per hour! And I thought oh my god, seriously? ... (sigh) You don't feel valued.*

***Chiara:** The pay is not great. It's only twelve bucks per hour. Yeah. So. (sigh).*

Chiara follows up her statement with a sigh showing a combination of frustration, dismay and resignation. Indeed, each participant talked about money with rueful laughter or a sigh, revealing a similar attitude of endurance and feelings of powerlessness. The topic of pay is important: I did not direct the conversation in any of the interviews towards income and money, and yet participants repeatedly raised the issue of their wage. Indeed, the only interview in which money did not come up was with Craig, a nurse who receives significantly higher pay and prestige than the other participants in this study.

In the following quote, Daisy expresses unhappiness and frustration over the low status and low pay of her current role as a home care support worker:

Daisy: Money doesn't mean everything, but it helps. (laughter) Once I felt, like, why am I doing this job? Is there any way to get a better job? I was thinking of different ways. You know, I get only eleven dollars and thirty-seven cents per hour.

Daisy indicates that she is interested in finding better employment and a different job, and relates this directly to the issue of her low pay. The issue of actively looking for a change of job or a change of career is a related theme arising in the data. Seven participants had recently changed their position or were actively looking for different (better) jobs, including two who were attending school and trying to find work in a different field altogether.

A paycheque is about material compensation, of course, but it also symbolically communicates the social worth of a person's labour. The low pay in frontline care indicates that the work is held in very low esteem, and this becomes a significant problem for participants with extensive experience who seek to take pride in their work. For example, Brent, with 16 years of overall frontline care experience, brought up the topic of his pay on four separate occasions during his interview, and each time he went on at some length about his feelings of frustration:

Brent: I sort of feel like this wage cap is disrespectful. Umm. (sigh) I'm really at the point of stay or don't. I'm getting paid the same as these others, and yet I trained them. You know. Yeah, I definitely feel undervalued.

Brent's passage reveals how low pay can assault self-identity: part of his job includes training new workers in the personal needs of his employer and general daily routines, but he receives the same wage as those he teaches. He is experiencing status inconsistency: his status as a teacher with valuable expertise is unrecognized and unacknowledged, leaving him dealing with shame and anger.

Feeling structurally undervalued and unappreciated shapes the ways that all participants talk about their job. Gloria and Jessie, two participants with decades of frontline care experience, particularly emphasize a general social and systemic lack of recognition of the skill involved in care, and express a great deal of anger over a system that seems to be indifferent, even dismissive, of their knowledge and skills:

Gloria: I started at a nursing home, and I took their training, whatever it was at that time. Now, that was over 45 years ago. And I've been managing with that, and experience, for many years. Until the government, and all the regional health authorities, have decided we all needed to have 'today's education' (Gloria does air quotes and uses a disparaging tone of voice). That left me out. So why do I want to go back and do that? Like really, I'm hoping people will hire me because I have years of knowledge and I can deal with any situation. I have a plan A, B and C if a problem should arise. I have that. But there's no respect.

Jessie: I think it's stupid. I really do think it's dumb, that my almost 40 years of experience in the job (pause), well I won't say my experience counts for nothing. But you see, the policies made it look like experience counts for nothing. It doesn't make any sense. It makes no sense to me. But. (pause) I'm not fighting the government. I'm not.

Both Gloria and Jessie are referring to the fact that graduating from 20-week care aide program results in a higher pay grade from their employers, while their significant breadth of experiential knowledge and practical expertise is not only unrecognized, but it appears to be relegated to a position of inconsequence and worthlessness.

In sum, over half of the participants in this study overtly speak about the relational rewards inherent in care work. However, care that is ruled by the clock and focuses on physical tasks does not always contain relational rewards, because emotionally rewarding relationships are rarely able to develop. Further, the low pay in frontline care leaves workers feeling unappreciated, angry, ashamed and embarrassed. Low pay is impelling many participants to seek different jobs or look for higher status work. The more experienced participants in this study have clearly decided to stay in the field of frontline care despite these challenges, and

despite feeling that their work receives little or no social recognition. This brings up a question which will be explored in the discussion section of this thesis: why do some care workers stay in positions where they are devalued and disrespected?

The field of care contains a number of emotional contrasts. Participants indicate that shared cultural norms and shared language are important in care relationships; at the same time, because of the wide variety of cultural backgrounds in Canada, misunderstandings due to miscommunication and breaches in normative expectations can easily occur. Such misunderstandings increase the need for workers to engage in emotional labour. Participants present themselves as having an intrinsic and genuine caring nature, and often enjoy their relationships with their clients. However, the data reveals that not all care relationships are positive and rewarding, and low pay leaves many feeling demeaned and degraded. The next section of this chapter examines some structural and organizational features within the field of care, and their influence on the emotional experience of frontline workers.

ORGANIZATIONAL AND STRUCTURAL FEATURES OF CARE

The field of care is defined not only through interaction and direct encounters, but also by the organizational systems and situational context within which care takes place. The situational context is shaped by a number of factors, most particularly by care need and social setting. Providing meal preparation, housekeeping, and companionship with a client in their home is very different from helping with the activities of daily living in a public institutional environment such as long-term care. In this analysis, organizational systems refer to the policies and practices that organize and structure the ways that workers do their job. As is the case in so many other aspects of care, situation and system intersect in complex ways in the lives of workers. For

example, a care aide employed by a for-profit care agency may work in the home of a client one day, and as a temporary worker filling in for staffing gaps in a publicly-funded care institution the next day.

The organizational themes in the data that intersect strongly with emotional labour are the care plan and organizational support. A care plan is a document meant to provide the worker with information about their duties while also tracking employee activities, and is an organizational feature that appears across all employer types. As will be shown, the information in the care plan is not always accurate, which has multiple implications for care quality as well as the emotional experiences of both the client and the worker. The emotional labour of participants is strongly influenced by the emotional support they receive (or do not receive) from management and immediate supervisors. This chapter concludes with an analysis of the difference between working alone in home care versus working in other environments. I begin by first looking at a common organizational feature that appears in care work across all employer types: the care plan. As will be illustrated, emotions are not limited to interaction and relationships with other people, feeling also arise as workers are involved with bureaucratic processes.

The Care Plan

Common to many care settings involving older adults is a document called the care plan, which is based on the medical practice of ‘charting’; the care plan appears to be a common feature of care systems globally (Bolton and Wibberley 2014; Stacey 2011; Stone 2002). Any type of employer may use a care plan; it is a provincially legislated requirement for publicly funded home care and long-term care in Manitoba (Manitoba Justice 2015) and, according to the

study data and my own personal experience, is also a common feature of work within for-profit care agencies and may also be found when working directly for families. The purpose of a care plan is to ensure that services are appropriate to needs, while also providing organizational control of multiple workers as they interact with individual care receivers. The care plan usually contains background information and biographical details about the care receiver with a focus on care needs, outlines the tasks that various workers are expected to perform, and may also contain additional record keeping forms (charts) to track the completion of health-related tasks, such as bathing, toileting or giving medication. Record keeping satisfies the need to maintain accountability of workers in all types of settings. As stated by Diamond in his study of care in nursing homes, “if it’s not charted, it didn’t happen” (1995:130).

From the perspective of workers, a care plan is a tool that helps in getting to know a new client and for knowing where their responsibilities lie, providing structure for their interactions. When organizational processes fail to provide accurate information and a structured work environment, frontline workers are required to assess and address the care needs of the client on their own. Despite a lack of education and training in these matters, the onus seems to fall on the worker to manage risk. Further, plans are not static documents, and systems can easily fall behind in keeping up with emerging and changing care needs. Workers and clients are both affected negatively when care plans neglect to comply with the expectations, needs, and capacity of those concerned with client care.

Several participants expressed dismay that care plans are frequently out of date, incomplete, inaccurate or insufficient. Chiara, an experienced care aide who has worked in hospitals, long-term care, and private home settings states:

Chiara: *The care plan tells you the current situation of the patient. But sometimes the patient’s condition keeps on changing and it keeps on*

deteriorating. So, sometimes there's kind of a little bit of mismatch or there's tiny issues, which you can simply forgive. That's the way it is, you know.

In this passage, Chiara downplays situations where the care plan does not correspond to the situation as *'a little bit of a mismatch'*, causing *'tiny issues'* that she *'can simply forgive.'*

However, in other parts of her interview she is far less magnanimous, as I will discuss shortly.

Gloria, a worker with decades of experience in multiple contexts explains:

Gloria: ... the agency pulls me in and says, 'you're not following the care plan.' And I don't want to be disrespectful, but what plan? (Laugh). You know. What plan? The plan that you made how many months ago? They should be revising that plan constantly, you know. And I go above and beyond for these people. I'm cleaning out ovens and I'm stripping floors.

Lisette: Not part of the care plan?

Gloria: No. Noooo. (laughs) Not part of the plan at all.

This care plan is woefully out of date and omits important tasks that need to be performed.

Gloria acknowledges that she is overstepping her role by doing what she feels needs doing—*"I go above and beyond"*—but she is confident in her experience and knowledge and does not appear particularly worried about potential repercussions. In this example Gloria shows that she acts with a great deal of autonomy, resisting organizational structures that seek to govern her actions. Her autonomy and independence is a key feature of work that takes place in the home rather than in a public setting. I discuss the implications in greater detail under the sub-heading *'working in isolation versus teamwork.'*

Another participant, Jessie, comments on the insufficiency of the care plan for one of her clients to whom she has become particularly attached, and for whom she has been hired to work with as an employee of a for-profit care agency:

Jessie: It is brutal for new girls, you know, walking in to a new person that you know nothing about. There's no assessment here for them to read, you know. Like they have a care plan, but it's so out of date! Okay, look. (Jessie pulls over a binder, sounds of paper flipping). It doesn't tell you anything.

Lisette: And who's job is it to update that information?

Jessie: The office. But you know, I've added to it, because (pause, more sounds of paper flipping) Look it's not even filled in! She's got dementia, but it doesn't say that. And under 'other' you could put in physical outbursts. Yeah. With this you get nothing. Pssshhh.

Jessie's tone throughout this portion of the interview becomes increasingly animated, and she expresses emotions such as exasperation, frustration and anger through her words and body language. Her feelings about the inaccurate documentation are, in part, based on empathizing with the situation for the 'new girls'; care plans are not merely a form of control and supervision, but are also an important source of information for workers. Jessie is also outraged on behalf of her client, whom she believes deserves care that is based on the accurate documentation of her needs. Jessie chooses to address her frustration and anger by updating the care plan herself. Both Jessie and Gloria have a great deal of confidence in their knowledge, and such critiques of the care plan may also be a way of reinforcing and communicating to me their own expertise and skill, and the pride they take in their work.

I return now to Chiara, a care aide who had recently started a new job with a for-profit home care agency. In her view, a care plan is a contract between herself, her employer, and the client about her duties and responsibilities. I tell her story in detail because she touches upon so many of the trigger points that cause role strains for care workers, and so eloquently details the implications for the emotional labour of workers. Her personal history is highly salient to her experience. Chiara is a small woman with back trouble, a relatively common issue in frontline care due to lifting, transferring, and supporting patients with mobility problems (Stacey 2011). To protect herself, she no longer works with clients who have mobility issues. Chiara's story involves complex interactions between herself, her client, her client's family, and her immediate

supervisor. However, this entire event appears to have been precipitated by the lack of a care plan, which protects not only the client but also the worker.

She relates her experience of being sent to a new the client only to find that she was unable to cope with his need for physical support. Chiara brought up this situation repeatedly throughout her interview, indicating that it is an important and unresolved emotional concern (Scheff 2009).

Chiara: At my old company in Alberta all of the clients had care plans and they would really update you and everything. But this company here, that's a different story. I was so shocked. There was no documentation at all! That's a very big problem. You know what, if you don't know what's going on you could be compromising the patient safety. This one I just did, it was a feeling like being in a nightmare ... I just asked them a couple of questions. Like, I asked them 'Can the patient stand on his own? Is he ambulatory? Does he need minimal assistance?' And they said yes. But that's not what happened during the night.

...Then I called the people at the agency. And they would not help! They would not come to the house just to help me. It's ridiculous, right? Anyway, it's not fair. So I had no choice but to ask the family for help. And, unfortunately, the family did not appreciate it at all. I felt kind of betrayed. Because when I came there the wife told me 'if you need something go ahead and call me'. But the son accused me of not doing my job after I called him. Like, there's a double-umm. (sigh) You know what I mean? Because. So. (pause) I don't know. (sigh)

...You know what, I feel like I'm being taken advantage of. I don't have any documentation, I don't have a care plan. The family complained, and I have nothing. I have nothing to protect myself, you know what I mean? It's unfair to me in a sense. So, I felt like the company was doing it unprofessionally. That's why I decided, you know what, I don't want to be part of your company. I don't want to be associated with you. That's why I don't even want to take the money. I found it very unprofessional, and barely legal. That's why I was like eeehhhhh (a sound of distaste). And part of it was, you know, they're ruining my reputation.

... You know, that got me mad. Like anger, real anger. Not only at the family but also the company. Because it's like, (pause) you know, the feeling of being taken advantage of? [Lisette is nodding] Yeah, it really was terrible. You know, now I give advice to people, don't pursue home care! Like, don't pursue home care here in Manitoba. You know? If you're in Alberta, you could consider it. But. How can you take that risk? Your reputation is at stake.

...I'm worried the family or the company may sue me for elderly abuse or something. But of course I didn't do anything! I never ever did any elder

abuse. But you know, you're stuck. You're just left on your own. I even told them I wouldn't take the money for the job. I just don't want to be part of their association any more.

The issues here are many. The misinformation Chiara received prior to accepting the new client suggests that she was not working for an ethically responsible care organization: *"I asked them 'Can the patient stand on his own? Is he ambulatory? Does he need minimal assistance?' And they said yes. But that's not what happened during the night."* Her client was agitated and active during the night, and she believed that he was unstable and in danger of falling. She called her employer in the middle of the night but *"they would not come to the house just to help me"* so she turned to the family for help. However, things appear to have progressed from bad to worse:

Chiara It was a feeling like being in a nightmare ... The son accused me of not doing my job after I called him. Like, there's a double- umm. (sigh) You know what I mean? Because. So. (pause) I don't know. (sigh)

Chiara was both horrified and afraid in this situation, which she describes as feeling like she was *"in a nightmare."* The family member she called was angry at what he perceived to be her incompetence, and Chiara felt unfairly accused. Her employer, a private care agency, provided no support during the incident.

Importantly, Chiara's experience also involves feelings associated with fear, which is directly related to her powerlessness in the situation (Kemper 2014). At the beginning of the passage she refers to feeling like being in a nightmare. Towards the end of the narrative, Chiara indicates that she is *"worried the family or the company may sue me for elderly abuse or something.":* In our interview, she also exhibited multiple markers of shame, such as speech disruption, repetition, long pauses, and not getting to the point (Scheff 2009). As noted earlier, her feelings of fear and shame are strongly intertwined with anger and outrage:

Chiara "It's frustrating ... it's ridiculous ... it's not fair...I feel like I'm being taken advantage of ... that got me mad. Like anger, real anger."

Chiara follows up on this idea, indicating that she felt personally attacked to the point where she felt she must prove her moral worth by refusing to accept pay:

Chiara I wouldn't take the money for the job ... I just don't want to be part of their association anymore

Chiara thinks that it was the agency, not the family, that is primarily accountable for the situation:

Chiara: I think it has more to do than just with the family. It's about how the company deals with it professionally. You know. Because with my old company, they really seem to care. Like they give you specific responsibilities. What you should expect.

Lisette: But in this case, you walked in completely blind?

Chiara: Yeah! You know, that's why I really feel, you know what, I think I should have a retirement from this home care business.

This experience appears to have been a breaking point for Chiara, who is now considering the idea of retiring altogether from frontline care work.

In alignment with Scheff (2009), Chiara's complex emotional experience is, can be understood as shame-fear-anger spirals, which involved Chiara working to manage her shame and the related emotions of fear and anger: being shamed by another, then feeling shame, which may become fear at being further shamed, which may switch to anger at others for causing and witnessing the shame, and so on in a loop until the feelings are resolved (Scheff 2009; Theodosius 2008). Chiara interprets the situation as unjust and unfair and works to replace the two problematic emotional categories of shame and fear with the more powerful and confident emotional category of anger. Her efforts at deep acting are not always successful, however, and she has flashes of self-doubt or uncertainty, and so the process continues.

A care plan is an important and necessary document for organizing public care. Suitable care plans are useful, however, when plans are inappropriate or absent there are significant implications for the emotional (and practical) labour of frontline workers. Further, plans are not

static documents, and systems can easily fall behind in keeping up with emerging and changing care needs. Workers and clients are both affected negatively when care plans neglect to comply with the expectations, needs, and capacity of those concerned with client care. In the next section I explore other participants' experiences of the support (or lack of support) found within workplace hierarchies and look in more detail at the emotional content of worker-supervisor interactions.

Organizational Support

Chiara's account, as analyzed above, contains a related theme found among other participants—feelings and the management of those feelings are influenced by the emotional support workers receive from superiors, and the generalized emotional atmosphere created by management. Chiara indicates that she was left to manage the above situation without help from her supervisors: *"I called the people at the agency. And they would not help! They would not come to the house just to help me."* Organizational support (and its lack) is an important aspect of the emotional experience of all care workers, and is particularly relevant for those working alone in private homes (Denton et al. 2002; Lopez 2006). Workers, whether working for a private agency or public home care, usually have a phone number for a workplace supervisor that they can contact should trouble arise. However, participants who indicated that they have called for help reveal that, rather than receiving support, they are more often told to just hang in there and manage until the next shift arrives. Chiara, based on her experience working with multiple private home care agencies in two provinces, reflects on her overall experience of calling a supervisor for help:

Lisette: And if you call the office for help, what happens?

Chiara; Nobody's ever really come to save me. (both laughing) I KNOW!

Lisette: (softly) Have you never had anybody come?

Chiara: No. (pause) Oh, you know what, no. (sigh)...Most of the time they tell you just wait for your next shift.

Lisette: Hmm. That's usually the answer you get, just deal with it?

Chiara: Yeah. So. It's sad to say, but that's the way it is.

Younger participants, or participants with less than two years of care experience, reported calling for help with challenging situations, particularly fear of harming the client through inaction or inappropriate action, and fear of being blamed should their client be hurt. Nevertheless, not one reported a supervisor sending another worker, nor did supervisors come out themselves. Participants then managed as best they could while fearing that their best may not be good enough. It is unclear how participants managed their fear—when pressed, participants simply reported that they did what they had to do, as they had no choice.

In contrast, participants with a greater depth of experience in frontline care did not talk about calling for help based on situations they could not manage, which suggests that they have greater confidence in their skills and abilities. However, such participants did report asking supervisors for direction and advice. As indicated by Craig, a home care nurse, supportive supervisors can be an important source of practical advice and for determining a plan of action:

Craig: ... as a way to kind of problem solve, you know, maybe come up with new ideas to improve somebody's care. That's important too for people, for people to come together to talk.

While two participants who worked for a formal organization talked about workplace supervisors as helpful, the remainder were less positive in their appraisals. For example, Jessie feels some contempt for what she perceives as indecisive “*wishy washy*” management. In this context, she is referring to her supervisors at a private agency at which she works part time, having a weekly eight-hour shift providing full care and supervision of an older client with advanced dementia.

The client's family live out of town and are not available for day-to-day decision making, and the passage below involves a situation where she suspects her client has a fractured hip:

Jessie: So I phoned the office for direction. (long pause, changes voice to high pitch, somewhat whiney) 'Do whatever you want. Do whatever you think is right' (Slams the table and uses a loud voice) I said 'NO. No! I want you to acknowledge this phone call, because I'm very concerned about this!' (contemptuous sniff, returns to regular voice) So I ended up taking her over to the hospital myself. (whispering) The office, it's so wishy-washy. (returns to regular voice) You know, a person should be able to phone the office and say 'I need some advice. What's your suggestion?' But no, they just say (high, whiney voice) 'Do what you want.' (claps her hands like she is 'washing her hands of it' and returns to a regular voice). I don't know. I just don't know.

This small selection from Jessie's transcript is emotionally expressive. She is slamming the table, clapping her hands, and raising her voice almost to a yell, indicating a great deal of anger. Her anger and frustration are further evident through her imitation of her supervisor, whom she characterizes contemptuously by using a high-pitched whining voice. However, when she overtly states that her supervisor is 'wishy washy' she suddenly drops her voice to a low whisper, suggesting that she wants to hide her low opinion of her employer. If Jessie were to be openly disrespectful it would threaten her job.

There is nothing unusual in having to be respectful to a workplace supervisor. However, the emotional context of this situation is particular to Jessie's role as caregiver, and also her role as caretaker. The client is predominantly non-verbal and cannot communicate through words what hurts or what happened to her. Further, the relationship between Jessie and this particular client has developed to the point that Jessie feels a great deal of attachment towards her. She is contemptuous of her supervisor not only because she finds her to be 'wishy-washy', but because she is generally upset about the quality of care her client is receiving. The tension in the passage is also about who has the responsibility for decision making; the organization is downloading liability onto Jessie. Based on this (and many other stories throughout the interview that refer to

this particular client), Jessie believes that her employers are inconsistent and careless, sometimes to the point of negligence. Jessie believes she is morally justified in her anger and frustration at her organization's irresponsibility, however she is structurally powerless to do anything about it. While Jessie is relatively comfortable expressing her anger towards her supervisor in my presence, I suspect that Jessie would have had to undergo a great deal of emotional labour to maintain civility with her supervisor.

Gloria, with over 40 years of experience in frontline care, also talks with some contempt about the management at the private agency she works for, and rarely asks her supervisor for any advice or direction. She believes that supervisors often act as communication gatekeepers, delaying appropriate delivery of care services:

Gloria: If I notice something immediately wrong with your mom, I will tell you directly. Because by the time I tell the agency and the agency DECIDES (strong emphasis) what should be said or should not be said. You know? Say I've got a lady that has chest pains and everything like that. I would phone the agency, the agency would phone the family, da da da da da (singsong). No. (loudly) No! (whispering) In fact, the agency doesn't know, but I have direct contact with the family.

Gloria breaks the systems controlling communication within her agency, and instead follows her personal sense of right and wrong. In these instances, the emotional labour for both Jessie and Gloria occur in the context of "moral labour" (Johnson 2015); the policies practiced by their employers conflict with their understanding of the moral imperative of care, so they act to defend the interests of their client. This resistance, however, is covert and circumspect. Gloria's volume drops sharply when she whispers "*the agency doesn't know*", as did Jessie when whispering "*they are so wishy-washy*". Scheff (Scheff 2009) indicates that whispering and hiding are markers of shame; neither participants wants to be caught breaking rules or showing overt disrespect, however, their fear is countered by anger and frustration with the actions of those who are in power.

The hiding behaviors of both Jessie and Gloria during their interviews, as expressed in the whispering and sudden drops in volume, suggest that they take on the subordinate features of their work role even outside of the workplace. For example, Gloria's interview took place in her home where no one could have heard anything we said. All interviews provide similar evidence, to a greater or lesser degree, that participants feel a need to exhibit norms of deference and respect based on their work role, even when feeling contempt for individuals or processes within the system, and even when talking to people outside the system.

An example of a clearly non-supportive workplace is provided by Craig, a public home care nurse with over a decade of experience. Just prior to his interview Craig had left his position due to a number of issues related to stress and burnout and had started a new job. Below is one of his stories, in which he was required to teach a family and a group of care aides in the use of a BiPAP machine (Bi-level Positive Airway Pressure). On arrival he found that the machine had not been personalized for the client, and believed at that point that he did not have enough expertise to proceed with the needed setup and training:

Craig: When I left the client's home I phoned my manager, and she was perturbed that I didn't provide the teaching. You know. Her tone, and everything on the phone with me. ... And then I was getting called into a meeting not long after that about my behaviour, and my lack of professionalism. Everything was about behaviour, or my tone, and this and that. ... And then when we go to talk to our manager, if we show a little bit of emotion in our voice, God forbid it be mistaken for passion! It's always, it always comes across as disrespectful or that. (laugh) We need to have managers that, instead of calling employees into meetings, they should know how to deal with those problems and issues. And, you know, that's what they should do, is deal with the situation instead of reprimanding someone. (laugh).

Craig has dealt with a number of difficult situations in his role as a home care nurse, and he indicated in this story and in others that his supervisor was not always happy with the decisions he made in the field. He reports some contempt for his supervisor, in that they did not “*know how to deal with problems and issues.*” In such cases, Craig needed to conduct a significant amount

of emotional labour related to maintaining a deferential demeanor in the presence of management, but based on the above passage, he was not always successful. While it is impossible to know, it is likely that he acted outside of the norms and professional expectations of nursing: “*I was getting called into a meeting not long after that about my behaviour, and my lack of professionalism. Everything was about my behaviour, or my tone, and this and that.*” In this story, and in other stories, he reported a great deal of conflict and mutual disrespect. Based on Craig’s narrative, this is not an individual problem on his part, or a personality conflict between himself and one supervisor. Rather, it is a systemic issue between management and all of the nursing staff in his particular area:

Craig: A mediator or something came in and spoke to all of us ... At the end of it the decision was made that she was going to go back to the management, (sing song voice) talk with them (back to regular voice) and then they were going to bring us all back together as a larger group, the managers and the workers, to discuss the findings and what we were going to do about it. And that never ever came to fruition. (sigh) It never happened.

He also indicated that a number of nurses were going off on stress leave. Although he does not directly state it, and was being careful to protect the anonymity of his colleagues, it appears that Craig interpreted the management style of his department as generating a negative, even toxic, emotional atmosphere for frontline staff:

Craig: And after his, his (pause) his situation, you know, it kind of went on through two other nurses that also ended up going on stress leave. And it was in direct relation to the work load and the way the job was being (pause), ah, you know just the way the job was (pause) being presented to us. Um. Stuff like that.

In combination with the additional workload to cover for staff shortages, Craig identifies repeated situations of high negative emotion and tension as the reason that led him to leaving his home care position and finding another job:

Craig: I’ve had many, many, many, many negative experiences with that. You know. All those things built up to a point where I was just, if I don’t leave this

job I'm going to be on stress leave myself. Or I'm going to get walked out of here. That's the way I saw things going. And it's sad! You know. (long pause) I truly love my job, but I don't know how much I have left in me. (voice breaking) I might get a little emotional.

Clearly, a workplace with a toxic atmosphere and a lack of emotional support from supervisors causes significant additional requirements for emotional management and emotional labour among frontline workers. Craig's feelings of burnout and stress are related to the emotional effort required of him as he navigated the organizational structures and management styles in his workplace. It is interesting that, for him, burnout and emotional exhaustion involved interactions with management rather than with clients:

Craig: You know, in homecare, there was nothing we could do without getting our hand slapped, or being told you can't do that ... I mean, don't get me wrong, it never stopped me. It never ever once stopped me. I did what I felt the client needed. And you know, I was always of the mindset that if I get hauled up on the carpet to address some of my actions, my response will be that's what the client required to keep them safe.

Craig's anger with his experiences of 'the system' are also indicative of the moral labour found in Jessie and Gloria. Workers are often powerless to provide what they believe to be appropriate care because of their position within the system, and unless they can learn to 'not care' the inability to act on moral beliefs can be debilitating. Craig expresses many of the markers of burnout, including emotional exhaustion, frustration and defeat. His ethical stance and identity as a caring professional are so strong that he disobeys regulations, risking reprimand and possibly his career in order to do what he thinks is right, he shows that emotional labour is implicated in the moral construction of care (Johnson 2015).

Craig's position within the hierarchy of health care holds higher status and esteem than the majority of frontline workers, and some of his emotional labour may be attributable to protecting his professional status from situations of insult and disrespect. The negotiation of status amongst nurses, and between nurses and doctors, for example, is explored in some detail

by Theodosius (2008). Within these data, however, Craig's experience aligns with moral labour, as he was calling on his employers to act with morality rather than bureaucratic rationality. Participants with greater age and/or experience, rather than professional status, felt free in the interview to express varying degrees of contempt and frustration with management and organizational systems. However, younger participants and those with less care experience appear to trust, and lean on, the knowledge-base of their supervisors and co-workers. The next section of this chapter compares the emotional experience of providing care while alone in a private home, versus providing care in a more public context.

Work Arrangements and Location

For many participants, a great deal of emotional labour occurs not only with managers but also in their interactions with co-workers. Relative power and status determine which emotional display is appropriate for each individual in such interactions, and often follow the emotional rules of everyday courtesy (Theodosius 2008). However, workplaces are hierarchically structured, and status levels are also determined by job title and seniority. Working people everywhere are familiar with the need to be deferential to their boss and civil to co-workers. The majority of participants in this study shared stories about care taking place in institutional settings, including retirement residences, long-term care facilities and hospitals. The data indicate that there can be strong differences in status between workers, even between those with the same job title. For example, workers may hold different status depending on the types of shifts they work, with the night shift holding less status than the day shift, and part time positions having lower status than full time positions. And status may change in the presence of certain clients or supervisors, such as when one worker is preferred over another.

Serena, employed by a temp staffing agency, describes her experience of holding a low status relative to other workers in institutional environments. When she arrives at a new workplace she is an unfamiliar face with unproven skills, and her co-workers know that she is untrained in local routines. Serena describes being treated disrespectfully by other workers, and sometimes with outright hostility. What she finds even worse is that sometimes she is not acknowledged at all:

Serena: Some people they don't say anything, they just look at you. Some people just look at you (she pauses, opens her eyes wide and looks directly at me with no expression on her face). Like that. So when you work for an agency it can be hard. You know how you feel, you feel (pause) I don't know. But that's hard. [...] Some people, you are working together for eight hours, and they don't even say hi to you. It's the worst.

Although Serena cannot find the words to describe her feelings, being excluded and ignored are intense negative social sanctions (Goffman 1963; Hochschild 2004; Wingfield 2010). Amid such an unwelcoming atmosphere, Serena must defer to the leadership of regular staff who know the clientele and the organizational routines. In the passage below, she explains how she suppresses her anger at being treated as though she is incompetent at her job:

Serena: Sometimes when they guide me I feel like I made a mistake, or someone's blaming me. Like, is something wrong? I remember there was [whispering] a regular staff who was not kind. [loud bossy voice] 'You have been here a half hour already, and you're not doing anything! This one is yours, this one is yours, this one is yours.' [regular voice] But she didn't give me any instruction before that. How was I to know the clients were mine? I didn't say anything. I just looked at her. I was so mad! But what can you do? So I just said 'What do you want me to do right now?' I just said that. And she was very strong, you know, she said 'You report to me'. But she should not be allowed to yell at me. The way she was treating me, and the way she asked me to do things (long pause, sigh) she should be respectful, not that way.

As part of her job, Serena puts in a great deal of effort into suppressing her anger at being treated shamefully and disrespectfully by her peers, and she shared many stories of experiencing shame-anger spirals in her interactions with co-workers.

Michelle, another participant, also describes anger and frustration in her interactions with other workers. In her role as a private companion, she is hired by individuals (and also employed by a private agency in the same role) to work with clients with advanced dementia who are living in a care home. Her sole duty as a companion is to provide her client with personalized attention and social interaction. She works within the setting of a long-term care home yet she functions in a rather nebulous position of status and power within the field of care; she is not employed by the institution, nor does she have family status (Daly and Armstrong 2016). In her interaction with other workers she shares a number of experiences that were not communicated by participants who hold a more secure role in the labour hierarchy. In the passage below, Michelle describes how workers employed by the care home appear to resent any comments she makes regarding her client:

Michelle: Sometimes there's misunderstandings. You know, I'll ask them something or say something and I almost feel like they're barking back at me. You know? I'm just asking! But I get bra rra rra rra rra rra rra. It's like maybe they think I'm expecting something from them and it's not their job, or stuff of that sort. Yeah, there's a little, you know, tension.

Although Michelle's data is less rich on this point, it is possible that she experiences shame-anger spirals triggered by unfair treatment from other workers, as did Serena. However, unlike Serena, she does not talk about this as a significant feature of her job, rather as a minor 'tension'. This difference is due to the what Daly and Armstrong (2016) refer to as liminal care labour: privately funded work performed in a public work space. As such, public organizations have little authority or power to oversee the work done by private companions. Michelle's position in the field of care is volatile, as her status and role are highly fluid and she is far less constrained by organizational rules than are those employed within the confines of the health care system. That, perhaps, is why Michelle does not exhibit fear in her shame-anger spiral; her position carries with it a degree of immunity to normal workplace role stratification. Nevertheless,

Michelle talked about a number of power struggles in the long-term care institution, primarily caused by resistance from other workers when she was ‘*expecting something from them,*’ or alternatively when she resisted the attempts by others to assert their own authority. In each case of conflict Michelle had to manage her emotions over conflict with other workers, rather than performing emotional labour in the service of her role as carer.

Rather than causing a little tension, other participants report that these clashes between workers sometimes become very intense. As Chiara indicates when describing a bad experience with a co-worker when working as a care aide in a long-term care facility: “*She accused me of doing something. She shouted at me. I cried after she left, throughout my shift. She was kind of bossy.*” Chiara felt unfairly accused, but expressed those feelings only after her co-worker left. Chiara’s story suggests that she controlled her feelings to avoid exposing her inner emotion to the other worker, as she indicates that she cried throughout her shift. In everyday interaction, emotional management hiding pain or injury preserves feelings of self-worth and helps the individual maintain their dignity and a positive self-image by not allowing the other person in the interaction to see that they have the power to hurt you (Orne 2013; Wilkins and Pace 2014). The threat was from her co-worker, whereas clients may have been sympathetic or simply unaware; Chiara mentioned that she liked working the night shift, so it may have occurred when clients were asleep.

Clearly, ‘caring’ workplaces are locations of disagreement and interpersonal conflict much like any other and participants generally indicate that it is not necessary to feel friendly with co-workers so long as you put on the appropriate emotional appearance:

Jessie: Nobody can get along with everybody, nobody likes everybody. That’s human nature right. But generally you put on your happy work face.

This appears to align with Theodosius' (2008) categorization of collegial emotional labour based on everyday manners and civility. Johnson, however, suggests that when frontline workers put on a smile it is based on a 'heartfelt demand' to align with their role as a kind and caring person (2015:121). Jessie did not like to take night shifts, so it is highly likely that her smiles occurred within the gaze of others and are not only for the sake of collegiality; when clients (or family) are the audience, the feeling rules of care trump those of workplace civility.

Despite instances of conflict and disagreement, participants contend that their relationships with co-workers is usually a positive feature of their job, as stated by Chiara: "*You have somebody to help you, you have support from somebody, you are a team.*" The support of co-workers is multi-faceted; workers often help each other instrumentally, sharing tasks that would be difficult or impossible for only one person to accomplish, and workers commonly share knowledge and information. Positive relationships with co-workers are also emotionally supportive. For example, Serena remarks that, despite working very hard one day, her emotional reserves were not depleted:

Serena: One aide, she was really good. We would both do what we needed to do. You know, I was so happy. I was tired, it was a busy day, but nothing made me mad that day. We did everything together. It was good. Yeah, sometimes it's a really busy floor, but I'm okay, I'm still fresh. I think it's because your insides are important. It's not your body, but inside, your feelings for that day. You know.

As Serena explains, she found this shift easier than others because '*nothing made me mad that day.*' She did not need to engage in the surface work of suppressing or disguising negative feelings with her co-worker, and it is likely that the support from the other care aide also buoyed her performance of emotional labour in client interactions. After a busy day she felt emotionally '*fresh*', and she connects her feelings directly to her positive interactions with her co-worker.

Workplace conflict and difficulty with co-workers is certainly an issue from a management and

care quality context, however it was not a major feature of the emotional labour of frontline carers in this study. Rather, emotional labour appears to be more intense, and more difficult, for those working alone in home care.

Some participants provided a direct comparison of their experiences of working in a team environment versus working alone in home care. For example, Craig, a home care nurse who previously worked in a hospital setting, states:

***Craig:** You know, in the hospital you have break rooms and stuff like that where people get together, and you see others in the hallway or whatever. You know. You're able to talk to each other about difficult clients or stuff that's bothering you that day. That's kind of nice. Now, with that being said, in home care it's also nice to work in an environment where you don't have to answer to a whole bunch of other people around (laughter).*

In home care, workers enjoy autonomy and independence, however this at the expense of support; working in private homes can be isolating. Brent, a disability support worker for his employer-client, describes his frustration at having no one to talk to other than his client:

***Brent:** There's no talking to other workers and there's very rarely a situation outside of work where I would ever see them. He's my client, but he's also my employer. Yeah. There is no real third party that is sort of impartial that you can talk to. It's kind of frustrating. [...] One of the big differences with where I'm working now whereas when I worked in the group home, there was management and there were other tenants there. I mean there was always another person there so you're not in this weird binary power situation.*

Brent speaks about the binary of himself and his client. There is significance in the number of people in social interaction: interaction between dyads (only two people) adds intensity to feelings, whether positive or negative (Simmel 1902). For example, if you are asked on a date with someone you do not care for, bringing a friend along makes the date more tolerable and less intimate. Adding a third person to any interaction allows for greater impersonality. Because Brent rarely interacts with other workers he cannot share information, discuss issues, air

grievances, or let off emotional steam. Overwhelmingly, participants indicate that they find being able to interact and talk with co-workers is emotionally beneficial.

Another common thread among those working in private homes is a sense of lone responsibility for the overall well-being of a client. As Chiara states “*if the patient’s health is deteriorating and you’re alone, that’s a problem. Yeah, that’s a major problem.*” The weight of this responsibility can cause anxiety when there is a persistent potential for a crisis.

***Brent:** So, one thing is he doesn’t have a system that he could make an emergency phone call from his bed, no panic button or anything to alert someone. If anything were to happen with his ventilator, he can’t call anyone outside of verbal range. I find it stressful, anyway... And you worry. That’s its own mental energy that just kind of continually, in the back of your mind, it gets to you. You know? In the back of your mind it’s always there, like you never get a break.*

***Lisette:** So in a worst case scenario, if you don’t check on your client, he could be dead?*

***Brent:** Oh for sure. Yes. You know, within a 15-minute span. Yes.*

Brent is not particularly challenged by the thought of responding to a crisis, but he does feel tension and a need to stay alert, ready to jump into action should a crisis occur. This constant sense of wariness is not common across all participants, but is an everyday emotional aspect of Brent’s work.

Other participants more commonly shared stories about feeling fear when confronted with emerging changes in the health of their client. The data suggest that the emotional impact of managing these situations is strongly dependent on years of experience and, as I mentioned earlier, whether they felt they could rely on supervisors to provide advice. While participants with more experience express confidence, those with fewer years of care practice describe feelings of self-doubt and fear, such as fear of the unknown and unfamiliar, fear of causing harm or making a mistake, and fear of being blamed or getting into trouble. In the following passage, Serena describes her first experience working alone with a client who could not communicate.

She describes feeling shock at the level of need she found in the woman she was to care for, and fear based on not knowing how to handle the situation:

Serena: All I could do was just watch her, and every day it was the same thing. It was so sad. And I couldn't help her, you know. It was so sad to see that. Yeah, I was shocked. And she was so ill. Like, you feel sad. I don't know about people here, but to me it was hard to see. I just cried. I was just crying. To me it was kind of a shock. Because when they said to me do home care, they said do home care, you know, it's easy!

Lisette: (laughing) Um hmm.

Serena: Yeah! (laughing) Just go. It's easy. After you're done your duties there's nothing to do, you can just wait for your time. So I said okay, let me try, maybe it'll be good. So I tried. You know, I thought there'd be nothing to do, maybe they would ask you to cook, make breakfast, you know, that's easy, not hard. But really, to do home care you take a responsibility over another human being. You are only by yourself in someone's house. And that's hard. You never know what will happen. And to me, I thought maybe they would say maybe I did something, you know? I was so scared.

The situation brings Serena to tears through feelings of moral distress (Austin et al. 2005). She says that she could not help her client, potentially because she did not know how to help. She also shares her incongruent expectations, thinking that home care would be easy but finding that it was not easy at all. She explains she was afraid she may have done something wrong and may be blamed by the family for harming her client: *"I thought maybe they would say maybe I did something, you know? I was so scared."* She also expresses her belief that care work carries a significant obligation: *"to do home care you take a responsibility over another human being."* This belief is strongly influenced by the working conditions in home care which places workers into situations of generally unsupported isolation. Much of Serena's experience is a result of her power deficit, that is, being a novice worker in a non-professional frontline job. In addition, Serena is a newcomer to Canada, and a member of a minority group, which is another dimension of status that places her in "a pejorative position in the scale of expectations" (Albas and Albas 1993:461). Taken together, it is clear that she has a low status position in the field of care.

According to Kemper (1978), people feel fear and paranoia when they feel powerless, and “the power deficit will bring about the classic sense of dread and impending doom often associated with anxiety” (1978:35). Being the lone care provider for a client with advanced care needs is a responsibility that she was neither expecting nor trained for, and the situation was emotionally unmanageable for her. She was so overwhelmed by her first encounter in home care that she decided she would not go back. Serena no longer accepts any assignments to work alone in clients’ homes.

We may presume that not everyone has as difficult an introduction into care work as Serena. However, many participants shared stories about their first day on the job, their first experience with dementia, or their first day with a particularly difficult client. For those who shared such stories, it was always an experience involving fear, self-doubt and shock at the unfamiliar. The following three participants indicate that some of their initial experiences were so bad that they all debated whether to keep working or not:

Jessie: Initially I was just like aaack. (choking sound). I’m surprised I went back the second day (laughter).

Daisy: That was really a bad experience for me. (clearing throat). But I went back again.

Michelle: It was very rough, tough at first. And I really debated, oh do I keep going here?

I did not follow up on this thread within the interviews, and did not ask participants why they did decide to go back. However, the data indicates that new workers are regularly faced with situations with which they are not prepared to cope. In such situations, workers will contend with the decision of whether or not to continue working with a specific client, working in a specific area of frontline care, or working in care at all. Those who exclusively work alone in private homes have no opportunity to interact with other workers and lack important emotional support and informational guidance. The data strongly suggests that those who work alone are much

more likely to experience emotional strain than workers who have the support of co-workers, peers and managers. Participants who most enjoyed the autonomy and freedom of working alone were those with high levels of expertise and experience. For the remainder, working alone was often associated with fear, anxiety, frustration, and a general sense of wariness and need to be alert for problems.

CONCLUSION

The complexity of the field of care derives from conflicting epistemological foundations of family versus work: paid care is driven by competing concerns over the welfare of others as well as an interest in economic and organizational rationalization. Frontline workers define their position in the field based on a family-like understanding of their role, describing a good care worker as being naturally suited to caring, as genuinely caring, and as loving to care. Participants reveal that the emotional labour they undertake to align with their role is not an innate talent but is a culturally informed skill that is learned and improved upon over time. Nevertheless, the idea that workers are natural carers may impel workers to give unpaid extras to show that they ‘genuinely’ care, most obviously material gifts but also gifts of time and emotional effort. Participants report that the emotional rewards found in care relationships are personally significant, however, such rewards are inconsistent; at the same time, participants consistently feel demeaned by low pay which symbolically and materially devalues their contributions in the public sphere of work and employment.

Organizational policies and practices also locate workers in the field of care, providing form and structure for the emotional labour of frontline workers. Care plans are an important source of information organizing the client-worker interaction, however, workers and clients are

both affected negatively when care plans are inappropriate or absent. When needs and plans are out of step the onus falls on the worker to manage the situation, which has additional implications for emotional labour. When such demands occur, younger and less practiced participants tend to experience shame-fear-anger spirals relating to their inexperience and lack of knowledge, while older and more experienced participants instead engage in the moral labour of client advocacy, predominantly managing feelings of outrage and anger. Emotional labour is also influenced by the involvement of co-workers and supervisors; when support systems fail, young and inexperienced workers struggle with emotional demands they have not yet learned to cope with. The data strongly suggests that those who work alone are much more likely to struggle than those who have the support of co-workers, peers and management. Relatedly, participants who most enjoyed the autonomy and freedom of working alone were those with high levels of expertise and experience, and who had also internalized and naturalized the feeling rules of their role as a care worker. The findings in this chapter indicate that family and work ideologies compete to give meaning to the role of a paid carer and describe three organizational structures that have a significant influence on the emotional labour of frontline care workers. In the next chapter, I present findings of the emotional labour in direct care relationships, and three important feeling rules that are common to all workers in frontline care.

CHAPTER 5

EMOTIONAL LABOUR IN CARE

The central question of this thesis is: What emotions do frontline care workers experience, and how do they manage these emotions? The previous chapter explored some of the important contextual factors that influence the emotional experience of frontline care workers. In the first section of this chapter, I explore the direct care relationship and uncover the emotional skills that workers bring to their interaction. I describe some of the ways in which a worker's capacity to accurately interpret social and emotional cues directly influences the care relationship. I also explore how participants manage the emotional content of their interactions with clients, identifying differences between care as 'motherly' or 'daughterly'. The findings focus on those emotions participants work hard to express—such as compassion and humour—and those they work hard to suppress—such as shame, anger, and fear. In the section "Feeling Rules of Frontline Care" I examine three of the dominant of feeling rules of care work identified in participant talk, including (1) the admonition 'don't take it personally'; (2) the expressive rule 'be respectful,' and (3) the complexities involved in the feeling rule 'treat them like family but don't get too attached'. Throughout this section, I continue to note the ways that the structural features of care work influence the emotional labour of workers.

CARE RELATIONSHIPS: EMOTIONAL LABOUR AND EMOTIONAL SKILL

Informal care often occurs within the context of kinship or some other pre-existing relationship. However, formal care workers regularly interact with people they have never met before. Their demeanor as they forge connections with new clients is an important aspect of the

emotional labour involved in care work. As indicated by Craig, a homecare nurse with over a decade of experience, relationship-building is an important skill for a frontline worker:

Craig: How we initially approach people can set the tone for the rest of the interaction together. So you know, you're mindful of how you present yourself.

The presentation of self is a well-theorized area of study in social interaction (Goffman 1959), and may be unconscious or purposeful; if purposeful, it also depends on the individual's understandings or assumptions of the interpretations of the other person in the interaction. Craig is '*mindful*' in his self-presentation, as are the majority of participants. Whether mindfully or unconsciously, the goal of such emotional presentation appears to be to establish or maintain a relationship that allows them to do their job. For example, participants' emotional presentation may be intended to expedite the instrumental duties of care or may have a therapeutic goal of emotional support. Interpretation and assessment of the other often proceed unconsciously and automatically (Hochschild 2003). However, more experienced participants describe how they purposefully go about achieving appropriate emotional understanding and presentation, quickly developing trust and rapport. Alternatively, when social and emotional clues are misinterpreted by the worker, relationships do not proceed smoothly or easily. Success or failure at either goal is dependent not only on the emotional skill of the worker but also depends on the situational goals and wishes of the client, who also has power in the interaction.

Gloria provides an excellent illustration of how an emotionally skilled worker may establish a positive rapport with a new client. Gloria has over 40 years of varied experience in frontline care, which has allowed her to develop a great deal of skill in the interpretation of social cues and in managing her emotional presentation to respond appropriately to those cues. The following excerpt describes her experience working as a volunteer 'friendly visitor' in acute care. She describes how she can walk into a room and almost instantly assess whether the other person

will respond best to a friendly laugh, to sharing reminiscences, holding hands or simply sitting quietly:

Gloria: I can walk into a hospital room, but so many people could not do it. I just couldn't understand that! (loudly) How could you not walk into somebody's room and not just judge a person just like that? (snaps fingers) Like, I can assess somebody just like that, you know?

I remember one experience, I went to a lady's bed and I start (loud friendly voice), "Hello, how are you? I'm Gloria. I'm a volunteer here, and I've just come to brighten your day. So how am I doing so far?" You know (laugh), like that. Then I see another lady over there, and she's watching me. She's calling my attention, (loud voice) "Don't bother coming and seeing me!" You know, she's already voicing this, "Don't you bother coming to see me!" I says, "Well, I haven't made my way round to you yet, I guess you'll be waiting for me." "No, I won't! I won't be waiting for you."

So I go and chitchat with different ones. One I hold her hand and just sit quietly. Different ones it's 'How many children do you have?' You know, it just depends. You can tell a lot from the cards on their wall ...

So I'm almost ready to leave. I don't even look at her, the lady. And then (loud voice) "Aren't you going to come and talk to me?" she says. (laughter) I says, (slightly mocking tone of voice) "Well sure. If you want me to. If you have time for me?" "Yeah, yeah, come on, sit down." (laughter) And she was all sarcastic, but oh we ended up talking forever and laughing about everything, you know. Like that. You just have to know where they're coming from.

Gloria's excerpt begins with a strong sense of pride in her skill in assessing the situation. She describes how she approaches each person differently depending on her initial interpretations of the person and their situation, which begin with visual cues of the individual and their environment (such as cards on the wall, and bodily appearance of illness or exhaustion). Analytically, this relates directly to Goffman's concept of the front-stage area, where assessments of the situation and the other person in the interaction involve a combination of the setting (such as cards on the wall), appearance (such as age, gender and wellness), and manner or behavior (such as watching, sleeping, or ignoring). In combination, these three factors create a front, or a set of expectations that help people interpret the situation and get ready for their own performance (Goffman 1959). Gloria prepares her front based on multiple details, working to

establish a positive interaction. Once she establishes communication, her initial assessments are refined through the process of interaction and reinterpretation.

The complexities involved in appropriately assessing the other is most evident in her story of a sarcastic lady, who is at first resistant and unwelcoming. The sarcastic lady initiates the interaction, taking control by telling Gloria to go away before she has had the chance to introduce herself. Gloria notes that the lady is watching and interprets as “*she’s calling my attention*” rather than being rebuffed. She moves on without anger or hurt feelings, adopting a teasing tone, and suggesting the lady will just have to wait her turn: “*I haven’t made my way round to you yet.*” On the surface this response is not very kind— rather, it is slightly shaming, as Gloria chides the lady for being impolite. However, it can also be interpreted as a show of respect: Gloria does not treat the lady with an excessively gentle response but instead treats her as she would an equal, as a ‘normal person’ rather than as a ‘sick person’ who needs pity. She then moves on to other clients and is careful not to push for further interaction with the sarcastic lady (“*I don’t even look at her*”). It is also possible that Gloria’s withdrawal of contact may be interpreted as punishing the client for her bad behavior. When the sarcastic lady later re-initiates the interaction, Gloria responds with a teasing and mocking tone saying, “*Well sure. If you want me to. If you have time for me?*”

Gloria’s responses send various emotional messages to the client. Her confident demeanor expresses power; the somewhat rude words from the client appear to cause her no personal distress; she is neither afraid nor angry and is willing to talk. She also shows a sense of humor, and her responses contain no suggestions of condescension or pity. This combination appears to have been the right attitude to take with this person since the two “*ended up talking forever and laughing about everything.*” While Gloria is somewhat acerbic with the sarcastic

lady, with the others her demeanor is alternately calm and soothing or perky and energetic. This is an excellent example of role-taking and role-making, as Gloria skillfully tailors her emotional presentation to best suit each individual, and to help each individual take up their own role in the interaction.

Jessie, another participant with decades of frontline care experience, describes how she uses situational assessment and managed emotional presentation to accomplish instrumental care tasks that others appear to find challenging. Jessie explains that she has found that an emotional appearance of confidence may reassure a client that a worker can be trusted to perform physical tasks with competence:

Jessie: The man felt very comfortable with me. He trusted me, in the respect that (pause). [she describes fitting a sling and operating an electric patient lift] ... Anyway, I'd say to him "Okay, we're going up. You want to drive, or am I?" And I'd either hand him the remote or "No, you can drive," he says. "Okay, hang on!" And I'd make sure he has his hands on the side, and I'd say, "Straighten up your back." So he'd arch himself up and pffttt. two minutes, I'd have him out of bed and in his chair. Anyways, it all ended up that I had no problem moving this 300-pound man. But the other staff were just "Aaaak. We can't do that! I can't do this! It's too much! It's too hard!" Hah (slightly derisive snort).

This slightly derogatory description of other workers is a form of identity work (Snow and Anderson 1987); Jessie distinguishes herself from co-workers by claiming to be better, developing her self-identity and her social identity (potentially improving my appraisal of her in our interaction in the interview). Jessie, like Gloria, expresses a great deal of pride in her ability to establish trusting relationships where others fail. This emotional-relational expertise encourages cooperation, allowing her to perform physical tasks where others fail. The client is further assured of her competence because of her instrumental capability; she operates the lift in a practiced and efficient manner.

Jessie encourages trust through shows of confidence, leadership, and respect. First, she directs her client through what she is doing and what he needs to do help the procedure go smoothly. She then softens her position as leader by joining him rather than directing him with the brief phrase “*we are going up.*” This is immediately followed by a show of respect and an avoidance of dominance by asking him whether he wants “*to drive.*” This small exchange is important: she relinquishes her own power by offering her client the power to control the situation. In this brief passage Jessie presents herself as both capable and respectful. Through gaining her client’s trust, Jessie also gains his compliance and successfully accomplishes the instrumental care task that forms one of the duties of her job.

The ability to easily establish trusting relationships is highly inconsistent among participants, however, and the ability to do so quickly is only apparent in the interviews of those with a considerable amount of experience such as Gloria and Jessie. Rather than exuding confidence and leadership, those with less experience instead describe feelings of fear, uncertainty, and shock at situations they are unprepared for, and report limited success at disguising or suppressing such feelings. Based on their stories, I believe that inexperienced workers may generally be less skilled in interpreting and understanding the emotional needs of their client with accuracy; in some cases they may not be able to interpret the physical needs of their client when they are lacking clear direction or guidance.

For example, Serena, a care aide working for a private agency, describes her very first interaction with a person with advanced dementia. She was not prepared for the interaction through her formal training, and additionally had no experience with dementia in her personal life. Serena reveals that she found herself entirely unable to interpret the needs of her client, and as a result felt unable to provide appropriate care:

Serena: In my life I'd never seen it, and I didn't know people could suffer like this. I called her husband, and he said she's just tired. But I didn't know if she was just tired. I would give her a hug, and you know, maybe try to fix her face. I don't know, but I think she was more than tired.

Lisette: And she couldn't communicate, and tell you?

Serena: She was just shaking her head, you know, she had a difficult time talking. I would call her name, and she would just shake her head. I was like 'oh my God.' Yeah. I was shocked. I was crying.

Serena has a care aide certificate; her difficulties are not because she lacks training in the basic physical tasks of care, it is because she is both untaught and inexperienced in the relational aspects of care, and is uncertain that she is doing 'right' based on the feedback (or lack of feedback) she is receiving from her client. I suggest that such feelings of shock and dismay are relatively common among workers who are new to the emotional and relational requirements of care work. This lack of knowledge is particularly salient for those working alone in homecare who do not have access to the support and guidance of a more experienced co-worker.

Another example is provided by Daisy, who has two years of experience in public homecare where she provides housekeeping, meal preparation, and medication reminders. She characterizes most of her client relationships as positive, "*most of my clients, maybe 95 or even 97 percent of my clients, love me. They tell me, 'You are really nice.'*" However, she also describes experiences of severe conflict with a few clients, which I explore in detail later. Interestingly, Daisy is highly educated and pursuing a post-graduate degree, but nevertheless has not had a great deal of training or experience in relational work and emotion management. In her interview she mentioned that, in her role as a home care support worker, she received some brief and superficial instrumental training but received no training in interaction or developing relationships. In the following passage, Daisy states that she recognizes a need to improve her ability to control her emotional expression and discusses different ways she might interpret a 'difficult' interaction:

Daisy: I took some courses at university and I learned about home support workers, the services provided, and the relationship between home support workers and clients. There are lots of problems. The first is a language problem and misunderstanding of Canadian culture or different cultures. So, knowing about those kinds of issues made me understand why I had difficulty. But when I have a real situation happening to me, and I'm faced with it, not in a book but it's real, I find that it's hard to hold my emotion inside.

As Daisy indicates, she has relatively advanced academic knowledge of the potential for care workers to encounter misunderstandings with their clients, but she is lacking experiential and practical knowledge, and is perhaps unaware of the expressions she gives off through her gestures, body language or tone of voice (for example) (Goffman 1959). She further points out that knowing about a problem is different from knowing how to effectively deal with that problem. She concludes that her emotional skills need improvement, as she is finding it difficult to suppress what she believes to be an inappropriate emotional expression.

Participants with many years of experience and highly developed emotion management skills are proud of their ability, and report success when working with clients where other workers have been unsuccessful. Participants with fewer years of experience and developing emotion management skills report generally positive interactions, but also report far more emotional effort and frequent negative emotional outcomes, particularly in their interactions with 'difficult' clients. In the next section, I try to examine the various methods that workers employ to interpret their client's needs and the ways that workers align their emotions according to their understanding.

Skill at Interpreting the Feelings of the Other

An important skill for the emotional labour in care work is the ability to accurately imagine the feelings of the other person in the interaction. This ability is described in classical symbolic interactionist theory as synecic role-taking (Lauer and Handel 1977; Schwalbe 1988).

The significance of being skilled at synesic role-taking varies among participants: for example, role-taking may be highly salient for those employed solely to provide social interaction and likely becomes more peripheral when emotional labour acts in support of instrumental duties. In any case, participants predominantly suggest that forming positive relationships is a significant aspect of their work, and those that have greater depth and breadth of skill in role-taking and appropriate emotional interpretation run into less conflict with their clients.

Private companions are direct care workers who focus their attention entirely on social interaction rather than physical support; it is likely that emotional presentation and synesic role-taking represent a significant proportion of their work. Michelle is a participant employed as a private companion: two of her clients are private, in that she is employed directly by the family, and a third client has been assigned to her in her role as an employee with a for-profit care agency. Additionally, she works in the homes of clients providing housekeeping and personal care, having again been hired privately or through the same care agency.

Lisette: What would you say is the most important part of your job?

Michelle: Oh, it is to be able to go in there with each client fresh and happy and ready to roar. Because really that's why we're there, right? To perk them up. To bring them – not excitement but... (long pause)

Lisette: Life?

Michelle: Life. Exactly. Exactly. (laugh) Yeah, you don't go in there (monotone and low volume voice) "Oh hi, what do you want to do?" (laugh)

Although Michelle does not specify which role or job she is referring to, she says that her emotional presentation is the most important part of her work, and the primary goal of her job is “to perk them up.” This points out an important insight of symbolic interactionism; interaction itself has formative power in that it leads to new behavior (Blumer 1969). Michelle’s emotional presentation creates a new emotional response in her client.

Another participant who emphasizes emotion in her care role is Gloria, who is officially 'retired' but continues in care work as a volunteer in an acute care setting, works on-call as a recreation therapist in a long-term care facility, and works in the home of a client as an employee at a for-profit agency. Gloria similarly believes that one of the most important aspects of her work is to provide emotional support, and part of that is exuding emotional energy, however, it is not always necessary or helpful to be perky.

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In this passage, Gloria portrays her emotional labour as the surface acting of display, "showing" energy to give a boost to the client. She also describes the work of deep acting, invoking the appropriate feeling: "*I can cry with them. I can. I can be emotional.*" Emotional labour in care, then, requires both surface and deep acting. The idea that a person's demeanor has important implications for the emotional reaction of the other person is echoed by all participants, and is supported by decades of social research (Goffman 1959; Mead 1934; Shott 1979). Whether the motivation is to provide emotional support or to achieve cooperation with the physical tasks involved in body care, participants work hard at achieving emotional understanding and good communication.

The passage also touches upon empathetic emotions, as shared by Gloria who states: "*I can be in their place and cry with them*". Empathy is often defined as feeling what the other person is feeling, or what you imagine you would feel in the same situation (Shott 1979), and is a process of synesic role-taking (Lauer and Handel 1977). Although Gloria clearly states that she shares emotion with her client in this excerpt, the vast majority of her data, and that of all other participants, suggest that workers do not commonly share in the felt emotion of their client. Rather, they use synesic role-taking to judge what would be an appropriate or inappropriate action to take to control (or at least influence) the behaviours of their client. This is also

exemplified in Gloria's passage when she states, "*You need to be able to go into their bad sadness emotion but bring them out.*" In this case, Gloria is using synesic role-taking as a means of providing therapeutic emotional support, but the data suggests that it is just as likely for workers to use their emotional skills a means of controlling the interaction and handling what would otherwise be 'difficult' behaviours.

Synesic role-taking is apparent in participants' descriptions of interactions with clients with cognitive impairment, possibly because participants are purposeful and aware of the work they do to achieve understanding. Synesic role-taking with 'confused' clients is often described by participants as '*know where they are coming from*' or '*go to where they are.*' Jessie, with many decades of experience, relates a story about working in a long-term care setting with a client with dementia. The excerpt below provides information about the use of imagination and personal knowledge to reach an appropriate understanding of the other. Synesic role-taking, unlike basic role-taking, includes emotional understanding (Lauer and Handel 1977), and Jessie uses this deeper understanding to help develop her own response and presentation with the ultimate goal of managing his emotional state:

Jessie: I had a gentleman years ago, oh, he'd get so agitated in the morning. ... And I'd say, "What's the matter?" "Oh, I've got so much to do! I've got to get out and feed those chickens, and I've got this to do, and that to do, and I've got coal to unload." He'd be just frantic. I'd sit down and I'd give him a big hug. And I'd say "You know what, I kicked those boys out of bed early this morning. I let you sleep in because it's Sunday. That work's all done for you. All you've got to do now is come down and have bacon and eggs with me." "Really?" he says. "Yup." And of course, it wasn't really Sunday. But it would change the whole atmosphere of the day. But each one is so individual, too. You've got to listen to them. You can't just go in like a bulldozer, do what you've got to do and go out. You've got to listen.

Jessie's description demonstrates the reciprocal nature of role-taking and role-making; after successfully understanding the role he is enacting, she creates a scenario or 'gestalt' so her client can more easily take on the role she is providing for him. Giving emotional support in this way

takes time, which may not be built into the schedule or her job description. It also requires a great degree of biographical knowledge of the care receiver, such as the fact that he was a farmer with a number of sons who could be expected to help him out, along with cultural knowledge of Sundays traditionally being a non-work day. If Jessie did not invest the time to provide emotional support she would be threatening her self-identity as a caring person, and would also be potentially unsuccessful at performing the instrumental tasks of her work, such as ensuring that her client eats his breakfast.

Michelle, in her capacity as a companion, works with clients who have lost much of their ability to communicate through language, and with these clients she relies almost completely on non-linguistic ways of achieving emotional understanding. She explains that such work is very challenging:

Michelle: I have one client right now who doesn't speak. She doesn't speak. Sometimes she cries, but there's no real communication from her ...

Lisette: So, if she's getting sad or she starts to cry, how do you manage that?

Michelle: Hmm. Generally, I ignore it. Because I know that sometimes you just can't help. (pause) Well, unless she looks uncomfortable or she's acting like she doesn't like something. Of course I'll ask, like, oh do you have a headache? But really, there is no communication. I'm not saying she never nods yes or no anymore, but not for that. So if something looks obvious I'll tell the nurses. Often I hear, 'Oh she's okay. She's always like that.' You know, that's what I hear. But if she seems in real distress I'll say hey, something's different here. But yeah. You know, sometimes you can't do anything.

Michelle's passage illustrates how successful role-taking relies on understanding the other: meaning emerges out of interaction (Blumer 1969), but her client has lost much of her ability to relate in meaningful ways. Michelle must work very hard to generate meaning without the feedback available in most relationships, and it appears that she is often unsuccessful at role-taking (or achieving understanding) with this client, and instead 'ignores' sadness and crying.

Her emotional labour appears to involve the suppression of empathy, that is, trying not to feel concern over the distress of her client.

She states that she looks for situation or physical causes for her client's distress, however she may be trying to protect her identity and reassure me, the listener, that she is an attentive and caring person even though she is describing a situation where she was acting in a way that may be interpreted as uncaring. She also reports that she is generally reinforced in her belief that nothing can be done: "*Often I hear, 'Oh she's okay. She's always like that.'*" It is apparent that neither Michelle nor the people around her have been able to find a way to soothe the distress of this client and have given up trying to help. Is it okay to accept that nothing can be done? For Michelle, it appears that she is uncertain whether it is okay or not, and this uncertainty is causing her some moral distress. Although she appears to be learning to 'toughen up,' requiring a person with a caring identity to learn to stop caring may involve managing emotions ranging from nagging discomfort to intense feelings of anxiety, fear and anger (Austin et al. 2005). In addition, it appears to be difficult for Michelle to be emotionally expressive with her client who she describes as generally non-responsive: "*It's tough. I guess I'm the one putting out all the time, there's nothing coming out of her end, really. Very little. And that's what I find tough. It's a long hour.*" This highlights the interactive nature of emotional exchange; without the feedback found in most relationship, emotional labour becomes more difficult to deliver with clients with restricted or declining cognitive capacity.

This theme arising from the transcripts show that it requires concerted attention and effort to be successful at synecic role-taking, and this analysis suggests that only experienced frontline workers have had the opportunity to develop this skill. It is not always quick nor easy to successfully understand the needs of a client, and this skill is perhaps most important in

situations where there is cognitive impairment. When workers get it right, their ability to manage their emotional presentation can help reduce agitation and unease, and when their client is content all aspects of care work become much easier. As I will address in the discussion, the findings suggest that more effort at enhancing the ability of frontline staff in their emotional interpretation may enhance the quality of care for clients and the overall quality of the work environment. The next section explores the ways that gender roles influence the emotional interpretation and presentation of those engaging in frontline care.

Gender Roles in Care

Participants commonly show concern and interest by simply talking with their clients. It is in simple conversations where many emotional markers and pleasantries are exchanged through supportive rituals (Goffman 1971), and it is also where non-work roles and identities overlap with workplace roles. Participants in this study show instances of managing emotion in gendered ways. In this sub-section I explore ways that emotion management is influenced by gender, power, and status in the confines of care relationships.

Female participants describe a number of ways that they see themselves as a daughter and imagine their client as parent or grandparent. However, this is an example of performing age roles rather than gender roles. Gender becomes more apparent when participants describe working with clients of the opposite sex. When female participants talk about male clients, they tend to discuss interactions involving teasing, joking, and play-acting. To illustrate, Jessie, a homecare care aide, describes how she uses play to allow her to perform her tasks with a male client who tends to be uncooperative with other workers:

Jessie: I've got another old gentleman, and he quite often won't cooperate for the other girls. This is a game that him and I play ... he comes to the door

“What do you want? [angry voice]” But you can see the little smirk starting, hey? I say, “I just came to tell you that I loved you.” “Oh, that’s enough of that crap! I’m calling my lawyer.” (laughter) And meanwhile, I’m walking in the door, right. And then he’ll look at me, and he’ll say some stupid word and he’ll say, “Do you know how to spell that?” So I’ll spell a totally different word. “Uh. Tsk. You failed kindergarten, didn’t you?” (laughing) So this is the kind of nonsense we go through, right? But it’s all in good fun. And that’s the way him and I get through it, you know.

Jessie describes using teasing and banter as a way of gaining cooperation, creating fun in what would otherwise be a mundane or disliked activity, and eliciting feelings of affection and amusement. The interaction highlighted in the above passage is highly gendered. First, she claims feelings for him *“I just came to tell you that I loved you”* while he claims outrage *“Oh, that’s enough of that crap”*. Following this, they both reinforce his status as capable and knowledgeable; as he tests her intellectual capacity and she intentionally fails the test. They both know that she will “needle” him until she gets what she wants, not unlike a daughter charming her father to get her way. Jessie describes a significant amount of emotional labour in this passage; presentations such as this include mixtures of surface and deep acting: smiles, giggles, ‘pretend’ outrage, all with an over-arching emotional tone of affection. It is hard to imagine two men engaging in such an interaction. This technique of playful banter is useful for Jessie; her client enjoys his time with her, he is more apt to ‘like’ her, and he is more likely to cooperate. It is also emotionally supportive and role-making; Jessie actively degrades her own status to that of a ‘dumb girl,’ positioning her client as a powerful in-charge male. She is quite likely unaware of the reduction of her own status, as this performance is intended to be a kindness and follows comfortable gender scripts. Her self-abnegation does not appear to damage her self-identity in any meaningful way, however it is somewhat telling regarding gender roles in general, as this act of self-subordination is so comfortable and easy for Jessie.

Unfortunately, neither of my male participants shared stories of specific interactions with female clients, so I have had no opportunity to explore their experience of gender performance with women. However, participant talk suggests that male workers and female clients also tend to conform to gender roles within their interactions:

Jessie. And you know she loves the boys, the male workers, when they're here. She just sparkles. (laughter) There's a couple she doesn't like, but for the most part the guys, they're good to her. Really good to her.

From Jessie's indication that her client 'sparkles' when working with male caregivers, I interpret that some gendered banter is occurring, but this is somewhat of a stretch based on limited evidence. By comparison, however, coquettishness disappears among female participants when interacting with other women.

It appears that female workers are more apt to take a commanding role with their female client to gain compliance, evoking obedience. Rather than teasing and pestering like a daughter, participants instead tend to take control like a mother. This is particularly evident among those caring for clients with confusion due to medications or cognitive disability, and those working in acute or palliative care settings where the client's health status is very low. In these settings a client is treated more like a sick patient, which has a number of ramifications for autonomy and status—in the sick role, people are expected to respect the authority of the medical establishment and cooperate with the instructions and expertise of health practitioners in order to get well (Parsons 1951; Varul 2010). In the context of aging, disability, and chronic conditions, the sick role arises not because clients are sick per se, but because they are people who have bodies or minds in need of support; the greater the dependency the greater the loss of autonomy. Over the course of this erosion of autonomy, workers gain power and authority; they are expected—required!—to perform their medically-prescribed duties even when clients do not want the 'services', and even when clients are uncooperative or belligerent. Nevertheless, participants

overwhelmingly suggest that they try not to be cruel and accommodate the wishes of their client as much as possible while also being obedient to the authority of medicine. Both parties, the frontline worker and the client, are relatively subordinate within the overall structure of health care, however, within the micro-interactions of the care relationship, the worker tends to hold more power.

Participants describe various duties they must perform that some clients do not like, such as turning people who are bedridden to avoid the development of bed sores, waking a client who wants to stay asleep, or controlling the movements of a client who seems determined to escape supervision. A common challenge in frontline care is medication; the worker's role is to 'remind' clients, while clients are expected to take on the sick role and cooperatively take the medication on their own. Importantly, all participants report running into the problem of a client who refuses to take their pills. To gain compliance from an otherwise unwilling person, workers exhibit careful emotional control to successfully manage the situation, including suppressing anger, maintaining a calm and patient exterior, exuding care and concern, perhaps wheedling, perhaps commanding.

In the next excerpt Michelle describes some of her struggles gaining cooperation from a woman for whom she provides home support through employment with a private agency:

Michelle. She would refuse her pills. That was another issue. Fights. Fights. That would make a fight. Actually, a lot of things. You know, it's her bed, she's going to make it. Make the bed fights. She doesn't want a bath, so bath fights. Change your clothes fights. All of those things, she'd get aggressive and angry. I had to learn how to say things without telling her what to do. You know, 'do you want to wear this outfit or that outfit' not, 'okay, it's time to get dressed.' But the pills ... I asked permission from her husband, and we started crushing them and putting them in her oatmeal or cereal so that she would get her medication. She would be like "Oh, this stuff tastes really weird." (laughter)

Michelle describes her difficulty in gaining cooperation as fights and ongoing conflict. This is an example of consequences of violating personal territory without consent (Goffman 1971).

Although it is not spelled out in the excerpt, elsewhere in her transcript Michelle describes feeling afraid of the aggression, and frustrated and angry with her client, with herself, and with the situation in general. She engages in emotional labour, controlling and suppressing her negative emotions, and continues to show kindness and concern. Over time, Michelle learns that she is more successful in completing her tasks if she first gains permission, which symbolically grants her client a somewhat illusory sense of autonomy: *“I had to learn how to say things without telling her what to do.”* Parents with young children might recognize the technique of giving limited choices rather than issuing commands, giving the child some sense of power and control to reduce tendencies toward rebellion. Goffman points out that many ‘compellings’ are disguised as ‘requests’ *“if for no other reason than the fact that the body is hard to manage nicely without cooperation”* (1971:115). However, Michelle could find no technique that would get her client to agree to take her medication and had to resort to trickery.

I previously described how Jessie uses teasing and play with one of her male clients, encouraging compliance through daughterly banter. With one of her female clients, however, she instead exerts dominance, demanding that her client do as she is told:

Jessie: She gets pills at night, and I give her the pills. I guess, for my counterpart, she won't take her pills.

Lisette: Oh! There's some trick that you have?

Jessie: (nodding) I go in and I generally wake her up at 7 o'clock. And she's "Oh, look. You're here!" And I say, "Come on, let's go get your pills." Well, she sits down. I give her a bottle of water and I punch her pills out. I take the Tylenol here, and I put another three or four here (she is placing imaginary pills in a straight line in front of her on the table). So she'll take the Tylenol first and then she'll say "I don't want to take those" or "I'll save those for tomorrow." And I say "Well there's not much point, because you've got more for tomorrow. Take them!" "No, no." (stern and menacing voice) "I said take them." And she's like (small squeaky voice) "Oh!" And then she takes them ... I don't know that that's the best way. But she knows I'm just going to tease her and bug her until it's done.

Jessie's emotional presentation is overt and obvious during the interview: in recounting the interaction she uses a menacing tone of voice, sits forward and stiffens her body communicating aggression. Altogether, these techniques intimidate her client who squeaks out a response and complies. Jessie is not fully comfortable with the way she bullies her client into doing as she is told ("*I don't know that that's the best way*") and softens it somewhat by describing it as teasing and bugging. Apparently, Jessie uses this technique of bossing or mothering because she finds it works and she has no time to engage in more involved emotional interactions. She has only a five-minute window to get her client to take her pills before she must move on to her next client.

The structural limitation of time is a key influence on how Jessie is acting in this situation; a classic study carried out among divinity students found that conflicting responsibilities and time pressures are a strong predictor of support and helping behavior, even among people with dispositions highly attuned to being a 'Good Samaritan' (Darley and Batson 1973). Dominant and aggressive emotional presentations may be interpreted as a misuse of power, however, many care situations require the worker to take on the role of caretaker, placing them in a position of higher status within the relationship, while still within a low structural status. The implication for a worker not carrying out their duties, particularly if they repeatedly fail at completing a 'simple' task (such as giving someone a medication reminder), is that the worker may lose their job. Female workers act either 'motherly' or 'daughterly' depending on which emotional presentation helps get the job done.

Jessie also reveals that emotional shows of dominance may be performed as a means of self-protection from violence and aggression. The following excerpt refers to her interactions when providing private in-home care for a woman with violent behaviours:

Jessie: The first couple of months were pretty rough with her. She was a handful. She was very combative, very nasty when I first started. But I learned

to handle it. It's 'Do not touch, and you do not scratch!' And I'm very firm with her. I will raise my voice and say 'No! No, you are not going to hurt me today.' ... You don't tell her 'You're bad. You're a bad girl for hitting me.' No. No, no, no, you don't do that. You say, 'I'm just going to leave you sitting here until you cool off.' And I come and sit in the dining room, and I'm away from her. I can still see her, right, but she can't see me. When she scratches my face, or if she's fumbling with my glasses and kicking and throwing and everything else, you know, I just hold her hands down, and try to control it, like (firm and loud voice) 'This is enough!' But yes, oh yes, there's times I would get very frustrated and very upset at what she does to me. But, you know what, you suck it up. You walk away.

When faced with violent and unpredictable behaviours, caregivers must protect themselves while also doing the best they can for their client. Care work often includes abuse and violence perpetrated against the carer, and this situation is not in any way unique (Bailey et al. 2015; Banerjee et al. 2011). Jessie is firm and commanding in her efforts to control the situation. Interestingly, with this client she does not appear to be menacing and aggressive (as she was with the client who would not take her pills). In this situation, Jessie is with the client for an entire eight-hour shift and has considerable freedom to manage her own time. She is acutely aware of ways of speech that may demean her client and avoids it: (“*You don't tell her 'You're bad. You're a bad girl for hitting me.' No. No, no, no, you don't do that.*”) Note that Jessie gets “*frustrated and upset at what she does*” but does not express those feelings: “*you suck it up. You walk away*”. This is a key technique that experienced caregivers learn so they can accept abuse while continuing to provide care: they separate their feelings about the behavior from their feelings towards the person. Jessie understands that her client often behaves in ways that may hurt her, and yet elsewhere in the interview confides that she feels a deep emotional attachment to this particular client.

Workers continually bring emotional effort to their care role, motivated variously by concern for their client's well being, by structural pressures requiring them to gain cooperation from their client, and by the need to protect themselves from violence. Status strongly influences

the shape and form of the emotional labour of frontline workers, as they try to negotiate the multiple roles they may hold, such as conforming to gender expectations or negotiating the client non-conformity to the expectations of the sick role.

In interpreting the emotional information communicated by their client, participants use synesic role-taking, however, success and ability in this area are highly variable: only the most experienced participants show evidence of a consistent ability to appropriately interpret their client's emotions. A well-developed ability to interpret emotional cues is useful in all care situations, however, it appears to become more imperative as other forms of communication fail. Participants use synesic role-taking and empathetic understanding in their efforts to show care and concern, however, emotional displays of dominance, intimidation, and aggression ensure that workers are able to perform the instrumental tasks of their job. Key structural factors that influence the emotional labour of workers are lack of time, the risk of being hurt, and unpreparedness; workers then find themselves managing their emotional presentations to conform to employment requirements, to protect themselves from harm, and to compensate for a lack of training and support. There are gendered aspects in the ways that carers go about their emotional presentations, such as female workers acting alternately motherly or daughterly. Underlying all of these features that influence emotion and the presentation of self are pervasive emotional norms and expectations, which are both implicitly and explicitly required as part of social understandings of what it means to care, and also what is required of a person working for a wage (Hochschild 2003/1973). Participant stories reveal three of the feeling rules that apply to frontline care work, as I discuss in the next section.

FEELING RULES OF FRONTLINE CARE

Feeling rules are normative expectations of the amount and type of emotion that should be felt or expressed in a given situation. These are influenced by general social expectations and internalized beliefs and are further influenced by organizational attitudes and goals. Hochschild (2003) found that airline workers are expected to be friendly and respond to anger with a smile, ultimately engaging in a great deal of surface acting in the service of corporate profit.

Theodosius (2008) found that nurses are expected to be compassionate and respond to anger with empathy, requiring both surface and deep acting in the service of professional ethics. In the following section I identify the emotional expectations of frontline care work and describe the three dominant feeling rules that arise in the talk of participants: don't take it personally, be respectful, and treat them like family but don't get too attached.

Don't Take it Personally

Care work involves the important feeling rule 'don't take it personally,' where normally unacceptable social behavior in a patient or client is excused due to their illness, their pain, their personality, their age and so on (Funk, Peters, and Roger 2018; Theodosius 2008). As previously mentioned, care receivers tend to be placed in the sick role and thus excused from 'normal' social responsibility (Parsons 1951). The feeling rule 'don't take it personally' encourages workers to banish feelings of anger or resentment at mistreatment. However, a tendency to view distressing client behaviours as unavoidable and forgivable because of illness or disability creates situations where discrimination and violence become an accepted and everyday part of care work.

Research undertaken in multiple care environments finds that workers are routinely subject to physical, verbal and emotional aggression from clients. (Arnetz and Arnetz 2001; Baines and Cunningham 2011; Lapuk 2007). In keeping with this feature of care work, all but one participant in the present study talked about physical and verbal aggression. Situations where participants call forth the feeling rule ‘don’t take it personally’ include snide, insulting, racist and sexualized comments, threats, and outright physical violence. All participants, regardless of gender, ethnicity or work role, spoke of such situations, as exemplified in the following excerpts:

Craig: There are clients that tell you to eff off or curse at you every day.

Michelle: And now he’s talking about us having a threesome? That was my first day!

Jessie: You know, sometimes you’re just like (ach – sound of distaste) I’m sick and tired of this resident beating the shit out of me, or being rude to me ...but you know you put on your fake face and in you go. And you smile and that.

In order to function under such conditions, participants were often explicitly told by employers and supervisors to learn not to take things personally. The rule helps workers create an emotional barrier between themselves and their client, a sort of emotional armor. The rule requires workers to use emotional labour, in particular, the surface work of emotional display, as stated by Jessie above: “...you put on your fake face and in you go. And you smile and that.”

Relatedly, Serena, a newcomer to Canada, explains that her job requires her to accept the behaviours of her clients rather than trying to address or correct discriminatory and racist comments:

Serena: You can’t tell them don’t do this, don’t say that. No! You can’t tell them that. But what you do, you just let them be the way they are. You know, that’s a part of your job.

Participants share their belief that clients are offensive and aggressive for any number of reasons, such as because they do not want help, do not like tasks that the worker is required to do, are unhappy with tasks the worker refuses (or is unable) to do, are confused, or have dispositions

characterized variously as grumpy, ornery, racist or sexist, and more generally these clients are often referred to as 'difficult'. Regardless of the reasons for the behavior, workers regularly need to provide care to abusive clients, yet participants reveal that workers' ability to align themselves with the feeling rule 'don't take it personally' varies considerably, as does their capacity to mask negative feeling. For example, in her story of dealing with overt racism from a client, Serena discloses that she had not yet learned to manage her hurt and angry emotions:

Serena: One day, a client, he told me, (angry tone of voice) 'You black devil!' He just talked to me like that! And I was so mad. But, what am I going to do? Nothing. There is nothing I can do with him. I can't fight him. What am I going to do? Nothing. I just left the room. I left. You get mad, but what can you do? I reported about the man to the nurse, and she said "You know what, I always report him. So many people are complaining about him." ... I see even the regular staff, they call the nurse to be with them. They don't want to go by themselves in his room. They say he's that way with everybody, not just with me.

Serena is unable to effectively suppress her anger and humiliation, but any expression of hostility would at minimum be interpreted as poor quality care, and could easily be interpreted as elder abuse. She has not yet mastered stoicism and emotional toughness, nor, apparently, does she have the self-confidence or assertiveness she needs to successfully manage the interaction. Because she could not manage her feelings, her response to the insoluble emotional situation is to end the interaction and leave the situation altogether.

Other staff call forth the feeling rule 'don't take it personally' by assuring Serena that '*he is that way with everybody,*' implying that she need not feel that she is in some way singled out, and is certainly not at fault for the negative interaction. When Serena reports the event, her supervisor commiserates by saying that many complaints have been reported, although it is unclear whether any action had been, or would be, undertaken to address the behaviours of the resident. In this story, Serena has not fully internalized the feeling rule 'don't take it personally,'

yet later in the interview reveals that she has begun to accept mistreatment as an everyday feature of her job:

Serena: You know, now I don't mind because of the yelling at you or something. Because everywhere that's how it is. It's not always happy. No. So. It's okay, I'm fine.

Serena is a temp worker, which means that she is parachuted into a variety of unfamiliar locations to fill in for short-staff situations (such as when regular workers are sick or on holidays). Serena rarely works at the same site for more than a handful of shifts, and despite working as a care aide for less than two years, she perhaps has more experience of differing situations as compared to other workers with more years of experience but with a regular clientele. Interestingly, she comments that *'everywhere that's how it is.'* It seems likely that she has begun to internalize the feeling rule *'don't take it personally'* and is gradually acquiring the emotional toughness, or is trying to act tough, as a means of dealing with various forms of abuse.

Daisy, who provides housekeeping and home support, has been working full-time in public homecare for just about two years. Over multiple transcript selections that follow, Daisy describes a situation that was so upsetting that retelling the story in the interview brought her to tears. She explains how she felt after an episode involving verbal assault and physical aggression from a new client, and discusses her attempts to manage her emotions over the course of multiple visits. In this first excerpt, Daisy talks about suppressing and hiding her emotions as self-defense, necessary both to keep her job and to protect her self-esteem:

Lisette: (Daisy is crying). [Your client], she was very very insulting hey?

Daisy: Yeah. Yeah. Um hmm. But I didn't cry.

Lisette: You're crying now.

Daisy: I know, I know, but not then. Here is different. Here you are listening to me. I didn't cry then. I told myself that I had to handle it. Because I am an immigrant, I don't have Canadian experience. Yes. (long pause, wiping more tears). Um. So. I thought I must finish my work very well. I have to maintain

my work very well because this foundation with the entry-level job in Canada will bring me up to a higher level.

Lisette: You've got to start somewhere, right?

Daisy: Yeah. Um hmm. When I left her home I closed the door softly. When I left her home I didn't feel very well. ... I called my supervisor and asked her can you help me to change, to meet another client instead of her? I want to know if there is an option for employees to choose another client? And she said no. No. So if my schedule is set up with her, then I should go there. (sigh)

Part of the reason Daisy did not cry during the interaction with the client was a sense of safety. In the interview, I was sympathetic and understanding, and clearly on her 'side'. During the interaction with the client, however, she did not express her hurt feelings since to do so would expose vulnerability and open the door for further feelings of shame. The effort of accepting emotional abuse without defending herself, suppressing her shame and anger, left her feeling physically unwell.

Daisy also reveals her subordinate social position as an immigrant care worker. As is probably true for many workers, she believes that acting inappropriately would jeopardize her job. However, this is not just any job, it is her first job in Canada. She does not have in-country work experience, nor the cultural capital and social networks that would allow her to easily find different employment. Whereas other participants working in various for-profit and public health contexts told me that they could turn down a client, Daisy's supervisor says she is not allowed to turn down shifts regardless of the behavior of the client. Daisy's account reveals the position of precarity and vulnerability that she and many other frontline workers occupy within the healthcare labour force.

Rather than taking steps to correct the client's abusive behavior, Daisy's supervisor tells Daisy she must learn to deal with the situation and explicitly invokes the feeling rule 'don't take it personally':

Daisy: I think about what my employer told me, don't take those things personally. Okay. A job is a job. Alright. I want to learn that ... It was a challenge. I kept thinking and thinking about why she was mad at me. And then I thought about how can I press down my anger and talk nicely to her? So I just decided, if she says this I will say this and if she says that I will say that. I will fix what's wrong between her and I.

As Daisy indicates, learning how to conform to the feeling rule 'don't take it personally' is a skill which can be learned, and it follows that it can also be taught. However, without direct support from her supervisor or a more experienced co-worker, Daisy is left trying to teach herself. In anticipation of her next visit with the abusive client, Daisy prepares herself, planning her words and reactions, and tries to find ways of thinking that will help her keep calm, maintain civility, and allow her to more easily "press down my anger." This is precisely what Hochschild refers to as cognitive emotion work, and it is recognizable by the effort rather than the result (2003:257). Daisy is determined to be successful at her job, and puts in significant planning and thought into her own behaviors in hopes of better managing the interaction. Yet the client continues to shower her with abusive tirades:

Daisy: When I came back again she was very insulting. And she told me "when you didn't visit me last time, I was so happy. Another worker visited me that was white! That was white! She cleaned up everything and you didn't." ... She was mad. Oh, she was mad. But that part, she is white and you are not. That makes me very sad. Canada consists of immigrants, right? So, I don't know, but I think she shouldn't have talked like that ... But I went ahead with my work, and I had a plan not to respond to her directly, so I just listened to her complain and I did the work. I was there for the whole two hours, and I even gave her an extra 10 minutes. So I told her I completed my work and now I am leaving.

The interaction contains overt racism, and Daisy is insulted but seems unsure if such behavior is an accepted norm in Canadian society. She decides to persevere, however, her method involves avoidance, disengagement, and passive listening: "I just listened to her complain and did the work". Unfortunately, she 'does the work' without working to change the tone of the relationship. Her emotion management is entirely concentrated on managing her own expression

and suppressing negative feelings, but she does not use synecic role-taking and emotional labour to influence the emotions and behaviors of her client.

Other participants generally indicate that part of learning how to ‘not take it personally’ requires deep acting, distancing themselves emotionally, putting up a protective barrier that enables them to continue to interact with their client. Here, I interrupt the analysis of Daisy’s situation to provide an example from Chiara, a Filipina care aide with over seven years of frontline experience. Chiara appears to easily distance herself from the attitudes of her clients, allowing her to claim invulnerability to racism:

Lisette: Have you ever experienced any racism from the people you work with?

Chiara: Oh yeah! (laughter) Oh yeah. In homecare it’s not the families, usually it’s the patient. And you know what I usually tell myself, is if she doesn’t like this employee because of race or culture or whatever she can just request another caregiver from the company. That’s pretty much it. Yeah, so I don’t take it personally. That’s their perception. It has nothing to do with me, you know what I mean? (laughter)

Chiara asserts that the behaviours of her clients do not threaten her identity in a meaningful way, again showing an example of cognitive emotion work in reframing the situation. Importantly, she has developed a working persona that can withstand negative judgments from her clients. Perhaps it does not work all of the time, but for the most part she has learned to interpret the situation so that she does not need to manage reflexive emotions of shame (Shott 1979). This is an example of deep acting; Chiara is so practiced at not taking things personally that her emotional response is ‘automatically’ appropriate to her perception of the situation.

I now return to Daisy, who has not yet learned to distance her sense of self from the attitudes and behaviors of her client. This following excerpt shows that her emotional difficulties are exacerbated when her client acts in a way that physically removes the distance between them.

Daisy: And then she said “Holy shit, you are such a tough girl! I want to hug you.” She said it like that. And then she grabbed me and hugged me. (long

pause) But I didn't want to hug with her! I was still angry. But I didn't express my anger to her, I just held my anger all in the inside. So all this garbage was in me. She just held me, and I didn't even breathe. And then I just thought, oh. (sigh) Like ugh. (sound of distaste) You know? I just wanted to leave there immediately. But she held me. Oh, but I was so angry.

Daisy's narrative shows how hurt and anger intertwine in shame-anger spirals (Scheff 2009).

Daisy is “*very sad*” about the racism, and at the same time “*so angry*”. However, she keeps her feelings to herself “*I just held my anger all in the inside. So all this garbage was in me*”. Here is a direct example of surface acting; Daisy's emotion work is devoted to controlling her display.

While Daisy is hard at work suppressing her anger the client hugs her. Hugging could be interpreted as an expression of positive regard, but it could also be a rather aggressive demonstration of physical power and control. Regardless of the client's motivations, her actions produced a physical closeness between the two that interfere with the distance Daisy has worked to maintain, and Daisy is not prepared for such intimacy. As she leaves the home the emotional experience transforms itself into a physical response, and Daisy again feels unwell.

Daisy is still processing the incident during our interview, using the opportunity of talking to me to help her reinterpret the situation, and potentially as another step in her attempts to try not to take such verbal abuse personally. In our talk she reveals some of the methods workers use to repair injured pride, such as positioning the other's opinions as invalid, or oneself as morally superior:

Daisy: But you know, (whispering) her home is so messy and so dirty. (normal volume) When she told me “the white girl did this and that” well I looked. And I thought, yeah. No way. It's still dirty (laughter). It's still so dirty. And you know I am a very hygienic person. I am a very organized person. Like in my home, I can find everything without even turning on a light.

Daisy believes her clients' complaints about the quality of her work are unsubstantiated by the evidence, therefore transforms her interpretation of the situation into one that is less personally wounding. She notes that despite her own and others' cleaning efforts, the home remains “*so*

messy and dirty.' It appears that Daisy interprets dirtiness as a moral failing, as she compares the client's home to her own home which is *'hygienic'* and *'organized,'* generating a sense of moral superiority, raising her status and self-image in response to the negative regard of the client.

In situations of verbal abuse, inexperienced workers engage in a great deal of surface work to disguise painful and problematic feelings of shame and anger, followed by attempting deep acting to change those negative feelings. Using the feeling rule *'don't take it personally,'* experienced participants appear to have successfully transformed their emotional response and no longer experience feelings that require surface acting. However, situations of physical violence and threat are not so easily managed by controlling only one's own response. In such situations, emotional experience involves not only shame and anger but also fear, which is an emotion that appears to be less amenable to management.

Whether client behaviors are *'personal'* or not, almost all participants reported feeling fear, most commonly when working alone or when working with clients who have a history of abusive and violent behavior. In addition, relatively inexperienced participants talked about feeling afraid far more frequently than did those who have worked for many years in the field of care, however, this is not solely related to care relationships, it is also related to generalized status and inexperience. To illustrate, Serena, a newcomer and younger participant, worked in frontline care for less than a year at the time of the interview, and talks about a great deal of trepidation in multiple situations, most particularly in situations where she is alone:

Serena: I don't have much experience working alone in homecare. Some people they scare me. You know? It's not always good to do homecare. ... You never know maybe something could happen. It's very scary. That's why I say it's really hard. Because it's not always good people.

Elsewhere in her interview, Serena also shares that she is also concerned for her physical safety in *'bad'* neighborhoods and is fearful of walking alone in the dark. Walking at night was a

particular problem for Serena as she used public transportation and was often called for late shifts or night shifts, and made a number of references to the few hours of daylight in Canadian winters. The issue for Serena appears to be that her role as an on-call temp worker often required her to go into unfamiliar environments, and deal with situations she did not fully understand for multiple reasons often hinging on language and culture.

Fear is not exclusive to inexperienced or young workers. Older and more experienced female participants also say that workers need to guard how they speak, how they act, and how they dress. This is exemplified in the following passages from Michelle's interview in which she refers to working as a home-helper in the apartment of a couple; the woman had dementia and needed help with bathing, dressing and medication, while the man needed household support. She had been working with the couple for more than two years, and at the time of the interview the woman had moved into long-term care. Michelle was continuing to provide housekeeping support for the man, and found it increasingly difficult to work alone with him:

Michelle: It was the very first day. I go into the home of the couple, and the wife has major dementia. I don't remember what she was doing, but he says to her 'you're stupid' or 'you're crazy,' or something like that. And I thought, oh my God, he's one of those people. And then he talks about, oh we're going to have a threesome. And I'm thinking oh my God! What did I get myself into here? But I just ignored it. I ignored all of that. But you go through the emotions, like what the hell did I get myself into? I'm thinking okay, he's an aggressive guy, talking to his wife like that, with severe dementia. And now he's talking about us having a threesome? That was my first day. More or less first thing in the morning. I thought oh my God! What do I do? (laugh) You know? Anyway, at first, yeah it was let's have a threesome. And later on there were jokes, sexual jokes. And you know whatever. Like nothing personal. ... And of course, you know, I'm careful. I don't wear short skirts or tights. I will occasionally wear them at the nursing home. But not there. No way. You know. This is a man alone in an apartment. I'm more careful. Yeah, I'm careful with this particular client. Definitely.

Michelle calls on the feeling rule, stating, 'you know, whatever. Like nothing personal'.

However, the feeling rule did not allow her to fully immunize herself against her fear: "oh my

God! What did I get myself into here ... what the hell did I get myself into... oh my God! What do I do?" She says that she ignores his comments, but this is not the same as not being emotionally affected by his comments. Rather it appears that she is somewhat paralyzed and does not acknowledge his sexually aggressive speech in the hopes that it will not be repeated. Michelle is trying to 'not take it personally' by ignoring the situation, and the man is allowed to continue his behavior.

This shows that when power is in the hands of the other, the feeling rule 'don't take it personally' can create a dangerous situation, encouraging workers to overlook bad behavior, and in doing so urges workers to minimize any danger they may feel. Indeed, the client's sexualized behavior escalated over time, his language became more and more overt, and he would physically move close to her making her feel trapped. After months of such interactions, Michelle learned that he had tried to pat another worker on her bottom.

Michelle: After his wife went to the nursing home, it was 'Oh, it'd be nice if you could lay with me. I need comfort'. But you know, from the very first visit these sexual comments were happening. And you know what, I didn't write about it. And I should have. I should have written it down. I didn't. Later on, as there was more stuff happening, I did start to write that there were sexual comments.... There were two of us looking after the couple, and all of a sudden after I wrote something about the sexual comments, then also she's writing it. And when I wrote about him telling me he was wanting comfort, she writes that that's what he said to her too. So yeah. (pause) So. And then she writes, he wanted to pat my bum! ... So that's when I thought okay, somebody needs to talk to him. So that's when I left a message with the office.

It may seem unbelievable that neither worker reported any incidents for an extended period of time, however, women tend not to report sexual harassment in a number of different situations (Hanrahan 1997). Further, the feeling rule 'don't take it personally' encourages care workers to interpret misbehavior and aggression as something they must learn to accept. Although it is unclear in the data, Michelle and her co-worker were likely trying to manage their fear by telling themselves that it was minor, or unimportant, or nothing to worry about. Interestingly, only after

they began writing notes to each other did Michelle realize that another person might be in danger too; that is when she finally reported the client's actions to her supervisor. The outcome of the situation was not fully resolved at the time of the interview. The agency had recently called the client's family, and the client had just apologized for his behavior:

Michelle: I was a little nervous. So I go to work, so he's eating his breakfast. After breakfast, he says 'Have I ever said anything sexual that was not appropriate?' I said, 'Yes, sometimes.' 'Well, I'm really sorry. I don't mean to. If it happens again tell me to zip it.' But he did say if it happens again — I thought that was kind of weird, for him to say 'if it happens again.' You know? Like no. It's not going to happen again! 'But if it does,' he says...

The feeling rule 'don't take it personally' is in many ways a double-edged sword. It allows workers to provide care despite mistreatment, and when this feeling rule is internalized workers may be able to withstand a great deal of verbal abuse. However, the feeling rule also encourages workers to expect abuse as an everyday occurrence and tends to force workers to minimize their interpretation of the potential dangers they may face. It may also create a situation where workers who do experience fear or anger are then faced with guilt and anxiety over their own failure to cope. Frontline care workers are often obliged to manage feelings of fear and anger, and although it may not be recognized as work, managing those emotions can be an oppressive aspect of the job.

Importantly, the feeling rule 'don't take it personally' is not about influencing the other person, or projecting an emotion, it is a proscription forbidding workers from allowing themselves to be hurt through self-control and the management of felt emotion. Another important feeling rule evident in the talk of participants is 'be respectful.' This emotional norm is different in that it is prescriptive, and is primarily about controlling appearance and often requires the worker to act in a deferential manner. However, as I show, workers often internalize

this feeling rule to the point where they act with respect through finding ways to admire and feel esteem for their clients.

Be Respectful

Shows of appreciation are important in all social relationships and are often enacted through an interactive dialogue involving polite words that acknowledge status and show positive regard, what Goffman (1956, 1959, 1971) refers to as offers and acceptances. When both people in the interaction show appropriate regard relative to each other's given status in the moment, social relations go smoothly and connections grow closer. Without exception, participants understand that shows of respect are an important part of their job—many describe treating clients with respect as the primary means of safeguarding the humane treatment and personhood of those receiving care. Broadly speaking, respect involves showing a positive regard such as approval, esteem or honour, and hiding inappropriate feelings such as impatience or dislike. Workers may feel genuine admiration for a client, may show approval in a maternal or paternal way, or may be deferential and obedient to the authority of their client.

Participants tend to embed the feeling rule 'be respectful' within the broad moral imperative that care work be protective of human dignity, as reported by Jessie, a care aide working in public homecare and for a private agency.

Jessie: The most important thing? Making sure that everybody's looked after how they should be, with respect and dignity. Because they're people! They're not just a thing that's part of my job.

A majority of participants also note that they have seen other workers behaving disrespectfully towards clients, often describing a lack of respect as a lack of kindness, and a moral failing in that other workers are not acting as they should. For many participants, to be respectful is to 'be

nice,' as in the following excerpt from Michelle from her vantage point of a private companion in a long-term care setting:

Michelle: Oh, it's amazing what you see. I'm not saying that it's necessarily abuse, but it's not nice behavior. It's not, to me it's not the way you treat anybody. It's all about respect. But some of the things I see the aides do ...

Shows of respect also have practical utility, and all participants point out that appropriate shows of respect allow them to get on with their job, as exemplified by Daisy, a support worker in public homecare:

Daisy: The easiest is when clients are cooperative. So when I say something to them, I always treat them very well and nicely.

Showing respect and treating people “*well and nicely*” is a fundamental emotional presentation for frontline workers, and helps participants gain cooperation from their clients.

Sometimes respect is not a show of kindness, but instead involves emotional suppression, such as disguising or hiding negative feelings. As indicated earlier, this is common among participants in hiding anger and shame at mistreatment. This may also be a common feature of the practical tasks of care; for instance, workers frequently hide feelings of anxiety, disgust or dismay when performing the intimate body care (Rivas 2011). Many participants in this study indicate that instrumental activities are indeed ‘common’, however, because of their routinization may not always involve negative feelings that require management. For example, although Serena has only been a care worker for about a year, body care (bathing, dressing, and peri-care—changing soiled briefs and diapers) are so familiar to her that she feels they are the easiest parts of her job.

Serena: So, what's the easiest? You know, peri-care it's always the same. When you dress them it's the same. Bathing, the difference is that maybe some people need a bed bath, some people they have a shower, some are in the tub. That depends on the situation, how their bodies are. But to me, yeah, to me it's all the same. I don't see it as difficult. It's all the same.

It is highly likely that the messy and dirty aspects of care work are more emotionally challenging for family members or workers who are not confronted with it as a regular feature of their job.

Even experienced workers, however, can come across situations they are not prepared for. Craig, a homecare nurse for over a decade, describes a situation where he had to mask intense feelings of disgust:

Craig: I walked into this home, and as soon as I walked into the front porch area, I was just woooo, there's something wrong with this place. I could see mouse shhh ... (pause) crap all over the place.

Lisette: (laugh) Droppings is the word you're looking for I think.

Craig: (laugh) Droppings everywhere. Everywhere I looked. ... (big breath) She informed me that an occupational therapist had been out to see her and seemed quite disgusted with the state of her home. And I told her the therapist was probably not disgusted by your home, just concerned about your wellbeing. I explained that it is a little concerning, that what I'm looking at is a little concerning. You know. That was that. But this was probably the worst house I've ever seen in terms of a mouse infestation. It was just disgusting, really. Nobody should have to live like that.

Craig's works to avoid expressing his negative emotions to his client. His emotional labour in this instance is motivated by a desire to protect the dignity of his client, as evidenced by the fact that he also reframes the reactions of another worker who had earlier shown signs of disgust "...the therapist was probably not disgusted... just concerned." Protecting the dignity and personhood of the client is thus implicit in the feeling rule 'be respectful'; showing disgust could not be interpreted as an expression of positive regard.

An important way that workers are respectful is by acknowledging the authority and dominance of the other person in the interaction (Goffman 1956; Rollins 1985; Scheff 2009). Workers may show deference as a means of supporting the dignity of the client, however, deference may be a requirement rather than a kindness or an optional courtesy. The difference is based on relative status; clients generally defer to the instructions of nurses, whereas support workers are more often expected to defer to the wishes of their client. Location is also relevant,

as clients can expect to have a certain degree of authority and autonomy within their own home, but likely have different expectations in different environments such as in hospital or in residential care.

Although there are exceptions, participants employed by for-profit agencies generally have some latitude in acquiescing to the wishes of their client. Participants employed by public health care, however, are much more circumscribed in the tasks they are permitted to perform. Public care workers must follow regulations geared towards the standardization of services, and this means that workers cannot always comply with the expectations of their client:

Daisy: I tried to talk to her about why I cannot clean up until she put her cat away. But she didn't listen to me. She said something like "This is my property. You are a worker. And you cannot tell me anything. I tell you! This is my house, not yours!" (sigh) So all right. This is your house.

Not only are clients unhappy when services are limited by rules and regulations, they are further upset because of the erosion to their sense of authority and status¹. However, a worker may be able to repair the situation by showing a suitably deferential attitude, what Goffman refers to as a 'remedial interchange' (Goffman 1971:64). In the following analysis, I will explore shows of appreciation by applying Goffman's concepts of micro-relations, supportive interchanges, and the interpersonal rituals that show gratitude and respect.

In interaction, the action of one person is immediately interpreted and accepted (or not) by the other person, and it is this that determines the next steps in that interaction. To illustrate some of the complexities and subtleties of the micro-rituals, I draw on a client-relationship from Daisy's interview which she characterizes as unpleasant and non-communicative. She believes

¹ Participants in this study working for public homecare report experiencing conflict with clients over two main policy areas: 1) Tasks requested by the client or family which workers cannot accommodate because of regulations aimed at standardization. Participants additionally report personal moral conflict when they perceive a need that is going unmet due to such regulations. 2) A specific regulation requiring home owners to lock their pets away while homecare staff is visiting.

that the problem arose because her client did not understand public health policies which limit the tasks workers are allowed to perform, leading to dissatisfaction. More generally, Daisy also thinks that many of her problems with clients are rooted in differences in language and cultural misunderstandings. Following is a narrative explaining the first encounter between Daisy and a 'difficult' client:

Daisy: One client, she doesn't speak English. A little. The first day she kept pointing at me, saying 'you—should—you—should'. Like this [Daisy aggressively points at my chest with each word]. 'I'm sorry,' I said. 'I can't.' She said she understood, but then she asked why. I told her, 'That's not my task.' And then she complained to me, 'you have two hours,' and she said it like this (in a strong voice) "you – two – hours!! You – don't – work!" I was so shocked! (laugh) Because that was the first time I met a difficult situation...

Lisette: Did you keep going back to that same client?

Daisy: Yes.

Lisette: Did it get better over time?

Daisy: Yes. Yes. When I visit her she doesn't talk to me and also I don't talk to her. When I open the door I say hi like a normal visit. Then I just say (sing-song voice) "How are you?" Then I say, (sing-song voice) "Did you eat supper?" You know, like that. But that's it, no more other talk. I just do my tasks perfectly, and I don't talk with her anymore, no private chatting. I could ask more questions like (sing-song voice) "What did you do today?" But I don't do that with her. She doesn't want to talk with me, so I don't talk with her because I don't want her to be upset with me. I just do what I do (laugh).

Daisy's response to the client appears to be lacking in important emotional subtleties involved in positive rituals that would signal respect and a positive regard (Goffman 1971). Daisy says "I'm sorry ... I can't ... that's not my task." However, the words 'I'm sorry' may carry little symbolic weight without additional emotional presentations that convey genuine regret. For example, she does not convey empathetic understanding through statements such as, "it's a stupid rule ... I would be angry too." Nor does she convey her powerlessness to change the situation with phrases such as "I could get into trouble ... I could lose my job." Daisy may have been successful in gaining her client's forgiveness by showing believable regret and contrition, with the aid of

showing empathy and appealing to the rules, which is what Goffman would refer to as a remedial action in response to a violation (1971). A worker with more emotional management experience might also have engaged in ‘dramatic realization’ (Goffman 1959) to stress or exaggerate her feeling of contrition, perhaps overcoming the difficulties involved in a language barrier.

However, Daisy instead uses distancing and avoidance to get through her work: “*I just do my work perfectly, and I don’t talk with her anymore, no private chatting.*” Without enacting a remedial ritual, Daisy’s actions shut down the dialogue and do not allow the relationship to develop.

Another emotional undercurrent that may have influenced the negative feelings of the client in this situation is found towards the end of the excerpt. In the interview, the tone of voice that Daisy used when imitating herself speaking to her client was dramatically different from her regular speaking voice. She spoke softly in a high key with musical up and downs in pitch, similar to the tone people tend to use when speaking to a small child or a frightened animal. It is quite likely that Daisy meant to convey deference and concern with this tone, but it is also quite possible that the client interpreted this tone as expressing condescension (garnering shame), which may have escalated the client’s anger. Without showing suitable emotions of contrition and regret, along with a tone of voice potentially interpreted as condescending, Daisy might have been understood by the client as being disrespectful. If so, this would be a violation of status, particularly as Daisy’s job involves the low-status work of housekeeping.

Another type of care relationship that requires the worker to act with a great deal of deference is disability support. The disability community has advocated strongly to ensure that those receiving services have the organizational power to be in control of the support interaction (Kelly 2016). Workers are explicitly required to respect the authority and independence of the

person they work for, and this is summed up by Brent who has worked in disability support for over a decade:

***Brent:** It's up to you to play the role of supporting independence as much as you can in that person's life. Yeah, sometimes it means allowing decisions you don't agree with.*

Throughout his interview, Brent talks about the ways that he is required to hide or suppress his own feelings and opinions in order to respect the autonomy of his client.

There are clear expectations for emotional labour embedded in this form of care work, as various forms of emotional expression are highly circumscribed. Goffman describes this as a negative supportive ritual involving withholding commentary (and emotional expression) to show regard for the other's privacy and to maintain a 'respectful' distance (1971:64). In Brent's particular situation, his client does not want emotional expressions of care or concern, he wants a worker who will perform his tasks with efficiency, competence, and obedience. In effect, this removes Brent's power and status to uphold that of his client. The literature commonly comments that disability support workers are expected to be invisible (Kelly 2014; Rivas 2011). On the part of the worker, however, it is belittling and demeaning to be treated as an invisible 'nonperson' and is suggestive of a highly stratified master-servant relationship (Goffman 1956:483). Brent finds this expectation of invisibility and extreme deference dehumanizing:

***Brent:** What happens is 'do this, do that,' there's no other interaction...*

***Lisette:** So it's kind of like the person who is staff is like a tool for the client's independence but is not always viewed as really a person in some sense?*

***Brent:** (nodding) Um-hmm.*

***Lisette:** How do you feel about that?*

***Brent:** I feel that way constantly. Yeah. Yeah. Sometimes it's good, and sometimes it's not. Like if it's a group situation where he's interacting with other people it's fine. But in a home situation where it's just the two of you, that lack of consideration is (pause) hmm. It's not necessarily that he's trying to insult you, it's just the way he is. But you are offended by it. I try not to be*

offended by it, I don't need to be offended by it, but (sigh). It's just easier if I don't act offended by it. It's easier that way.

This passage indicates that Brent's interactions with his employer-client are lacking the grateful language of supportive interaction rituals; there are no pleases and thank-yous signaling that Brent is valued and has worth as a person (Goffman 1971:63). Brent does not want to feel offended, but the lack of appreciation and positive regard creates shame. This is evident in Brent's speech patterns, which contain the shame markers of repetition and pauses (Scheff 2009). It is also evident in his words; deep acting has failed, and he must fall back to the work of surface acting to hide his shame:

Lisette: So how do you hide that from him?

Brent: I do hide it, I do, I do. I just kind of. Hmm. At this point, I'm just doing things by rote. I just do it. I just kind of shut that off, kind of go on autopilot. What can you really say? ... I've kind of gotten quite good at it, actually. But, I think that it also works against me in a way. Like after work you're like 'Oh man, I feel so wound up'

As Brent says, he temporarily shuts down his emotional self altogether, doing things 'by rote... shut that off ... go on autopilot.'" Brent and his client have been working together for 13 years, and Brent believes that he has become quite skilled at maintaining invisibility. However, he is finding it increasingly difficult to sustain acting like a non-person; continued repetition and stammering in his speech are suggestive of a deep sense of shame. Brent also has insight into the fact that constant surface acting has begun to work against him; he has become alienated from himself, alienated from his client, and alienated from his work. It is quite possible that he has also become alienated from his family and friends. He says that dealing with his emotions, and trying to unpack or understand how he is feeling, is the most difficult part of his job:

Brent: I would say that the hardest thing is the debriefing with yourself about of these little things that you can't say or do anything about. Like you can't easily take it apart or deal with it, or you can't communicate it with others. I would say that's probably the hardest ... I think, like well, why are you so

wound up? There was basically nothing going on today. But the negative stuff just sticks with you. Those little things where you don't have control. And where you worry but you can't say anything. That's its own mental energy that just kind of continually, in the back of your mind, it gets to you. In the back of your mind, it's always there. You never get a break.

According to Brent, boxing away emotions means that those feelings remain but go unresolved:

“the negative stuff just sticks with you ... continually, in the back of your mind, it gets to you. In the back of your mind, it's always there. You never get a break.” The emotional effort he must exert is worsened by his isolation, as he has no opportunity to talk about his feelings with an understanding peer. Brent is holding on to years of unexpressed and unresolved feelings. Brent's words align with Goffman's important insight that performances of everyday etiquette are not trivial and meaningless. These little things are not “part of the dust of social activity,” but are in fact “a central organizational device of public order” (Goffman 1971:63–64)

For the most part, the emotions that Brent works at suppressing are associated with being treated without everyday respect and having to hide his own views and opinions. It is likely that his employer believes that financial remuneration should be enough, but Brent is acutely aware that he is not accorded emotional payments of appreciation, nor does he feel that his financial compensation is enough:

***Brent:** I really r-e-a-l-l-y don't feel respected. I feel like I'm extended only the bare minimum. ...I feel like I'm not valued nearly as much as I feel like I need to be.*

The combination of emotional exhaustion, feelings of devaluation and disrespect, powerlessness, and lack of work satisfaction are classic markers of burnout (Wharton 2009), and it appears that Brent has reached the limits of his emotional stamina.

As exemplified by Brent's situation, shows of respect and deference from the worker serve to uphold the dignity and power of the client, but when care requires continual shows of deference without reciprocal shows of appreciation it undermines the self-esteem and well-being

of the worker. In disability care workers are explicitly required to support the autonomy of their client because of inherent vulnerabilities involved in requiring physical support for everyday self-care, and this idea of dignity and respect also manifests in care for older adults generally. However, it must be noted that carers also represent a generally vulnerable group of people (Armstrong et al. 2008), as exemplified by many of the participants in this study. Despite the fact of mutual potential vulnerability, it is the worker who is enjoined to show respect, whereas clients tend to be excused for rude and even violent behaviours.

The feeling rules outlined above, ‘don’t take it personally’ and ‘be respectful’ are fairly straightforward and simple to interpret. However, a third feeling rule identified by participants is anything but straightforward. It calls upon workers to conform to emotional expectations of care as a family activity of love, compassion, and support, but at the same time warns workers of the dangers of feeling family-like emotional ties. The next theme explores the complexities and confusion of participants as they try to conform to the rather ambivalent feeling rule ‘treat them like family but don’t get too attached.’

Treat Them Like Family but Don’t Get Too Attached

Care relationships generally involve more complex relationships and closer emotional connections than most service-related work interactions. If we flip this perspective, paid care also lacks the stability of kinship ties common in informal care. For example, workers are frequently reassigned because of organizational scheduling or restructuring, or may be let go because of a change in the client’s needs or financial resources. Relationships are also interrupted when workers move to different employers or new careers. Indeed, the turnover rate in frontline care work is high (Armstrong et al. 2008). . And the feeling rule ‘treat them like

family but don't get too attached' tells workers that they must position themselves in their role of paid carer somewhere in between the traditional world of work and the traditional world of family.

Professional approaches to care, as exemplified by the feeling rule '*don't take it personally*,' discourage familial-style relationships, and are closely associated with the second part of the feeling rule— '*don't get too attached*.' Taken together, these two expectations for emotional behavior suggest that emotional involvement is harmful for the worker (Stone 2002). Typical (medical) approaches to care also suggest that emotional involvement is bad for the client; for example, clients may worry about the personal troubles of staff, or workers may leave causing distress (Arnado 2013; Rivas 2011). In contrast, person-centered and family approaches to care encourage workers to '*treat them like family*,' suggesting that the development of emotional attachments are beneficial, at least for the client (Dodson and Zinbarg 2007). In such cases these are two completely different and competing ideas, and the emphasis of either part of the feeling rule is generally dependent on the organizational approach to care. Rather than choosing one or the other as distinct and contrary, however, the majority of participants in this study strive to find a balance between the two seemingly competing ideas. There may be a gendered aspect to this feeling rule, however, as neither of the male participants gave even the slightest suggestion that they held any expectation of family-style emotional attachment. To better understand the complexities of this feeling rule, I begin by examining the first part of the feeling rule, 'treat them like family'.

This part of the rule is not universal: as was outlined previously, there is no suggestion that Brent is expected to care about his client in the same way he would care about his own family. The emotional features of his relationship with his client are greatly influenced by the

culture of independence and empowerment in the disability community, and he is expected to refrain from overt emotional expression. The other male participant in this study, Craig, however, was far less circumscribed in his role as a home care nurse. There is no question that Craig cares about his clients (he was frequently emotional in his interview); however, he used no words implying feelings of tenderness or family-like affection. Instead, the emotional content of his talk centered around outrage at bureaucratic regulations and managerial attitudes which he believed interfered with his moral duty to provide competent nursing care, as was explained in chapter four.

Nonetheless, it appears that the emotional rewards of his care relationships allowed him to remain in his job as long as he did, and he obviously forged connections. Below he relates how he continued to visit with a client even after their care relationship ended:

Craig: I've always taken great pride in the fact that I build relationships with my clients. That's (pause), that's where I get the most joy out of doing my job. (emotional) ... You know. I used to see a gentleman, he's actually a colleague of my dad's. He was a police officer, and my dad was a police officer. So, I've always kind of kept in touch with him after my relationship with him through homecare was terminated. You know, the odd time I'd stop in and see him, just to say hi and see how he was doing.

While it is notable that the language of 'love' is absent, Craig is otherwise emotionally expressive, and the excerpt above provides an example of a meaningful relationship based on a prior association between his father and his client, which certainly implies a family-like connection. An additional caveat to inferring too much about his feelings and experience of emotional connection is that Craig has been well-socialized into the ethics of nursing and would likely be hesitant to show a lack of professionalism. Craig and Brent both appear to be following the feeling rules specific to their structural position within the field of care, that is, the profession of nursing and the ethical stance within the disability community.

In contrast, almost all of the remaining participants use family analogies to describe the emotional quality of the relationships they have with their clients:

***Marjorie:** It is family. It is not only a job. I don't respect it only like a job. When I come over here I am with my family and I am very happy.*

***Jessie:** I don't have a mom, and it doesn't hurt me to bring a couple little things to this lady to make her life easier.*

***Gloria:** Trust and loyalty and compassion for your person is what you would want in a companion. What I would want for my mom, who passed away many years ago.*

***Daisy:** I loved my grandparents. That's why I like this work.*

***Serena:** Elderly people, they usually treat you like you are family, or someone they knew before.*

***Chiara:** Some of them, they don't treat you like a caregiver, they treat you like a part of the family.*

Michelle is the only female participant who does not use familial terms to describe her relationships with her clients, yet she does use numerous terms of affection and tenderness throughout her interview and has developed a close friendliness with one of her clients.

The literature repeatedly notes that feeling rules are gendered and that care is a feminized work culture (Hochschild 2003; Matousová and Tollarová 2014; Power, Cole, and Fredrickson 2011; Wilkins and Pace 2014). The portion of the feeling rule that requires many workers to 'treat them like family' does not appear in the transcripts of the male participants in this study. This does not mean that such connections are always absent, nor does it mean that male workers are in fact 'tougher' than women. Further, Brent and Craig are organizationally and structurally positioned in the field of care so that they are strongly pressured to refrain from emotionality. Nevertheless, it is possible that men may be somewhat shielded from some of the familial expectations of care because of gender roles, and the emotional expectations of masculinity and femininity.

Because of the lack of familial references in the male participants' interviews, I am drawing solely from the data provided by the female participants for the remainder of the analysis. Essentially, the feeling rule '*treat them like family but don't get too attached*' calls on workers to find the 'sweet spot,' the balance between caring too much and not caring enough (Daly and Armstrong 2016; Graneheim et al. 2005; Salmela 2014; Stone 2002). While most participants state that relationships with clients are 'like family,' nevertheless there is a strong recognition that a paid care worker is not actually part of the family. For example, Chiara believes she has been able to achieve a good balance between engagement and detachment:

Chiara: If the patient's health is deteriorating sometimes you can no longer catch up, or give the appropriate care. That's a big challenge. And sadly, I have had a few clients where I had to tell the company, you know what, I still love them, but because of their condition my competency can no longer keep up with them. And they understand. It's about patient safety. And they find another caregiver who will fit that need.

While Chiara states that she 'loves' her clients, she has no qualms about ending the care relationship. The change makes her sad, but not deeply distressed, and she is comfortable in conforming to the limitations of her role. It may also be that Chiara's use of the word 'love' is an overstatement, aligning with organizational expectations and her own caring identity.

In contrast, other participants struggle with feeling overly involved and describe some of the dangers of caring too much. Jessie freely admits she is not always successful at the balancing act of engagement and detachment. She describes a deep connection with one client, symbolized by the personalized care and the effort and time she devotes to this client:

Jessie: I bought little plates, three little plastic plates because she loves her bread and marmalade. It's like a staple of her diet. Otherwise, we had no plates to use. ... I can remember bringing bottles of laundry soap. She had nothing to wash her clothes with. Again, just this morning I brought a bottle of dish soap because we've been out of dish soap for a week. But you phone the office, or you send them a list of what you need, and then you get 'Supplies are delivered once a month.' (sigh) And I bring her chocolate bars every week. I go to Dollarama and I buy five Cadbury bars so she's got chocolate bars. I

bought face cloths because we had none. What are you going to wash this woman with, you know? ... She's the only one I do this with, though, because she's got nobody. What family is here never comes to see her.

Jessie has begun to act like a surrogate family member for this particular client. Feminist streams of research are generally critical of emotional expectations of paid care being connected to the emotional qualities of family obligation, pointing to the potential for exploitation of the worker through pressure to provide 'extras' without pay (Aronson and Neysmith 1996; Dodson and Zincauge 2007; Romero 1990; Stone 2002). Jessie has become involved to the point where she provides many material extras. The emotional pitfall, potentially much more costly than buying soap and chocolate bars, is that she feels the weight of responsibility as if she were a family member but her position as paid help limits her ability to act on those feelings. For example, she is morally outraged at her belief that her client is receiving sub-par care when she is not the carer, and she has advocated on her client's behalf by phoning the office to complain. However, she is structurally constrained by her role and status and does not have the power to enforce any changes. She feels a great deal of distress on behalf of her client, but she is trying to step back and accept her position of non-family:

Jessie: You know, sometimes it just gets to you, even though you don't want it to. There's a couple times I did get really bent out of shape about all that's going on with her. (whispering) I would just lose it. I would lose my mind. Just get crazy. (regular voice) But I've come to the conclusion now, I can't do this. I can't do this anymore. As long as I know when I leave that I have done a good job, (bangs the table) then the rest of them have to live with their own karma. But you know, every time I see a new bruise, or a new skin tear, it gets me boiling. I've generally learned to go nope, nope, not my circus, not my monkey. But when it comes to her, when I come in and see new bruising, new skin tears, and they haven't been charted, then I do phone the office. And I say 'Look, this is what's going on here.' But anyways. I've learned I just have to go nope! Walk away.

Lisette: Well, it sounds to me like you're working at that (pause). Maybe you're not always successful?

Jessie: Not always successful. That's right. (laugh) There are days where I have trouble, I'm telling you that right now. But for my own sake, I have to

learn to let it go. And it's hard. It's very, very difficult. ... the downfall of it all is (long pause) I become so invested. And depression sets in. And anxiety sets in. And anger.

The contradictions in the passage are quite striking, shifting back and forth between statements communicating high levels of emotional involvement (*I did get really bent out of shape ... I would just lose it. I would lose my mind. Just get crazy... it gets me boiling*) to saying she should not feel familial responsibility (*As long as I know when I leave that I have done a good job ... I've generally learned to go nope, nope, not my circus, not my monkey ... I've learned I just have to go nope! Walk away.*) This highlights the fact that emotions can be unruly and difficult to control, and emotion management is not a straightforward process: “*sometimes it just gets to you, even though you don't want it to.*” Jessie recognizes that she has fallen into the trap of caring too much and is struggling to change her emotions. “*There are days where I have trouble, I'm telling you that ... I've come to the conclusion now, I can't do this. I can't do this anymore ... for my own sake, I have to learn to let it go. And it's hard. It's very, very difficult.*” In undertaking this interpretive emotional work, Jessie is continually reminding herself that she is not family, potentially alleviating her feelings of distress and guilt over not being able to help her client. The work of deep acting, of fundamentally changing what she feels, may not be possible for Jessie, but she believes that she must limit her feelings of attachment to protect her own emotional wellbeing, otherwise “*depression sets in. And anxiety sets in. And anger.*”

It is quite likely, however, that the consequences of being attached are not rooted in the relationship and emotional ties, per se, but in the worker's ultimate powerlessness to act on those emotional impulses in a larger context. The structures of health systems, and society more broadly, elevate the institution of family as legitimately regulated by emotional ties. However, other relationships are rarely recognized as emotionally and institutionally legitimate, and this is certainly true of worker-client relationships. Further, the expertise of non-professional workers is

rarely regarded as legitimate. When organizations fail to respond to identified needs of clients and patients, frontline workers have an extremely limited capacity to advocate on behalf of the person they care about.

Michelle is another participant who has struggled to find the balance of ‘*treat them like family but don’t get too attached,*’ although her connection to her client feels like a friendship rather than a family-like relationship. In the excerpt below, Michelle explains how a for-profit agency she works for tries to enforce a certain level of distance between workers and clients, providing explicit rules about topics that workers should not discuss, curbing the sharing of opinions and private information.

Michelle: We’re not supposed to see our clients outside of our paid time with them, right. We’re not supposed to. And it is stated that politics and religion are not things you talk about. And of course, personal issues.

However, Michelle also explains that she has not followed these rules with one of her clients because she works directly for the woman rather than for the agency:

Michelle: But with her we’ve probably talked about everything, you know (laugh). We are friends. I leave sometimes, and she says ‘Love you lots.’ (laugh)...But that’s becoming a bit of an issue for me. So, I had breast cancer two and a half years ago, and of course I talked about that with my friend, and about some personal relationship stuff. And I get that she’s got her own issues, her own family, her own health, her own everything. She’s got that to worry about. So now she’s also got me to worry about too! And I realized one day, she’s worried about me. I don’t like that. I don’t want her to worry about me. So I wonder, did I tell her too much?

The relationship between Michelle and her client has become quite intimate; they share personal information and they lean on each other for support: Michelle recognizes that their friendship involves reciprocity, and she is concerned that she is potentially violating her role as carer by receiving support from her friend. Her excerpt reveals that abiding by the feeling rule ‘*don’t get too attached*’ not only protects workers from pain, it may also protect clients from intimate

emotional entanglements that can evoke stress or worry, or some cases may lead to material and financial abuse.

Participants commonly explain that a good reason to maintain an emotional distance from their client is that, inevitably, their relationship will end. Interestingly, participants indicate that natural endings such as death cause expected sadness, which they generally deal with according to standard emotional scripts. It is when relationships are cut short for organizational or financial reasons that participants find that their emotions are difficult to resolve, and rather than the socially acceptable feeling of grief they feel variously angry, frustrated, shamed, and devalued. For example, Gloria specifies that ending her care relationships it is one of the hardest parts of her job:

Gloria: The most difficult part is ...leaving them. Having to say I'm no longer coming back. It's awful! And like I was saying, the agencies, they don't allow you to go back. But I sneak back and I say goodbye to the people.... because they don't know why I'm gone! "How come you're not coming anymore ... we did lots of things together!" "That's what the family has decided." (sigh) I feel bad having to say that because I just told them that they're not in control of their own life. The happiness and contentment and safety that they want from me is no longer important to their family (voice begins to break, emotional)

While Gloria is upset about ending the relationship, it seems that most of her distress focusses on her interpretation that neither the families nor her employer see value in the emotional ties she develops with her clients. She is also troubled by disrespect she interprets as occurring in such situations, such as not informing the client of the change, and giving the client no choice in the matter. Gloria sneaks back on her own time, refusing to accept that her care relationships are so unimportant that they do not warrant the basic social ceremony of saying goodbye. By doing so, she acknowledges that the relationship did have significance, and it gives both Gloria and her client an opportunity to honour their feelings for each other.

One participant, Marjorie, is unique in that she has made no attempt to keep her clients at an emotional distance. More than ‘like family,’ she claims full kinship ties to the extended family of the people she is paid to care for. Marjorie works full-time through the self- and family-managed care program, in which public funds are supplied to an individual (either the person receiving the care or a responsible other), who then takes on the responsibility for managing the care which would typically be supplied through public systems. Marjorie’s employment is overseen by the male head-of-household who hired her to care for his wife and mother-in-law, both suffering from dementia. The relationship between her biological family and her new extended family began to develop a few years prior to their formal working relationship, as she and her family arrived as refugees in Canada and moved into a house next door. A few months prior to the interview the younger woman she was caring for died, and Marjorie is grieving while she continues to care for the older woman.

The emotional ties between her biological family and her new extended family are strong: her husband and children are also involved in the lives of the people that she works with. The distinctions between paid work and private life that are typical in the talk of the other participants are absent in Marjorie’s interview. Instead, she refers to her clients and employer through their proper names or family titles such as uncle and grandma, and corrected me when I used workplace terms such as boss or employer:

Marjorie: You call him my boss, but no. No. My children, they come over here and talk to him, and he is grandpa. I call him uncle. This family, they will have my love, always, always. My husband and I, when we came to Canada, God gave us another family. Sorry (crying).

Lisette: It sounds like you’re saying that a lot of your family back home, many of them were taken from you, but God gave you a new family here in Canada. Is that what you’re saying?

Marjorie: Yes. Yes. Yes. A new family! Yes. I never had expected it.

Voluntary kinship, often referred to as fictive kin in academia (Braithwaite et al. 2010; Nelson 2014), is viewed with some suspicion in mainstream Canadian culture, aside from adoption which is accepted as a ‘real’ form of family. The fundamental issue of what is perceived to be an authentic family is that most people understand kinship through the lens of biology and ancestry or the authority of the legal system (Braithwaite et al. 2010; Nelson 2014). However, Marjorie understands her kinship ties through the characteristics of her emotional bonds: her clients are not ‘like family’ they ‘are family’.

Marjorie fully embraces familial and gendered conceptions of herself as a caregiver, and takes on care responsibility in the ways that she understands a daughter should:

Marjorie: It is my responsibility. I never wait for uncle to say what to do. I know what is needed and I have the responsibility for the entire house, I never wait for him to say “Do this”. No. Sometimes I even forget that it’s his house! (laughter). I forget! I sometimes, I move something, I want this here, or I think this would look better over there. And he says, “Oh, Marjorie this is where it goes.” Then I remember it’s not my house. (laughter).

Indeed, Marjorie’s sense of emotional responsibility includes many extras that range from staying late when needed to making meals for extended family members in times of crisis:

Lisette: When she passed away, did you come over on the weekends or in the evenings? Did you do anything extra during those times?

Marjorie: Yes. Of course. Yeah. Yeah. [crying softly] The kids would come to talk with uncle. And his daughter lives in a house nearby over there. I called her and asked, do you need supper? I did that. I made food, dinners. Yeah.

Lisette: For many people, they go to work and then they go home and they forget about it till the next day. It’s kind of separate. But it’s not like that for you?

Marjorie: No. No, it’s not like that. In fact lots of times my kids are over here. Uncle never says it’s time to go. No. When I’m finished at 5:00 I can stay here until 6:00 or longer. I don’t care, because it’s family.

While it is inarguable that Marjorie often gives many extras that do not normally belong in the paid care context, Marjorie and her entire family also receive a lot of extras in return. She

describes uncle attending school events of her children, multiple ways that he and his family have helped them adapt to life in Canada, and joint family celebrations at holidays such as Christmas. She also speaks of her amazement at her first experience of summer at the lake in Canada: her children joined her as she worked as a live-in caregiver at the family's cottage, while uncle/grandpa not only provided her with a wage, he also welcomed her husband who joined them on weekends, paid for all the food, and organized many of the activities her children enjoyed.

Marjorie: He took us to Victoria Beach two years ago. I never paid, not for anything, not the smallest banana. I couldn't believe that (crying). He fed my children for the two months we stayed, we never paid for anything.

She spoke quite a bit about how wonderful that experience was for her, and feels blessed to be able to work for pay while also spending time with the people she loves. If we accept that Marjorie is really part of the family, then it is inappropriate to judge her emotional connection by the standards of paid care, just as many argue that it is inappropriate to judge paid care by the standards of family. Interestingly, Marjorie's situation as a paid family carer may be unusual, but Manitoba Health has a policy regarding hiring family members (Government of Manitoba 2017). The existence of a policy indicates that the situation is not entirely unique, and is another piece of evidence showing that care straddles the divisions we normally expect between work life and family life.

CONCLUSION

Throughout the care relationship, a worker's ability to engage in synesic role-taking, that is, accurately interpreting the emotional position of the other person in the interaction, directly influences the care relationship and has implications for emotional labour as the relationship unfolds. Simple conversations and the exchange of pleasantries are forms of emotional support

that are commonly found across all contexts. Everyday civilities are essential and vital in the care relationship, serving to uphold the dignity of the client while at the same time encouraging compliance to make the workers' job flow more easily. Emotional labour is imbricated with role performance, and this study shows evidence of female carers acting alternately daughterly or motherly, enacting power and status relevant to their gender role. People in need of support tend to be positioned in the sick role but may or may not accept that positioning; this positioning has multiple implications for carers, particularly when workers are expected to enforce medical and organizational expectations. In the process of presenting emotion, workers commonly suppress negative emotions such as shame, anger, and fear, and also produce emotional shows of energy, compassion, patience and humour.

The three feeling rules of care provide the emotional framework for workers to understand their feelings, and to engage in emotional labour to adjust and manage those feelings according to social, professional and cultural norms. As with other knowledges, participants are variously adept or inexpert at understanding and acting on these rules, and the data indicates that it takes time for participants to internalize the rule 'don't take it personally'. Until the rule is internalized, participants must work hard at their emotional experience, and engage in a relatively high degree of emotional labour. This rule also tends to encourage workers, supervisors, and systems to underestimate the relational and physical dangers frontline carers encounter on the job. The feeling rule 'be respectful' is driven by the moral imperative that workers uphold the dignity of those receiving support, however the data shows that a continuous lack of reciprocal shows of appreciation can result in devaluation and dehumanization of the worker. Participants with the most difficulty managing their emotion appear to be those that follow organizational feeling rules that seek to standardize and control the intimacy of one-on-

one relationships. The implications of these findings, and those from the previous chapter, are summarized and discussed in the final chapter.

CHAPTER 6

CONCLUSION

This thesis explores the emotional experiences of frontline care workers through qualitative interviews and thematic analysis using a micro-sociological lens. Care has been defined broadly as human activity providing what is needed for the health and welfare of others; care is about doing and it is also about intentions, thoughts and feelings. The activity of care crosses many social boundaries, and the work of paid care also links the formal sphere of work with the informal sphere of family (England 2005). This study narrows its investigation of care work to focus on emotions, and uses the theory of emotion management (Hochschild 2003) which is a sociological approach that understands emotion to be experienced and shaped based on socialization and the internalization of emotional norms (referred to as feeling rules). When emotion is managed in the course of the duties required of a person receiving a wage, feeling rules may be imposed by workplace expectations rather than personal and social expectations, and emotional effort is then referred to as emotional labour. The goals of this study were to: (i) identify how various contextual and structural influences shape emotional labour in care work; and, (ii) consider emotional commonalities in care work across a variety of job titles and workplaces.

The findings have been organized into four broad themes and associated sub-themes describing different aspects of the emotional labour of participants. The themes and sub-themes are:

- 1) The meaning of care as constructed and interpreted by participants
 - (i) Caring identities—we are ‘naturally’ suited to care
 - (ii) Purchased intimacy—we genuinely care

- (iii) The emotional and material rewards of care work—we love to care but the pay is demeaning
- 2) The organizational and structural features of care workplaces
 - (i) The care plan
 - (ii) Organizational support
 - (iii) Work arrangements and location
- 3) Care relationships: emotional labour and emotional skill
 - (i) Skill at interpreting the feelings of the other
 - (ii) Gender roles in care
- 4) Feeling rules of frontline care
 - (i) Don't take it personally
 - (ii) Be respectful
 - (iii) Treat them like family but don't get too attached

In this chapter I summarize and further synthesize these findings and highlight the contributions of this study, and provide some organizational and policy suggestions that may better support the work of care. This thesis concludes with a consideration of the limitations and strengths of the study, and suggestions for future directions for research.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Meaning of Care

Participants described care as a vocation or a calling that naturally aligned with their culture or personality—we are naturally suited to care. Despite these assertions, participant data revealed that the emotional labour involved in care was not necessarily easy and was certainly

not instinctual. Newcomer participants in particular spoke about struggles with language and culture, all of which required additional emotional labour to align with Canadian norms, beliefs and attitudes. Alternatively, care receivers themselves could be from a variety of cultural backgrounds. In either situation workers were required to adapt to the emotional expectations of their clients. Participants showed different levels of emotional literacy based primarily on years of experience in care; emotional acumen and emotional control develop over time, and requiring both effort and practice. Findings from this study indicate that emotional labour requires far more effort than is generally recognized. Participants talked about feeling exhausted following their shifts, specifying that it was not as a result of physical labour but because of the emotional demands of their job. The emotional factors of care work, however, are rarely recognized as important, and such skills continue to be broadly understood as a natural talent of certain types of people, particularly women (Armstrong et al. 2008; Bolton 2000; Clow et al. 2014). While emotional knowledges have been greatly developed over the past decades (Bone 2002), and some sets of emotional skills are taught in the formal training of caring professions such as nursing, social work, and psychological therapy, there is little I could find specific to training in emotional competencies. In Winnipeg, individuals may attend half- and full-day workshops on ‘emotional intelligence’ (often at a rather hefty cost), however, I have attended such a workshop and found the instructional content to be targeted at developing personal leadership and the skills of manipulation and persuasion rather than caring skills. A more involved ‘emotional competence’ program appears promising (see Nelis et al. 2011; Weiszbrod 2015), however its utility for frontline care has not yet been assessed. This would be an interesting direction for future research in emotion and care work.

Participants also described themselves as emotionally authentic and altruistic rather than grasping or materialistic and working only for money—we *genuinely care*. The actions taken by participants based on this concern reveals the ways in which workers in frontline care may be easily exploited; participants commonly described extra things they did for their clients, including spending considerable time outside of work in invisible emotional labour, thinking about their client, planning outings or activities, baking treats for a birthday, running errands, purchasing supplies, or worrying about a client’s welfare. All of this is work done for free. It is obvious that such gifts from workers to clients should never be a requirement or formal expectation of their role, although this has been found to be the case in some organizations (Dodson and Zinbarg 2007). However, organizations should not lean too far in the opposite direction and forbid such activity, as to do so may only create barriers and distress for workers who try to personalize care (Bolton and Wibberley 2014; Johnson 2015). Emotional labour should be valued and encouraged rather than restricted and organizationally controlled. The risk of systematizing and standardizing emotional labour and ‘genuine’ care is that it would strip care of the nuance and responsiveness required to develop a sense of empathy and understanding between two people (Bone 2002). Perhaps emotional labour will eventually be valued for what it is – a uniquely human activity that is not easily regulated.

Further, this notion of emotional authenticity itself is suspect. As Hochschild points out, emotional authenticity “is understood to refer to spontaneous, natural, artless feeling” (2003:274). However, the theory of emotion management insists that our feelings do not arise out of uncontrolled and uncontrollable impulse or instinct. Emotions are a response based on interpretation of the situation (and the emotional status of others within the situation), followed by calling forth the emotion deemed appropriate. The important thing is that the process of

emotion management operates invisibly through our internalization of emotional norms and deep acting; elicitation of the ‘correct’ emotion and suppression of the ‘incorrect’ emotion occurs without us necessarily realizing it, and so *feels* spontaneous and authentic. Frontline carers, like all others in society, internalize the broad and pervasive feeling rules associated with the role of carer long before they imagine or plan for a career in care work, and because of this fact their emotional presentations in care often feels completely ‘natural’ rather than inauthentic or forced (Erickson 1995:126). From another point of view, spontaneity may also be understood as unreflective, habitual, somewhat thoughtless behavior. A deliberate emotional attitude, a conscious effort involved in transforming feeling and presenting a specific emotion, is evidence of a deeply held and sincere belief (Salmela 2014). Showing appropriate emotional expression, whether felt or not, is also a requirement for the everyday supportive exchanges, such as please and thank you, which are exceptionally important and yet simple rituals that people use to acknowledge that another person is owed positive regard and respect (Goffman 1971:64). When a carer intentionally calls forth an emotion in the interest of their client it should be understood as an authentic expression of concern and support, rather than a ‘fake’ emotion (Bolton 2000). From this perspective, purposeful emotional labour provided by paid workers is an expression of respect for the humanity and dignity of clients, has higher value than thoughtless and careless habits of ‘spontaneous’ feeling. Emotional labour, then, is not only an essential aspect of the work of care, a skilled emotional labourer should be very highly valued indeed.

The idea mentioned previously, that certain people (usually women) have an inborn emotional ability relates to a similar idea that care relationships have emotional rewards that certain (emotional) people tend to value very highly. Indeed, for participants, both male and female, an important benefit of working in care came from the emotional and social rewards they

found in their relationships with their clients. However, this research found that not all interactions with clients were particularly rewarding; many participants remarked on rude, abusive, racist, uncooperative and difficult clients. Such relationships and interactions were not rewarding at all. In addition to the unreliability of intrinsic relational rewards, the majority of participants consistently felt insulted by the amount of their pay—*the pay is demeaning*. While I did not ask any questions regarding pay and money, all but two participants brought up the topic themselves, with some bringing it up repeatedly throughout their interview, which is an indicator of how important it was for them (Scheff 2009). Low pay leaves workers feeling unappreciated, angry, ashamed, embarrassed and demeaned. Indeed, low pay symbolically and materially undervalues the importance of care in broad social terms, and also devalues each individual workers' skill and expertise. Low pay impels many frontline workers to seek different jobs or look for higher status work.

Nevertheless, extrinsic rewards for care work, such as money, tend to be perceived as sullyng or corrupting the value of the intrinsic emotional rewards found in care relationships. This perception pushes participants to prove their 'genuine' commitment. In her qualitative study of home care nursing aides, Stacy concludes that the "relational aspects of the job are just as important as monetary compensation, for it is through connections to clients that aides ... achieve a sense of dignity at work" (2011:158). However, the data and conclusions of this study problematize her findings; not all care relationships are positive and rewarding and intrinsic relational rewards are not a certainty (Daly and Armstrong 2016). Further, while there was evidence of job satisfaction and personal fulfilment among participants, this was not exclusive to relational rewards as it was most visible when participants spoke of their pride in personal skills and achievement, and their belief in the broad social value of the role of carer. Direct interaction

with clients did not necessarily provide a sense of dignity to the worker, indeed, as Stacy herself argues, dignity would be improved if emotional labour were better recognized, and if workers were to collectively organize and campaign for improved wages and benefits (2011). It is evident that the low pay, low status, and precarity of labour in frontline care leaves many workers feeling demeaned and degraded. This research adds one more voice to the many authors who have called for improved working conditions, higher pay, and who point out the important collective power of unionization (see for example Armstrong et al. 2008; England 2005; Rivas 2011).

Organizational and Structural Features of Care Work

Most workplaces have routines and systems that organize the way work is performed, and care is no different. Three items were found to interact strongly with emotional labour among participants; the care plan, organizational support (and its lack), and working alone in clients' homes as compared to working in semi-public and public spaces. For the most part, participants indicated that the care plan is a useful tool in getting to know a new client and for knowing their tasks and responsibilities. However, participants also commented that care plans frequently fall out of date, are sometimes insufficient or incomplete, and are occasionally absent altogether. When this happened, participants described a great deal of emotional labour involved in controlling feelings of fear, confusion (even panic) at unexpected circumstances, and managing strong feelings of anger and outrage at negligent systems. Many found themselves unable to cope effectively with unexpected needs. Participants were critical of ineffective management and negligent systems and were outraged or angry on behalf of their client, pointing to the obvious implications for poor care quality. Highly experienced participants circumvented the problem of misinformation by providing services that were missing from the care plan and thus outside of

the official scope of their work role. Throughout all of these experiences, participants managed their emotion in order to provide the best care they could for their clients. Unfortunately, in such situations it appears that the responsibility for systemic problems such as insufficient or incorrect information falls to frontline workers, who are neither paid nor trained to take on such responsibility.

Those working in institutional settings tend to receive a great deal of direction and direct supervision, whereas those working in home care appear to receive little to no immediate support. Unsurprisingly, highly experienced participants found working in home care to be liberating and enjoyed the freedom of controlling their own work. Nevertheless, even the most experienced participant believed that important decisions regarding the health and wellbeing of clients should be made by those with more authority, and in these situations a lack of support, a lack of communication, and a lack of decision making by those in authority angered experienced workers. This lack was felt most keenly by inexperienced workers who were more reliant on the knowledge base of their supervisors and managers.

In addition to lack of support and sense of isolation across all forms of home care, some concerning organizational practices were revealed by Serena, Chiara, Jessie and Gloria in terms of the ways that private for-profit home care companies organize their approach to care. Serena and Chiara shared experiences involving misinformation, absent documentation and insufficient organizational support, and both told me that they would move to other areas of health care service but would no longer work in home care. Licensing requirements and regulatory oversight would ensure at least minimum labour and care quality standards were adhered to by all organizations (Brassolotto et al. 2017; Daly and Armstrong 2016). For example, if organizations were required to keep up-to-date and complete care plans frontline workers would not find

themselves determining and responding to care crises on their own, benefitting both the worker and those receiving services. If organizations were required to assess and re-assess care plans on a more frequent basis the occurrence of such problems could potentially be reduced. Of course, more frequent and regular updates to care plans would not completely solve the problem of emergent and changing care needs (Diamond 1995), however, it would benefit workers if organizations were to acknowledge that care is not fully predictable, and have appropriate processes set in place. For example, organizations could arrange to have more highly experienced staff to make drop-in visits to clients. Organizations could create positions for more experienced staff to prioritize their responsibility on being available to immediately assist workers should difficulties arise. This would be most beneficial for those working alone in home care and home support; the data strongly suggests that those who work alone are much more likely to experience emotional strain related to fear, stress, conflict, and uncertainty than those who have the support of co-workers, peers and managers.

The issue of working alone is problematic in many ways, but most particularly for inexperienced workers (such as those with two years or less of care work experience). Employers and managers would be well-advised to note the experiential level of employees, and send those with lesser experience to work as part of a team, paired with a more experienced worker as a form of training, rather than having to work alone. Brief training sessions do occur currently (Jessie and Brent talk about training other staff), but such training is often geared towards teaching workers the individual preferences of a single client rather than the generalized interpersonal and emotional skills of care or how to respond to abuse. While some organizations do invest in training for their employees (Michelle, Daisy, Gloria and Jessie talked about various workshops they have attended), on-the-job experiential training could be extended to a longer

period for inexperienced employees, with more regularity to keep experienced employees updated and involved, and with a greater focus on learning the important interpersonal and emotional skills required for successful, and supportive, care relationships.

Two exceptions to the overall sense of support participants felt from coworkers were found in specific work roles, that of temporary and on-call workers as exemplified by Serena, and the role of private companions working in facilities as exemplified by Michelle. Temp workers rarely have the time to develop relationships with coworkers, are unfamiliar with local routines, and their skills and abilities may be suspect. The combination leads to a great deal of mistrust from coworkers and attendant emotional labour on the part of temp workers as they must work harder on developing relationships with a constant rotation of new clients, new coworkers, new supervisors and new organizational routines. Private companions are in an ambiguous or ‘liminal’ position in health care and also face distrust from other workers (Daly, Armstrong, and Lowndes 2015; Outcalt 2013). This emotional tone is not founded on unfamiliarity, as companions may work for many years in the same health care setting with a given client. Rather, wariness from other workers is based on uncertainty and ongoing negotiation over status and role. Further, the role of companion may be perceived as frivolous non-work and thus met with disparagement or outright hostility from others, leaving companions relatively isolated from the support of coworkers (Brassolotto et al. 2017; Outcalt 2013). Companions provide almost none of the task-based or physical support found in other care roles and, because of this distinction, future research interested in advancing our understanding of emotional labour in care may benefit from an in-depth exploration of the “commodification of friendship” in the work of companions (Outcalt 2013:94).

Care Relationships: Emotional Labour and Emotional Skill

The third theme, presented in the first half of chapter five, concerns the direct care relationship, and the emotional skills that workers bring to their interactions. Care workers frequently interact with new clients, and their ability to quickly forge connections is important. Participants with many years of experience and greater levels of formal education in care work described quickly establishing positive relationships through concerted emotional labour, whereas the emotional presentations of less experienced and less directly trained participants were less successful. Participants also spoke about using their own emotional presentations to provide emotional support to clients, particularly those feeling particularly unwell, or those with cognitive decline. However, participants also described the ways that emotional support takes time, requiring workers to follow the pace of the client rather than the pace of schedules and time tables. Unfortunately, participants often had to cut short such supportive interactions in the interest of keeping their job. Participants also talked a lot about using their emotional labour as a means of gaining cooperation. In this aspect of emotional labour in care work, I found a great deal gendered emotional interactions. For example, Jessie would tease some clients like a daughter (often male clients), but would command and control others more like a mother (typically these would be her female clients). Situational factors also played a role in these emotional performances, however: Jessie would more often resort to commanding when under strict timelines, or when her client was aggressive and violent.

In analyzing the emotional labour (and emotional skill) of participants in their relationships with clients I relied heavily on the concept of synecic role-taking—imagining the feelings of the other, and doing so accurately (Lauer and Handel 1977; Schwalbe 1988)—to describe the ways that care workers develop relationships and deliver suitable and appropriate

emotional support. The findings suggest that skills in synesic role-taking become more important as those being cared for become more dependent on support, such as when caring for people whose verbal ability or cognition are compromised. And yet, only the most experienced participants in this study appear to have a well-developed ability in synesic role-taking. In 2014, the Government of Manitoba released a framework for Alzheimer's disease and other dementias, outlining a provincial strategy for care improvement which identified gaps in care and support. On the topic of workforce dementia education, the report calls for the expansion of dementia education to community care and social services, and to evaluate the available curricula in relation to dementia and cognitive impairment (Manitoba Health 2014:14). The findings of this study suggest that more effort at enhancing the ability of frontline staff in their ability to interpret and respond to emotional signals would greatly enhance the quality of care for clients. Additionally, care organizations and employers need to recognize that emotional support requires that workers follow the lead of their client. The requirement for strictly efficient schedules based only on tasks interferes directly with workers capacity to provide emotional support, and in some cases creates structural conditions that may lead to social isolation and the mistreatment of clients through organizational negligence (Lopez 2006).

Successful emotional support requires a degree of emotional literacy from care workers, which means that frontline care workers of all descriptions need to be able to perform synesic role-taking and then have the skills to consciously perform emotional labour and deliver the appropriate emotional presentation. Although emotional skills continue to be imagined as in-born rather than learned (Armstrong et al. 2008; Bolton 2000), the data in this study suggests that these norms are under negotiation. For example, the majority of participants directly expressed pride in their interpersonal (and thus emotional) skills. Nevertheless, there was a generalized

lack of recognition of emotion as a significant aspect of interaction and care. Participants tended to mis-identify or under-appreciate and downplay the way that their emotional labour defined and shaped their relationships with clients, coworkers and employers. The more experienced participants did express pride in their ability to manage their emotion, and their talk was infused with descriptions of their emotional labour as integral and vital aspect of their support role with their clients. And yet this talk was indirect and contextual, contained in narratives and stories and examples which had to be teased out through analysis. No participants had been exposed to the concept of emotional labour before I explained it to them in the interview, and none could directly describe what it was they were doing and experiencing. This is a problem—emotional labour is vital for interpersonal service work, particularly the highly relational work of care, and increasingly is being offloaded from nursing onto other forms of frontline care (Bone 2002; Stacey 2011). If emotional labour is unrecognized then emotional competency goes unacknowledged and unrewarded and, perhaps more importantly, fundamental emotional and interpersonal skills among workers are untrained, and thus unreliable and unpredictable in levels of competency. Workers must figure out for themselves that which could be much more quickly and easily acquired through formal education.

Feeling Rules of Frontline Care

Feeling rules are social norms and generalized expectations of the amount and type of emotion that should be felt or expressed in a given situation. A pervasive feeling rule of care work identified in this study and many others is *don't take it personally* (see for example Funk et al. 2018; Matousová and Tollarová 2014; Theodosius 2008). The emotional toughness implicated in the feeling rule has two faces: one is in learning not to let the pain and distress of

others affect oneself. However, toughening up is not necessarily an ideal to strive for in all situations as it may lead to ignoring the distress of the other (such as when Michelle was told that there was nothing to be done for a distressed client, as discussed in chapter five). In an extreme situation, it can be imagined that one may become so tough that one ceases to care altogether (Theodosius 2008).

The other face of the feeling rule *don't take it personally* is that, in not taking things personally, workers are encouraged to carry on with their duties despite verbal abuse, threats, and even assault. Workers are urged to understand aggression and violence as an everyday feature of their work, and something that they must simply learn to accept (Gates, Fitzwater, and Meyer 1999; Kelly 2017; Rippon 2000). The potential for abuse and violence is routinized and minimized and, according to participants, they are left to manage their experiences with little or no organizational acknowledgement and support. I do not believe that the potential for violence can be entirely removed from the work of care, as that could shift care back to models of patient restraint (Baines and Cunningham 2011), which is contrary to current morals of care and governed in many jurisdictions by 'restraint minimization' or 'least restraint' policies and legislation (see for example Winnipeg Regional Health Authority 2017). However, violence in care should be acknowledged and discouraged wherever possible, and instances of violence should be immediately addressed. Frontline carers working in social and home support should not be expected to work alone in situations of violence; situations where aggression is a potential should be directed to workers who have access to appropriate resources and appropriate training (Farrell and Cubit 2005). To better protect workers, care for aggressive clients could be provided only through team-based approaches. Other structural changes, such as a culture of recognition of violence in care, better enforcement of violence reporting (Pulsford and Duxbury 2006), and

clients themselves being held to a higher degree of accountability for their actions (Lopez 2006), would make inroads into the current standard of *don't take it personally*. At minimum, counselling and emotional support should be easily accessible for all care workers and provided directly by employers rather than through insurance or public health.

As the findings have shown, participants with less experience (and less emotional expertise) tended to express confusion, difficulty, and distress in managing their client relationships. Their talk was more likely to concentrate on instances of conflict and their struggles as they worked to manage hurt feelings, fear, frustration and anger. Indeed, fear arose as an important and problematic emotional response to abuse, aggression and the threat of violence. In this study, fear was associated with many structural features of work, including a lack of training, a lack of formal support, bureaucratic errors (such as incomplete care plans), rationalization (such as policies seeking to standardize and depersonalize care), and working alone. Fear among frontline workers could be reduced by many of the same responses as I suggested for the issue of violence; including more training in interpersonal skills and emotion management and clearly stated policies asking clients to treat workers with respect, and increased levels of organizational support particularly for those working alone in clients' homes. Such shifts in policy and organizational structures would not be a panacea and would not correct all instances of abuse and violence, nor address confusion in-the-moment arising from lack of training and shifting care needs. Nevertheless, it is vital that organizations acknowledge that such situations do occur, and that workers deserve recourse and support.

A second feeling rule expressed by participants across all types of frontline care was *be respectful*. Without exception, participants shared their understanding that shows of respect are an important part of their job, and many described treating their clients with respect as a primary

means for maintaining the dignity of people receiving support. However, more bureaucratically organized care systems (such as public home care or highly medicalized long-term care homes) appear to interfere with the ability of workers to show deference, instead requiring that workers act as enforcers of rules and regulations. It is here that traditional workplace processes of the public sphere clashes with the basic premise of care, which is that individual need determines the work to be done. The fact is that need is contingent, changeable, and unpredictable. Such unpredictability flies in the face of standardization, control, regulation, and orderliness required for economic and bureaucratic efficiency and rationalization. Frontline workers are the people best positioned to note changes in need, yet rarely have the power to move systems to address those needs. This is a rather large issue, as it implies a need for sweeping changes to traditional hierarchies of medical authority which tend to discourage the flow of knowledge from any direction other than top-down. However, positive outcomes for both workers and clients have been found within long-term care organizations where information flows through networks, and management and leaders spend time with, listen to, and show respect for staff in the frontline (Bishop et al. 2008; Gittell and Douglas 2012; Lopez 2006)

This study also points to a specific issue that arises when clients purchase or directly control their own care services: such clients are owed respect not only because of their humanity but are structurally positioned to command deference and obedience as a ‘customer’ directly purchasing services (Callahan 2011; Dennis and Martin 2005; Goffman 1956; Kelly 2016; Yagil 2008). Six participants (Brent, Chiara, Gloria, Jessie, Michelle and Serena) found themselves in difficult emotional predicaments due to working directly under the authority of a client or the family of a client, either in the self- and family-managed care program or as employees of a private for-profit organization. While mistreatment is not by any means exclusive to paying

customers, and some families and employers are highly supportive (as was the case in Marjorie's situation), there nevertheless seems to be a greater potential for the status subordination of care workers when the client is paying directly for the service (Lan 2011). The potential for devaluation and exploitation intensifies when the client is also the de facto supervisor of the work. Participants indicated that the work was far less secure in such situations; clients could, and would, 'let you go' with little or no notice, and new positions were not guaranteed. As I described in chapter five, Brent was treated so poorly by his employer-client in the self-managed care program that he could not imagine asking for a raise without also imagining that to do so would mean the end of his job, and in many ways the end of his career. He knew he would not get a good reference if he made his employer-client angry.

The industry of social support and private health care exists with a generalized lack of regulatory oversight; privately hired care labour is "liminal, invisible, and precarious" and characterized by low pay, limited entitlements and benefits (if any), and a high degree of uncertainty (Daly and Armstrong 2016:487). In the area of direct-pay services, there is currently no comprehensive information available that can describe who receives the services, who pays for the services, and who does the work. In Manitoba, the only oversight for self- and family-managed care is in terms of accounting and funds management, not in the management of staff, nor in the ethical application of minimum labour and care standards. While it may not be possible to completely oversee the grey-market of private services, certainly when funding is provided by the state (as it is in self- and family-managed care in Manitoba), the state should take more responsibility over the provision of services and ensure that minimum standards are maintained for the rights of labour.

Finally, this thesis describes the third feeling rule *treat them like family but don't get too attached*. This feeling rule is rather ambivalent and difficult pin down, and participants were not consistent in the ways that they balanced the two contradictory ideas, nor were the ideas themselves fully consistent. For example, Brent, who works in disability support worked within the context of only one side of the feeling rule, '*don't get too attached*.' There was absolutely no suggestion that Brent was expected to care about his client the way he would care about his own family, and the feeling rule in his situation might be better stated as '*don't get emotionally attached at all*.' This is likely influenced by a number of factors including his client being middle-aged rather than older, their genders (both male), and perhaps most importantly the culture of independence and empowerment in the disability community (Kelly 2016). Brent was not only discouraged from providing emotional care in a paternalistic sense, he was also discouraged from all emotional expression in his client interactions; he did not have the somewhat equitable peer status of friendship as described by Michelle in her work as a companion. This contrast is highly suggestive, as the roles and duties of each job are also diametrically opposed: Brent's work was exclusively task based and Michelle's work was exclusively relational. Further, Michelle also did not share the '*treat them like family*' portion of the feeling rule, rather she tried to '*treat them like friends*'. This is interesting, and perhaps these early insights could be developed through future research.

Overall, the idea of family was a strong theme in the data, and most of the participants use family analogies to describe the emotional quality of the relationships they have with their clients. Despite the fact that most participants state that relationships with clients are 'like family,' nevertheless there is a strong recognition that a paid care worker is not actually part of the family, and my analysis suggests that the social esteem ascribed to the emotional ties of

family (with high value and importance) versus non-family (with low value and relative unimportance) are at the root of the portion of the feeling rule warning workers *don't get too attached*. Systems and organizations may encourage workers to treat clients like family, but they certainly do not treat workers like family.

Among the participants in this study, and with the notable exception of Brent, the effort involved in the surface work of display rarely led to the emotional dissonance and emotional alienation found in Hochschild's flight attendants (2003). Instead, I found that dissonance occurred more often because of the divide between moral impulse and a powerlessness to act on those beliefs. For example, Craig, Gloria and Jessie related uncomfortable and conflicting emotions in terms of outrage, anger and frustration over bureaucratic structures and processes which limited their ability to provide care the way they believed they should. Those who care for older adults form personal and long-term relationships with their clients (Bondi 2008), tend to identify strongly with their role as carer (Brown and Korczynski 2017; Dodson and Zinbarg 2007), and may have firmly held moral beliefs about care (Brassolotto et al. 2017). When carers find themselves constrained by organizational rationality (with a goal of providing cost-efficient services) they may become deeply demoralized by their inability to provide what they believe is necessary for quality care (Austin et al. 2005). This situation may also call on workers to put the interests of their client above their own self-interest, pushing workers to provide additional emotional labour (such as those little 'extras') in an effort to make up for organizational processes that depersonalize care (Johnson 2015). The powerlessness and emotional distress experienced by participants in this regard is perhaps better described as moral distress or moral dissonance rather than emotional dissonance or alienation (Austin et al. 2005; Brassolotto et al. 2017; Johnson 2015).

Although contrary to their own expectations, a recent study by Jakobsen and colleagues (2016) found that frontline care workers with more than five minutes of interaction with clients living in long-term care reported higher levels of depressive symptoms than workers who spent less time with clients. Employing the concept of moral distress, the findings of Jakobsen and colleagues make sense. Frequent interaction leads to closer social ties (Friedkin 1990) and an increased sense of responsibility (Funk 2012). Another more recent study found that closer emotional attachment measured by the frequency and duration of interaction leads to greater levels of moral distress among nurses specializing in dementia care (Pijl-Zieber et al. 2018). The feeling rule ‘*treat them like family*’ thus complicates moral distress. Organizations may urge workers to build family-like emotional bonds, but workers do not hold the same status as ‘real’ family and their emotional interest has far less authority. As much as informal carers find it challenging to negotiate and access quality care for a family member (Funk, Dansereau, and Novek 2017), it is much more difficult for workers to advocate on behalf of their client. This, perhaps, is one of the reasons why care workers are also urged to be wary of close emotional ties—workers must find some emotional ‘toughness’ to protect themselves from the potentially debilitating outcomes of moral distress (such as anxiety, depression and burnout). Thus the emotional labour involved in avoiding attachment is self-protective rather than in the service of the client or in service of the employer. This feeling rule is unique to paid care and is part of the professional distancing traditionally taken by nurses; workers must find ways to insulate themselves against the potential harms caused by the messy overlap between the rationalization of work and the emotionality of care.

I also found a gendered aspect to the feeling rule “*treat them like family*” in that the tradition gender roles within the family appear to replicate themselves in formal care roles. There

is a full body of literature on sex roles and gender roles within feminized or pink collar work, much of it finding that men doing women's work are supported by a 'glass escalator', or a fast-track to positions of authority (Smith 2012; Williams 1992) . Gendered differences in emotional labour include the effects of a status shield, which is a term coined by Hochschild to express the ways that the higher status of being male protects men from emotional labour related to dealing with aggression and the "displaced feelings of others" (2003:163). Recent research on emotional labour in nursing has found that men may not only benefit from a status shield, they may enjoy a 'status bonus' in that they are rewarded simply for attempting to feel and show 'authentic' emotion, whereas women are judged negatively if they do not succeed in their emotional labour (Cottingham, Erickson, and Diefendorff 2015). Although somewhat outside of the primary focus of this research, a more thorough examination of gender performances in the work of care would be highly interesting.

This study also ran across an unexpected but wide divergence between the situations and experiences of two participants working full-time in the self- and family-managed care program. At one end of the spectrum is Marjorie, working for a family-manager, who had the closest emotional ties to her client (and client's entire family) of all participants in this study, and provided one of the most positive descriptions of her working relationships. At the opposite end of the spectrum is Brent, working for a self-manager, who had the most impersonal and business-like relationship with his client, and provided one of the most negative descriptions of his working relationships. The two extremes of attachment versus detachment (as well the two extremes of satisfaction and dissatisfaction with their job) were found in participants working under the direct-pay scheme, which leads to many questions that have no answers in the literature, such as who are the workers in direct-funded care in Canada? How are they hired, and

what are their labour conditions (that is, what kinds of hours, pay, job security, and benefits do they receive)? Do they have the opportunity to participate in ongoing career support and training? Does it make a difference to work for a self-manager versus a family-manager? I hope to continue learning and researching, and plan look into the answers to at least a few of these questions.

STRENGTHS, LIMITATIONS AND CONCLUSION

A key strength of this thesis is its broad approach; existing approaches towards the emotional labour of care are highly context specific to nursing and do not fully address the work of all frontline care. As discussed in chapter two, Bolton's typology of emotion management in nursing discards the concept of emotional labour, arguing that the emotion management of nurses is not 'labour' because very little of it is under the sway of employers (Bolton 2000). Instead, much of nurses' emotion management is informed by their professional commitment to the feeling rules prescribed through education, nursing ethics, and nursing socialization, rather than the motivation of commercial profit-seeking (Bolton and Boyd 2003). Brook (2009) critiques Bolton's theorizing in this regard, arguing that the important foundation of Hochschild's conception of emotional labour is not that emotion is pressed into the service of profit, it is that emotion itself is a commodity paid for through employment. Emotion is no longer personal, it is "part of what we sell to an employer in return for a day's wage" (Hochschild 2003:54).

Hochschild explicitly draws on Marx with the basic premise that workers are always exploited when they sell their labour power (Lopez 2006). To this idea Hochschild also suggests that it is more exploitative to sell your heart and feelings than it is to sell the use of your muscles

or knowledge (England 2005). Emotional labour is certainly less visible as compared to the labour of our arms and legs, and is less materially productive than the labour of our minds and imagination; the hidden nature of emotion management leaves it more open to exploitation than other forms of human labour (Aronson and Neysmith 1996; Dodson and Zinbarg 2007).

However, I suggest that emotion management in care is often labour performed in the service of the person being cared for, not only in service to oneself or in the service of an employer.

Whether paid or not, emotion management is fundamentally necessary in the relational work of care (Cancian 2002; Gray 2012; Lopez 2006; Rae 1998; Simpson and Acton 2013). I find myself coming into agreement with some of Bolton's argument: emotional labour in care is often motivated by the need of the other person in the interaction and therefore cannot be fully imputed onto the wage-slavery implicit in the Marxist foundations of Hochschild's emotional labour.

However, I believe that Bolton's conception of compassion and beneficence as 'gifts' relegates emotional labour to a position of non-work, unnecessary and excessive. Her argument that the majority of emotion management in nursing care is based on professional ethics and nursing socialization serves only to minimize and derogate the social, relational, and interactional skills of non-professional carers, whether paid or unpaid.

I also attempted to use the typology of emotional labour developed by Theodosius (2008), however, I found that collegial emotional labour, which is found in interaction amongst health care professionals, is largely absent in many areas of care, such as home care situations where workers are alone with their clients. More importantly, collegial labour as described by Theodosius reflects the specific interactions between high-status professional health workers. When we examine interaction between co-workers of any status, including that found among peers, subordinates, and superordinates, the emotional labour found amongst care workers is in

many ways similar to that found in other types of workplaces (Fineman 2003; Wharton 2014), and is less like the negotiation of status between nurses and doctors as described by Theodosius (2008:182). The approaches of both Bolton and Theodosius centre on the nursing perspective, and this narrow focus appears to miss the fact that the ethics of nursing themselves sit upon a strong foundation of broad social mores, which are far more powerful than those imposed by organizations and professions.

Despite these theoretical contributions, there are limitations of the study. For example, my assumptions and expectations of what I might hear limited my questions—I did not explore reasons why participants kept working despite feeling underappreciated and disrespected. Others have looked into this question, and part of the answer appears to be the worker's level of identification with and commitment to their role, that is, how much they identified as a carer and how much their work role aligned with their overall self-values (Bolton 2000; Brown and Korczynski 2017; Erickson 1995; Johnson 2015; Meyer and Herscovitch 2001; Salmela 2014). However, this is not an entirely satisfying motivator to work at a job that is underpaid and tends to involve situations of abuse and violence. Another reason found in the literature is that frontline workers are constrained in their occupational choices due to structural factors such as low education, foreign educational credentials not accepted in Canada, challenges regarding language and cultural skills, age, gender, race, and so on (Armstrong et al. 2008; Stacey 2011). It is possible that it is a combination of socialization and structure: frontline carers tend to have been socialized to care about the welfare of other people, with the additional factor that there are barriers to finding better work for certain groups within society. This speculation could be confirmed with more research. I also did not explore forms of resistance to the social devaluation of care work and the trivialization of interpersonal and emotional skills. This too could be a topic

of future research. Another limitation is the fact that I am a student researcher, and my knowledge of analytical techniques are developing, as is evidenced in my discussion in chapter three regarding the trouble I had with analytical software. However, it may also be a strength in that I am looking at the phenomenon of emotional labour in care from a somewhat fresh (if novice) perspective.

I believe that the primary strength of study is in my methodological approach. During the open-ended interview participants were allowed to take the lead, telling me as much or as little as they wanted to, and choosing to talk about whatever they believed was important (Rubin and Rubin 2005). To better understand emotional labour and to theorize how emotional labour works in care it was important that I first try to better understand what was going on in a broad context, to strategically and carefully watch and listen, and to foreground the viewpoints of participants rather than my own viewpoint (Marvasti 2003; Swedberg 2017). Additionally, by choosing to interview frontline workers who were quite different from one another I was able to find commonalities in emotional labour across a range of contexts and situations, as the experiences of participants were not specific to a certain job status (such as only nurses, or only care aides), nor were their experiences specific to a certain employment type (such as only a certain site, only home care, only long-term care etc.).

During each interview I tried to be highly self-aware of my own emotional labour and the relative shifts in power between myself and the participant throughout the interview (Rubin and Rubin 2005). I approached interviewees as experts while also sharing many of my own experiences; together we tended to see each other as insiders with lived experience in frontline care. In using this approach, researchers are able to collect more data, have greater insight into the nuances of the data, and develop a greater understanding of the research topic (Hoffmann

2007). I observed that in using this technique many of my participants opened up to me and shared deeply personal stories and emotions.

In sum, this research finds that there is a generalized lack of recognition that emotion and emotional labour are a significant aspect part of the work of care. Care involves much more than physical tasks, it requires the worker to respect and uphold the humanity and dignity of their client, and provide social and emotional support. These aspects of care work are not possible without emotional labour. The concept of emotion management and the importance of emotional labour needs to be more widely understood, particularly amongst those working in the frontlines of care. Training in inter-personal and relational skills should become a basic part of the educational curricula for all frontline workers. Workers in home care or home support would benefit from peer networking opportunities, team meetings, and the like. Frontline care workers deserve less precarious labour conditions, higher pay, more access to benefits, and on-going training. Management and leadership can have a great deal of influence on the emotional quality of work, and the satisfaction of workers and clients alike. If working conditions are to improve, however, it may first be necessary for unions to take an interest in this sector of the labour force. Finally, the state should take a more active role in ensuring that labour rights are maintained throughout all areas of the health care and social support labour force.

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APPENDIX A
ETHICS CERTIFICATE AND RENEWALS



UNIVERSITY
OF MANITOBA

Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
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APPROVAL CERTIFICATE

November 27, 2015

TO: Lisette Dansereau (Supervisor: Laura Funk)
Principal Investigator

FROM: Kelley Main, Chair
Psychology/Sociology Research Ethics Board (PSREB)

Re: Protocol #P2015:148
"The Emotional and Relational Aspects of Home Support Work"

Please be advised that your above-referenced protocol has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. **This approval is valid for one year only.**

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Coordinator in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: <http://umanitoba.ca/research/ors/mrt-faq.html#pr0>)
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

umanitoba.ca/research



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RENEWAL APPROVAL

October 28, 2016

TO: Lisette Dansereau (Advisor: Laura Funk)
Principal Investigators

FROM: Kelley Main, Chair
Psychology/Sociology Research Ethics Board (PSREB)

Re: Protocol #P2015:148 (HS19137)
"The Emotional and Relational Aspects of Home Support Work"

Please be advised that your above-referenced protocol has received approval for renewal by the Psychology/Sociology Research Ethics Board. **This approval is valid for one year and will expire on November 26, 2017.**

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Coordinator in advance of implementation of such changes.



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RENEWAL APPROVAL

Date: November 20, 2017

New Expiry: November 26, 2018

TO: **Lisette Dansereau**
Principal Investigator

(Advisor: Laura Funk)

FROM: **Kelley Main, Chair**
Psychology/Sociology Research Ethics Board (PSREB)



Re: **Protocol #P2015:148 (HS19137)**
"The Emotional and Relational Aspects of Home Support Work"

Psychology/Sociology Research Ethics Board (PSREB) has reviewed and renewed the above research. PSREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

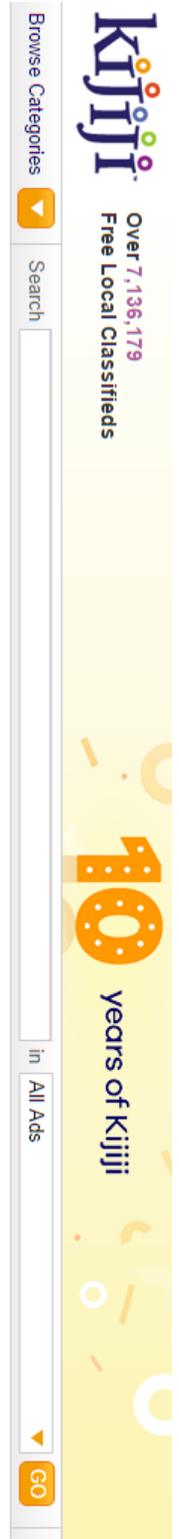
1. Any modification to the research must be submitted to PSREB for approval before implementation.
2. Any deviations to the research or adverse events must be submitted to PSREB as soon as possible.
3. This renewal is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
4. A Study Closure form must be submitted to PSREB when the research is complete or terminated.

Funded Protocols:

- **Please mail/e-mail a copy of this Renewal Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.**

Research Ethics and Compliance is a part of the Office of the Vice-President (Research and International)
umanitoba.ca/research

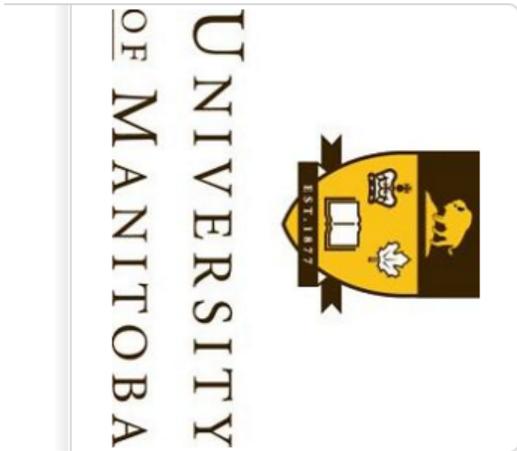
APPENDIX B
RECRUITMENT MATERIAL



The screenshot shows the top of a Kijiji search page. On the left is the Kijiji logo with the text "Over 7,136,179 Free Local Classifieds". To the right is a search bar with a "Search" label, a dropdown menu set to "All Ads", and a "GO" button. Below the search bar is a yellow banner celebrating "10 years of Kijiji" with confetti graphics.

Preview Your Ad Below

VOLUNTEER STUDY PARTICIPANT



Address

Winnipeg, MB R3T 2N2
[View map](#)

Job Offered By Individual
Company University of Manitoba Sociology Department
Job Type Please Contact

 Veteran Friendly [Learn More](#)

EMOTIONAL EXPERIENCES OF HOMECARE WORKERS
Are you a homecare worker helping older adults stay in their home?
I want to talk to you!

I am a master's student at the University of Manitoba studying the emotional experiences of homecare workers. This study will form my thesis. Most research on homecare comes from the perspective of the client, family caregiver or professionals such as nurses. I invite you to talk about your perspectives as a front-line worker in a private interview. If you are interested in volunteering to participate in this study or want more information please call/text Lisette Dansereau, [REDACTED] umdanser@myumanitoba.ca
SUPERVISOR: Dr. Laura Funk, Associate Professor

Screenshot of online ad
for participant
recruitment

Are you a homecare worker helping older adults stay in their home? I want to talk to you!



UNIVERSITY
OF MANITOBA

HOME SUPPORT WORKER, HOME CARE ATTENDANT, PRIVATE COMPANION, HEALTH CARE AIDE, RESPITE WORKER, HOMEMAKER, PAID CAREGIVER, HOUSEKEEPER, CARE WORKER, SUPPORT WORKER, CARE ATTENDANT, HEALTH ATTENDANT

I am a master's student at the University of Manitoba studying the **emotional experiences** of **homecare** workers. This study will form my thesis. Most research on homecare comes from the perspective of the client, family caregiver or professionals such as nurses. I invite you to talk about your perspectives as a **front-line worker** in a private interview.

Please call, text or email Lisette

umdanser@myumanitoba.ca

Supervisor: Dr. Laura Funk, Associate Professor, Sociology

Homecare Study
Lisette @
umdanser@myumanitoba.ca

APPENDIX C
CONSENT FORM



UNIVERSITY
OF MANITOBA

Department of Sociology

Lisette Dansereau
Rm. 301-L Isbister Building
Winnipeg, Manitoba
Canada R3T 2N2

umdanser@myumanitoba.ca

Informed Consent Form

Study Name: The Emotional and Relational Aspects of Home Support Work

Principal Investigator: Lisette Dansereau, Graduate Student, Sociology
umdanser@myumanitoba.ca

Research Supervisor: Dr. Laura Funk, Associate Professor, Sociology
204-474-6678 Laura.Funk@umanitoba.ca

Sponsor: None

This form is only part of the process of informed consent. It is intended to give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please feel free to ask. **Please take the time to read this carefully.** For your records and reference, I will give you a paper copy of this consent form, or email a copy to you based on your preference.

Project Description and Purpose: “The Emotional and Relational Aspects of Home Support Work” explores how general social expectations and institutional policies may influence caregiving and care relationships, and examines the emotional experiences of homecare workers. The purpose is to learn more about how homecare workers feel and how they manage their emotions. Research in the experiences of support workers suggests that time constraints and an emphasis on task-based job duties may get in the way of social and emotional interaction between workers and clients. At the same time, scholarly articles that examine all types of care work emphasize that personal interactions are essential for the emotional wellbeing of clients and patients.

I am conducting this research as my thesis project to earn the degree of Master of Arts in Sociology, under the supervision of my thesis supervisor, Dr. Laura Funk. Although this research is primarily directed towards the completion of a thesis, **I intend to provide a summary report to all participants by the summer of 2016**, and will pursue public presentations and academic publications if possible.

About the Interview: Each interview will take about 1½ hours and will primarily take the form of a conversation. There will also be a few demographic questions and a short checklist of

emotions, but for the most part I will ask broad questions about your experiences as a homecare worker, and ask you to tell me stories about how you manage your emotions while at work. With your consent, interviews will be digitally recorded and later typed up and transcribed for analysis.

Confidentiality: Any information gathered during this research project will be kept strictly confidential. Digital recordings will be saved under a numerical code, and kept on a password encrypted device. You have the choice to remain anonymous or to be recognized for your contribution to this research, and you can indicate this choice as part of this consent form. Recordings will be transcribed as soon as possible, removing any personal identifying information as necessary, and then the recordings will be destroyed. All digital files will be stored on a password encrypted computer, and organized by your name if you choose to be recognized, or a pseudonym if you choose to remain anonymous. Other important records, such as these consent forms and contact information, will be kept in a locked filing cabinet within a locked office at the university. Upon completion of my thesis and distribution of the summary report, all personal records and consent forms will be destroyed. *With your consent, data files and interview transcripts will be stored indefinitely.* **Please note that any reports of elder abuse will be reported to authorities** using the procedures outlined in the Winnipeg Regional Health Authority's "Elder Abuse Decision Tree", which is attached at the end of this consent form.

Risks and Benefits: By participating in this research project, the risks of personal harm are very minimal, although recollections of strong personal emotions during the interview may cause emotions to re-emerge. **It is important to know that you do not have to answer any questions that you do not want to, and you can stop the interview at any time.** By participating in this research project, you may benefit by having the opportunity to talk about your feelings and work experiences. You may choose to attend my thesis defense and/or receive a copy of the full thesis in the late spring or early summer of 2016. You may also choose to receive a summary report by mail or email (as you prefer), outlining what has been learned through the stories of yourself and other frontline home support workers.

Consent

Your signature on this form indicates that you have understood to your satisfaction the information regarding this research project and agree to participate. In no way does this waive your legal rights nor release the researchers and involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. If you choose to stop the interview, the information you provide will not be used unless you consent to this at the time of withdrawal. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout the interview.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba. If you have any concerns or complaints about this thesis project you may contact myself or Dr. Funk through the contact information printed at the beginning of this form, or by contacting the Human Ethics Coordinator at the university at 204-474-7122 or at humanethics@umanitoba.ca.

I _____ (print name) understand what this research project is about, and what my participation involves. My signature below means that I agree to participate and make the following choices.

I prefer to: **be recognized by name** **remain anonymous**

I consent to Lisette Dansereau indefinitely storing the interview transcript yes no

I would like to receive a summary report of this project by mail email

at this address: _____
(if you don't want a summary report, just leave this blank)

I would like to be invited to the thesis defense and be invited to receive a copy of the full thesis yes no

Participant Signature

Date

Please provide additional guidelines involved in your consent to participate in the space below (such as preferences regarding the use of pseudonyms, the storage of personal information or any other personalized instructions):

APPENDIX D
INTERVIEW GUIDE

Date _____

Location _____

Participant ID _____

Thank you for agreeing to participate in this interview. I want to hear about **your relationships** with the people that you work with, **how you feel** about your work, **and how you manage** your feelings at work. This interview will not be a survey, it will be more like a conversation. I will ask very broad and general questions, and you are encouraged to talk as much as you would like, and share examples and stories. The interview will take about an hour and a half, but of course this depends on how much we end up talking.

Before we start, do you have any questions?

THROUGHOUT INTERVIEW: Prompt with feeling words IFF necessary, such as (basics): fear, anger, joy; (complex): resentment, anticipation, responsibility, contempt; (reflexive negative/positive) shame, envy, pride; (empathetic cognitive/emotional/action) perspective-taking, distress, concern/compassion. Also expressions of emotion &/or control; smile, polite, respect, professionalism

- 1) Let's start by you telling me about your work ...
PROBE FOR: hours, employers, number of clients, job title(s) job duties, length of time as care worker etc.
- 2) Speaking generally, **how you feel about the work** you do?
PROBE: can you give me an example? positive and negative feelings? mixed emotions?
- 3) How do you approach **working with a new client**/person/family
PROBE: anything you regularly do when meeting a new client? tell me more
- 4) Do you feel that part of your job is to **build a relationship** with your client(s)?
 - a) do you think part of your job is to **provide emotional support**?
- 5) Can you tell me about **a client that you have worked with for a long time**?
PROBES: like family? professional? close?
- 6) How do you **work with the moods of your clients**?
PROBES: tell me more, can you think of another example

- 7) Tell me about when you **work with other staff**.
 - a) do **other workers** talk about emotions and work?
PROBES: what do you think about that? how does that make you feel?
- 8) Does your **employer or boss** give you guidelines or support?
PROBES: How do you feel about that? How do you feel about your boss/supervisor?
- 9) At work, have you been in a situation where you **felt a strong emotion but had to control it**?
PROBES: any other examples? how do you manage the situation?
- 10) What would you say are ...
 - a) the most *difficult* parts of your job
 - b) the *easiest* parts of your job.
 - c) the most *important* parts of your job?

OKAY! We're almost done. For this last part of the interview, I'm going to ask you just a few survey-style questions about yourself such as your age and education.

- 11) First I want to confirm your gender is _____?
- 12) How old are you? _____
- 13) Were you born in Canada? Yes No
 (If no) Where were you born _____ and how old were you when you came to Canada _____.
- 14) What is your **ethnic/cultural background** (if immigrant, So then would you say your cultural identity is [place of birth])? _____
- 15) What is your **educational background**? (if immigrant, ask about education in home country too!)
 - a) what about certifications, workshops or other kinds of job-related training or workshops you have taken (such as first aid, transferring, dementia training, conflict training etc)

And that's it. **We're done. Thank you! Before I turn off the recorder...**

Is there anything you'd like to add? **Is there anything that you think I should have asked about that I didn't?**

APPENDIX E
NVIVO 11 CODEBOOK

Node	Sub-node	Sub-Sub node	Description	Sources	References
WORKPLACE DETAILS	Job Title		# of clients, length of time working, employer, job title etc.	9	42
	Length of Time		Code Length of time in JOB; also length of time with specific clients, maybe figure it out later ---- put into case classification after first go-through	9	38
	Number of Clients		Specify # of clients worked with the week of the interview, or else code as "irregular". (to be put into case classifications)	9	6
	General Descriptions		Participants thoughts about care work, characterization of the work, work locations. Also role identity as care worker. (tease apart later)	9	319
	Caregiving as a calling/personal identity		Talents/skills described as natural, or part of individual personality (part of ethnic identity)	6	17
	Characterize other workers	Questioning Competency	Hints about interpretation of definition of quality care, good caregiver	6	21
		Questioning Ethics		6	13
	Characterize Job	Difficult	Q. what is the most difficult	9	22
		Easy	Q. what is the easiest	9	12
		Important	Q what is the most important	9	9
FEELINGS			Any emotion words that pop up, phrases that indicate a 'feeling'	9	300

			(pay attention to non-linguistic verbalizations, tone of voice etc where possible)		
	Not a Big Deal		Minimizing a feeling - may indicate downplaying/re-framing something that was felt as a strong emotion	3	7
Emotion Work			<u>Explicit</u> examples of emotion work	5	5
	Surface Acting	Suppression of feeling	Not being able to let out feelings/thoughts.	9	35
		Face work	Managing appearance.	9	17
Care Relationships			Discussion of clients	9	264
	New/First Time Client		Characterization of 'getting to know' new clients	7	18
	Family member		Interaction with family	3	3
	recognizing the other's standpoint		Empathetic interpretations – 'they feel', I'm sure it's not easy for them because... they don't like etc.	9	32
	Excusing bad behavior		It's not their fault because	7	28
	Dementia Care and Communications		Talk of clients with dementia	7	16
	business only relationship		'put up with each other' type of thing	8	56
	Reciprocity		Explore idea		
	Fictive Kin		Like family;	6	14
		Worry	Thinking of client outside of work	3	15
		Friendships	With client or family	2	3
		Getting invested	Explore as feeling rule "don't get too attached" perhaps?	5	14
Emotional Labour with			Emotion work relating to JOB role, in	6	79

coworkers			interaction with employers, following organizational feeling rules		
	Relationship with boss/supervisor		Talk concerning employer/supervisor – subcategorize into feelings/power	9	98
	Relationship with coworkers		Talk concerning other health workers – subcategorize into feelings/power	9	125
	Relationship with family		Talk concerning client's family: NOTE: this relationship is complex and variable! maybe needs sorting into boss vs co-worker vs client	9	62
	Organizational Feeling Rules & work policies		Talk about system & organization - relationship with the 'rules' 'regulations' etc.	9	230
		Systemic critiques and issues		3	11
		Autonomy V Support	Differences between work in homes and in institutions	8	14
Process of Emotion Work	Don't take it personally		Explicit instruction of feeling rule.	7	8
	Learning		Process, getting better at feeling rule	3	5
	Re-framing the situation		Self-talk	6	19
	Disengage			8	40
		Cannot Disengage	Directly tied to labour - cannot self-protect/disengage INTERESTING	4	10
RESPECT & PRIDE					
	Pride	Skill	Participant talk about their abilities/skills at	8	44

			what they do		
		Education	Formal Education	7	28
		Experience		5	18
		Training others		4	10
	Receiving Respect			2	2
	lack of respect			9	54
		pay		9	40
GREAT QUOTES				9	52
Items to ask Cheryl about			Interpretive situations particularly shame/pride/ stuff that is unclear	3	6
POWER & CONFLICT			Subordination/power over (sort out)	9	193
	Racism & Immigrant experience		Talk about being immigrant, or being of color, or language skills	8	57
	Resistance			5	12
	Deference			6	7
Reaction to Interview				4	5

APPENDIX F

CASE SUMMARIES

Serena - F, 30, emigrated from Ethiopia in 2013, care aide certificate earned 2015, with just over one year of related work experience. Serena is the most recent newcomer among the participants, and seems to be acutely aware of cultural differences between her home country and Canada. Serena is employed by a for-profit agency as a casual worker, and has recently been getting a lot of shifts working at a large care home as ‘float’. She also has a regular bi-weekly shift providing homecare in a public housing complex. She is hoping to get a full time job in the near future, as she has found casual work unpredictable and problematic for her personal finances. She explained that she doesn’t like working in homecare; she generally felt anxious when walking into an unknown situation, and felt threatened by some of the neighborhoods she was sent to, particularly when she had to arrive or leave very early in the day or late at night when it was dark. In her few experiences with homecare the people were either aggressive and unwelcoming, or were very ill, leaving her feeling out of her depth and uncomfortable with the lone responsibility of ensuring the client’s wellbeing. She expressed a strong preference for working in institutional settings where she has backup and support from other coworkers and supervisors. She gets satisfaction from learning new skills at work, and enjoys interacting with friendly clients and coworkers, particularly those who can help her improve her understanding of Canadian culture. **In common with most of the other newcomers who participated in this study, and she provides examples of the emotion work involved in dealing with racism** (Bourgeault et al. 2010; Power et al. 2011; Wilkins and Pace 2014), which differs in handling other forms of disrespect in that it is sometimes more difficult to ‘not take it personally’ (? Check (DeVault 1999; Dodson and Zinavage 2007)). **In common with Michelle and Chiara, Serena provides a lot of examples of the emotional labour involved in dealing with co-workers** in an

institutional health care setting (Piper and Monin, Nanette 2006), however **Serena is unique in the emotion work involved in adjusting to constantly changing work conditions**, with a new set of coworkers, supervisors and clients each time her work location changes.

Jessie – F, 53, born in Canada, care aide certificate earned 2014, with 35+ years of related work experience. A few years ago, Jessie moved and left her position of almost 30 years working in a large care home in another urban area. After moving to Winnipeg she went back to school to earn her care aide certificate and began working part-time for a for-profit agency, and has recently gained part time work with public homecare. In her position for the public health authority she has over 30 clients all living in the same seniors housing complex. She sees her clients on multiple brief visits throughout the course of a day, primarily helping with personal care. Jessie expressed that care work in homecare is not fundamentally different from that in institutional care, although there are significant differences in the details of policy and ‘allowed’ tasks. She talked a lot about the pleasure she feels from the busyness, structure, and routine of the work, and through interacting with many different people through the day. She shared a number of stories of instrumental and therapeutic **emotional labour, particularly using humor** (Bailey et al. 2015) **or maternal ‘motherly’ behaviors** (Bondi 2008; Heaney 2011) **both in managing the behavior of her clients so she could accomplish her tasks through instrumental emotional labour, but also as a gift to her clients in the form of therapeutic emotional labour** (Bolton 2000; Theodosius 2008). Jessie makes a concerted effort to show her clients respect, and show that she values her clients as important. As an employee at a for-profit agency, Jessie works a full day as a companion/caregiver for one client (Anna – pseudonym), who is living with advanced dementia. Over the course time Jessie has become **emotionally**

attached (Thoits 1989), **like a substitute daughter or voluntary kin** “*I don’t have a mom, and it doesn’t hurt me to bring a couple little things to this lady to make her life easier.*” She has invested a significant amount of effort to ensure the Anna’s wellbeing, including putting in extra time, running errands, creating care plans and task sheets for other workers, and purchasing household items and personal treats. **Jessie also performs a significant amount of emotion work through advocating on Anna’s behalf. It is difficult to analyze Jessie’s emotion management as theoretically distinct from emotional labour. Jessie openly talks about her struggles in separating her work role, her personal attachment to certain clients, and her expression of identity through advocacy and negotiation with an imperfect system on behalf of her clients.** Jessie expressed a lot of humor and exhibited a great deal of maternal affection for Anna, hinting at her position of relative power and her role as a caretaker for Anna. Jessie also shared a number of stories that involved **conflict with other workers and challenging her employers** to ensure what she felt was an acceptable level of care.

Gloria – F, 64, born in Canada, characterizes herself as a companion, a caregiver, and a recreation therapist, with 40+ years of related work experience. Gloria has recently retired from full time work as a director of a recreation program in a large residential institution for mental health. After retiring she took on part time work, and currently works for a for-profit agency as a companion for one client, works on call as a casual recreation therapist for a large care home, and also volunteers part time at a hospital as a friendly visitor for palliative care patients. Gloria has a considerable breadth of experience, working for many years in various aspects of mental health, including institutional work, running a suicide crisis phone line, and doing direct-care work in group homes. Gloria likes companion work, but she does not enjoy working for for-

profit agencies – she was quite critical of a profit orientation in health services, and is hoping to get regular part time work with a not-for-profit care home. Gloria provides ample of evidence of **therapeutic emotional labour, geared towards the emotional wellbeing of her clients.** During the interview, she showed the ability to adjust her emotional tone at the snap of her fingers, providing practically any emotion that she might deem necessary for the situation. In getting ready for work, she explained that she did not ‘put on the smile’, instead she ‘put on the energy’. Only rarely did she show emotion that was not managed, and she even elicited a number of emotional tones just because I asked her to, such as serenity and calm, confidence and authority, and silliness and playfulness. She provided many stories, through her experience in mental health, on a suicide crisis phone line, and in palliative care, that showed willingness to accept sadness and distress in others without becoming too distressed herself. I believe this is evidence of a truly professional emotion worker. She provides **great examples of deep acting, feeling not merely showing the emotion she called forth. Interestingly, while I found her to be exceptionally adept at emotion work, she did not understand the concept until I explained it to her towards the end of the interview. For the most part, Gloria’s emotion management involved deep acting, and she was generally unaware of working on her emotions, except for when she was unsuccessful at deep acting.** Note that Gloria generally keeps work separate from personal relationships, but not always. She shared with me that she met her current husband while helping him with his grief after losing his previous wife to cancer, and had informally adopted a young immigrant care worker, treating her like a daughter. Similar to Jessie, Marjorie, and to some extent Craig and Michelle, Gloria would regularly cross the work/home line by bringing gifts to her clients, primarily in the form of extra time and thoughtful gestures. For Gloria, and similar to Jessie, care and concern would often be expressed in the form of food

(cookies/ethnic treats), and maintenance of the surroundings (such as holiday-themed decorative gifts, but also includes extras such as cleaning the oven or organizing the pantry).

Daisy – *F, 49, emigrated from Korea in 2004. Home care attendant with 2 years related work experience.* Daisy works full time, regular shifts, for the public health authority, primarily doing housekeeping, with some meal prep and laundry. She is working towards an advanced post-secondary degree, and took on the position in homecare primarily to gain Canadian work experience while gaining first hand knowledge about long term care for old people. Like Serena, Daisy is acutely aware of cultural differences between her home country and Canada, and like Marjorie she is particularly frustrated by what she sees as her inability to become fluent in English. Although she says that she has a very good relationship with the majority of her clients, she has been **showered with disrespect from three clients in particular, and she shared information about the emotional labour she performed to maintain her composure** in the face of their abuse. **As with other newcomers, she shares examples of the emotion work involved in dealing with overt racism** from some of her clients. Additionally, she has run up against problems with **organizational rules versus client’s expectations, involving the feeling rules of care but perhaps more often the feeling rules of being a domestic worker** (Bolton and Wibberley 2014; Rollins 1985), **since her tasks primarily involve housekeeping.** To protect herself she has determined that she will follow organizational policies to a tee, but she has discovered that some of these policies anger her clients, creating additional conflict. This has only redoubled her resolve to work in ways where her employer will not be able to find any fault. **Daisy speaks quite fervently about acquiring the ability to ‘not take it personally’** which she

believes is an important skill that will help her in her future career, and has been identified as a **key feeling rule for many care workers** (Bolton 2000; Matousová and Tollarová 2014),

Chiara – *F, 27, emigrated from the Philippines in 2009, care aide certificate earned 2010, with additional educational certifications and 6 years of work experience in various areas of health care in Canada.* At the time of the interview, Chiara was going to college to get a certificate in pharmacy technology, had previously earned a certificate as a physician's assistant, and held a nursing degree from her home country. She has worked for multiple private agencies in home care, in clinics and in institutional settings, with experience working with children with autism, providing medical care in clinics and in hospital, and working with older adults in care facilities and in their homes. Just prior to the interview Chiara had started a new job with a for-profit agency as a casual homecare worker, and had a very bad experience with her first client in her new position. She was upset and angry, and felt that the agency did not support her properly. She had always considered direct care work to be a stepping stone to a better career, and this experience reinforced her opinion that she needs to move on. Despite the difficulty of having no backup or help when working in private homes, Chiara says that she generally enjoys home care work because she likes to be able to make her own schedule and follow her own routines. She pointed out that there are positives and negatives to any work situation. Her expression of **emotional labour was predominantly surface work regarding instrumental emotional labour, managing her emotions in order to be effective at her tasks.** While she did not share any examples of therapeutic emotional labour, she was personable and appeared highly capable of establishing a quick rapport with clients, a key skill for therapeutic emotional labour (Theodosius 2008). **Unlike Daisy, she usually had no problem with the skill of not taking**

things personally, but she also talked about difficulty **controlling her anger or her feelings of being hurt when feeling personally disrespected**. For Chiara, her need to manage her feelings depended on her interpretation of the other's intent, and she rarely classed her clients as responsible for their own behavior. She was **able to apply this ability to instances of racism, she said that it was their problem, not hers, and it the prejudices of others didn't affect her**. When she interpreted the other's behavior as the fault of dementia, or illness, or generational norms, or even ethnic background, she was able to insulate herself from emotional hurt and reduced her need to practice emotional labour.

Brent – *M, 43, born in Canada. Disabilities support worker, with 15+ years of related work experience*. Brent works full time in a self-managed care program. He is the Monday to Friday support worker for an employer/client with physical disabilities, and they have been working together for over 10 years. Brent characterizes his interactions with his client as transactional. *“At this point it feels like, you know that cartoon with the sheepdog and Wile E. Coyote? Where they're just like punching in and out? Lisette: (laugh) The old Bugs Bunny cartoon? Brent: Yeah. We're kind of like that. It sort of seems like that, kind of transactional. I don't think there's any animosity, but it's just kind of we're both in the same place at the same time and there's not really much going on.”* It is as though **emotional reciprocity has been removed from the relationship, and Brent is reduced to merely selling his labour** (Bondi 2008). The **feeling rules for a disabilities support worker demand a highly constrained range of acceptable emotional displays**. When out in public with his client, Brent strives to fade out of the picture, to almost become a non-person, and yet be attentive and on hand to provide any necessary physical support. According to Brent this is not a problem at all, however he does have a problem with

maintaining the appearance of emotional detachment and subservience the privacy of his client's home. He would like to be shown that his work is valued, but he does not feel any sense of appreciation from his client for the job that he has been doing for over a decade. His **situation is complicated by the fact that his client is also his employer**, and in this context he has been **stripped of all avenues for airing any grievances. Brent is emotionally exhausted in no small part due to his need to suppress emotions of anger and irritation, and his interview provides a stark example of how constant surface acting, and failed deep acting, can result in emotional dissonance** (Hochschild 2003), **burnout** (Wharton 2009), and **alienation** (Rivas 2011).

Michelle – *F, 55, born in Canada. Companion and support worker, with 7 years of related work experience, and prior work experience as a massage therapist.* Michelle works part time for a for-profit agency, and is also self-employed with a few private clients. She does a variety of support tasks, such as yard work, cleaning, laundry and meal preparation, and she also does companion work for clients with dementia. Michelle describes differing levels of emotional attachment to her clients, with the strongest attachment to her private clients, one of whom she characterizes as a close friend. Working in a care home as a private companion hired by the family, Michelle does not fit into the traditional workplace hierarchy. The nurses and care aides cannot exactly give her orders or instruction, but at the same time she is working on their turf and is expected to recognize their general authority. In this capacity, she provides a lot of information about **organizational emotional labour, and the emotional dynamics of care work in institutional health settings** (Miller et al. 2008; Theodosius 2008). Michelle provides additional information about how care workers deal with disrespect and abuse; she expressed

some difficulty learning to manage the aggressive behaviors of dementia clients, and also shared her experiences of dealing with inappropriate sexual comments and behaviors from a male client (Denton et al. 2002). Additionally, Michelle describes **the lack of reciprocity she receives when working with clients with profound dementia as exhausting, highlighting the interactive nature of emotional experience**. In common with Serena, Chiara and Daisy, Michelle explained that dealing with difficult situations when alone in the client's home was significantly more challenging than when working in a care home, highlighting the different emotional context of working in private homes versus other settings.

Marjorie – *F, 47, born in Congo (emigrated in 2010). Caregiver, with 4 years of related work experience, plus many years of experience as an unpaid caregiver.* Marjorie has worked for a family in the self-managed care program for about three years, originally caring for two women with dementia, one of whom passed away shortly before the interview. Marjorie refers to her employer as uncle and her client as grandmother, and when I referred to her employer as 'your boss' she told me it made her uncomfortable. Marjorie's family, and her employer's family have become **voluntary extended kin** (see Braithwaite et al. 2010 for a discussion on the academic use of "voluntary kin" rather than "fictive kin"). Marjorie's children and husband, and her employer's extended family of children and grandchildren are a mutual support system, although I did find evidence of relational **power imbalances, particularly through the intersections of race, nationality, and gender** (Bolton and Wibberley 2014; Dodson and Zinbarg 2007; Noveck 2013; Parreñas 2000; Rollins 1985). Nevertheless, Marjorie cares for her uncle's immediate household, and he and his extended family have in turn helped her and her family adjust to her new life in Canada. They attend each other's family events, and celebrate holidays

together. While her paid work for the family must eventually come to an end, it seems likely that their relationship will continue. Marjorie's attachment runs deep (Thoits 1989). "*I don't know how to tell it. They showed me love, this family. (crying softly) They are amazing.*" The feeling rules of Marjorie's work place are indistinguishable from the feeling rules of family, and in her role as paid caregiver she experiences none of the negative effects associated with emotional labour (Hochschild 2003; Wharton 2009). During her interview, Marjorie's emotion work centered around trying to manage her grief over the recent death of one of her charges, and managing her frustration over my occasional misunderstanding of her English.

Craig – *M, 40, born in Canada. Nurse with 10 years of work experience.* A few months prior to our interview, Craig had changed jobs to a community outreach organization, after almost 10 years of working full time with public homecare in an inner-city neighborhood. As might be expected, his experiences of emotion work were not dissimilar to what can be found in the nursing literature (see for example (England 2005; Miller et al. 2008; Theodosius 2008)). He experienced fewer instances of disrespect from his clients than did the others in this study, possibly due to his combined status as a health professional and a white male, although being a male in a female dominated caring role has its own challenges (Bondi 2008; Clow et al. 2014) However, through his role as a nurse, he felt a great deal of responsibility towards his clients (Funk 2012). A handful of clients were of particular concern for Craig and, **similar to Jessie, he would find himself gifting his time or performing tasks outside of his work role.** He experienced a great deal of conflict with his supervisors, and frustration with the system, often trying to advocate on behalf of his clients. **Similar to Jessie, who also undertook advocacy work, Craig described a great deal of emotional turmoil related to contesting workplace**

policies and systemic injustice rather than in interaction with his clients. His stories communicated stress and falling job satisfaction, a sharp reduction in his sense of personal accomplishment at work, and an eventual move to a new work position, all features of burnout (Wharton 2009). **He provides examples of how conflict between workplace policies and personal expectations of care can result in emotional dissonance and moral distress.**

APPENDIX G
PARTICIPANT SUMMARY

Emotional Labour in Frontline Care Work

May 2018

Lisette Dansereau

Who were the participants?

Gender

Seven women and two men

Age

Average of 45 years old

Years of Experience

Range from 2 to 45 years

Job title(s) at the time of interview

Support worker, health care aide, home care aide, home care attendant, caregiver, companion, recreation therapist, nurse, friendly visitor, home support worker

Thank you for taking part in this study. My goal was to learn more about how people working in frontline care with adult clients manage their feelings and emotions. This summary reports on the findings of this study. Emotional labour refers to the effort people put in to their emotional expression while working; frontline care workers are expected to be kind and considerate and show respect and compassion. These expectations are the 'feeling rules' of care—the often-unspoken rules about how people ought to feel in a given situation, and how people are expected to show that feeling.

Who were the participants?

Nine frontline care workers (two male and seven female) agreed to participate in lengthy and sometimes highly emotional and personal interviews. Five were born in Canada and four were newcomers from Somalia, the Congo, South Korea, and the Philippines. Participants in this study were fairly mature: the youngest participant was 27 and the oldest was 64, averaging 45 years old. The experience level of participants ranged broadly: three participants had worked in frontline care for three years or less, three had worked in care for 10 years or less, one had more than 15 years of work experience, and two had more than three decades of experience in care work.

Participants held a broad range of job titles, including support worker, care aide, private companion, and nurse, and similarly had a broad range of employers, including the regional health authority, for-profit care agencies, as well as working directly for families and clients. Four participants had full-time work: two were employed by the regional health authority in home care and two were employed through the self- and family-managed care program. Of the five participants holding part-time and casual positions, three held down more than one job, including one participant who found clients through word-of-mouth and by providing yard care and general household help. Attached to this report you will find a table of all participant characteristics, including age, gender, job title, years of experience, employer and employment type.



UNIVERSITY
OF MANITOBA

Faculty of Arts
Department of Sociology and Criminology

What does it mean to be a care worker?

All people have a shared idea of what it means to care, such as be kind, be nice, be concerned. In care work, it also means be reliable, show up on time, perform your tasks. These meanings matter, because they influence the ways that workers understand their role, and how they believe they should feel. Three common meanings came out of the interviews: we are 'naturally' suited to care, we genuinely care, and we love to care but the paycheque is demeaning. In presenting my findings, I include short excerpts from the interviews to illustrate the themes. To protect anonymity, I have changed all names except for Gloria who asked that I use her real name.

We are 'naturally' suited to care.

All participants talked about being a 'natural' at caring, whether it was a personal vocation, a part of their culture, or a spiritual calling, as stated by Gloria, a participant with a history of working in care for over 40 years:

Gloria: *You're either a natural at it or you're not.*

Unfortunately, this idea that the ability to care is 'inborn' can downplay the real skills and effort participants brought to their work. Much of the work of emotional labour was learned over time—participants with many years of experience showed high levels of skill at managing their emotions at work.

We genuinely care.

Care tends to be idealized as higher quality when it is given freely; genuine care is somehow cheapened by money. This idea means that paid workers may be viewed as not really caring. This issue came up in the talk of all participants. An example is provided by Serena, a temp care aide:

Serena: *Some people, some workers ... are they working for money or are they really helping people out, you know?*

Wanting to appear genuine meant that many participants gave their clients 'extras', which sometimes meant purchasing or making things for their client. However, most often it meant that participants gave of themselves, showing their authenticity by giving extra emotional labour, extra time and extra effort. To show that they really care, participants sometimes work for free.

We love to care, but the paycheque is demeaning!

For most, an important benefit of working in care came from the emotional and social rewards of their relationships with their clients. However, not all interactions with clients are particularly rewarding, and some relationships are not rewarding at all. Except for one nurse (who likely receives higher pay than other frontline carers in this study), low pay also left participants feeling unappreciated, angry, embarrassed and demeaned. I include two examples:

Michelle: *My raise was eight cents. Eight cents per hour! And I thought oh my god, seriously? ... (sigh) You don't feel valued*

Brent: *This wage cap is disrespectful. Umm. (sigh) ...Yeah, I definitely feel undervalued*

Low pay tells workers that their job is has very little prestige in a broad social sense. While participants themselves believe their job is important, low pay devalues and demeans the skill, commitment, expertise, and effort that workers bring to the job.

The Feeling Rules of Care

Feeling rules are the expectations for emotion in a given situation. For example, the feeling rule for everyone at a funeral is 'be sad', although just how much sadness you should feel depends on how connected you were to the deceased person. In this study, I identified three feeling rules of frontline care from the participant data: don't take it personally, be respectful, and treat them like family...but don't get too attached.

Don't take it personally

The feeling rule 'don't take it personally' allows workers to care for their clients even in the face of offensive or abusive behavior. Rudeness, harassment, racism and even overt violence are excused because of the client's illness, pain, personality, age and so on. All but one participant talked about physical and verbal aggression, and many were explicitly told by employers and supervisors that they must learn to not take things personally.

***Daisy:** I think about what my employer told me, don't take those things personally. Okay. A job is a job. Alright. I want to learn that.*

However, this feeling rule is in many ways a double-edged sword. It encourages workers to expect abuse as an everyday occurrence. To abide by this feeling rule, participants tended to minimize the dangers they were facing:

***Michelle:** I ignored all of that ... And later on there were jokes, sexual jokes. And you know whatever. Like nothing personal.*

This feeling rule allows abusive clients to continue their behavior. And because of this feeling rule, employers may tend to place workers in harm's way.

Be respectful

Without exception, participants understood that showing respect to clients is an important part of care work. When workers show respect, they are supporting independence and upholding the dignity of their clients:

***Jessie:** The most important thing? Making sure that everybody's looked after how they should be, with respect and dignity. Because they're people!*

However, sometimes systems and processes get in the way of workers' ability to treat people the way they want to be treated. Employers, whether public health or private agencies, tend to have policies and rules in place that workers and clients must both follow, whether they like it or not:

***Daisy:** I tried to talk to her about why I cannot clean up until she put her cat away. But she didn't listen to me. She said something like "This is my property. You are a worker. And you cannot tell me anything. I tell you! This is my house, not yours!" (sigh) So all right. This is your house*

When clients feel disrespected by organizational policies and systems, frontline workers are left to repair the situation. The way most workers solve the problem is through the emotional labour of being (or acting) apologetic and deferential.

Be Respectful

A specific type of frontline work that requires a great deal of deference is disability support; the disability community has advocated strongly to ensure that those receiving services are in full control of the support interaction. Brent is a disability support worker, and after a 13-year relationship with the same client he found it easy to act with respect. The problem was that his client was not respectful in return.

Brent: ... that lack of consideration is (pause) *hmm. It's not necessarily that he's trying to insult you, it's just the way he is. But you are offended by it.*

As part of being respectful, Brent was expected to be unobtrusive and somewhat invisible. However, being consistently treated as a non-person, even in the privacy of the home, had become belittling, demeaning, and deeply offensive for Brent. It seems like such a tiny thing, but it is those little words of appreciation—please and thank you—that signal to a person that they have value and worth. Shows of respect and deference from the worker can uphold the dignity and power of the client, but giving too much power to the client can in turn compromise the dignity of the worker. Any worker in any work place deserves to be acknowledged for their effort. In Brent's case, his self-esteem and well-being were threatened by a lack of appreciation.

Treat them like family...but don't get too attached

Person-centered and family approaches to care encourage workers to 'treat them like family,' suggesting that emotional attachments are beneficial. However, the feeling rule 'don't get too attached' suggests that emotional involvement might be a bad thing. These are two completely different and competing ideas. Most participants in this study tried to find the 'sweet spot', a balance between not caring enough and caring too much. However just where that balance might be found is not clear.

Some participants preferred to stay relatively detached. For example, Chiara, a care aide working for a private company, had a very personable, friendly and concerned demeanor, but had no trouble staying relatively detached:

Chiara: *I have had a few clients where I had to tell the company, you know what, I still love them, but because of their condition my competency can no longer keep up with them. And they understand. It's about patient safety. They find another caregiver who will fit that need.*

At the opposite end of the spectrum, Marjorie, a caregiver working in the family-managed care program, became an integral part of the family she was working for:

Marjorie: *You call him my boss, but no. No. My children, they come over here and talk to him, and he is grandpa. I call him uncle. This family, they will have my love, always, always.*

Marjorie was not 'only' a worker, she was treated like real family and talked about the many benefits she enjoyed about working with the people she loved. When I asked her "what is the worst part of your job" she could think of no answer. For other participants, becoming 'overly' attached did have negative consequences. Interestingly, however, it appears that the negative

Treat them like family ... but don't get too attached

experiences were not directly related to their feelings about their clients, but in an inability to act on their moral beliefs about care and the ways that they believe their clients should be treated.

For example, Gloria talked about times when her services were cancelled by families without advanced notice and without consulting the client:

Gloria: The most difficult part is ...leaving them. It's awful! And like I was saying, the agencies, they don't allow you to go back. But I sneak back and I say goodbye to the people... because they don't know why I'm gone!

The problem for Gloria was not that she had to end the relationship, it was that neither she nor her client were being treated respectfully. By sneaking back to say goodbye, she acknowledged that the relationship was important, and both Gloria and her client had the opportunity to honour their feelings for each other. Again, those little things can really matter, as it is in those little things where respect is shown.

In another example, Jessie talked about her frustration at trying to improve the quality of care for one of her clients:

Jessie: You know, sometimes it just gets to you, even though you don't want it to. There's a couple times I did get really bent out of shape about all that's going on with her. (whispering) I would just lose it. I would lose my mind. Just get crazy. (regular voice) ... you know, every time I see a new bruise, or a new skin tear, it gets me boiling ... But anyways I've learned I just have to go nope! Walk away ... There are days where I have trouble, I'm telling you that right now. But for my own sake, I have to learn to let it go. And it's hard. It's very, very difficult.

Jessie cared deeply about her client and felt the weight of responsibility for her wellbeing as if she were a family member. But her position as paid help severely limited her ability to act on those feelings. Jessie could not advocate with the same authority as a 'real' family member would. When emotional labour and emotional commitment are under-valued by care organizations, workers pay a high price for getting 'too attached'.

Final Word The themes that arose in the interviews reflect one of sociology's main concerns – what may appear to be a personal trouble may in fact be rooted in broader public issues. For example, a negative interaction with a client may be caused by an incomplete or incorrect care plan, or by organizational policies that are strongly disliked by a client, or by the fact that many workers do not have total control over the quality of care they provide. I have presented preliminary findings at two different venues, and hope to publish my findings in the near future. I will be defending my master's thesis in the summer of 2018, and will be starting PhD studies in the Faculty of Health Sciences at the University of Manitoba in the fall. My research will continue to focus on the experiences of people who care for others. I believe that our society would be a far different, and far worse place, without people doing the work of care. Thank you!

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