

CARE HAS LIMITS:
WOMEN'S MORAL LIVES AND REVISED MEANINGS OF CARE WORK

by

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Abstract

What exactly keeps women 'in' inequitable care relationships, and how do we get 'out'? This dissertation offers a timely response to a pressing societal problem – that of how to understand and organize care. Feminist scholarship and debates focus on the redistribution of care, considering how to shift care responsibilities from women to men or from individuals to the state. My research expands this work by critically reflecting on (shifting) relationships between women and the care economy with a focus on the moral dimensions of care work and on the narrative, intrasubjective work that women do.

The research mobilizes sociological theories of care work, gender and moral worth, and uses feminist life history and arts-based, auto-ethnographic methods to contribute to a conceptual reimagining of "care." Taking an interpretive, narrative, feminist approach, I draw on 20 in-depth life history interviews with 12 participants, as well as on my own autoethnographic experiences as a live-in care worker at L'Arche. I analyze how women narrate renegotiating care responsibilities or expectations across our lives and in different paid and unpaid care contexts in Ontario, Canada. Making links to class, gender and conditions in the caring economy, the project contextualizes women's narratives of orienting to projects of care, negotiating moral dilemmas at the limits of care, and stepping back from or renegotiating care responsibilities.

The study enriches feminist theories of care by developing a theorized account of the "relational care economy" that makes intrasubjective conditions, and the contradictions that people negotiate, central. I also contribute to a conceptual reimagining of "care" both by raising questions about whether "care as an ethic" should apply at the level of individual women's lives, as well as by calling for a conception of care that makes limits central. Aiming to foster solidarity amongst carers in different roles, I ask tough questions about what we expect of ourselves and others, how we can stop setting women up for such intimate losses, and how our lives can be otherwise.

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INTRODUCTION: BEGINNING AT THE LIMITS OF CARE

Women talking

From the fluorescent lights beaming to the plastic folding chairs set up in a circle, I have a strong image of what it would look like if the participants in my study and I met in a community center or maybe in the basement of a library to talk about care. The theme of the event would be something like “What stories do we tell about caring for others, and how can we tell new ones?” I’d have set out coffee and donuts and maybe something to go with hummus. I imagine myself coming on strong, with a provocative “we need to talk about care, let’s lay it all out on the floor” pep talk to get things rolling. I would try *so* hard – rehearse long and hard – for a talk like that.

I’d likely lead off the talk by sharing about my own experience as a care worker. “No one went under as I hard as I did,” I’d joke, wanting my narrative to register as unique and interesting, while secretly looking around the room and hoping that there’d be someone who resonated with me. I’d speak back to the assumption that exiting care work is a ‘privilege’ for ‘heartbreakers’ walking off the job. The part that I’d most want to put on the record is how painful it had been for me to reach my limits and resign from care work. I’d share that I had committed to care as a vocation, had entered into the work to listen and learn from others and to build community, but that—overtime and without the needed resources or supports—I struggled to live out such a moral, feminine project. I’d emphasize that no longer being able to uphold the caring ideals that I had internalized felt like a crisis of self – something that I struggled to make sense of or talk about. I felt duped and betrayed – like I had been lured into care work with the promise of belonging,

only to have the rug pulled out from under me or be left with limited other scripts to affirm my worth or build a life around. To close, I'd suggest that we might learn from considering stories of care resistance or from listening to the stories of women who no longer want to do it anymore. "Women should know the stories of our lives," I'd say. "So, ugh—can you—ugh—can you relate to my experience at all?" I'd ask, by way of inviting dialogue.

Drawing inspiration from Toew's *Women Talking* (2019) – an imagined response and work of fiction that sees women coming together to reckon with violence against women in their Mennonite community, I've thought a lot about how a meet-up between myself and participants in this study might play out with us variously positioning and distinguishing ourselves through our stories. Our conversation would likely sputter at first, like an old car trying to start. There are conventions for speaking about care, and I suspect that we'd uphold them. Similar to me, most would likely flag that they were good and moral and well-meaning, before elaborating on any tensions or turning points.

As I picture it, we'd find ourselves pit against each other so friggin' quick. We'd hardly have time to finish our coffee. I picture the elite, happy-go-lucky good girls with empowered stories to tell about care on one side of the room, with me and the other care junkies or dupes, emphasizing our resentment and bitterness, on the other. I picture one of the good gals, purring, "I *loved* caring for others, came through well and whole and in one piece, and can't understand why *they're* so bitter." On the other side of the room, I picture one of my cronies sarcastically quipping, "Fun, fun, fun," before joking about going over the care cliff and hardly being able to recognize herself when she was done with care work. "Must be friggin' nice to have pulled it off," she'd say. I imagine that

we'd all stand back, imposing on one another the "cultural meanings [our] historical moment required" (Garland-Thomson, 2017, p. 39). More than a passive, innocent spectator throwing my hands up in the air and watching it go to crap, I'd likely be taking the bait, rolling my eyes at some of the sentimental accounts, wondering how on earth to put our stories in common with the stories of others.

In conducting this research, I was confronted from the start by the wide range of ways that women frame our lives and position ourselves in relation to "care." Not everyone framed themselves as resisting inequitable care relations or challenging moral, gendered imperatives for women to care. In a study about the "limits of care," many were hesitant to go there. Attending to these differences—to how we set ourselves apart—became the work of this project. As the project progressed, and in conversation with others, I worked hard to take responsibility and to be accountable to the relations I was enacting through my research. There was no neutral, innocent position to occupy (Code, 2006, p. 219) as I put my "subjectivity ... on the line" and assumed responsibility for the world I was helping to bring about through my research (Code, 2006, p. 275). I worked to put our lives in common, to attend to differences and contradictions, and to situate and contextualize our practices and perspectives. I opened myself up to others and to creative possibilities.

Problematic for investigation: Debates on the distribution of care

Achieving the kinds of changes needed to produce a society that values caring will require *transforming the ways we think about ourselves*, our relationships

with others, the family, civil society, the state, and the political economy. (Glenn, 2010, p. 201, emphasis added).

My work contributes to a pressing societal problem – that of how to understand and organize care work. Through narrative research with women situated differently in Ontario's care economy,¹ I critically reflect on the stories that women tell about care and moral obligation, our narrative conventions for telling them, and the contexts in which these stories are told. My aim is to explore women's agency as we negotiate responsibilities for care *across our lives* in relation to gender, class and conditions in Ontario's "care economy." With a focus on how such relations shape women's moral lives, as well as how women reshape them, I argue that women's relationships to ourselves—"the ways we think about ourselves" as Glenn (2010) puts it—are critically important to the story of gender and care work. I push care theory forward by attending to women's subjectivities and life trajectories, to (moral) contradictions that we negotiate, and to the limits of conceiving care as an ethic at the level of individual women's lives.

The organization and division of care work is a fundamental issue that is tied to histories and realities of gender, race and class relations – to how people's lives are valued *and* to how people produce value for themselves, including through the work of care. Never have tensions around care provision been more evident than in the current conditions of the COVID-19 pandemic in Canada, where there have been worker shortages, care home closures and service suspensions, as well as reports of abuse,

¹ Braedley (2015) conceptualizes the care economy "as the constellation of social relations through which care needs and wants are met, including market, household, familial, community and state actors" (p. 265). She writes, "A society's care needs and wants, as well as its care labour supply, expand and contract due to socio-demographic, political, economic and social factors, from wars to baby booms. All human life depends upon these relations" (p. 265)

neglect and inadequate care. The pandemic has illuminated the failures of Canada's social welfare state, as well as the presence of economic inequalities, structural racism and employment instability (Armstrong et al., 2020; Bourgeault, 2020; Daly, 2020). It has made visible the limited social and material infrastructure and profound underinvestment in public sector supports for care that have led to "care crises," "care deficits" (Fraser, 2016), and gender and intersectional inequalities. That said, for many years, austerity measures and inadequate funding have led to care work labour shortages and inadequate care levels across the spectrum of care in Canada, including in homes, organizations and communities.

Feminist academics and advocates push for redistributions and revaluations of caring labour, including for a dramatic reordering of the division of caring labour from women to men and from individuals or families to the state. In speaking of progressive movements mobilizing around social reproduction, Black (2020) writes, "Typically, such projects involve demands for the state to socialize more of the costs of social reproduction and responsibilities for it, easing the burden on households and communities, especially the women in them" (p. 23). Examining these dynamics at the level of political and economic relations, feminist political economists identify broader social patterns or divisions that engender long-standing social inequalities and relations that socialize men and women differently in relation to care work. Care work is conceptualized in this analytical framework as work that is central to social reproduction and involves a range of activities related to sustaining others such as providing direct care for a person, maintaining physical surroundings, and fostering or maintaining relationships (Glenn, 2010, p. 5-6; see also Black, 2020). For the purposes of my study, I

attend both to care as work and to the concept of “care” as it is remade in relation – embedded in and brought about through “histories, networks, and narratives” (Somers, 2008, p. 209). I take seriously that understandings of care matter in that they not only “describe social life” but “are also active forces shaping it” (Fraser & Gordon, 1994, p. 310).

My desire to contribute to a conceptual reimagining of care is motivated by my own experience of reaching my limits as a direct care worker, which I experienced as a painful crisis of self that came with contradictions that I had to negotiate. To leave seemed like an erasure of self, but to stay didn't seem possible either. Even long after I technically resigned from care work, I still felt as though I was still “in” it, still activated, still preoccupied with questions related to my moral life trajectory. I struggled to put a name on what felt like an invisible framework that had kept me in the work. Care *still* had a hold on me. Braedley (2013) writes that “historical relations of sex/gender get *into* us, shaping our sense of who we are, how we must be and what is possible, desirable, or necessary to us, so that we regulate and/or liberate ourselves” (p. 66). She points to relations that extend beyond and intersect with particular care relationships or settings and are about more than work we do on the clock. Asking how exactly care gets “in,” and how exactly women get “out,” this study both critically reflects on structures of care that can have a hold on our lives, while also considering women's agency as we engage in practical and conceptual work to make choices and remake our lives. When confronted with a contradiction, one must generate a practice (Connell, 2012b); such practices – of handling, unpacking or thinking through contradictions – are visible in our personal

narratives and in figures of speech. They tell us about how the 'care economy' is organized and put together.

Good girls care? Setting the scene, pushing forward care theory

My research engages with and expands feminist research on care and gender that examines and critically reflects on how women end up in care – how gendered divisions of labour are brought about. I follow suit in exploring the relationship between care and gender, but with a focus on how women renegotiate or step back from care responsibilities. In particular, my work extends scholarly understandings of care through analyses of women's: (1) diverse accounts of renegotiating care responsibilities; (2) agency and implication in caring structures; and (3) experiences *across our lives* and beyond particular care roles, relationships or settings. Before I situate my study as responding to currents and conversations in the feminist care theory, I want to first set the scene with a brief overview of research and thinking that has informed by own.

Feminist political economists make visible and analyze how valuations and divisions of labour assign care work to women or induce "women to assume responsibility for caring" (Glenn, 2010). Dominant gendered assumptions frame care as an intrinsic feminine capacity centered on (good, moral, women) carers willingly self-sacrificing in service of others and at the expense of ourselves (Baines & Armstrong, 2019; Baines & Daly, 2015). Care scholarship observes that, in dominant imaginaries, care work is seen as a moral responsibility or natural social expectation of individual women who are expected to do it (Gonyea, Paris & de Saxe Zerden, 2008), rather than as skilled or valuable work (Armstrong, 2013). In feminine discourses of care, 'caring'

subjects and practices remain strongly linked with women and femininity, as well as with moral and family ideologies about women's roles in the family (Dodson & Zinzavage, 2007; McMahon, 1995). As Braedley (2015) writes, care as a social construct is tightly "co-constituted with a deep cultural understandings of care as a feminine activity and domain, tightly associated with feminine identities and moral worth (Gardiner, 1997; Gilligan, 1977)" (p. 265). Dominant discourses of care promote social expectations that link women to care, frame care as moral, feminized, familial work, and shape how care for the vulnerable is understood and institutionalized.

First, my research pushes forward care theory by examining how women narrate stepping back, renegotiating responsibilities for care or otherwise getting "out." In analyzing dissonant accounts of renegotiating care, my project responds to a pressing need to consider the experiences and perspectives of those opting out of or stepping back from care responsibilities (Herron et al., 2019). To date, the life stories of people who have reached their limits and stepped back from care or family responsibilities have not been accounted for in dominant conceptualizations of 'care.' Public debates, organizational or policy decision processes, and studies of care work or public service restructuring have not considered or consulted former carers to understand their perspectives or how the structuring conditions of their lives gave rise to social processes of opting out or renegotiating care responsibilities (Armstrong, 2019; Herron et al., 2019). I consider dissonant perspectives that are ever-present, but clash with dominant or normative discourses of care and family responsibility, and don't fit the imaginary or make sense in light of broader, social patterns that assign care to women. I examine dissonant stories (such as participants' accounts of walking off the job or resisting

conventionally feminine approaches to care) with the goal of bringing inequitable relations that underpin care in Canada to light in a different way. With a focus on women's choices as we relate to our internalized self-expectations, I consider the redistribution of care at the micro level of subject formation and narrative storytelling. While I don't attend to care in practice or to embodied care relationships, I focus on women's life narratives of negotiating gendered, moral expectations or responsibilities for care.

Second, the project contributes to feminist theories of care by rethinking women's agency and implication, elaborating the ways that women inhabit care relationships and resist expectations to care, including through our narrative practices. As I discuss in chapter one, my project contributes to research in feminist political economy that reveals broader social patterns in how girls and women are assigned responsibilities for care. Through structural analyses, research in the tradition traces organizational, political and economic relations that socialize men and women in relation to care, assign care to women or otherwise see women shouldering responsibilities for care in relation to others, including in households, communities and workplaces. How I contribute is by using interpretive, narrative inquiry, as well as some tools of feminist political economy to focus on women's agency in making choices, as we variously position ourselves in relation to care, negotiate dilemmas and renegotiate care responsibilities. While not all choices are available, I consider how women choose and innovate with what is available. One of my goals is to consider the agency and reflexivity that women bring to our work, without overlooking the various constraints or oppressive social histories and realities

shaping our lives. I consider how our social practices, including our narratives ones, are patterned in particular ways, and change over time, in Ontario's care economy.

Third, my research examines women's stories of caring *across our lives*. In care theory, forms of paid, unpaid, formal and informal care work are sometimes considered separately, including through sector-specific accounts of care in practice or carers at work. For the purposes of this research, I focus on the life stories of women. I take into account various kinds of caring work that women do throughout and across our lives in diverse paid and unpaid care contexts. Such of a line of inquiry is motivated by feminist scholars who understand paid and unpaid forms and contexts of care as interconnected and interwoven (Doucet, 2016; Hill Collins, 1994), including in the context of transnational care (Dobrowolsky, 2016). Research underscores how care work – in its paid and unpaid forms – blends and melds in people's lives and spans the private, public and non-profit sectors (Duffy et al., 2017; Baines & Armstrong, 2019), as women's lives involve unpaid care that takes place over time and across contexts (Aneschensel et al., 1995; Barken, Daly & Armstrong, 2016; Gladstone, Dupuis & Wexler, 2006). My focus on women engaged in different forms of paid and unpaid care is well supported by Folbre (2020) who uses a broad definition of "care worker" to include those who perform paid and unpaid work, as well as high and low-wage work, and to acknowledge how *all* care work plays a central role in sustaining the economic system or producing and maintaining workers. I follow scholars who challenge dichotomies between carers and care recipients or between those who are 'dependant' and not (Aubrecht, & Bofo, 2019; Gee, 2002), for example in focusing on carers' own vulnerabilities.

Research objectives: Undertaking a conceptual reimagining of 'care'

The aim of this interpretive, sociological study is to deepen understandings of the relationship between care and gender by focusing on women's agency as we negotiate responsibilities for care *across our lives* in relation to gender, class and conditions in Ontario's "care economy." I situate my discussion in Ontario – a setting contextualized by Canadian welfare state developments and demographic shifts, where participants' life histories and mine have taken shape. With the aim of contributing to a conceptual reimagining of care that makes women's narratives of care and moral obligation central, my study uses life history and autoethnographic research to pursue three lines of inquiry. I ask:

- (1) How do women narrate negotiating responsibilities for care across our lives? In what ways do we take on moral, feminine positions through our narratives?
- (2) What exactly keeps women 'in' care, and how do we get 'out'? How do women shape and how are we shaped by class, gender, and conditions in the caring economy?
- (3) What approaches to conceptualizing care work and the care economy are most promising for promoting equitable care relationships, adding nuance to conversations about care, and acknowledging differences in women's perspectives and structuring contexts?

My first line of inquiry analyzes the contradictory and unexpected ways women narrate life stories of caring for others, including with accounts of orienting to care, reaching the limits of care, and renegotiating care responsibilities in diverse paid and unpaid care

contexts. I critically reflect on the various kinds of narrative work that women do in negotiating various calls, coercions, and reasons to do, and not to do, the work of care. Illuminating differences in how participants in different social locations (e.g., age cohorts and class positions) frame their lives, I consider *how* women narrate their caring life histories as cogs in the wheels of Ontario's care economy—taking on moral, feminine positions, negotiating moral injunctions to care, and resisting and/or revising inequitable coercions into care work. I attend to women's narratives as socially produced and situated through social relations, and as evoking broader, circulating narratives that reveal unstated assumptions.

Second, with a focus on structure and on women as agents, my aim is to elaborate the relationship between care and gender, with a focus on embodied and moral dimensions that produce contradictions women negotiate through practices, including interpretive or expressive practices. I analyze links between women's practices, and gender, class and conditions in the care economy. Expanding work that looks at organizational and structural dimensions, I theorize intimate, micro and intrasubjective relationships. I show how conditions really matter, and part of these conditions is people's own moral sense of selves or what we expect of ourselves. Along the way, with my analysis unfolding as we go, I build a theoretical account of the care economy as it shaped through people's (1) conditioned work in particular social and historical conditions; (2) agentive work to negotiate moral dilemmas; and (3) intrasubjective, intra-active work to unpack contradictions and alter conceptions of care.

At a time in history when care work shortages and the precarity of public care structures are increasingly apparent, it has never been more important to figure out how

to think about care, share caring work, and support equitable care relationships. My third line of inquiry aims to deepen and expand on conceptions of care work and the care economy to highlight possibilities for transformative structural change. In particular, I aim to develop more nuanced theories or conceptions of care, while creating space to resist inequities or foster equitable care arrangements that value both those who care and those who require it. Such a project contributes to the International Labour Organization's (2019) aims of "improving the status and working conditions of care workers," and "promoting ... care workers' representation [and] social dialogue" (p. 21).

Study design and overview

My project takes up these lines of inquiry through life history research and arts-based, autoethnographic research with women situated in Ontario, Canada – a context shaped by demographic shifts and neoliberal social welfare restructuring. I mobilize an integrated mixed methods qualitative approach, using the two methods as part of a sustained program of inquiry. Rather than using one method to support, add on to or confirm the findings of another; my autoethnographic experiences shaped the life history research, just as the life history work shaped my autoethnographic work.

Connell's (2005) life history approach enables me to contextualize participants' stories, linking their stories about their care experiences to the stories of others and to intimate and extended social and conceptual relations (Berteaux & Thompson, 1997; Connell, 2005). My work follows a tradition of care theorists who engage in narrative inquiry (Doucet, 2006; Funk, 2015; Funk & Hounslow, 2019; Funk & Outcalt, 2020; Stacey, 2005, 2011; Silverman et al., 2020). I am inspired by this work that attends to people's narratives of caring, to contexts and meanings, and to how narratives are co-

constituted. I follow suit in situating and contextualizing narratives of care, and tracing out to reveal broader discourses or circulating narratives, as well as intimate and extended relations or forces.

Aiming to reveal the social through people's narratives, I gathered life history narratives through 20 interviews with 12 people, including 11 women and one trans non-binary person. It is worth noting that I at times use the term 'women' to refer to participants in this study or to speak about how women are socialized into care. While I initially experimented with using gender-neutral terms such as "people" or "participants," I noticed that in a trans participant Troy's own account, they themselves were making sense of the way they had been socialized into caring for others as an "oldest daughter" and as someone who was "A.F.A.B." (assigned female at birth). The term "woman," as it is used here, references those least likely to benefit from patriarchal forms of oppression (Eltahawy, 2019). While participants were relatively homogenous in race, gender and sexuality, a sampling issue I discuss in more detail later in this manuscript, they had different perspectives and social positions with experience in diverse care roles and realms. In our conversations, I invited them to explore their life histories, with a focus on memories of caring for others across their lives. I then situated their narratives socially and historically, illuminating complexities and nuances in how they positioned themselves in relation to care, negotiating contradictions and responsibilities.

Engaging in artistic, auto/ethnographic work enables me to implicate myself and others in social relations of care. Following feminist scholar-artists, including those who use memoir as a scholarly method (Cvetkovich, 2012; Hartman, 2008), I revisit my own care history to produce what I call a "revised memoir" in chapter six – a work of art and

scholarship that elaborates on how I reoriented to my own care history in conversation with participants and over the course of conducting the research. Rather than taking a bird's eye view from above, I locate myself in conversation with others and represent the world from inside its social organization (Smith, 1990, p. 633; see also Hurl & Klostermann, 2019).

Chapter summaries

There is a structure to how this dissertation is written, with my analysis of the 'care economy' unfolding as I go. I tell stories to introduce myself and participants, and to rethink how we make up our lives in relation to 'care.' I present patterns in others' narratives, before coming full circle to reflect on my own implication in the creative memoir chapter. Chapter one delineates the project's core concepts of care, gender and morality in reference to their development in feminist, sociological theory. In chapter two, I both elaborate on the project's engagement with life history and 'sociology as art' approaches and discuss the study design. I introduce participants and their positioning in Ontario's care economy before both presenting a brief history of Ontario's post-welfare state context and explaining why Ontario makes a compelling context for a study of the caring lives of women.

Chapters three through five lay out my interpretive, socially contextualized analysis of participants' diverse caring life histories. In chapter three, I theorize differences in how participants in two different age cohorts evoked images of "good" caregivers and oriented to care work, variously aligning with and resisting conventionally feminine approaches to care, while *still* facing gendered, moral expectations to care. In

chapter four, I examine participants' accounts of reaching their limits, showing how they paradoxically narrated their experiences—including as embodied breaking points, moral, feminine achievements and sources of guilt. In chapter five, I theorize participants' accounts of stepping back from care responsibilities, arguing that, central to processes of redistributing care are carers' relationships with their sense of selves and self-narratives.

My final chapters include further interpretation, reflection and discussion. In chapter six, I present a creative memoir, writing in a performative, literary mode to reflect on the relational life of the project as it involved coming to tell my own life story differently. The piece further sheds light on care relationships as we inhabit, embody and resist them. In the conclusion, I summarize my key contributions and related implications. I reflect on the benefits of using life history and sociology as art praxis. My final remarks stretch toward possibilities of how to foster mutual empathy and solidarity among carers, as well as how to embrace possibilities and necessities for redistributing or stepping back from care.

**CHAPTER 1: THEORIZING CARE, GENDER AND MORALITY: MY
CONCEPTUAL FRAMEWORK AND A FEW CONCEPTS TO THINK WITH**

“Is it ‘care’ if you can’t get out?” and “How do women get out?” are two questions underpinning and motivating my research. To even begin to respond to them, I needed theories of care to help me critically reflect on activities and structures of care. I also needed a theory of the social that could help me to examine women’s agency and reflexivity as we negotiate the circumstances of our lives. This chapter introduces my conceptual framework and elaborates the foundational concepts of care work, gender and morality that support my sociological analysis and inform the life history approach that I take. First, I share how I use a practice-based social embodiment lens (Connell, 2005, 2012b) to foreground and attend to people as agents and to people’s practices, as we shape and are shaped through the conditions of our lives. I clarify how I think about the field in which participants are standing, or the structure that constrains their agency. Second, I introduce feminist political economy, elaborating how I theorize care as work and attend to structuring conditions in the care economy. Along the way, I raise questions about agency and structure, and about what we might learn from attending to women’s stories and women’s relationships to our expressed sense of selves, which I argue are questions that can be best responded to through narrative, interpretive research. From there, I further elaborate on foundational concepts of gender and morality that support me in rethinking the relationship between women and care, including its moral dimensions. To come full circle, I bring together theories of care, gender and morality to propose and develop a working definition of what I call the “relational care economy.”

Before I proceed, I should note that I engage with and contribute to two distinct feminist traditions that investigate and conceptualize the relationship between care and gender. As feminist analytical and political projects, feminist political economy and feminist care ethics have distinctive ways of conceptualizing care and its central problematics (Armstrong & Braedley, 2013; Mahon & Robinson, 2011). Feminist political economy applies a historical materialist approach to examining care as work as it is organized and structured through political and economic relations, while feminist care ethics articulates care as a moral force and extends philosophical and political theory. Both approaches have overlaps, including with authors who draw on both, but ask different questions about care, gender and the social. My research stretches feminist political economy, while raising questions about core assumptions in feminist care ethics.

A theory of the social: Our expressive, embodied practices make up our relations

Practice-based theories of the social assist me in attending to people's practices, including their narrative practices, with the goal of explicating how those practices are co-ordered with the practices of others, with circulating narratives, and with intimate and extended social relations (Connell, 2012b; Siltanen & Doucet, 2017). I theorize how participants' practices expand and produce new social realities and meanings (Connell, 2012b; Rudy, 2019). Taken together, my framework provides a conceptual basis for taking seriously people's agency and creative potential (Chivers & Kriebner, 2018), and reconsidering how their practices shape and are shaped through intimate and extended relations. My approach also recognizes that the stories we tell hold invitations for how care relationships and responsibilities are organized (Braedley, 2018; Chivers, 2013; Grigorovich, 2020).

My work applies Connell's (1987) practice-based theory of social embodiment to account for the social shaping of people's lives – capturing both the subjectivity and agency of people as we negotiate the circumstances and relationships of our lives, as well as the ways our lives are constrained or drawn into history through external forces that limit our options. People are not passive receivers or objects being acted on; we are socially located subjects and agents of practice who shape and are shaped by the relations of our lives (Connell, 2002; see also Bryant & Scholfield, 2007; Jackson, 2018).

Connell's work makes human agency and change central, leaving space for new social forms or patterns of human agency or solidarity to emerge. Such an approach supports my dialectical analysis of people responding to and negotiating the circumstances of our lives. It helps me to consider women's agency, recognizing that, while not all choices are available and women are constrained differently, women do make choices and do contribute to reshaping our relationships.

My understanding of the social acknowledges how relations run across different domains, are historically mediated, and are constitutive of reality (Connell, 2012b; Rudy, 2019; Shotwell, 2016). I use the notion of the "social" to refer to constellations of relations, including connections and coordinations among people who are not necessarily in face-to-face contact or personally known to one another (Smith, 2005; see also Klostermann, 2017, 2019a). I am attentive to different levels of social organization including (1) structural and symbolic relations; (2) institutional and organizational

relations;² and (3) intimate, micro relations (Connell, 2002, 2005; Storm, Braedley & Chivers, 2017). In looking at women's narratives, I take seriously that "micro-level social relationships play a part in contesting or reproducing power at the level of social structures" (Brickell, 2003, p. 165). Drawing inspiration from Wolfe's (2006) theorization of colonialism, Shotwell (2016) calls attention to the "patterned and continuing network of social relations" (p. 36) across time, highlighting how hard, if not impossible, it is to unmoor from the "past that constitutes our material conditions and our most intimate subjectivities" (p. 38-9).

In mobilizing a social embodiment lens, I not only examine social practices that participants told me about, but analyze their narrative practices in our conversations together. I take seriously that our social practices, including our narrative practices, bring about social relations (Connell, 2012b; Rudy, 2019). Connell (1987) writes, "practices do not sit around outside time, but themselves become the grounds of new practice" (p. 79). From this "ontoformative" perspective, we bring about social relations through our embodied, social practices, including through the practices of narrating (Connell, 2012b, p. 210; Rudy, 2019). Skeggs (2004) writes, "Culture also involves labour; it is produced" (p. 153). We actively make up our lives by engaging in practices in relation to our past, presents and futures. I follow social theorists who call attention to the embodied and relational nature of creativity and narratives (Dupuis et al., 2016; Kontos, Grigorovich & Colobong, 2020), as well as to the "body's potentiality for both telling one's story and for

² Following Coser's (1974) theory of greedy and exploitative institutions, social relations can involve non-physical mechanisms to instill voluntary compliance, commitment and loyalty from their members—shaping their desires and attachments, while weakening their attachments to outside institutions or people.

innovation and creative action ... (Miller & Kontos, 2016)” (Dupuis et al., 2016). As my research illustrates, the work that we do through our narratives matters. From figures of speech to unique and unexpected ways of putting it, our embodied, expressive practices tell us about the social.

Care as work: Stretching feminist political economy

Feminist political economy, as an analytical and political project, supports me with investigating and rethinking the conditions under which care work is organized and practiced (Armstrong & Braedley, 2013; Barken & Lowndes, 2018). Researchers working in the tradition are attentive to long-standing social inequalities and oppressive relations that rely on an inequitable gendered division of labour that perpetuates women's oppression and socializes men and women differently in relation to care practices and responsibilities. I share with feminist political economists the aims of elevating the value of care work, redistributing the work of care, and promoting equitable and sustainable relationships that support flourishing. With a focus on the work of care and how it is organized and structured, I draw on feminist political economy to situate and contextualize participants' narratives of negotiating responsibilities for care in the context of their lives and in relation to other mediating social or historical relations. That said, I also stretch feminist political economy research and thinking by using interpretive, narrative tools to attend to women's expressed sense of selves and self-expectations.

While Marxist theory accounts for the relations of production and how they shape the social, feminist political economists deepen and shift their analysis to recognize social reproduction – the paid and unpaid, daily and generational work that people do to

produce life – as vital to sustaining people and populations (Bezanson & Luxton, 2006; Armstrong & Braedley, 2013; Haley, 2017). Social reproduction “includes not only household and community contributions to care and domestic work but also state welfare programs, including health care, education, pensions and social assistance, child care and longterm care, as well as market involvement in this sphere” (Braedley, Côté-Boucher & Przednowek, 2019, p. 3). Rather than exploring how costs and benefits are produced and distributed, feminist political economists explore the relationship among markets, states, communities and households, working to explicate how labour and relations of production and reproduction are connected, structured and institutionalized through political and economic processes (Armstrong & Braedley, 2013; Vosko, 2002). The approach underscores the “public function that care labor serves” and its “central place in the economy” (Glenn, 2010, p. 10).

Feminist political economy offers robust conceptions both of care as work and of the “care economy” as a constellation of social relations that I apply in my own research. Feminist political economists define care work more broadly as social reproduction, which includes maintaining people and populations. Central to the approach is the recognition that social reproduction, as it involves the work of care, is central to maintaining and reproducing human life, including by reproducing the workforce for capital. Care work refers to the ordinary work involved in providing direct (physical and emotional) care for a person, maintaining physical surroundings, and fostering relationships and networks (Glenn, 2010, p. 5–6; see also Black, 2020). Care work is understood, not as an economic product, but as a relationship, collective responsibility and form of work that takes time, energy and skills as well as resources and supports

(Armstrong, 2013; Armstrong & Braedley, 2013; Chivers, 2013). The care economy is a conceptual framework primarily developed by feminist political economists (Braedley, 2015; Lutz, 2011). The clearest articulation of the care economy was by Braedley (2015), who defines it “as the constellation of social relations through which care needs and wants are met, including market, household, familial, community and state actors” (p. 265). She notes that “human life depends upon these relations” (p. 265), with meeting care needs central to her theorization.

Research in feminist political economy traces how intersecting political and economic relations produce structural inequalities that deeply structure people's work and lives (Bezanson & Luxton, 2006; Black, 2020; Braedley & Luxton, 2010; Vosko, 2002). Researchers pay particular attention to how gender, race and class, as social relations not only categories of difference, shape these social processes (Armstrong & Braedley, 2013). Work in the tradition details how the way care is organized relies on and reinforces gender, race, and class inequities, as well as aged and abled norms (Bezanson & Luxton, 2006; Braedley, 2013; Haley, 2017; Levitsky, 2014, p. 8). As research shows, the ‘right to care’ is a matter of gender and intersectional inequities.³ With a focus on oppressed groups, feminist sociologists of care (Duffy, 2011; Glenn, 2010; Dodson & Luttrell, 2011) track the direct and indirect coercion of girls and women into care, making

³ Gender, racial, class/income and citizenship differences not only shape access to care (with some not being able to afford care), but also shape who is tracked into care roles, which happens along axes of gender, race/ethnicity, class/income and citizenship. For instance, Indigenous and racialized communities experience higher rates of poverty (Ravanera & Sultana, 2020) with less options to pay for care. Further, Canada's colonial legacy has prevented Indigenous families from caring for their children or communities, while disabled people have also been refused the right to care or prevented from having children. Caring for others can be a privilege for some who have the resources needed to pull it off, and a burden for others who are conscripted or coerced into care. That said, my work also shows how what is thought of as (top-down, authoritarian) coercion into care and what is understood as a (consensual, democratic) care responsibility can be hard to distinguish in looking at women's narratives of caring across their lives.

visible how race, gender, class and citizenship status operate as central organizing forces in valuing and assigning care work responsibilities.⁴ Not only is care devalued as feminized labour (Baines & Daly, 2015) or as “low-skilled ‘dirty work’” (Glenn, 2000, p. 86), “low-income and minority groups tend to bear an unequal share of the burden and costs of care” and tend to have higher needs for care, for instance with higher rates of chronic illnesses or disabilities (Levitsky, 2014, p. 8).

The “social organization of care” which “refers to the location of this work, the conditions of those who provide it, and the value the work is accorded (Glenn 2010)” (Black, 2020, p. 24) is brought about through labour and relations of production and social reproduction (including everyday care relationships) that are connected, structured and institutionalized through political and economic relations and processes. Care relationships are brought about through the gendered valuation and division of labour achieved through family formation, work and organizational relations, labour markets, social struggles and state regulations (Black, 2020; Braedley, 2013, 2015; Storm, Braedley & Chivers, 2017). In other words, relationships, understandings and arrangements of care have a history.⁵ Through structural analyses of relations of power

⁴ Such accounts emphasize how some people are uniquely structurally positioned to care such as with “limited education and job skills, physical impairments, age, race and history of providing informal care to family” (Stacey, 2011, p. 87-88). Glenn (2010) notes that diverse forms of coercion have propelled those from oppressed groups, including “poor, racial minority, and immigrant women[,] into positions entailing caring for others” (p. 5). Her work shows how race operates, elaborating how whiteness, which is linked to power and moral superiority, is central to capitalist accumulation and to the exclusions and harms experienced by women and people of colour.

⁵ Scholars make visible how gendered understandings and arrangements of care have a history. With shifts in the organization and valuing of men's and women's labour in the second half of the nineteenth century, only men's labour was viewed as work, with men being seen as independent wage earners, and women as dependent housewives (Glenn, 2010, p. 35; Struthers, 2013). Care has historically been “stripped of economic significance and instead viewed as moral and spiritual vocations” (Glenn, 2010, p. 35). Glenn (2010) writes that “[r]ecruitment into caring, has historically relied on coercion, either direct or indirect” (p. 184); girls and women have historically had a status obligation to care, doing the bulk of caring across their

and inequality, the approach recognizes that “there is a central friction, tension, or contradiction between social reproduction and capital accumulation (Cameron 2006; Picchio 1992)” (Black, 2020, p. 22).⁶ Researchers make links to historical and social relations of capitalism, patriarchy and colonialism (Federici, 2012; Murphy, 2015), for instance by tracing intersecting capitalist and patriarchal social relations that privilege separation, rely on a hierarchy between men and women, and devalue the work of care (see Gilligan & Snider, 2018; Robinson, 2019; Schmitt, 2018, p. xi).

My project pushes forward research and thinking in feminist political economy in two key ways. While I do not take up all of its concerns (such as capitalism, race, social reproduction, state and market relations), I apply insights from feminist political economy in working to contextualize participants’ practices in the social relations of their lives. My first contribution is deepening and extending theorizations of the ‘care economy’ by drawing on and bringing together insights from theories of care, gender and moral worth. I will elaborate on this contribution at the end of this chapter. My second contribution is to complement feminist political economy approaches with an interpretive, narrative lens to look more closely at women’s choices in relation to their

lives. Extending this point, Abel (2000) acknowledges the “oppressive ideological and material forces compelling women to deliver care,” yet also notes that “poor women, especially women of colour, historically have had to struggle to care for intimates (p. 8-9) and have been prevented from caring. With colonialist and ableist legacies and realities, this has been the case for Indigenous and disabled individuals and families. These histories and realities – that mandate some to undertake the work of care, while preventing others from doing so – are shaped by classed and raced relations and norms (Braedley, 2013; Storm, Braedley & Chivers, 2017).

⁶ Having capital at the center of power in society, with hierarchies of labour that privilege global capital development or profit-making (Braedley, 2013), sets in motion ways that caring labour is marketized, commodified and devalued (England & Dyck, 2011; Wood & Skeggs, 2020). Shedding light on austerity, precarity and on neoliberal, market-embracing and capitalist currents, research tracks the restructuring and deterioration of conditions of care work and labour relations in a globalizing world (Cunningham, Baines & Shields, 2017; Fanelli, Rudman & Alrdich, 2017; Irving, 2017; Rudrappa, 2004; Vosko, 2006).

expressed sense of selves and self-expectations. Following Campbell (1997), Schein (2008) notes that individuals' experiences of their "interior lives are constituted relationally, in the interplay between individuals' expressive practices and their social reception" (p. 143). Exploring and interpreting the stories that women tell as stories, and not as claims of fact or experience, helps to shed light on how women make sense of conditions in the care economy, including its intrasubjective dimensions.

Without overlooking structural constraints, my research examines women's intrasubjective lives, with a focus on their sense of selves and self-expectations. As noted above, research in feminist political economy attends to political and economic relations shaping people's lives. Scholars primarily make structural, macro arguments that put the focus on organizational or structural patterns and arrangements, where differences in how people *variously* embody, inhabit or resist care relations are less of interest. One example of this tendency to emphasize broader social dynamics was in a recent article by Baines and Armstrong (2019) that claimed not a single care worker that they interviewed as part of their research in over 70 long-term residential care facilities reported "wanting to care less or to avoid caring," with all workers reportedly wanting "to be able to care more" or undertake additional unpaid care beyond the work contract (p. 7). While such an analysis generatively captures dominant discourses and relations that relentlessly assign care work to women and strongly associate care with feminine and moral roles that are intrinsic to women, it misses something important about care workers' agency or the various ways that they do innovate, renegotiate or resist. Conducted by researchers focused on broader organizational and structural dimensions, the "research data bears the imprint of its context of production" (Throsby & Gill, 2004, p. 335). With that I ask, what about how

women opt out or get out? What about creative acts of agency or resistance? In attending to the diversity of people's choices, biographies or approaches, I follow calls to "foreground the experiential and human agency" (Ferguson, 2008, p. 48). With that, my aim isn't to reclaim individualism, which is critiqued in feminist epistemological approaches, but to engage "with the specificities of agency, detail, and situation" (Code, 2020, p. 39-40). Through an interpretive, narrative analysis, I consider the role that women play in the distribution of care, as it involves practices of reorienting to one's sense of self, expectations and biography.

Gender as embodied social structure: Mobilizing a gender lens

I mobilize Connell's (1987, 2002, 2005, 2012b) theory of gender that conceptualizes gender as a social relation at the level of the gender order, gender regimes and gender relations. Bringing context into view, and attending to the dynamic between people's agency and structure, the approach enables me to explicate gender relations constructed in practice, probing how people agentively make up their lives and relationships through social practices. Connell's theory of gender offers a framework for understanding how configurations of practices, which are central to making of (moral, caring) femininities, change overtime and in relation to different levels of the social. Following Connell (2000), I approach femininities not as "fixed" or as "states of being," but "in tension"; these "tensions are important sources of change" (p. 13). That said, while Connell primarily attends to embodied patterns of social practice that people report on in their accounts, I focus on people's narrative practices in telling their stories as practices that make up the social.

My work is influenced by Connell's (2012a) conceptualization of gender as a social relation that is both embodied and structural. She understands "gender as embodied social structure" (Connell, 2012a), conceiving of gender practice as a "reflexive process of social embodiment" (Connell, 2012a). Gender, in this view, is not only at the level of individual identities or identity projects, but is socially and historically mediated. Connell (2020) defines gender as "a multi-dimensional, historically changing structure of social relations – relations constructed in active social practices" (np). Such an approach calls attention both to people's embodied agency as they negotiate their circumstances and shift gender relations through their gender practices, as well as to the ways that people's practices and relationships are socially situated or constrained (Connell, 2005, 2012b; see also Jackson, 2018). As Jackson (2018) writes, "Gendered and sexual practices are both shaped by structures and can help to sustain them, but are also negotiated in everyday situations and can therefore sometimes contribute to challenge or change" (p. 143).

I draw on Connell's (2002, 2005, 2012b) robust theorization of gender that includes: (1) the gender order, which is the symbolic and structural order that includes divisions of labour; (2) gender regimes, which are conceived at the organizational and institutional level; and (3) gender relations, which are at the micro, intimate level of social relations (see also Storm, Braedley & Chivers, 2017). These notions are helpful in trying to understand the asymmetry of power that variously positions people in different gender positions and that people actively negotiate (Storm, Braedley & Chivers, 2017). First, Connell uses the notion of *the gender order* to refer to overarching structural and symbolic relations that include "power relations, divisions of labour, affective relations,

and symbolic relations” (Storm, Braedley & Chivers, 2017, p. 197; see also Braedley, 2013, p. 64). In speaking of the links between symbolic and structural relations, Braedley (2018) notes that the conditions of our lives deeply shape our possibilities for imagining or remaking the social (see also Schein, 2014).⁷ Historic gender inequities and gendered divisions of labour (which are connected to a capitalist, global economic order that relies on profound disparities of wealth and power) are examples of this. The gender order changes overtime (Connell, 2002) with “economic, political, and cultural shifts” (Connell & Wood, 2005, p. 348). It also structures gender differently and takes on contextually specific forms in different contexts such as through processes of colonization or globalization (Connell, 2014; see also Connell & Wood, 2005, p. 348).

Second, Connell uses the notion of *gender regimes* to refer to institutional and organizational relations that define places for women and patterns of femininity (Connell, 2008, p. 242), as people’s lives are deeply institutionalized through social circumstances or conditions of work and life. Connell (2008) writes: “In the social sciences, the term “institution” has two main meanings. In the narrower sense, as when we talk about a school or a bank as an institution, it means much the same as “organization.” In the broader sense, as when we talk about the institution of marriage or property, it means a deeply-rooted pattern of practice that gives a general form to the life of a society” (p. 238). One relevant example of a gender regime is in studies that show that care work is

⁷ Schein (2014) writes, “the conditions of everyday life under neoliberalism mean that few people have sustained, positive experiences of collective decision making, socialized resource allocation, or solidaristic, noncompetitive environments in which to work, learn, or play” (p. 173). Braedley (2018) writes, “This circumstance may limit our imagination and capacity to provide caring to frail older persons, as well as to welcome this care when we need it. ... The inequitable underpinnings of capitalism deeply structure our experiences of care and caring (Luxton 1980, Luxton and Corman 2001), imbuing how we think about, plan for and organize care” (p. 58).

organized and valued as low-skilled feminized work in the context of long-term care (Braedley, 2010; see also Storm, Braedley & Chivers, 2017).

Third, Connell also theorizes gender at the micro, intimate level of *gender relations*. As Braedley (2013) notes that “historical relations of sex/gender get *into* us, shaping our sense of who we are, how we must be and what is possible, desirable, or necessary to us, so that we regulate and/or liberate ourselves” (p. 66). In Connell’s work, gender relations are those at the micro level of social relations, for instance that we embody, inhabit and live out. Such relations include the micro, intimate, intrasubjective relationships people have with their sense of selves, self-expectations, as well as with intimate others in self-other relationships. McMahon (1995) writes, “men and women tend to experience themselves and self-other relationships in gendered ways because social situations are deeply gendered, both in the structures that organize them and in the expectations we bring to them” (p. 269). Making a similar point, Finch and Mason (1993) note that experiences of caring for others are both interwoven with “people’s identities as moral beings,” which are actively “constructed, confirmed and reconstructed” (p. 170) and “with reference to other people” (p. 61). These powerful insights can also be applied to participants, who not only internalize expectations in care roles (Ruddick, 1995; see also Doucet, 2004; McMahon, 1995), but also negotiate internalized expectations. Changes in intimacy are not simply about relationships between people, but about how we relate to ourselves (King & Cronin, 2013). Not only do care relationships involve embodied intimate relationships between intimate others, they are also about people’s sense of selves.

My work attends to the dialectic between agency and structure in looking at patterns of practice in how women embody and negotiate personal and structural contradictions at the limits of care. I consider how women's contradictory experiences of embodiment present practical and conceptual dilemmas in the course of their lives that they negotiate. I try to capture the diversity of experiences that women have, including in unpacking moral associations of care. Of particular interest to my research, Connell (2012b) attends to trans women's practices of negotiating the contradictions of their lives, seeking recognition, articulating their existence or making their lives intelligible. She both traces social histories of exclusion, while also making a point to acknowledge that trans women have argued back and have been sustained and supported in practice and in their personal relationships. As she puts it, support "never entirely disappeared" (p. 860). Her work inspires my own efforts to consider how participants negotiate the contradictions and complexities of their lives and are supported in the process. The ways that women redistribute responsibilities for care or otherwise get "out" offer insights into how care relations operate.

Femininities as they are shaped by race and class

My study considers how caring femininities change over time and take different forms in different contexts. Gender practices can be coded as masculine or feminine, which are categories of difference that are situated socially and historically. Connell's (2005) research and thinking on masculinities has clear applications for conceptualizing femininities. Following Connell (2005), my research attends to femininities as configurations or patterns of social practices that women engage in across our lives (see also Bryant & Scholfield, 2007). I also consider how new forms of feminine practices

arise, shape and are shaped by people in different contexts. Femininities or ways of being and relating are defined for women in different life circumstances; they are socially and historically mediated. As McRobbie (1993) notes, “gender practices and meaning structures” change overtime with different narratives circulating among particular age-cohorts that reflect and shape different political, economic and social periods. New emergent “modes of femininity,” as they are put in practice, “tell us something of real significance about the society in which we now live” (McRobbie, 1993, p. 156).

Critically reflecting on and trying to unpack expressions of caring femininity as they change over time is part of the contribution I make here. As I touched on above, femininity, or the normative feminine position, historically has strong links to caring and has traditionally involved inhabiting passivity or non-assertiveness, as well as otherwise accommodating, supporting, or nurturing others (Ringrose & Renold, 2010; Skeggs, 2001; Gilligan, 1982). That said, as Connell notes, understandings or versions of femininity shift over time and in context. There are multiple ways of expressing femininity. From caring for others to talking about care, our practices don't express a pre-existing femininity, but are used to produce and reproduce femininity through particular encounters in particular contexts and ways (Warhol, 2001, p. 183). More recent modes of feminine expression combine masculine and feminine qualities to cultivate an empowered feminine neoliberal subjectivity (Ringrose & Walkerdine, 2008; Rivers-Moore, 2010). There isn't a binary between feminine and masculine, nor is there only one way of expressing femininity or masculinity. That said, it's notable that the options or avenues that we have for displaying or expressing femininity are shaped by our social locations or positionings. We are gendered as “specific sorts of women” through

social processes (Skeggs, 2001), with women in different aged, abled, raced or classed locations having different options or avenues. As Shotwell (2013) puts it, “the way one is gendered, or the gender expression one can produce, is in some real way shaped by the social location one occupies” (p. 121). Others also highlight how aged, abled, raced and classed dimensions are central to expressing femininity.⁸ There is a symbolic and material base to how we are positioned and how others read us, as well as to how we position ourselves and come to know and understand ourselves.

Moral contradictions: Shifting the feminist ethic of care

My research draws on theories of morality, with the goal of exploring women's moral practices as they are shaped through and help to reshape their lives and relationships.

Some tie the notion of “ethics” to one's individual character or the individual assessments one makes, while using the notion of “morals” to refer to socially mediated or commonly held societal norms about “what is good, right or just for all” (Walker & Lovat, 2014).

Following these distinctions, I use the notion of morals. A moral dimension is at play

⁸ Feminist scholarship analyzes how classed, raced and aged dimensions are central to expressing femininity. While Skeggs (2001) notes that (black and white) working-class women have access to femininity as a form of cultural capital, and have historically been understood *as* feminine, she also notes that constituting oneself as feminine, or being read as feminine, requires economic and cultural resources, for example to be able to invest in one's appearance. One's classed location shapes how one can express one's femininity, as well as how one's femininity is read. Skeggs (2001) writes, “Femininity was thus a spatial and temporal matter, and those that did it in the wrong place or at the wrong time were severely chastised” (p. 299). In the context of home care provision, a person's age, health status or care needs often shapes how a person's masculinity (or femininity) is read (Barken & Sims-Gould, 2020). Feminist scholars have also helped me to think about how femininity as a pure, moral project usually references or is seen as the project of a “white, Western, middle-class woman” (Beverly, 2011, p. 152; see also Yelin, 2016, p. 185). It is *white* femininity that has historically been a position of moral superiority, with white women expected to domineer over racially marked others (Schaffer, 2019, p. 91). These hierarchies of difference are also negotiated or resisted in practice, for instance in the case of Filipino live-in caregivers agentively negotiating cultural stereotypes others have of them (Pratt, 2000; Gardiner Barber, 2000). People engage in creative work to renegotiate, for instance in playing with or inviting new meanings of aging and femininity (see Swinnen, 2018 on Louise Bourgeois) or in being in on the joke or “aware of inadequate and unrealistic representations of older women” in the magazines they read (Sawchuck & Ly, 2020).

when someone has a sense of what they “ought” to do or how they “ought” to conduct themselves, as well as a sense of how they think others in their community would perceive or judge their actions (Doucet, 2006, p. 182). Moral understandings and judgements are socially situated and mediated (Walker, 1997); one’s sense of what is moral is shaped by one’s location in particular circumstances or contexts, and is also collectively constructed or institutionalized overtime in relation to broader circulating narratives or relations.

Morality can be thought of as embodied, constructed, sustained and ordered in relationships between persons (Eicher-Catt, 2005). There is a personal and public dimension to cultivating morality, as we negotiate our sense of ourselves as moral beings in relation to ourselves, others and social expectations (Doucet, 2006; Mattingly, 2014). Goffman (1961) theorized one’s life as a “moral career” with internal dimensions pertaining to how people see themselves, as well as external dimensions pertaining to the influence of groups, organizations or systems (p. 19, 128). Doucet (2006) notes that we negotiate morality in public encounters or settings, including where we may have fears about being judged by others.

My research examines how people actively negotiate moral concerns or dilemmas in the conditions of our lives and in conversation with others. My aim isn’t to track people’s emotional states, levels of moral commitment or sense of moral obligation, nor is it to report on experiences of moral distress, overwhelm or demoralization as they “impact” or “happen to” people.⁹ Instead I am guided by contemporary social theorists,

⁹ Moral distress refers to painful emotions or disillusionment that arise when one cannot live up to how they perceive themselves, uphold their internalized moral convictions or carry out what they perceive to be

who have helped me to think of the work that people do to negotiate such dilemmas (Mattingly, 2014; Santoro, 2018; Zigon, 2013). I draw inspiration from Zigon (2013), who writes, “A moral breakdown is an experience of self-reflection during which persons must ethically work on themselves in order to transform their moral subjectivity, even if ever so slightly, so that they can return to the everydayness of their life trajectory” (p. 211). Zigon (2013) makes a powerful point by calling attention to people’s agency and reflexivity in working through it. Similarly, Santoro (2018) uses the notion of demoralization, which she notes is about more than burning out or no longer having anything to give, but centrally involves people negotiating moral dilemmas or conflicts that are relationally mediated. She challenges individualistic notions of “burnout” that frame it as the experience of individuals, who have finite or limited resources, and in turn burn out like a candle (Santoro, 2019). She has also helped me to think about how even pejorative experiences of demoralization may occasion new ways of relating to or understanding (Santoro, 2018).

My understanding of moral work encompasses and draws inspiration from Mattingly’s (2014) notion of moral experiments.¹⁰ I define moral work as the real,

a morally appropriate action (Jameton, 1984; Corley et al., 2005; Kelly, 2002). Moral distress can be evident in frustration, anger and guilt with some people experiencing a deep sense of loss, pain or alienation (Gonyea, Paris & de Saxe Zerden, 2008; Kelly, 2002). In the context of caring for people with dementia, guilt has been linked to “the expectation of a moral responsibility to care,” to “a negative, subjective appraisal of one’s own caregiving performance,” and to a “sense of transgression or violation of a moral standard” (Prunty & Foli, 2019). Some research observes that people in different social locations have different levels of moral commitments or senses of obligation (Pierce et al., 2001), as well as different moral experiences or levels of moral distress (Corley et al., 2005).

¹⁰ Developed by Mattingly (2014), the notion of moral experiments refers to experiments in one’s social personhood or in relationships that respond to moral concerns by finding different ways of orienting or relating (see also Kuan & Grøn, 2017; Taylor, 2017). Mattingly (2014) conceptualizes people as “experimenting” with constituting a moral life through particular moral roles and repertoires. These moral

embodied or expressive work that people do, as they variously negotiate their moral sense of selves or self expectations in relation or reference to themselves or others, including through their narratives (Doucet, 2006; Finch & Mason, 1993). I attend to a range of moral work, including the work involved in establishing or negotiating a moral perspective, reorienting to one's sense of oneself as a moral person or negotiating moral experiences or dilemmas. While one may not necessarily use the word morality to talk about their experiences, it is notable that people express moral dimensions in making comparisons to others, in talking about right, wrong, good and bad, in sharing experiences of responding to vulnerable others (Kelly, 2002), or in depicting moral emotions such as guilt, shame, anxiety or embarrassment (Santoro, 2018). In the context of care, people who need care and people who provide care are implicated in moral relations. That said, while caring is often associated with moral traits, in calling attention to the practice of “[r]esponding morally to others in the register of care” Robinson (2019) hints that direct care provision is one of many ways of offering a moral response. She notes that “our ways of responding morally are constructed in and through relationships and a wide variety of broad and specific contexts.” (p. 7).

Similar to a point that I made about femininity above, morality has a social and historical context. As Levitsky (2014) writes, “Feelings of ‘duty,’ ‘obligation,’ and ‘responsibility’ are not natural feelings; they are prescriptive concepts, rooted in a particular view of the moral order of the social world (Finch 1989)” (p. 5). Mannay (2015) emphasizes that discourses of moral worth and value are always classed and

experiments can be thought of as formative, with the formation of people's moral identities or imaginations going beyond particular domains or contexts (Farmer, 2010).

gendered, giving the example of how working-class women have been scapegoated in historic and contemporary moral panics. Public moral visions or imaginations valorize, idolize and elevate some figures, while criminalizing or stigmatizing others as ‘threats’ to social values (Cohen, 1980, p. 9). As Ladd-Taylor (2004) puts it in a study of the cultural politics of mother blame and worship, “You can’t have a “good mother”—at least the way the dominant culture defines her, as selfless, nurturing, and true—without a bad mother to compare her to” (p. 7). That said, there are also contradictions in the ways care as a moral practice is valued or understood in public discourse.¹¹ Sociological studies of workplace and moral hazards reframe issues (such as those related to moral despair, injury, disillusionment and distress, as well as work overload, discrimination and harm [e.g., accident, violence, injury]) as structural problems, recognizing that “how issues are framed is critical to how issues come to be understood and addressed” (Braedley et al., 2018, p. 105; see also Banerjee et al. 2012; Grigorovich & Kontos, 2019; Irving, 2017; Pijl-Zieber et al., 2016). This research makes visible how such hazards are brought about in particular organizational relations or in wider political and economic contexts. Moralities are politically mediated, contextually-specific and brought about in social, cultural and historical contexts in relation to larger public moral visions or evaluative frames (Doucet, 2006; Kelly, 2002; Levitsky, 2014).

¹¹ For instance, public discourse at times valorizes or idealizes care such as by framing carers as heroes or saints. At other times, caring at the individual level is associated with less desirable traits (e.g., martyrdom, controlling, over-mothering). Another example is how some media portrayals frame care workers as abusive, all-powerful, morally-compromised individuals, without accounting for institutional contexts that devalue and objectify residents of long-term care facilities or commodify care practices (Lanoix, 2005).

Inserting fine print on moral injunctions to care

One way that moral worth is connected to care in society is the way it is used in the feminist care ethic literature, where care is framed as a socially necessary moral force. Feminist care ethicists forward relational perspectives on caring that challenge notions of liberal, autonomous “individuals” (Kittay, 1999; Tronto 1993). Their work acknowledges vulnerabilities and dependencies as central to the human condition, while acknowledging relationality and care as central to social and political life (Gilligan, 1982; Tronto, 1993). Moving beyond an ethic of justice, research in the tradition theorizes care as an ethic, arguing that care relations offer a basis from which to constitute an ethic for political philosophy and for democratic life. With a focus on how women negotiate responsibilities for care, my doctoral research raises questions about whether care as an ethic should apply at the level of individual women’s subjectivities and lives. While I don’t apply the theoretical approach of feminist care ethics, I contribute to conversations in the field that reflect on the nature and moral significance of care.

Aiming to revalue care, feminist care ethicists propose an ethic of care and draw on political and philosophical developments to argue for revaluations of care as central to a just society. Ethic of care assumptions frame care as a moral force, underscoring “that humans are interdependent and hold responsibilities to others” (Daly, 2013) and that “everyone is entitled to receive adequate care throughout life” (Tronto, 1993, p. 19). Care is understood as necessary, and society is understood as having a moral obligation to provide care. Recent developments in ethics of care literature further underscore our relational nature and challenge normative understandings of care (Fitzgerald-Murphy, 2020; Robinson, 2011). Scholars theorize how care relationships are shaped through

oppressive histories of colonialism and capitalism, calling attention to how understandings of care erase, devalue or oppress those who need care, granting moral status to those who care or framing people who care as independent and care recipients as dependent or as charges (Fitzgerald-Murphy, 2020; Robinson, 2011). Studies also show how care is shaped transnationally, including in the contemporary contexts of neoliberalism, global politics or human security (Mahon & Robinson, 2011; Onuki, 2011; Robinson, 2011).

The ethic of care was first introduced as an alternative to dominant moral theories by Gilligan (1982), with others promoting an ethic of care and calling attention to interdependence, connection, relationships and responsibilities (Kittay, 1999; Noddings, 1984; Tronto, 1993). Through her research in moral psychology, Gilligan (1982) theorizes care as a mode of responding to others and resisting patriarchy's separations. Of interest to my project, she powerfully shows how women make up our moral worth through caring roles. Gilligan's work began with a critique of Kohlberg's psychology of moral development that championed masculine norms of separation, autonomy, individualization and natural rights. With a focus on gender as difference, she challenged theories that saw male voices as more moral, rethinking constructions of morality. Rather than an ethic of justice or rights centered on rights and roles, abstractions or principles, she introduced an ethic of care centered on responsibilities, relationships, concrete circumstances and the activities that people do. In distinguishing between the ethic of justice and the ethic of care, Gilligan (1982) writes, "the moral injunctions, not to act unfairly toward others, and *not to turn away* from someone in need, capture these different concerns" (p. 20, emphasis added). With a connection-based, relational

ontology, Gilligan frames care, as it involves sustaining the vulnerable, as a way of resisting “forms of patriarchy that value separation, independence and autonomy in ways that cast concerns about relationships as ‘women’s problems’ (Gilligan, 1993: xiv).” (Robinson, 2019, p. 4).

Tronto’s (1993, 2013) work in political theory has the goal of putting care at the center of social and political life, including by forwarding a moral injunction to care and promoting the redistribution of care labour. Tronto’s (1993) aim is to expand “moral boundaries to include a concept of care” (p. 59) as central to democratic moral and political life. Elaborating the ethical elements of care (as it involves attentiveness, responsibility, competence, responsiveness and trust), Tronto (1993, 2013) emphasizes that people who rely and depend on care deserve to have their care needs met. In looking at people getting a “pass” from caring for others, Tronto (2013) argues that people who opt out of care responsibilities are enacting privileged irresponsibility, deputizing care to others and acting as token men. She writes, “[t]hose who are relatively privileged are granted by that privilege simply to ignore certain forms of hardships that they do not face” (1993, p. 120). In turn, she argues that everyone should take on democratic or communal care responsibilities. She contends that people will “become more adept at caring once they have become attentive to needs” (2013, p. 180-181), proposing that our “capacities to care for ourselves and others will increase only if we have the courage to admit that we need, and will benefit from, recognizing the large web of caring relations within which our lives gain meaning” (2013, p. 182). Following Hollway (2006), I challenge whether people would naturally care more or develop the capacity to care, if political barriers or moral boundaries (e.g., between public and private) were redrawn (p.

11). As my research shows, stepping back from care does not always signal privilege but limits to human emotional, physical and mental capacities.

My research also engages with and extends questions that Kittay (1999) raises about society's moral responsibilities to carers (who she refers to as dependency workers). In developing an ethic of care her work challenges liberal theories of equality that rely "on a vision of autonomous individuals who stand outside relations of dependency" (1999, p. 47). She argues that dependencies make moral claims, not just on dependency workers, but on others in society. She rewrites the principles of justice proposed by John Rawls, arguing that care is central to building a liberal democratic order as relations of dependency are central to social and political life. Theorizing an example of extreme dependency or vulnerability (Clifford Simplican, 2015), Kittay (1999) elaborates how dependency workers are incredibly vulnerable and can be susceptible to harm or injury and to experiences of moral diminishment in situations where they are mandated to "defer their own desires, and even needs, to meet those of their dependent child" (p. 52). In turn, she argues that it is imperative to ask what moral obligations people should have to care for dependency workers. She calls for a democratic order replete with social, economic and institutional supports and arrangements to sustain dependency workers, underscoring that dependency workers need to be nourished and sustained to be able to nourish and sustain others. While Kittay argues that we should invest in carers so they can continue to care and do the moral work of turning towards others, my research shows the importance of supporting carers, not only in continuing to care, but in redistributing care responsibilities and detaching from care as an ethic.

My work raises questions about core assumptions in the feminist ethic of care literature, highlighting that granting moral status to those who care can make carers themselves vulnerable, as it can be hard for them to step back or renegotiate responsibility when needed. In saying that, I acknowledge the ethic of care as an important moral and political philosophy, useful in its applications to democratic life and structural changes. Tronto's work is about democratically imposed responsibilities to care; it is care as a collective responsibility that she is promoting. Her point is that we need to organize care in a democratic way, and she doesn't use the word coercion. I share commitments to valuing and investing in care and take seriously that people who need care deserve to have their care needs met. That said, my research considers how care as a gendered ethic that operates in the social can and does negatively affect individual women's lives. With a focus on women's life stories, I raise questions about how we can tell the difference between the moral coercion of girls and women into care and taking a democratic, collective responsibility for care. In looking at how women negotiate responsibilities for care *across our lives*, I ask, should we insert fine print on care ethics in speaking of care as an activity or part of one's moral life trajectory?

The 'care economy' diffracted: Care (+) gender (+) moral contradictions

Braedley (2013) theorizes "gender as a central aspect of the social relations of care, and care as a central aspect of inequitable gender relations" (Armstrong & Braedley, 2013, p. 19). With a focus on these intersecting relations, I propose and develop the conceptual framework of the "relational care economy" through what Barad (2007) calls "diffractive

readings” (see also Doucet, 2018b).¹² Engaging diffractively to develop the concept, I bring scholarly conceptions of care and gender in conversation with my own insights and findings as a way of “reading texts intra-actively” (Hacking, 2002) or “intra-acting” (Barad, 2007; see also Doucet, 2018b). I draw on Braedley’s (2015) definition of the care economy that encompasses relations that respond to care needs, Connell’s (2002, 2005) gender theory that theorizes gender at the level of the gender order, gender regimes and gender relations, and theories of moral contradictions. I read these insights “intra-actively” and alongside each other with the goal of “enacting new patterns of engagement” (Barad, 2007, p. 14) or opening up new meanings.

As introduced, the “care economy” is a new conceptual framework primarily developed by feminist political economists (Braedley, 2015; Lutz, 2011), who attend to intersecting political, economic and social relations that produce structural inequalities shaping people’s work and lives (Black, 2020; Braedley & Luxton, 2010; Bezanson & Luxton, 2006; Vosko, 2002). Recall that Braedley writes: “the care economy is conceptualized as the constellation of social relations through which care needs and wants are met, including market, household, familial, community and state actors” (p. 265). I deepen and extend existing theorizations by drawing on gender theory (Connell, 2002, 2005) to look at structural and symbolic relations, organizational and institutional ones, and intimate, micro relationships. I also make certain contradictions central – contradictions that people actively unpack, think through and negotiate. These

¹² Barad (2007, p. 30) writes, “diffraction involves reading insights through one another in ways that help illuminate differences as they emerge” (p. 30). The idea is that concepts are always interpreted, engaged with or intra-acted with, as we make choices thereby “casting our lot with some ways of life and not others” (Haraway, 1997, p. 36; see also Doucet, 2018b).

contradictions are not idiosyncratic, but socially organized disjunctures that people live out and negotiate, including as they traverse “complex interior landscape[s]” (Schein, 2008, p. 176). As Connell (2012) writes, “The contradiction has to be handled So, from contradictory embodiment and the moment of recognition, [one] must generate a practice” (p. 868).

Following Hill Collins (2002) who theorizes Black motherhood as a social institution, the care economy can be thought of as involving a “series of constantly renegotiated relationships” (p. 176). So, while some care theories put the focus on “meeting needs,” as though care can be accomplished once and for all, drawing on Hill Collins’ (2002) and Connell’s work, as well as on my own research, I acknowledge that people find themselves in the midst and reality of suffering, among others with unmet care needs, and implicated in fractured relationships that are a matter of design. I make contradictions and the ways they are negotiated central.

In this dissertation, I propose and develop the concept of the *relational care economy* as the constellation of social relations through which care relationships, *and the contradictions that come with them*, are inhabited and negotiated, including at the level of (1) symbolic and structural relations; (2) institutional and organizational relations; and (3) micro, intimate, everyday relations. Such an understanding brings together theories of care and gender with my own and others’ research on moral contradictions. The framework supports with theorizing what keeps people in (inequitable) care relationships, and how people negotiate those circumstances and conditions. In developing this lens, I draw inspiration from Rivers-Moore’s (2016) definition of the “relational economy,” which encompasses relationships that are “highly productive, in the sense that gender and

sexuality are systems that produce value (Wright 2004)” (p. 39). While my focus isn't on value production,¹³ I follow Rivers-Moore in her attention to gender as highly productive, as I trace gendered dimensions in the relational care economy.

Two questions—“Is it care if you can't get out?” and “How do women get out?”—anchored my review of the literature, directing my attention to theories of caring structures and of women's agency. The concepts of care, gender and morality introduced in this chapter, along with my practice-based view of social organization, support my analysis of the relationship between care and gender, with a focus on women's choices as we make up our caring lives. Having introduced my foundational concepts, and my diffractive approach to bringing them together, I will now introduce the life history and arts-based methods that support the project.

¹³ Feminist theorists note that people's practices are a way to produce value for themselves (Skeggs, 2011; Rivers-Moore, 2016; Carrier-Moisan, 2015). Values can be thought of as shared understandings that are lived and produced – “materialised, carried, inscribed and recognized” (Skeggs, 2011, p. 509). Rivers-Moore (2016) writes that people “make value judgements, weigh the advantages and disadvantages of their choices, and invest in particular discourses and corporeal practices. These discourses and practices in turn produce economic, embodied, and emotional value” (p. 39).

CHAPTER 2: NARRATING CARE: LIFE HISTORY, A NARRATIVE APPROACH AND METHODS OF ANALYSIS

This study uses a feminist, interpretive sociological approach to examine the diverse ways participants (including 11 women and one trans non-binary person) narrated negotiating care responsibilities *across their lives*. Consistent with my theoretical framing that elaborates gender and care as social relations shaped by and shaping both caring women's moral subjectivity and the material relations of a relational care economy, I mobilize life history research and engage in sociology as art through artistic, auto/ethnographic work. Inspired by the work of scholars who take a narrative approach (Funk et al, 2019; Stacey, 2011), I trace how people produce and position themselves through their narratives, making links to social and historical relations. In particular, I mobilize life history research and artistic, auto/ethnographic writing—opening up the incredible range of ways that women in different situations frame their lives, as they inhabit and resist structures of care and gender. The sociology that I have come to practice begins in conversation with people, attending to contradictions as openings from which to theorize, and working to investigate and contextualize how intimate and extended relations shape their lives.

My research can be thought of as feminist and interpretive. Feminist research centers on “theorizing from the basis of embodied lived experience, on critiquing systemic and structural power relations, and on producing research geared toward social change” (Hampton, 2017, p. 85). My study is a modest way of enacting a trans-inclusive feminist politics that fosters solidarity with and mutual empathy among people in different gender positions. It is also an obvious move given that the accounts of women

and trans people alike capture experiences of contradictions that people live out in relation to gender relations that can be inhospitable to them (Connell, 2012b; Rudy, 2019; Irving, 2017). Rudy's (2019) work shows commonalities in the struggles of lesbians and trans women, saying, we share "the shared condition of being 'spat summarily out of reality' (Frye, 1983: 173), but we also share the experience of refusing to accept this condition" (p. 5). As a feminist researcher who recognizes the relational nature of our existence (Klostermann, 2020a), I too was active in the research process and relationships – accounting for my own social location and positionality through reflexive and analytical writing, presencing myself by interjecting in life history interviews, and rethinking my understandings.

Interpretive research – concerned with meaning-making and contextuality – involves exploring the intersubjective meaning-focused work of people to interact with, bring about and make sense of their social and ethical contexts (Schwartz-Shea & Yanow, 2013). Following Gubrium (1995), the goal of interpretive work is to attend both to how people narrate their subjective experiences, while also examining the local cultures and discursive contexts through which these experiences are understood and expressed. The interpretive work that I engaged in can be thought of as reflexive or self-reflective; the goal wasn't to reduce bias or set aside my assumptions, but to reflect on and convey my awareness of contextual influences shaping the research inquiry (Mauthner & Doucet, 2003). I engaged, not as a pre-existing narrative-self, but as one who is constituted through acts of reflexivity (Willis, 2007, p. 102). My reflexive work was both implicit and explicit; it is perhaps most obvious in the interlude and in the memoir chapter where I write within the event and in an autobiographical "I," but

reflexivity was also a strategy for the study design, data collection and analysis (Finlay, 2002). I engaged in “uncomfortable reflexivity” to be accountable to my own and others’ struggles (Pillow, 2003, p. 193; see also Visweswaran, 1994, p. 32), to reflect on my own shifting sense of self or self-narratives, and to commit myself to an imperfect, non-innocent “ethics of solidarity” or to putting my life in common with others (Stam, 2019). My reflexive strategy can be thought of as both performative (Doucet, 2015) and onto-formative (Rudy, 2019). Even in presenting a storytelling show or a conference paper, it was notable how much I learned from the response of others as I was spurred to think more deeply about my own positionality or to think about how my own stories intersected with the stories of others. Like a stand-up comic learning from the laugh of the crowd (Klostermann et al., 2020; see also Berlant & Ngai, 2017),¹⁴ putting myself out there and at times presenting my own vulnerability offered a way to open up new insights through unexpected and co-constituted encounters.

As I will explore below, two methods – life history research and arts-based approaches – enabled me to put my relational approach and radical sociological imagination to work, engaging in an investigation of how women make up their lives, while co-producing alternative knowledges. In what follows I elaborate on life history research and on sociology as art. From there, I introduce the five phases of the research

¹⁴ Berlant and Ngai (2017) write that stand-up comedy helps us to work out the conventions of a culture. They note that we can learn from the response or reaction that a joke receives – that comedy can help us to “figure out what it means to say ‘us’” (p. 235), to “figure out what we desire or can bear” (p. 235) or to “figure out distances and differences” (p. 248). They also point out that comedy as a genre is “unusually sensitive to timing” (p. 237); this applies to the pace or timing of the joke, and to its historical realization in a particular context and in encounters between the performer and audience. Context matters; “the audience’s aroused hilarity as a thing collectively held” (p. 246). Cracking a joke is a way of making an offer or expressing something, just as laughing is a way of responding or reacting (Marso, 2019).

process, as they centered on exploring contradictions. I then close with a discussion of the study and of participants' positioning in Ontario's relational care economy.

Life history

Life history research centers on gaining insights into social life through exploring the life stories of oneself and others (Cole & Knowles, 2001; Plummer, 2001). The aim is to reveal the social through people's narratives, linking people's "lives, their perceptions and experiences" to "historical and social context and events" (Goodson & Sikes, 2001, p. 2). My life history research involved 20 interviews with 12 women, as well as a life history analysis. The approach enabled me to examine how participants narrated their caring life histories in relation to their sense of selves, others and social institutions.

Connell (2010) understands the development of one's gendered subjectivity as an active project that occurs through configurations of practice over time, including through the creative practices of interpretation and narration. The aim is to attend to and contextualize people's social lives and relationships as expressed through narratives—considering how people narrate patterns of practice over time as they "move through" life and produce themselves as subjects (Bryant & Scholfield, 2007) in relation to social relations that can be examined as classed and gendered. I oriented to participants as active agents (Bryant & Scholfield, 2007) both using the notion of "agency" to refer to social action rather than individual will (Anthias, 2011) and recognizing socially defined processes forming subjects.

The life history approach is explicitly "autobiographical and relational" (Cole & Knowles, 2001, p. 10); it involves eliciting and engaging with narratives, as well as

contextualizing those narratives in the contexts in which we are deeply situated (Connell, 1995; Plummer, 2001). The approach enabled me to reveal dimensions of social relations through an analysis of people's life stories—considering how narratives shape and are shaped (though not predetermined) through the social relations of which we are a part, while working to identify social patterns, contradictions or links between people's stories and the stories of others (Berteaux & Thompson, 1997; Connell, 2005; Ezawa, 2016, p. xxi). The approach gave me a way to explore lives in context (Cole & Knowles, 2001), beginning in conversation with people, exploring *how* people construct their stories, and examining social and conceptual relations.

Life history research helps with attending to the dialectic between people's social practices, including their expressive, narrative ones, and the mediating relational conditions of their lives. The aim is to reveal “the collective and institutional as constructed by practice” (Connell, 2010, p. 69). Through the work of contextualizing, the approach enabled me to identify patterns in participants' social practices and meanings, as they were socially and historically mediated, and as people creatively and agentively negotiated their circumstances, including through making choices in constructing narratives.

Narratives have representational and non-representational dimensions (Doucet, 2015). As representations or ‘reflections,’ narratives give meaningful form to experiences we have lived through, offering a way to “frame our understandings of raw, unorganized experience” (Garland-Thomson, 2007, p. 122). We plot or elaborate the circumstances we find ourselves in in nuanced and particular ways (Doucet, 2015). As social practices, narratives are also “ontoformative” (Connell, 2012b) in that they “act” and “do things”

(Frank, 2010, p. 43), enabling us to create new relationships or realities (Connell, 2012b; Frank, 2010). We produce narratives in particular temporalities within the context of our lives, and use stories to “make sense of – indeed, to act in – [our] lives” (Somers, 1994, p. 618). As Somers (1994) argues, “it is through narratives and narrativity that we come to know, understand, and make sense of the social world and it is through narratives and narrativity that we constitute our social identities” (p. 606). She notes, narratives “are constellations of relationships (connected parts) embedded in time and *space*” (Somers, 1992, p. 601; see also Doucet, 2018a). Narrating is how we discursively reinforce or maintain our expressed subjectivities (Funk et al., 2019, p. 2), including by “welcom[ing] the selves to come” (Shotwell, 2016, p. 193). Narrating can serve as a mode of subject production through which people compose their lives (Randall, 2014). Narratives offer insights about the conventions of a culture; “style or delivery itself is not just a superficial quality of social relations” (Randall, 2014). As Garland-Thomson (2007) puts it, “Narratives do cultural work.”

Artistic, autoethnographic work

Informed by arts-based and autoethnographic scholarship that uses the creative arts in social research (Leavy, 2020), I also engage in what I call ‘sociology as art’ – an ethically accountable and relationally transformative mode of interpreting and representing social life in relation to an audience or public. A key part of any research process involves the intersubjective analytical work of reconstructing and selectively representing social life (Demjaneko, 2011). I use artistic forms in chapter six to challenge divisions between art and life (Jones, 2008), to dramatize how myself and others are active and implicated both in making meanings about care and in inhabiting and resisting structures of care.

Autoethnographic work and artistic representation helped me to narrate the conditions of my life, rethinking underlying assumptions or arrangements, and grappling with the ways my own positioning guided the research discovery process and analysis (Ellis & Bochner, 2002; Richards, 2008). The goal is to have a presence in the text (Denzin, 2003, p. 259), as well as to make sense of the relations of which I am a part and through which I am constituted (Ellis & Bochner, 2000, p. 737; Reed-Danahay, 1997; Uotinen, 2011). I use a performative mode of writing, not only to articulate my own personal investments or perspectives, but to illustrate how I myself negotiated contradictions in my life, reorienting to my own perspectives and structuring conditions.

Taking a feminist approach to knowledge production came with an ethical demand to represent the relational, co-constituted aspect of stories and of the research process itself. My work follows feminist theorists, who understand the production of knowledge as embodied, contested, ethical and political work (Baines, 2007; de la Bellacasa, 2011; Haraway, 1991; Tuana, 2004; Murphy, 2015). Rather than pulling a “god-trick” (Haraway, 1991, p. 191) or taking a bird’s eye view from above, my goal was to locate myself in relation to my research (Cavanagh, 2011) and to bring the “social relations underpinning knowledge” (Connell, 2005, p. 5), or the affective and intersubjective conditions under which we know, into the narrative. I sought to represent the world from inside its social organization, rather than in the abstract (Smith, 1990, p. 633; see also Hurl & Klostermann, 2019).

With my feminist and relational theoretical commitments, my work diverges from some arts-based and autoethnographic methods. While arts-based approaches (as methods of investigation) can center on the researcher denying herself, disrupting her own

expertise, accommodating participants or allowing others an outlet for *their* creativity (Karabanow & Naylor, 2015), I use sociology *as art* to explore and reorient to my own perspectives and insights, while meaningfully addressing others. Such an approach was in the spirit of a research project that critiques gendered expectations for women to care or to be of use or of service. That said, while autoethnographic research can center on positioning oneself as the “subject” or producing an evocative account of one’s own feelings, thoughts or emotions (Ellis & Bochner, 2000; Reed-Danahay, 1997), I take a feminist, revisionary approach to it in that I write about the relational encounters and conversational relations involved, while working to invite and multiply new meanings, stories or possibilities—recognizing myself, others and concepts of ‘care’ as in motion (Douglas et al., 2019).

Probing contradictions through the research process

My study involved five key, overlapping phases: (1) locating other former carers; (2) narrating memories of caring across our lives; (3) analyzing and contextualizing social relations and circulating narratives shaping our narratives and lives; (4) producing artistic and analytical representations; and (5) pinning down the project. These phases allowed me to probe the contradictions of care work as it is organized and imagined, while also exhibiting and rethinking meanings of care. The notion of ‘contradictions’ served as an organizing principle in the analysis. While I didn’t begin by framing or thinking of the study in this way, as the research developed, I noticed that I had designed the study to respond to the contradictions of my life and had been exploring contradictions in the interviews, employing the notion of contradictions analytically in the analysis and representing contradictions in writing. The study was approved by the Carleton

University Research Ethics Board (#109030). It adhered and adheres to the principles and requirements outlined by the ethics board and the Tri-Council Policy Statement.

Phase 1: Locating participants

The first phase of my research involved recruiting people for what I called the ‘Caring Life History Project’ – a project examining the stories of those who had reached their limits while caring for others, before either renegotiating or stepping back from a care responsibility or position in some way (e.g., by sharing responsibility, finding other supports, resigning or opting out). I wrote on the poster that the aim was to “tell new stories about care and the limits of caring in Ontario.” I located participants by forwarding recruitment posters to established contacts in Ontario – drawing on my connections with care providers and colleagues. Rather than approaching people in particular roles (e.g., personal support workers) or focusing on those in particular care relationships or sites (e.g., long-term residential care facilities), I recruited participants with diverse care provision experiences (e.g., paid, unpaid, formal, informal, public, private, volunteer) in diverse contexts (e.g., homes, hospitals, day cares, residential group homes, live-in spiritual communities, shelters, long-term care facilities). Rather than ‘fixing’ or ‘grouping’ people (Anthias, 2011), my goal was to connect with diverse participants. I drew on my intuition, supported by my engagement with care theory, that exploring people’s narratives of different kinds of care relationships would also reveal continuities and differences among them. As there is very little research in this area, I selected participants to offer some breadth in order to compare stories and interpretations from people with experiences in a variety of contexts. “Lumping” carers in my recruitment gave me opportunity to “slice” in the analysis (Stone, 2000; see also

Armstrong & Armstrong, 2004), looking at differences and being more exploratory about dimensions or patterns of life shaping interactions.

Participants contacted me directly by email after receiving the recruitment poster. Committed to ensuring their consent, I provided participants with information about the study, consent forms, and *possible* interview questions prior to setting up interviews, so they could discern whether participating or sharing was right for them. I also emailed them to set up an interview at a location that was convenient for them or by phone for participants in other areas of Ontario. The recruitment process helped me to refine and nuance my area of focus, as I found myself shifting from saying 'exiting care' to stepping back from or renegotiating a *particular* care responsibility, as carers often told stories about stepping back from particular responsibilities, but not from "care" in general or from other, ongoing caring commitments. The recruitment process also helped to reveal circulating assumptions about care, as I received charged responses from several people. One woman said, "Must be friggin' nice; I didn't bail on my kids," while others 'credited' me for researching those in such "privileged" positions or advised me to redesign the study to focus on *working* care providers and people who need care who they saw as more marginal, vulnerable and worthy of scholarly exploration.

Phase 2: Narrating the conditions of our lives

In phase two, I conducted 20 in-depth life history interviews with 12 Ontario-based participants (b. 1940 to 1991) who reported reaching their limits in diverse paid care work or familial care roles. Along the way, I also engaged in interpretive and narrative work to make sense of my own care history. Interviews were a means of occasioning life

narratives. They can also be thought of as performative in that the work we did in them was “embodied, relational, spatial, and active” (Gray & Kontos, 2018, p. 441). Engaging in dialogical co-productions, I invited participants to produce their life histories with a focus on care.

I conducted all interviews, including one in-depth, audio-recorded interview with each of the 12 participants, as well as one or two additional interviews with eight participants in the summer and fall of 2018. In total, I conducted 43 hours and 15 minutes of recorded interviews, with each interview averaging an hour and a half.¹⁵ The shortest interview was 53 minutes (in my second meeting with Marilyn), and the longest interview was three hours and nine minutes (in my third meeting with Gracie). We met in coffee shops, participants' homes, long-term care facilities and hospitals. Facilitating long, in-depth interviews helped with building rapport and with eliciting complex, contradictory narratives. Meeting more than once also helped with taking side angles. As I said to Carrie regarding setting up a second interview, “Maybe we'll have different parts of the story to explore. Maybe you'll remember something more, or we'll take a whole different side angle on it.”

I began all interviews by asking participants if there were any stories or memories that came up as they were thinking of our conversation or about my area of focus on the

¹⁵ I completed two in-person interviews with Betty (2h 37m total), one in-person interview with Rhonda (1h 40m total), two in-person interviews with Judy (3h 25m total), one in-person and one phone interview with Marilyn (2h 20m total), one in-person interview with Sheila (1h 30m total), two phone interviews with Gina (5h 16m total), two phone interviews with Dale (3h 02m total), three phone interviews with Gracie (8h 23m total), one in-person interview with Anne (1h 57m total), two in-person interviews with Carrie (3h 53m total), two phone interviews with Nora (4h 02m total), three phone interviews with Troy (7h 56m total), and one phone interview with Julie (1h 54m total).

limits of care. Some started with earlier, formative childhood memories, while others started by sharing about more recent or more affectively charged care experiences. Other scholars have focused on embodied care relationships, care in practice or the everyday work that people do on the job. Part of my contribution was in looking more broadly at how people make up their lives. I didn't start off by asking people to tell me about themselves or the people they supported, nor did I focus exclusively on the work involved in supporting others. Looking at the level of life history helped to attend to 'care' differently. My goal was to learn about the conditions of their lives – the relationships between agency and structure – through their stories. With interview questions that invited people to be self-focused, some interviews seemed to bulge out of the seams with multiple metaphors, angles, storylines or reflections. Others were tighter or seemingly more orderly or bounded with participants seemingly having a handle on their stories as they listed off the chronological 'facts' of their lives.

Engaging in a collaborative, interpretive inquiry, I tried to allow for flexibility or for pursuing organic, divergent lines of thought (Bryman, 2004), using the interview questions as a guide and as needed. I also attempted to give participants control over the trajectory of their narratives and sharing, informing them that they could stop or withhold at anytime.¹⁶ I invited participants to contemplate the meaning and significance of their care experiences. Depending on how the conversation progressed, I prompted participants to explore memories of taking on care responsibilities, as well as reaching their limits and stepping back or renegotiating care responsibilities. Notably, in a study on the limits of

¹⁶ With open-ended interviews with different lines of thought, it's worth noting that each findings chapter relies more on some participants' stories than others. Participants varied in their points of focus with some focusing primarily on care in practice or on the work involved in supporting someone.

care, several participants were hesitant to talk about dissonant experiences or tensions such as reaching their limits – a contradiction that I explore in greater detail in the findings.

The life history interviews that I conducted were relational encounters. As does any interviewer, I played a role in influencing participants' narratives, including by reinforcing or conditioning certain narratives through the questions I asked or through laughter or other responses (Poletti, 2011; Smith & Watson, 1996). For instance, when Nora asked, "What's the common narrative around pain—err—not around pain around care?" I giggled. "Good slip with care and pain," I said. At times I also interjected to claim solidarity and express understanding, as well as to occasionally share examples from my own life experience. Something as simple as sharing how I came to a question – acknowledging other contexts, histories and relationships – helped to produce clarity. In a project that was about rethinking gendered expectations for women to care for others at all expense, it was also important to me not to repress my own voice or perspective. I oriented to participants as critical thinkers,¹⁷ understanding that they were already in conversation with their worlds and already engaged in critical dialogue and debate. As a researcher with stakes in the game, I worked hard to ensure participants' narratives were given space to develop, including when expressing something quite different or contradictory to my own views. My involvement worked as a catalytic device—helping

¹⁷ In their academic writing handbook, Graff, Birkenstein and Maxwell (2014) write: "by entertaining counterarguments, you show respect for your readers, treating them not as gullible dupes who will believe anything you say but as independent, critical thinkers who are aware that your view is not the only one in town" (p. 79-80). While their point is about how academic writers address readers, it captures how I approached participants in my study. Rather than pretending to engage as an objective, detached, distant, disembodied observer, I mobilized an overtly feminist approach, acknowledging partiality and situatedness in knowledge production (Ryan-Flood & Gill, 2009; Throsby & Gimlin, 2010).

participants to access other stories or memories, while offering them a perspective to align with, resist or speak back to. Moments of identification and disidentification with them helped me to produce clarity. Participants exercised an incredible amount of agency in their responses – letting me know I wasn't getting it, brushing off particular lines of exploration or distinguishing their perspectives from mine. As they contemplated how their lives were put together, I did similar analytical work.

In addition to the interviews, I engaged in interpretive and narrative work to revisit and represent my own memories of care and to craft my own stories. I wrote about and reflected on past experiences and on conversations with participants, and revisited past diary entries, poems and essays that I wrote as a care worker. Doing so helped me to reflect on the situatedness of my own knowledge production, as well as on my own presence and active contribution to the research process. Considering where participants had stakes, and where I had stakes, helped me to ensure that my own interpretation wasn't overtaking theirs.

Phase 3: Analyzing and contextualizing social relations of care

While “[t]he life story is the ‘story we tell about our life’; the life history is a collaborative venture, reviewing a wider range of evidence” (Goodson, 1992, p. 6). The life history is the life story deeply contextualized within its social and historical context. In phase three, I transcribed and analyzed audio-recorded interviews, reading and re-reading them in conversation with one another and considering what they revealed about how people framed their lives. As I compared and contrasted participants' accounts, I analyzed contradictions, reflecting on the various ways that people remake their lives.

Beyond identifying emergent themes, my goal was to produce an integrated interpretive analysis of participants' narratives with the goals of theorizing social relations and exploring meanings as they arise in practice.

My analytical work involved four modes of analysis that I primarily undertook over the course of four months while I was completing a visiting fellowship at Maastricht University in the Netherlands in the winter of 2019. As part of the process, I shared three different anonymized transcripts with each of my committee members (Drs. Braedley, Siltanen and Rivers-Moore), meeting with them one-on-one to read through and analyze the transcripts in conversation. This was an incredibly generative process that opened up new ways for me to orient to the transcripts, including by engaging in a more appreciative literary way (as though reading a good book), attending to the 'work' participants were doing in relation to me, considering when particular stories they were telling overtook others, and making links to social or historical relations. Inspired by Doucet and Mauthner's (2008) listening guide that can be used to examine questions of subjectivity or to attend to "knowing narrated subjects," I developed a listening guide with my supervisor Dr. Braedley. The guide helped to me to attend to, analyze and *engage with* individual interviews as (1) social texts; (2) life stories; and (3) relational encounters, and to put interviews in conversation to (4) identify continuities and differences and manifestations of the social. As an interpretive analysis tool, the 'guide' supported with the dialectical work of both *reading* multiple, relational layers of narratives, as well as critically reflecting on or actively interpreting by working with or writing about the material. Writing to think was central to my analytical approach.

My first mode of analysis involved considering the interview transcript as a *social text*, with myself and participants engaged with language and producing culture.

Attending to transcripts as vibrant, alive literary and artistic works, I recognized that how the story gets told tells us something (Agnew, 2018; Klostermann, 2019b). I attended to the situatedness of language in use, as well as to the significance of terms and values backing them. I understood stories as a way for people to creatively and agentively respond to the circumstances of their lives, for instance by finding unique, unexpected or evocative ways of putting things or “new patterns of imaginative engagement” (Chivers & Newman-Stille, 2018, p. 155). Reading individual interviews as social texts or cultural productions, and considering how stories get told, I asked: *What terms, turns of phrase, tropes, metaphors or narrative devices entered into their story making or captured my own creative imagination? What were the refrains or common phrases in their story? What phrases seemed unique or unexpected?*

My second mode of analysis involved producing chronological accounts of participants' *life stories*, identifying and reflecting on the life-spanning and relational conditions of participants' lives as represented in their narratives. To do so, I spent 3-4 days per person, writing up an in-depth ‘relational vignette’ (or chronological account of their life story) of approximately 6,000 words per person. I wrote a condensed summary of their accounts of: (1) growing up; (2) entering into care relationships; (3) providing care; (4) renegotiating or stepping back from care responsibilities; and (5) reorienting to their lives afterwards. I summarized forms of work and relationships, including both immediate (bodily) material relations as well as to social or institutional relations that they participated in and helped to shape (Connell, 1995; Smith, 2005). My goal was to

identify patterns of experience as well as social relations, discourses, debates or taken-for-granted assumptions. Along the way, I asked: *What practical or conceptual work (e.g., ordinary activities or practices that took time, energy or thought) did they narrate? How did they understand this work, and how was it situated in relation to intimate others or social institutions? How did their social location shape their life trajectories? What key contradictory moments, tensions or turning points did they narrate?*

My third mode of analysis involved attending to and reflecting on interviews as **relational encounters** involving dialogical, participatory telling, attentive listening and meaning-making. I understood participants and researchers alike as coproducing knowledges in conversation—contributing as conversation partners and engaging with the “contested and politicised nature of knowledge building and transfer” (Baines, 2007). In this mode of analyzing the interviews, I reflected on and wrote about the relational encounter of the interview, with a focus on the affective and intersubjective dynamics and on my own interpretations or involvement in shaping the production or in influencing what was revealed. Analyzing the interview in this way also helped me to ensure that my investment in the story or in the research didn't overtake theirs in the analysis. For each participant, I wrote a brief reflection on the relational encounter of the interview that explored some of the following questions: *What was my part in co-producing the story, and what interventions did I make throughout (e.g., comforting, encouraging, laughing, affirming a dissonant perspective, introducing concepts or terms)? How were we positioned differently? Where were my stakes, where were their stakes? When did emotion enter into the telling of a narrative? Where did it get real (e.g., dramatic reveals, turning points or affectively charged moments)?*

The fourth mode of analysis involved contextualizing participants' stories as *manifestations of the social*—linking and juxtaposing each participant's account with the accounts of other participants, while working to identify complexities and nuances. Reading and re-reading participants accounts alongside one another helped me to consider how participants' seemingly unique expressions or isolated life experiences reveal patterns of experience (Ezawa, 2016). Distinguishing and contextualizing their stories helped me to appreciate context-specific historical or relational conditions (such as how people in different care roles were made to feel alone or to internalize personal responsibility). I reflected on participants' social, moral or cultural locations (Ezawa, 2016), and on differences related to their social location (e.g., age, gender, class or care setting). The goal was to attend to the links between stories and the social or material conditions of participants' lives—opening up and contextualizing their expressions and experiences. *What commonalities and differences did women in different social locations (e.g., care setting, age, class, gender) have with one another? How do their narratives reveal dominant social arrangements or assumptions, including gendered expectations around care?*

Contextualizing the research in this way helped me to consider how participants variously positioned themselves, and were positioned, in relation to 'care.' Such an approach enabled me to bring social relations and meanings of care into view, considering how they are co-ordered across settings and across people's lives. I illuminated different ways of engaging language in the discourse surrounding care, considering how narratives shape and are shaped through social contexts and histories.

Phase 4: Producing relational representations (including a revised memoir)

In phase four, I produced a written analysis that was both overt (expressed in findings chapters) and implicit (through the medium of artistic expression). In addition to the conventional findings chapters, I produced a work of art and scholarship (aka a “revised memoir”). It was a choice not to list quotes to illustrate a point or to present chronologies of participants’ life stories from birth to the time of telling them. Instead, with my poetic sensibilities, I brought participants’ work and words to life, and put their *stories in context* – both in the context of their lives and in the relational context of the interview in which I myself was present. I worked hard to represent contradictions or productive tensions that participants negotiated, considering differences in participants’ narratives and structuring contexts. I also presented contrasting stories (e.g., of participants in different class positions or care roles) next to each other. Putting one participant’s account of paid care work next to another participant’s account of unpaid care work not only helped to illustrate how there are some rhetorical conventions for narrating care, but also brought into view structures of care and gender that extend beyond particular care roles or realms.

Not only did I attend to representational, non-representational, performative or ontoformative dimensions of narratives in my analysis, my qualitative and post-qualitative approach came through in my writing. In general, in the first few findings chapters I focus on presenting people’s narratives, honouring and attending to the representational dimensions of stories (Doucet, 2015), while in the memoir chapter, I unpack and interrogate how the narratives arose in the relational encounters of the interviews. Part of my hope was to “hang back” in the earlier findings chapters, analyzing

and contextualizing others' narratives, without presenting my own perspective. As someone with a lot of skin in the game, I didn't want my story or analysis to overshadow theirs. That said, I do present and rethink my own perspective in both the interlude and "revised memoir" chapter, working with narratives in a different way by representing the interviews as interactional, relationally co-constructed encounters.

Following feminist artist-researchers (Cavanagh, 2013; Cvetkovich, 2012; Keleta-Mae, 2012; Tamas, 2016), I engaged as an artist and used an artistic representational mode in order to communicate in visceral, ethical ways that convey the affective and intersubjective impacts of encounters (Cavanagh, 2013). I aimed to register complexities, without distorting, oversimplifying or absorbing stories into a central one (Steedman, 1987, p. 22). I also tried to expand "dominant modes of thinking to envision the world anew" (Keleta-Mae, 2012). Producing a "revised memoir" about the stories we tell helped me to enact creative resistance—expressing sociological truths in an artistic form, challenging divisions between public and private, and situating care socially and politically. I put myself on the line—writing through discomfort, shame and confusion, while reflecting on my own "affective and ethical investments" (Cerwonka & Malkki, 2008, p. 173). Engaging in a performative way, I addressed readers emotionally and invited uneasiness, rather than making an argument about a factual world. Exposing myself offered a way to expose the relational conditions, mechanisms of power, and subject positions that underlie intellectual production (Cvetkovich, 2012, p. 75). The project and the representational form are about intimacy, and part of my hope was to enact a different understanding of public and private by considering how researchers are also participating in and helping to shape the care economy. I wrote in a conversational,

literary and accessible way that conveyed a sense of performance and real time, and created more space for readers to participate in the ritual of meaning making. Producing a revised memoir supported me in making way for “multiple and contested meanings and experiences” (Aubrecht & Keefe, 2017, p. 215).

Phase 5: Pinning down the project

My analytic and line of inquiry shifted along the way, with pinning down the project almost seeming like a phase in itself. The study was exploratory with its broader focus on the limits of care and initial focus on leaving, exiting or stepping back from care work. Initially I was interested in, and had a strong rationale for, focusing on the narratives of people who had reached their limits and stepped back from paid or unpaid care responsibilities in different contexts. That said, from the start and along the way, such an area of focus came with methodological and analytical challenges.

The project, and my sense of the topic, evolved in an iterative way as the research progressed. To start, in designing the study and identifying recruitment criteria, it was a struggle to conceptualize leaving care work or to figure out how to go about exploring such a topic. After much deliberation, I specified on the recruitment poster (see Appendix) that I wanted to speak to “people with experiences *reaching their limits* and/or *stepping back from* a care responsibility or position in Ontario in some way (e.g., by sharing responsibility, finding other supports, resigning or opting out).” At the time it seemed important to specify a *particular* care responsibility, rather than trying to recruit participants who had “exited care” once and for all.

That said, even with such an area of focus on *particular* transitions, exploring “leaving care” was a challenge in the life history interviews that I conducted. The majority of participants’ accounts bulged at the seams, as they told stories of fits and blasts, entrances and exits and overlapping care responsibilities. Several told stories of setting limits or stepping back from care in one context only to dovetail into another care role or live out “care dynamics” in other ways. Not a single person I interviewed could be easily classed as a “former care provider.” Some participants indicated that leaving hadn’t been a choice, preference or clear-cut process; their stories were more complex than that, and were challenging to analyze. For instance, I struggled to link people’s narratives of leaving with the conditions of their lives or to identify social patterns with so many differences in their points of emphasis, in the nature of the care relationships they described and in the associated gendered, moral expectations at play.

Speaking in a more explicit, in-depth way to unique contexts of care or to particular types of care was hard to do. It wasn’t just that the concept of “leaving” didn’t fully describe my topic, but that it didn’t fully capture how people lived their lives or were positioned in the care economy, which is something that I reflect on in chapter five. That said, I also acknowledge that beginning with such a line of inquiry provided a powerful entry point for opening up questions about “care” in a different way. Critically reflecting on “leaving”—or whether and how women can leave—supported me in theorizing gendered, moral relations in the care economy that extend beyond any particular care role or setting.

The participants

This section begins with a description of participants' backgrounds and social locations, and then presents vignettes for each person to show the range of ways that participants told their stories. To close, I situate my discussion in Ontario, Canada, the context in which research participants' life histories and mine have taken shape. I should also note that I have used pseudonyms for all participants, and in a few rare cases have anonymized some very specific details about their lives.

Participants were variously positioned in relation in Ontario's relational care economy. Most participants presented their lives as deeply involved in care across their lives; they narrated care provision work in or outside many Ontario cities, including Belleville, Bowmanville, Cobourg, Hamilton, Kingston, Mississauga, Oshawa, Ottawa, Peterborough, Sudbury, Thunder Bay and Toronto. Ranging from ages 27 to 78 at the time of the interviews, and born between 1991 and 1940, there were differences in participants' social locations or identifications: rural and urban, single and partnered, parents and non-parents, queer and straight, trans- and cis- gendered, Indigenous and settlers, low- and high-income, disabled and able-bodied, mad or mentally ill and 'normal.' I acknowledge the absence of racialized and immigrant women in the study.

The absence of racialized and immigrant respondents points to limits in my recruitment strategy, and raises questions about who gets to exit care, as well as about whether historically disadvantaged populations or groups are harder to reach if engaged in other precarious employment following care. My recruitment strategy relied on snowball, word-of-mouth recruitment through my own and others' personal networks. I

also recruited primarily through contacts in rural and small-town settings where care facilities are known for being “white” and where research is needed into the experiences of racialized workers in those contexts (Owusu, 2019). Had I recruited through unions I may have been able to connect with paid workers in more diverse social locations. With the exception of one participant that didn’t share how she found out about the study, all other participants had received a personal invitation by email either from me or from someone I knew. This is important to note, as several participants mentioned in our interviews that they didn’t identify with my recruitment criteria, but that they figured they would participate anyway since they had received a personal invitation. One participant expressed that she resonated with the recruitment poster and had a shared desire to challenge dominant ideals about care although she didn’t technically qualify as having “opted out” as she was working as an informal carer. In hindsight, I suspect that some people didn’t identify or self-select based on the recruitment criteria that specified “former care providers.” Another barrier to recruitment was that on the poster I framed the study as a conceptual project – about changing the stories that we tell about care. While tapping the shoulders of potential participants as storytellers and critical thinkers who could contribute to a conceptual reimagining of care felt like a radical way to honour their insights, I can see that such an invitation may have implicitly addressed those in more privileged positions or with access to critical discourses. One participant mentioned having a panic attack before our session together as she wasn’t sure what the dominant narratives around care were or whether she could expand them. While I was quick to put her at ease or to joke that I’d be hard pressed to name them, her comment points to the importance of ensuring an inclusive, accessible research design. It also has me aware of

how I might distinguish my own work as at theorist making an argument from participants' contributions. With an interest in "universal form[s] of insecurity, vulnerability, and potential suffering." (Grenier et al., 2017, p. 323), I strived to be accountable to others and responsive to the contradictions of my life through the research. Moving forward, I am committed to applying a gender and intersectional approach in all stages of the research design and study.

Taken together, participants described engaging in an incredible breadth of care responsibilities across their lives, including in paid, unpaid, familial and volunteer roles in different contexts. Their stories weren't just about caring for their own children. They reported holding a variety of care roles across their lives, including as family care providers (e.g., as children, siblings, spouses, partners, parents, grandparents), as informal care providers (e.g., babysitters, activists, volunteers, friends, doula, care team members, camp counsellors), and as paid care workers (e.g., direct care attendants, homeless shelter workers, support workers, therapists, social workers, nurses, teachers, day care workers, live-in care workers, community service workers). They also narrated providing care in a variety of settings (e.g., apartments, homes, hospitals, home day care centers, home care, schools, long-term residential care facilities, retirement homes, residential group homes, intentional communities). Notably, even participants who described providing support in public settings such as in long-term care at times had a sense of total responsibility as the primary carers or "the main worrier[s]" (Doucet, 2006, p. 199). Their accounts also offer clear examples of the complex, skilled, unpaid care work that (women) family members provide that is essential to the running of the care

economy though not formally recognized or rewarded (Armstrong, 2013; Barken, Daly & Armstrong, 2016).

Several participants were life-long carers who narrated lives dominated by care, including overlapping paid, unpaid, formal and informal care responsibilities across their lives. Some participants recounted examples of working “double duty” as paid care workers, while also providing unpaid care to their family members off the clock. Almost everyone had experiences of paid and unpaid care across their lives, which speaks to how different forms of care blend/meld across people’s lives (Baines & Armstrong, 2019), as well as to how women are often “hit twice” with cuts in public sector and with more work being sent to households or families (Braedley, 2015). I examine care as it turns up in individual’s lives, whether as episodic care for fits and blasts (such as supporting someone recovering from a surgery) (Popiel, 2019), consecutive care (such as those who cared for siblings in childhood, then their own children, and then their parents), compound care (such as for those who provide life-long care to children with disabilities and then take on additional responsibilities for their parents or other family members) (Perkins, 2010), simultaneous, multiple “double duty” care (such as experienced by the so-called sandwich generation and by many women who do care work for pay and unpaid at home), or not at all.

The following table provides a brief overview of participants, with brief vignettes below that give a taste of how they narrated their life histories.

Table 1

Overview of participants

Name	Age cohort	Ethnicity	Family ties	Class position and resources	Care experiences
Betty	World War II (b. 1940s)	Indigenous	Married with three children	High-income professional class household	Late life family carer (for husband)
Rhonda	World War II (b. 1940s)	White	Single with three children	Moderate-income professional class household	Late life family carer (for late husband) Paid care worker (nurse)
Judy	World War II (b. 1940s)	White	Single with two children	Moderate-income household	Late life family carer (for late husband)
Marilyn	World War II (b. 1940s)	White	Married with two children	High-income professional class household	Late life family carer (for parents) Paid care worker (nurse)
Sheila	Baby boomer (b. 1950s)	White	Married with two children	High-income professional class household	Family carer (for mother)
Dale	Baby boomer (b. 1950s)	White	Single with no children	Moderate-income professional class household	Social movement activist
Gina	Baby boomer (b. 1950s)	White	Divorced with two children	Low-income working-class household	Family carer (for mother) Informal carer (day care operator)
Gracie	Baby boomer (b. 1960s)	White	Married with two children	Moderate-income household	Family carer (for mother, husband, children) Informal carer (day care operator)
Anne	Baby boomer (b. ?1960s)	White	Married with two children	Moderate-income professional class household	Family carer (for disabled child) Paid care worker
Carrie	Millennial (b. 1980s)	Indigenous	Single with two children	Low-income working-class household	Paid care worker
Nora	Millennial (b. 1980s)	White	Partnered with no children	Low-income household	Paid care worker
Troy	Millennial (b. 1980s)	White	Single with no children	Low-income household	Paid care worker
Julie	Millennial (b. 1990s)	White	Single with no children	Moderate-income professional class household	Paid care worker

Emphasizing that she was raised to be “self-reliant,” to “keep [her] own counsel,” to look “outwards not ... inwards,” **BETTY** told a straight-forward story of caring for her husband at home and then in a long-term care facility. Born around 1940 and in her late

70s when we spoke, she showed up armed with notes to share. “I guess the first thing is that I’m first nations,” she said, mentioning that she was raised by her grandma on a rural reserve. Without missing a beat, Betty zipped through the facts of her life, mentioning that she went back to school, became a teacher, met her husband who was a doctor, had kids, and worked her way up in a government department. The first story she told in which she identified as a caregiver was in speaking of caring for her husband in late life. She said, “When I retired [at age 71 in 2013], I saw for the first time how frail my husband had become.” She recalled noticing that her husband’s “world was ... closing in on him” with dementia and other chronic health issues, before elaborating how her own “world has become so restricted.” She said that she took care of him – supporting him around the house, accompanying him to doctor’s appointments and sourcing out a chair lift for the stairs. She also narrated that, when he had a stroke in 2016, he moved into a long-term residential care facility, where she supported him daily. In speaking about the experience of supporting him there, she made clear links to “bureaucracy” or to organizational processes in long-term care. For instance, she remembered how she asked to read the policy about how often the rooms should be “scrubbed and polished” before making a request for staff to clean her husband’s room.

“*Hello!*” and “*Excuse me*” were punchy refrains in **RHONDA**’s story, as she narrated a variety of care experiences, including as a (single) mother, nurse and late life family carer to her late husband. Born around 1940 and in her late 70s when we spoke, she supported her late husband for a decade after his stroke, including at home and in a long-term care facility up until his death. She proudly introduced herself as a “shit disturber” as soon as she sat down. She described a constant battle to discipline paid care

workers—instructing them on how to appropriately bathe, toilet, feed, transfer or care for her husband. “I’m giving you information that works. Use it,” she said. She remembered getting married, having kids, training to become a nurse in the 1960s, and going back to school as a single mother to upgrade her credentials. She shared a hard life story, including violence in a previous marriage, economic hardship, and conflicts with others. She remembered yelling “over my dead body,” at the first sign of her husband going into a long-term residential care facility. “It was CCAC that said, ‘we can’t do this anymore.’ *Well, excuse me!* However, you’re looking for this part, I was exhausted,” Rhonda said. She said it as though she was trying to pick a fight with me. She hinted that she had been afraid of losing the “first man that loved [her] for [her]” – afraid of a situation that made her feel so powerless or out of control. She emphasized that she had tried *so* hard in coordinating all aspects of his care or everyday life. “I did my best,” she repeated, “I did my best.”

“At the time” was a refrain in **MARILYN**’s story, as she spoke with a sense of control or personal power, summing up and synthesizing her story. She was born in the late 1940s and around age 70 when we spoke. The first time that we chatted we met in a private meeting room in her luxury condo building, where I took note of the concierge desk, security, walking track, swimming pool and manicured gardens. She shared that she had retired from her work as a nurse practitioner and had spent the last decade caring for her family, including for her parents, husband who was an elite international business executive, and two adult daughters. With a brief, condensed summary of others’ medical needs and her caring competence, she underscored that she was on top of it. She recalled supporting both her parents at home and in a private retirement home starting in 2005,

and then supporting her Dad in the retirement residence and in a long-term care facility. At the time we spoke, Marilyn was also supporting her husband who was in his 80s and had anemia and her two adult daughters who live in another city and have chronic health problems. “Knew it already,” Marilyn said. She emphasized that she knew how to navigate the care sector, to set boundaries, to be smart, to prepare for the caregiving work and the emotional process, to cope when the time comes and to access resources. She emphasized she was not stranded. In a distancing account that emphasized how rewarding and meaningful care had been and how well she had pulled it off, Marilyn emphasized there was nothing that she hadn't anticipated would happen in her past care experiences. She said that it was smooth sailing; it was easy with good rapport and a supportive family, teamwork. “So, that helps with caregiving, doesn't it? When you've got that support?” she said.

JUDY welcomed me into her rural home, served tea, and affectionately teased me for ringing her neighbour's doorbell. I also teased her, saying, “I see a little lipstick now!” after she mentioned that she “grew up in a Pentecostal home,” where she wasn't “allowed to wear makeup.” Judy was born in the mid 1940s and was in her early 70s when we spoke. “Blessed” was a refrain in her account. She narrated a history of caring for others starting with supporting her frail Mom and baby sister growing up. She also remembered dropping out of school to help out when her father lost their family home to debt when she was 17. She shared that took a secretarial course, met her husband, got married in the mid-1960s, had two kids and moved a few times for her husband's work. She also elaborated that she had spent the last several years caring for others, including for her husband who had cancer and her Dad who had dementia. She mentioned that she

was struggling to adjust to Friday nights alone since her husband had passed away; she was still grieving. She took pride that others thought of her as a positive, empathetic, caring person. Speaking of caring for her father and her husband at the same time, she said that she was “blessed” to have a care aide sit with her husband for three hours a day so that she could visit her father in long-term care during that time. “Aw, busy year and a half then,” I commented, to which Judy replied, “I was exhausted at the end—that’s true, but you draw inner strength, you know you really do.” She positioned herself as always and still caring, and emphasized that it is rewarding. As she put it, “I’ve always been a very positive person, in spite of all the crises is in life, you know?”

“As I say,” was a refrain in **SHEILA**’s story, which seemed to give off an air of formality. “How can I put this?” she said, pausing to reflect or put it delicately. Sheila mentioned that she had been a caregiver since a young age—tracking down stray cats or playing with dolls. Born in the early 1950s, and in her late 60s when we spoke, she shared that she went to university, got married, had two kids, worked as a government director and supported her Mom in late life. She hinted that direct care wasn’t a source of self-worth or way to produce value, as she had a lot of meaning in other areas of her life such as at work and strong family ties. Sheila summed up the aspects of the story involving direct care for her Mother such as sleeping with the baby monitor on when her Mom lived in a granny suite in Sheila’s home or visiting daily when her Mom lived in a private retirement residence. Emphasizing the love and connection, Sheila narrated magical summer holidays at the cottage, kids sitting on her Mom’s lap, card parties, costumes and skits. I laughed when she mentioned how her Mom trick-or-treated at her

front door shortly after moving into the granny suite in her home, noting that “You couldn’t tell it was her in the Halloween costume, until she brought her cane around.”

“Fun, fun, fun” was a cynical and sarcastic refrain in **GINA’s** story. She was in her early 60s when we spoke and born in the mid 1950s. She narrated lived experiences of disadvantage, including tumultuous family relationships, violence in a previous marriage, and health issues such as long-term physical disability, chronic pain, and mental health issues. She said that she was forced to be a primary, full-time family carer when her Mom had a stroke in the early 2010s – when “she died in [her] arms,” before she “sat there for days, telling her to breathe the right way.” Growing up, Gina remembered caring for her younger sister who was like a “doll” and for her Mom who had nervous break downs. She shared that she was “pawned” off for marriage, had two kids of her own, and had operated a home day care until her Mom went into the hospital and she closed the daycare to support her mother. Gina shared that she moved into her Mom’s geared-to-income one-bedroom apartment when her Mom was released from the hospital, bringing her cat and her two dogs with her. She said that she provided around the clock, 24/7 care, sleeping in the same bedroom, listening to her Mom’s breathing and making sure she was sleeping upright. “Fun, fun, fun,” she said. Looking ahead, Gina wanted her kids to “pull the plug” on her, rather than suffer the way she did as a care provider. “Never. Not in a million years,” Gina said, “I know what those people [would] have to go through to keep me just breathing; it’s too much to ask of any person.”

“It’s so interestingly mixed up, when you’re a sick person giving care,” **DALE** said, in speaking of engaging in support and advocacy work as an HIV-positive woman and activist. She was born in the late 1950s and in her early 60s when we spoke. When it

came to care, Dale mostly distanced herself from caring work, although she did share examples of providing informal support on care teams and as a friend or community member. As we chatted twice over the phone, she elaborated that she was a long-time HIV/AIDS activist who became involved in the movement after being diagnosed in the late 1980s. She recalled how there was a “sense of immediacy” in the movement at the time – how “people that were well one week were unwell the next.” With “people with HIV threaded all through [her] life,” she wanted it on the record that her care relationships were mutual and ordinary, just part of life. She didn’t identify with conventionally feminine notions of care, and emphasized there was a “whole politic around AIDS [and one of the] unspoken tenets of it was: no pity.” She challenged the horrific discrimination of people with AIDS, giving examples of how state policies aimed to prevent transmission not to help people survive, how people with AIDS were refused care in hospitals, and how women were excluded from AIDS service organizations. Hers was political, life-sustaining work.

“Always a caregiver” **GRACIE** said, “Just became a part of me.” She introduced herself as a “pretty normal 55-year-old woman.” We chatted three times on the phone for about three hours each time. “I grew up seeing, knowing and believing that human beings were supposed to help to take care of the people that they love that needed help. Like that was just normal for me,” she said. Born in the early 1960s, Gracie narrated a lifetime of caring for others out of the goodness of her heart, from supporting her two children and running a home day care when they were young, to providing direct daily care for her Mom following her major heart attack and for her husband following his stroke. She shared that she had gone to university for a year, but entered the work world when she

was offered a great job as an administrative assistant. At the time we spoke, Gracie was also working as an administrative assistant at a social service agency and supporting her adult daughter who was recently diagnosed with chronic health issues. "It wasn't because I had to. I wanted to," Gracie said in speaking of supporting her Mom. She elaborated that she didn't have a choice and had to care and be selfless, but that she always felt satisfied and content and rewarded for what she was doing. "Soothing souls" made her happy.

"Been there, done that," and "didn't bat an eye," ANNE said. With a theatrical language with a wild west flair to it, her story was a well-crafted political narrative centered on challenging the political structures that had shaped her experience of caring for her disabled son. She shrugged off questions about her early life, sharing her intellectual and political analysis and keeping the focus on how contemporary political conditions gave rise to her more recent experiences of care. She didn't mention her year of birth or tell any coming of age stories, but I would guess that she was in her early 50s and perhaps born in the mid 1960s. She mentioned that she had completed postgraduate education and she drew on discourses of social work and social movement activism, positioning herself as someone committed to helping other women and families who have it worse than she had it. She narrated a life of overlapping paid and family care responsibilities, including as a paid care worker (at a residential group home and in social work) and as a mother of two children, including a son with a developmental disability (who she described as nonverbal, developmentally delayed, and cognitively, socially and behaviorally about two years old with other complex support needs). She recalled how her son was no longer eligible for public support when he turned 18, although he needed

24/7 around the clock support. She said that her and her husband feared for his life and could no longer keep him safe at home, which led her and her husband to make the difficult decision to drop him off at developmental services. She noted that they did it out of knowing him, and talked about continuing to visit, support him and to build relationships with the staff at the residential group home where he now lives. She said, “And at the end of the day, you have to do what you have to do to get your kids’ needs met.”

“Some pedophiles groom children for that abuse, my mother groomed me to be a caregiver for my sister,” **CARRIE** roared. With her artistic impulses as a storyteller, and in a way that I related to, she was at ease challenging “familiar meanings and [putting herself] at the mercy of the situation” (Hendriks, 2012, p. 459). She delivered her life story in such a mode—establishing herself as an entertainer, landing jokes, and going for the jugular, including by telling stories that didn’t always put her in the best light. She was born in the early 1980s and was around 35 when we spoke. Dynamics of settler colonialism were traceable in her narrative, as she elaborated on experiences of childhood neglect and poverty that she had been vulnerable to as an Indigenous woman. She didn’t bat an eye in talking about her own experiences of precarity or vulnerability and distinguished herself from others who might be ashamed or embarrassed about such experiences. She also drew on conceptual ideas that she had encountered in university, which she had entered into after several years of working as a support worker. Carrie described a slew of care responsibilities across her life—helping to raise her siblings, babysitting to buy family groceries, working at a native women’s shelter (alongside staff members who had stolen her clothing and possessions when she had been a shelter

resident), and working as an informal carer supporting parents at risk of having their children taken away. She joked that she got her start building her “babysitting empire”—setting out to prove that she was responsible, respectable and not a “slut” like her Mom. She also recalled reaching her limits in the mid 2010s, when she had been working 90-hour weekends at a local shelter on top of raising two kids and going to university full time. She said, “I would finish work, pick [the kids] up and I’d be driving home and just crying ... from exhaustion! I’m a weirdo. I get really tired, I cry. My eyes just leak. And I get pale. Eyeball vampire!”

NORA’s life story was laced with metaphors about being seen or disappearing. Born in the early 1980s and around 35 when we spoke, she talked about how she felt seen and affirmed when she first started as paid care worker, but was made to “disappear” by the end of it. Nora narrated working at a residential group home, where she supported people with developmental disabilities for four and a half years. She started the job after graduating from university, and said it was the only position she could find in the small city where she lived. She detailed throwing herself in to anti-oppressive work that she found meaningful, burning out, going on sick leave, burning out again, and resigning with chronic pain when it was physically difficult to work, get through the shift or do the bare minimum. As she put it, “It’s like looking after people with disabilities, and then kind of like becoming disabled yourself.” She spent half the conversation reminiscing about how meaningful, relational and energizing working as a care worker had been, and half the time talking about “really unhealthy and really traumatic and really just debilitating” it was. She also spent time considering why or how she had burnt out,

reflecting on her own personal history of putting others before herself, as well as on organizational “bullshit, like politics and bullying and stuff.”

“So that was the end of work,” **TROY** said. When we chatted, Troy who identifies as trans and uses the pronouns they/them, had just resigned from paid care work only a couple months before. They were processing the experience and discerning whether they could return to work. They were around the same age as me in their early 30s and born in the mid 1980s. We chatted on the phone three times for almost three hours each call. They detailed a slew of care responsibilities across their life, from pitching in at their Mom’s daycare, babysitting full-time and then working as a support worker at a social service agency for several years after they graduated from university. They remembered that they loved the responsibility and meaning that came with skipping school to work at the daycare. Their paid care work position was meaningful at first too. They used to get told how “young and bouncy and fun” they were. They were “kind of like Mary Poppins.” Troy emphasized that it was meaningful, social justice work motivated by their engagement with critical theories of power and privilege in university. Yet they were also critical of the uncaring organizational conditions that couldn’t support the work. At the time we spoke, they were in the process of applying for long-term disability, after having resigned and filed a Worker Safety and Insurance Board [WSIB] report. They shared that their body had just “stopped,” and that they were at times no longer able to do basic activities, like reading forms or going for longer walks. Even after resigning from care work, when offered a job in the film industry, Troy struggled to move on. As they put it, “Yeah, but, see, I don’t know if my soul would feel very fulfilled if I just did that.”

“When I saw your poster, it definitely resonated with me,” **JULIE** said when we first started speaking. She was born in the early 90s and was in her late 20s when we spoke. Drawing on a professional and scholarly discourse, she reflected on past care experiences, including as a summer camp counsellor for children with disabilities and as a live-in assistant at L’Arche, where she lived with and supported people with disabilities. She framed moving in to L’Arche after she completed her undergrad as an intentional next step that was informed by her critical reading of dominant medical or behaviouralist perspectives of disability in university. She remembered that the readings said, “These are the symptoms, this is how you fix it, and this is how you create normal,” and that she was critical of that. She challenged functionalist or biomedical understandings of disability (Douglas et al., 2019), and wanted a meaningful year of service. In speaking of moving in, she said that she “noticed red flags that were very disenchanting” and “knew it wasn’t going to be a comfortable place for a long-term commitment.” As she put it, “the expectations of the community didn’t really align with what I wanted to give.” She chalked up reaching her limits to her young age, her lack of experience in the workplace and the community’s lack of regard for the lives of live-in assistants.

Ontario’s care economy: Situating the study

Now I want to situate my discussion in Ontario, Canada, the context in which research participants’ life histories and mine have taken shape. Ontario’s care economy is far from unique to this context, and in some ways provides a case study of the care economies of many contexts shaped by neoliberal post-welfare states and what is sometimes called financial capitalism. The social organization of care work in Ontario

has garnered substantial interest from scholars, who have produced literature on people's positioning in everyday care relationships (including relations of power and dependency) and in extended social relations (including those thought of as political, economic or transnational). These relations are intersecting and difficult to distinguish or think of in terms of "scales" in that the global political economy is produced through the everyday practices of people and groups (Onuki, 2011). In what follows, I show how, despite an aging population and rising health care needs (Peckham, Williams & Neysmith, 2014), (1) neoliberal and transnational developments, and (2) increasing privatization or public sector cuts in Ontario have shaped practices and possibilities for care relationships in Ontario, giving rise to productive tensions and contradictions that people negotiate.

Neoliberal agendas that privilege for-profit production, reduce public sector support for care, and set individuals apart from one another have contributed to how care is organized (Baines & Armstrong, 2019). Neoliberalism "sometimes refers to a cultural project based on creating self-regulating, individual subjects (Rose 1999)" (Rivers-Moore, 2018). In Ontario, neoliberal agendas have often been linked to the Harris conservative government cutbacks in the 1990s. Not only is the onus on self-regulating individuals, not the state, to provide care, people's ways of understanding care provision are shaped through "individualist, market-based, privatized articulations" (Schein, 2014) that devalue the work of care and individualize responsibilities for it. Relatedly, the advancement of global capital puts extreme pressure on everyday care relationships (Wood & Skeggs, 2020). The devaluation of care is evident in and brought about through global care chains that unevenly distribute resources globally and rely on a surge of (women) care workers coming from poorer countries to take up care responsibilities in

Canada (Mahon & Robinson, 2011; Yeates, 2004; Williams, 2011). There is an increasing demand for care workers and an increasing reliance on migrant (women) care workers, which is often linked to transnational circuits, dynamics or divisions of labour (Gottfried & Chun, 2018; Mahon & Robinson, 2011; Michel & Peng, 2017; Williams, 2011). The global division of labour centers on gender and intersectional inequities, as care is assigned to women, or immigrant, racialized and working-class women in particular (Baines & Armstrong, 2019; Braedley, 2015; Chun & Cranford, 2018).

The Ontario provincial government has been actively privatizing care and limiting the scope and responsibility of the welfare state by restructuring, deregulating and devolving social services (Daly, 2007; Joseph & Skinner, 2012; Skinner, 2008). These shifts have increased demands for individuals or families (women in particular) to provide care, including through paid, unpaid, informal or volunteer roles or forms of care (Baines & Armstrong, 2019; Daly, Armstrong & Lowndes, 2015; Hande & Kelly, 2015). Constrained public welfare spending and the ongoing restructuring of the care economy have framed care provision as a private (family) responsibility, while also leading people to rely on the private market. This is evident in initiatives to deinstitutionalize care or provide for-profit care at a lower cost (Armstrong & Armstrong, 2019; Banerjee & Armstrong, 2015; Daly & Szebehely, 2012), as well as in efforts to promote managerialism, market logics, standardization or accountability requirements (Baines et al., 2016; Bourgeault et al., 2010). The Ontario provincial government has been shifting from publicly-funded care to (1) community-based care that relies on individuals, households, communities or on the voluntary sector; and (2) market-oriented, managed competition that relies on for-profit, private corporations securing contracts (Daly, 2007;

Skinner, 2008; Skinner, Joseph & Herron, 2016). In the face of “Canada’s supposedly fragile welfare programs” (Braedley, Côté-Boucher, & Przednowek, 2019), individuals and private families (women in particular), are assigned care in the global division of labour (Braedley, 2013, 2015) and often pressured to do more care than they are prepared for, with complex or intensive aspects of care being carried out in the home or community such as with direct funding models (Kelly et al., 2020) or with the expansion of care technologies at home. In this context, aging in place is often understood as the ideal choice, with nursing homes or long-term residential care facilities viewed as a “failure” (Chivers & Kribernegg, 2017) or “last resort” (Campbell-Enns et al., 2020).

These conditions and currents have given rise to productive tensions. In particular, the restructuring and devaluation of Ontario’s care sector has given rise to deepening and intensifying experiences of precarity or social isolation that are noticeable in long waitlists, care shortages and unmet care needs, and in intersubjective tensions, forms of violence, and scandals (Banerjee et al., 2012; Braedley, 2015; Funk et al., 2019; Kelly, 2017; Lloyd et al., 2014). Research highlights how, across the spectrum of care work in Canada, labour shortages have become a persistent problem (Bourgeault et al., 2010; Braedley, 2015; Canadian Health Coalition, 2018). In Ontario, staffing shortages have been linked to inadequate care levels and long waitlists, as well as to escalating violence, accident and injury rates (Armstrong et al., 2019; Ontario Health Coalition, 2019). It is on this terrain that people experience profound social inequalities and unmet care needs, with efforts underway to recruit and retain workers or incentivize workers to continue to care, including in situations where they are experiencing harm or abuse (Herron et al., 2019). Paid care workers are exposed to physical and psychological

hazards and experience “work overload, low worker control, disrespect and discrimination” (Braedley et al., 2018), with unpaid carers increasingly responsible for providing more complex or comprehensive care (Funk & Outcalt, 2019). Notably, paid and unpaid care are linked, as it is often the same group of women who are doing both across their lives.

My research considers how conditions in Ontario’s care economy give rise to contradictions that women negotiate in practice. Neoliberal and transnational developments, as well as on public service restructuring and the privatization of care set the stage for participants’ creative and agentive work to remake their lives. I consider how women are set up to face dilemmas that they negotiate in relation to their sense of selves and self-expectations, intimate others and practical and conceptual relations. Having introduced my theoretical and methodological approach, I will now turn to presenting the findings in chapters three to six. The next chapter begins with an examination of how participants in different age cohorts variously evoked images and ideals of care, taking on moral positions in particular social and historical relations.

CHAPTER 3: FIXING GIRLS: CARING FEMININITIES AND DIVERSE FORMS OF GENDERED, MORAL COERCION

To understand how women exit, leave, step back from or otherwise “get out” of care work, we need to understand *how* they “get in,” as well as *what* exactly they are in. Exploring how women unpack their sense of self, gender and moral worth in making decisions to step back from care has the potential to shift sociological theories of care. But first it is important to understand how women variously describe orienting to, or being oriented to “care,” depending on the social and historical conditions of their lives.

Feminist political economists analyze the division of care work at different levels of social organization, emphasizing that the way it is organized can be a significant determinant to women's equality (Luxton, 1980). Through normative upbringings and admonitions to care that frame care as a feminine activity (Braedley, 2015), society has worked to produce girls and women who willingly assume their gender roles and undertake gender-assigned duties and obligations for care, including in the family or in unpaid or low-paid positions (Glenn, 2010, p. 43). As Braedley (2013) puts it, “Exposed to these messages and admonition that *good women* care for others and especially for their families, girls grow up amenable to uncompensated or low-paid care work as an opportunity to attain feminine moral worth” (p. 60). Funk et al. (2019) call attention to “dominant conceptions of gender roles, whereby caring activities are connected with caring identities which provide self worth and a sense of self” (p. 6). Sectors where women ‘choose’ to work are often lower paid (Armstrong, 2007), with such choices not “a matter of unconstrained will” but rather “heavily conditioned by structural social arrangements that impose limits on what women can do” (Wajcman, 2000, p. 188).

Women are attracted into paid care positions in organizations typecasting for care positions, tugging at the heart strings or playing up the emotional rewards (Palmer & Eveline, 2012). One example is how “care workers’ job titles do not distinguish the worker from the task: they are attendant care workers, or personal support workers” (Daly, 2013, p. 35). Women are also funnelled into care work in relation to limited other labour market options (Dodson & Lutrell, 2011).

I contribute in this chapter to scholarship and debates on women’s coercion into care and gendered divisions of labour by tracing changes in the production of caring femininities over time. Femininities can be thought of as “configurations of practice” or patterns of agency associated with the social position of women (Connell, 2005, p. 13). Such practices “arise in specific circumstances and may be severely constrained by them” (Connell, 2005, p. 13). Femininities change, as they are “created in specific historical circumstances and, as those circumstances change, the gender practices can be contested and reconstructed” (Connell, 2000, p. 13-14). With such a focus, my research draws inspiration from Kennelly’s (2014) study that illustrates how young women activists “continue to be tied to the gendered expectations that they care for others” (p. 246-7), which she refers to as the “retraditionalisation of gender under neoliberal modernity” (p. 248). As she puts it, “It is not surprising that under increased pressures to become more self-regulating and to shift the emphasis of care away from the state and towards individuals that women have come to play a central role” (p. 246). I also draw inspiration from Silverman et al.’s (2020) research on the care histories of young adult carers (ages 25-36), which makes visible how “gendered expectations within a capitalist system” (p. 12) play out, even with “feminist theorising and activism regarding the denaturalisation

of care as women's work (see Hooyman and Gonyea, 1999)" (p. 12). Both studies caught my attention in suggesting commonalities between women in different generational cohorts. They also raise questions for me about how, whether or to what extent meanings and practices of care change over time.

In this chapter, I map changing relations between women and the care economy, making visible how shifting social and historical conditions reshape practices and meaning of care. I begin by contextualizing the diverse ways women in two different age-cohorts conceptualized and oriented to care—evoking images or ideals of “good” caregivers and establishing their moral sense of selves in relation to care. Along the way, I situate participants' stories, making links to their different life circumstances and to broader social and historical relations. While I identify some differences both in participants' narratives about what makes a “good” caregiver and in their accounts of orienting to or being oriented to care, I argue that the result is similar – some women are constantly caring or facing demands to care. To close, I theorize what I call the “set up,” elaborating on how participants are positioned by gender, class and conditions in the care economy. I critically reflect on how care “gets in,” with the moral coercion of girls and women into projects of care taking on different forms in the lives of women in different social locations. With that, my argument isn't a hopeful note about the development of different modes of caring femininity, nor is it an indicator of any kind of “progress” in the care economy. Part of what is troubling to me is how younger participants often distinguished their approaches from the conventionally feminine ones primarily mentioned by participants in the older cohort, but that they too described facing and

adhering to gendered, moral expectations for girls and women to care in ways that served similar social functions.

Women in different generational cohorts figuring “care”

With the goal of elaborating the shifting social and historical conditions, I illustrate how women in different age cohorts had different patterned ways of figuring themselves as caregivers and orienting to care relationships, but were still responsible for providing care. Differences in women's perspectives and positions are important to notice, as they tell us about how they are implicated in care relationships or the extent to which caring is interwoven with their sense of selves. That said, even with different social conditions underpinning participants' lives, and with different critical resources or discourses to support them, my analysis shows how women still have to care, or negotiate responsibilities to care, with totalizing care expectations or responsibilities for some.

Participants' stories tell us about transformations in Ontario's relational care economy and about the socio-cultural or conceptual narratives circulating among particular age-cohorts that reflect and shape different political, economic and social periods. I didn't set out to do a cohort analysis to compare people in different age, generational or birth cohorts who came of age in different historical periods or were narrating at different phases of their lives. It was in analyzing social patterns in how participants figured their mothers (e.g., as models or anti-models) that led me to attend more closely to the different circulating narratives they drew on. I focus here on women over age 60 (born before 1964) and women in their 20s-30s (born after 1982). I also recognize that what constitutes an age cohort (e.g., such as young adulthood) relates “not

only to chronological age, but also to developmental and experiential factors” (Silverman et al., 2020, p. 4). Taking age as a social relation and organizing principle, I do not look at these cohorts as “static” or “horizontal slices” (Edmunds & Turner, 2002; see also Katz, 2017), but instead consider how structuring contexts replete with circulating narratives shape people’s perspectives, practices and possibilities. In speaking of masculinities, Connell (2005) writes, “The masculinities of adolescence, then, will generally have a close relationship to the masculinities defined for adults in the communities concerned – though they do not simply photocopy the older models” (p. 24). She notes that “existing masculinities are appropriated and inhabited,” and that “there is contradiction, distancing, negotiation, and sometimes rejection of old patterns, which allows new historical possibilities to emerge” (p. 24). Contradictions are central, and people negotiate them.

In this study, all participants seemed to have some sense that “gendered power relations socialize women into feeling that caring is something that should be done altruistically” (Palmer & Eveline, 2012, p. 257), and all seemed to work with or position themselves in relation to that assumption. While participants hardly used the word ‘choice,’ they were making choices in their narratives and often speaking of (constrained) choices, as they recounted orienting to care or investing in particular ways of life. Most participants cited common stereotypes about care or about women being taken advantage of. “If I had a resentful, jealous husband, it would have been really ugly,” Gracie said. In conversation with Anne, I asked whether she “always had a sense of justice for sticking up for bullies,” to which she nonchalantly said, “Oh, sometimes I was the bully.” She spoke back to conventions for narrating care in a way quite different from carers in

another study who reported being “born to care” (Stacey, 2011). “It’s not that,” participants seemed to say, “I might seem like the type, but I’m not.” Participants’ storylines were more complicated, and there was more to it than a straight-forward reading of them living out normative feminine positions or saying the type of thing that women in their age cohort say. Such an observation is important to note in light of critical aging studies scholars, who refuse to classify people in particular age groups as “other” (Swinnen, 2018), who refuse to cast older people as a “blob” of neediness and vulnerability (Chivers, 2020), and who note that older women are lesser represented in political “activism and in society more generally” (Sawchuk, 2009, p. 183).

In looking at the circulating narratives for women in different age cohorts, my point isn’t that all people of a certain age have the same experience or same ways of framing their lives. Far from it. These age groups are not homogenous. I interviewed activists, storytellers and a woman who identified as a “shit disturber.” They weren’t women who said a type of thing. Participants had unique and unexpected ways of putting it and unique circumstances. “I’m contradicting myself all the way through this,” Dale said, curbing any reading of herself as a ‘type’ of person who says a type of thing. What I do focus on, however, are the broad patterns in the circulating narratives among particular age-cohorts that reflect and shape a particular historical period. Participants stories help to show how practices and meanings of “care” change over time, as they are institutionalized, as well as socially and historically variable. The idea is that a group’s age, phase in life, social background or life-spanning experiences (such as of a recession, labour or economic conditions or cultural and political currents) enable and constrain their practices and possibilities. As Peltola et al. (2004) write, “As individuals pass from

one life stage to another, their microlevel experiences and self-attitudes are influenced by the macro-level historical context” (p. 124). People’s life experiences make a difference, as do the socio-cultural and conceptual narratives that they have been exposed to in making up their lives in particular social and historical contexts (Mora, 2006, p. 58-9). Different discourses offer “symbolic or practical resources” for people to negotiate their life circumstances (Ringrose & Renold, 2010, p. 584), for instance with normalized discourses of care seeming to limit some women’s options for renegotiating without coming off like “heartbreakers.”

Good girls: Family ideologies and (un)conventional femininities

Gendered structures of power shape women’s lives and experiences, from who does what to the stories people tell afterwards. In what follows, I detail the range of ways that women in the older cohort understood and oriented to “care”—variously evoking figures of good caregivers, while taking on moral positions in relation to care. Along the way, I also make links to class, gender and conditions in the care economy, as well as to circulating narratives that frame care as an individual family responsibility. I argue that, while participants in the older cohort variously aligned with or rejected dominant ideals of “care” or conventional femininity, and variously constituted themselves as caring subjects, they all described care as a force in their lives that they positioned themselves in relation to.

When I first started analyzing how women found ways of making up their lives in relation to care, I noticed how many framed caring for others as a way to be “good,” which can be thought of as conventionally feminine practice. The most common figure

mentioned by older carers was that of the “good mother,” which was central to the accounts of Gracie, Sheila, Judy, and Marilyn. The figure of the “moral overseer” came to mind as I analyzed their stories. In speaking of her work as a nurse practitioner, Marilyn said, “And I certainly was given a lot of respect for my role that I played.” She also talked about overseeing others’ involvement in caring for her parents, saying, “I’ve been supportive and appreciative of [my brother’s] input with father, so he feels valued, you know, within the family, and that’s helping him maintain his status.” With such a framing, she almost made it seem like she had been humouring her brother or letting him in on what was *her* responsibility or domain. Such expressions of power in participants’ accounts seem in part about the life situations participants were in when they were speaking to me and looking back on histories of caring for others, for instance with Sheila talking about welcoming her mother into her own home. The majority of women in the older cohort seemed to position themselves as moral overseers. That said, not everyone bought into such a conventionally feminine role or situated themselves exclusively in relation to their families. Upon closer analysis, I also noticed other ways of representing care, with some participants using figures of the advocate and dupe. Women embody caring personas differently.

“Nobody would have been able to care the way that I did” was an overriding sentiment in Gracie’s life story as she narrated multiple care responsibilities across her life and over the last five decades. In her story, family was conceived as the most important area of her life with examples of care that took place almost exclusively in relation to her family. She positioned herself as a moral subject by explaining how she emulated her mother. She said, “My Mom was always taking care of somebody. ... So, I

always have been somebody who has wanted to take care of people.” With a “So, I,” Gracie framed caring as a natural inclination; she said that her Mom “passed it on,” that it was “just normal” for her, and “just became a part of” her. She said that she grew up “seeing, knowing and believing that human beings were supposed to help to take care of the people that they love that needed help.”

Gracie remembered how, as one of the “very popular kids” growing up, “she was always quick to support other kids, including those who were “were looked upon as the difficult strange, weird or bad ones.” Such a memory was one example of how she took on the role of moral overseer or of someone caring from a more empowered place. She framed caring as a service that benefits others, claiming a narrative form of power and producing value for herself through the register of care in ways that aligned with and reproduced dominant gendered feeling rules. Another clear example of how she oriented to care was in how she framed her experience as a day care provider. She didn’t talk about money or the work involved or about limited access to public care for her two children who were in her home day care. Instead, framing it as a “fabulous” experience, she reminisced about soothing souls and framed care as an act of love that wasn’t about the money. As in dominant constructions, care was not framed as skilled work deserving of wages, but as a social expectation of women (England, Budig & Folbre, 2002).

For Gracie, caring was about her own generosity, not others’ entitlement (see Tickin, 2011). To be positioned as the “good” caregiver in her family seemed to be a valued, desirable position, with cultural or moral accolades accompanying it. It came with something. There was a gendered division of labour in her family with women taking primary responsibility for care responsibilities, and men working full-time. In

speaking of caring for her mother, she said, “I needed to be with my Mom. I wanted to be with my Mom. My Mom really needed me to be with her. She didn’t have anybody else that could care for her.” While Gracie noted that she didn’t have another option and *had* to care, she said that she would have provided full-time care “*just because* of the relationship” that she had with her Mom. As she put it, “I would *want* to care for her. It wasn’t because I had to. I wanted to.” So, although she admitted that she didn’t have a choice, Gracie framed caring for her family members as a preference or something she would have done anyway, which implies alternatives and speaks to taboos around framing it in other ways (Levitsky, 2014). Backed by discourses of family responsibility, Gracie emphasized how much she enjoyed caring for others. She found self-worth and meaning in the work she was sentenced or obligated to do, registering caring as something she did as a “good” woman.

Sheila, who was in her late 60s when we spoke, also framed caring as a way to be good, evoking the figure of the “good” mother in her account of caring for others across her life. Conventionally feminine discourses of care and family responsibility that draw on maternal, familial ideologies of “care” were noticeable in her account, providing a resource to make sense of her life. Such discourses took on a particular flavour with her classed social location. Sheila framed the position of mother as an honourable, esteemed position in speaking of her own mother: “I can remember other school kids walking [to and from school] with us, because they liked [my Mom] so much. And there was one fellow who was the real bad boy of the school who always walked with her. He loved my Mom.” Sheila evoked images of her own good mother, and shared about her own practices as a mother, as she elaborated on her investment and identification as a

caregiver. Such a maternal discourse was supported by an ideology of family responsibility, as well as by a particular gendered division of labour that sees women shouldering responsibility for care. "I'm the one, you know, who brought home all the stray cats and looked after dolls and all that. I've been the caregiver since I was that high," Sheila said, pointing to her waist. With her elite social location, past experiences of advantage, and with the nature of dependency relationships at home (e.g., without any sick family members growing up), Sheila didn't mention caring for money or to meet others' basic needs growing up. She was speaking on a different material basis, with many other sources of meaning and self-worth in her life.

Research shows some carers are uncomfortable with recognition (Funk & Outcalt, 2019; see also Folbre & Nelson, 2000, p. 133), and Sheila's account was no exception. She didn't put herself on a pedestal or brag so to speak. She emphasized that there was nothing "unique" or "special" about the care she provided; it was just what she did for someone that she loved. As opposed to framing caring as a form of individual self-expression or way to matter, Sheila hinted that caring wasn't a way to attain status that she already had. It was one of her many commitments. She said, "You say, 'What was special? What was unique?' These were just things we did. We put a lot of time into her care, but I didn't consider that anything special." Ironically, she seemed to claim power through a story of not having needed to care to claim power.

Judy, who was in her early 70s when we spoke, described taking responsibility for caring for family members from a young age, with family also serving as a site of socialization. While Judy also framed herself as a good mother, she talked about financial hardship and experiences of disadvantage, which seemed to shape her orientation to

caring or supporting her family. She shared about how her Dad lost their family home and she worked to support her family as a teenager. She also emphasized that she didn't have a choice about caring for others; she narrated how, in her childhood and with a "frail" Mom, she was her younger sister's first caregiver with her father "helping out" in the evening when he got home from work. Similarly, in speaking of how she took care of her two kids while her husband worked, she said, "So *I had to* be strong and be the caregiver. But I accepted that challenge, because I just found it so rewarding" (emphasis added). So, while she had to care, it also seemed to offer a way to establish a moral sense of self. Her identification as a good caregiver seemed to go beyond any particular role. For instance, she mentioned that she had promised her late husband that she "would continue with [her] volunteer work and that [she] wouldn't become a hermit." She vowed to continue being of service. In situating and contextualizing her story, it's notable that caring offered a way to sustain herself and her family. Backed by discourses of family responsibility, her perspective was also shaped through particular micro relations of care and gender that assign responsibility for care to women in relation to men making up their lives in the public domain through waged work.

"There are people who put their loved ones in long-term care homes and don't see them or see them maybe once a week, but I couldn't do that to my Dad," Judy said. She took on a moral, feminine position in speaking of caring for her father. She talked about her own mindful or self-sacrificial commitments and identified as a caregiver with the social status and self worth such a label entails (Funk & Outcalt, 2019), while distinguishing her approach from that of others'. In speaking of helping her Dad when he lived in a long-term care facility, she recounted (gently) disciplining several others

including a “little PSW” who “softened after a while.” “That is deplorable” she remembered saying. As she put it, “She—maybe in her culture and her ethnic background—she wasn’t taught that, you know, maybe she didn’t know. Maybe that’s her mannerism.” Through what Espiritu (2001) refers to as “ethnic boundary practices,” Judy reinforced divisions between herself and others to “reaffirm [her] self-worth and value” “in the context of racial and ethnic subordination” (Kim, 2018, p. 1046). With a distancing account, Judy in some ways got a leg up. She legitimated her belonging to a caring life project—making uncaring, racialized subjects into the problem, while inflating her own innocence. She distinguished herself from other carers who violated normative modes of feminized caring activity—using them as objects to draw her “own moral value, purity, and distance” (Wood, 2018; see also Dosekun, 2020). Inhabiting the figure of the ideal carer set her up as the only one who could do it – the kind of woman who always cares and cares at all expenses. Such a position as the “only one” was also a precarious one to be in as future chapters explore.

“When I was maybe five, I told my mother I would be a nurse or an airline stewardess and she said, ‘I think a nurse dear,’” Marilyn said. She was around the same age as Judy, and she too evoked the figure of the “good” caring subject, establishing a moral sense of self in relation to care. That said, speaking with an air of formality and from a position of power, her account was spoken with particular class undertones. She framed both of her parents as good people who came from families that were “upstanding in the community.” She noted that her family was well-educated, and remembered her grandmother wouldn’t let her children take up a paper route, as there were “more people less well off than they were.” “So having a lot of standing in the community,” Marilyn

said again. Her class privilege seemed to give rise to her other-oriented concerns for others in the community. In speaking of her care memories, Marilyn talked about the importance of “order and discipline” and “etiquette,” describing how she taught her own two children “proper manners” and how to “set the table for meals.” She said, “I credit mother with really giving us stability—you know, well-organized house ... The stability of the household serves you well.” There was “no chaos at the dinner table,” and Marilyn seemed to hint that they weren’t running around trying to meet their basic needs, but engaging in care as a particular classed practice. Even still, she described a particular gendered division of labour in the home, remembering that her Mom did more work, and that even her grandmother who was well-educated had to “cow-tow” to her husband. She also talked about how this played out in her own family growing up: “So I’d come home from high school and start the vegetable ... My Dad said it was only fair to mother if we should do a little bit to start to help.” Marilyn stated this in a way that showed she was aware of the gendered dynamics, noting that she was “helping out” Mom with what was her Mom’s responsibility.

“Uh, yeah, I did. I know I did, but I don’t have strong feelings for memories about it,” Dale, who was in her early 60s, said when asked whether she had any memories of caring for her younger siblings growing up. Her off-the-cuff response illustrates the intergenerational differences in the ways that participants framed care as a moral, feminine project. Dale’s account challenged conventional understandings of femininity, at times even taking maternal ideals head on. “There’s no mother,” she said, “There’s no—I’m not a mother.” She said that she wasn’t a “maternal person,” couldn’t “retreat behind an appearance ... of heterosexuality and child-raising and family life,” and couldn’t follow

caring as a “schtick [that] can be very gendered” and can have a “power imbalance.” She noted that she didn’t fit into “paradigms about a progression in life that has a lot to do with partnering and having kids.” In the feminizing culture of which she was a part, and where definitions of femininity are quite strict, she mentioned that she had limited options to “retreat.” She drew on and acknowledged dominant narratives that frame care as a way to be “good,” but she resisted and distanced herself from them. Her life project wasn’t a heteronormative, maternal or charity project. Both as a woman who wasn’t able to have kids, and as an HIV-positive woman who needed to “get with the group” or contribute to social movement activism to ensure her own survival, she had a different basis for constituting herself as a caring subject, with different gendered, moral dimensions at play. Informed by discourses of social movement activism, and by her life’s work as an activist, she talked about mutual relationships and about political forms of care at the community-level. She called attention to “alternative power dynamics” or “expression[s] of power” that center on “non-reproductive” forms of care that are “against gender roles.” That said, while she certainly didn’t position herself as a good mommy or moral overseer and didn’t draw on conventionally feminine discourses of care, she too carved out a particular moral position in relation to care, claiming power for herself in relation to care in a different way.

“Dumb enough” to care for others is how Gina described herself, with her life history making it hard to uphold straight-forward, conventional readings of care or femininity that center on caring to be “good.” Her experiences of disadvantage were apparent as she described being coerced into care or handed care across her life. At the time of looking back on her life in her early 60s, she didn’t frame herself as caring from

above or from the position of moral overseer, nor was care a straight-forward form of generosity from an empowered position. She described caring to survive and to sustain her basic needs, with the threat of violence and other experiences of precarity shaping her approach. She remembered her childhood spent caring for “sick, sick, sick” family members and raising her baby sister. As she put it, “When my sister was born, my Mom handed her to me, and said, ‘here you go,’ and that meant ‘she’s yours.’” Gina recalled being forced to care by her “dysfunctional Mom who never liked” her. She said, “Mom would just be laying there—despondent and shaky with shot nerves, and during the day, it was on me, before my Dad could get home and help out.”

Gina’s orientation to care was powerfully shaped through relations of class and dependency. “Helping out” was how Gina referred to her father’s efforts, as she recalled the household work being assigned by gender (by her Mom who was responsible for assigning it). She recalled a gendered division of labour, saying, “My sister and I had to make all the meals, do the vacuuming and washing floors, cleaning bathrooms. And, because Mom was brought up this way, the boys didn’t have to anything, because you had to support your man.” She rolled her eyes at this, hinting that the promise that comes with being a “good” caregiver hadn’t come with social or material benefits or moral and cultural accolades in the way other women describe. That said, Gina also took on a moral position in speaking about her caring commitments. For instance, in talking about supporting her sister, she said, “She was the baby, so what’s not to love?” Gina’s story provided a clear example of how women described finding meaning in caring work that they are obligated to do. In speaking of a more recent example, she recalled undergoing a “caregiver time warp” when she was left stranded supporting her Mom in her Mom’s

geared-to-income, one-bedroom apartment. She framed it as the ultimate sacrifice as she blamed her siblings who left her “stranded” and talked about being the “only one” willing to give up her life to keep her mother alive. She emphasized that she was uniquely capable of caring for her Mom in relation to her siblings and other relatives. “None of them were willing to do what I did,” she said, painting herself as the one who did the right thing.

In contextualizing and situating participants' narratives, it was clear that expectations for girls or women to care are supported by family structures (Levitsky, 2014), as well as by broader cultural and policy discourses and gendered directives that frame care as an assumed or expected emotional or moral commitment – a practice that offers a way to constitute oneself as a feminine and moral subject (Donath, 2017; Palmer & Eveline, 2012). Women make up their lives in contexts where men “help out” and where the work of care is the domain of women. Participants negotiated or worked with these gendered, moral expectations to care, finding ways to make sense of their experiences and to figure themselves. We can see the different ways participants take on moral positions in orienting to care depending on the conditions of their lives, with intra-generational, classed differences here too. Class, gender and conditions in the care economy that frame care as an individual family responsibility were apparent in their life stories.

Rebels: Precarious work and politicized struggles

For participants in the younger cohort, there were differences in the dominant social or political discourses of care they drew on, with ideals of friendship and social justice

activism running through their narratives, as they described caring to rebel or resist. As I will illustrate, class, gender and conditions in the care economy shaped their practices and possibilities for constituting their caring femininities. Along the way, I will also make links to broader social and historical relations, and attend to intra-generational differences that have to do with their life circumstances or critical discourses they had access to.

The figure of the rebel gives a useful way to think about younger participants' accounts of caring to resist dominant ideologies of motherhood or family-making. On the surface, caring for others was not part of establishing a feminine self-image through a feminized practice. Signalling an anti-conformist orientation to care, caring to resist was a strong theme in their accounts, as they distinguished their approaches from conventionally feminine approaches to care that center on caring to be "good." Almost everyone in the younger cohort distinguished themselves from women who constitute their femininity by being nice, passive, accommodating or nurturing (Ringrose & Renold, 2010). For instance, Troy critiqued gendered divisions of labour and distinguished themselves from their mother's maternal, subordinate approach. They also rejected middle class norms or normative expectations around career-building or professional development. Care was framed as part of a resistance project, offering a different way of inhabiting a moral position.

Caring to rebel was a strong theme in Troy's life story, with gender, class and conditions in the care economy shaping their narrative. Troy called attention to gender throughout their account, making sense of their history as a trans person who was "A.F.A.B." or assigned female at birth. They used a gender lens to make sense of their

care history, and didn't identify with conventionally feminine orientations to care. That said, they indeed described facing gendered, moral expectations to care for others in ways similar to participants in the older cohort. "Quite frequently it's the oldest female, right?" Troy said, adding, "I just was thrown into that and never really questioned it until recently."

Speaking as someone in their early 30s and looking back on their childhood in the mid-1980s on, Troy recalled that their Mom always volunteered and "put a lot of other people before herself" – she was an elementary school supply teacher, ran a daycare, and would volunteer at night with girl guides or at a local seniors building. Troy critiqued the gendered division of labour in their household – the way their Mom was stuck with the care work, while their Dad was let off the hook. Troy recalled being "handed" babies when their Dad lost his job and their Mom opened a day care. Troy mentioned that they started caring because they had no choice, saying, "When she [Mom] had to do day care, I just got, 'No, you're looking after the kids when I can't do it.' I had to pick up the slack as the oldest, because of our financial situation." Troy also noted that "there was a lot of pride" in the work. As they said, "I think there probably was some like, 'Oh! I'm responsible enough that my Mom needs me to come home and take care of kids.'" So, while Troy noted that there was never "permission" and that they had been forced to care, it was still a way to establish a moral sense of self or to connect. What was notable was how Troy distinguished themselves from conventionally feminine orientations to care that involve caring to be "good." Troy poked fun at their mother's approach, as they remembered learning from her that caring and having "other people come first" is "how you build community," which Troy didn't think was "completely healthy." Resisting

such an other-oriented, self-sacrificial approach to maternal, familial care, Troy instead described pursuing care as a political, social justice project. Caring offered a way to resist.

An example of how Troy distinguished themselves from their mother's approach was when they described entering social service work despite their mother pleading them not to enter into such dangerous work with vulnerable, marginal populations. Troy said, "I think there's a lot of propaganda around how dangerous—you know, and a lot of stigma and sanism around folks with mental health and how dangerous they are." For Troy, having people raise red flags about the work seemed to bind Troy to the work, creating space for them to undertake a counter-cultural social justice project centered on claiming solidarity and building strong relationships with society's most vulnerable. They drew on critical perspectives of disability and power and made links to anti-oppressive, social justice or anti-racist agendas. Troy provided a clear example of this when they talked about advocating for a Black client who was written up for public indecency after having his pants fall down. "The problem is poverty," Troy said, challenging others for their racist or classist approaches. Caring offered a way to resist dominant social expectations, contributing to new forms of disability activism and care politics (Hande, 2019; Hande & Kelly, 2017). Their approach seemed to challenge the figure of the "innocent white expert," while reflecting on their own implication in existing power relations and challenging ideals of helping or rescuing (Occhiuto & Rowlands, 2019). As Troy shared, laughing, "Like as if I was in it for the money!" Drawing on discourses of friendship and activism, they described work as an adventure or experience of building

strong relationships, and remembered visits to parks, beaches and playgrounds with the people they supported.

Troy also gave a more recent example of how caring work that people are mandated to do provides a sense of meaning and moral worth. Speaking of supporting a client at the social service agency where they worked, Troy said, "I had to help him do all his grocery shopping and all his appointments." As they said, "I kind of became his interpreter as well, because although he has dentures, people can't understand and then he gets frustrated with people and I think he got very attached to me." Troy emphasized they were the only one who could communicate with him and support him. They also recalled having uniquely and intimately connected – becoming like "family," as he was the only person they supported with "no other family." Such a family ideology downplays the work involved (Stacey, 2005; Funk & Outcalt, 2019; Braedley & Martel, 2015); as I have been tracking, it also makes it hard to renegotiate responsibilities. Troy noted that they had serious concerns about "tak[ing] time off," as they knew that "balls are going to get dropped" and "people aren't going to get the services they need." Rich (1980) writes, at work, and in other social institutions, women (or, in this case, those in feminized roles) are socialized "to accept male violation of our psychic and physical boundaries as the price of survival" (p. 642). With conditions of overwork at an organization with no boundaries, and with people who deserved to have their care needs met, Troy felt integral to the organization. Troy also noted that they were motivated to care or to make up for gaps as a paid care worker at a social service agency that was stretched thin and didn't have the resources to properly support people.

Nora, who was around age 35 when we spoke, didn't straight out frame her mother as an anti-model, but she did elaborate that something was missing in her early life experiences that led her to orient to care in a different way. She questioned whether her desire "to be the caregiver ... came out of this sense of feeling not cared for." Speaking of her childhood, she said, "my physical needs were met and stuff, but I don't know if emotionally, I was—" This was something that she wrestled with as she elaborated that paid care work was a way of connecting deeply and building strong relationships with others. She framed herself as taking a caring counter path in relation to her own parents who came from "emotionally distant" and "very kind of standoffish" families. She described orienting to care as an incredibly meaningful project centered on building strong friendships with the people with intellectual and developmental disabilities that she supported. Drawing on discourses of social movement activism, there was an emphasis on listening and learning from others, cultivating reciprocal, mutual relationships, and expressing herself. Nora said, "I never expected to find so much meaning and community." "It was the relational stuff at least at the beginning or for the first few years," she said, noting that she really enjoyed "simple things" like "sitting with the people [she] supported, having a conversation, joking around, relating on a human, person-to-person level." Nora's orientation to care was a way of resisting dominant professional understandings of the work that centered on managing behaviours, controlling others or getting the people she supported to be "quote unquote normal."

In situating and contextualizing Nora's life narrative, I came to appreciate how her orientation to caring as a way of cultivating friendships or engaging in political, advocacy work had a material and conceptual basis to it. She referenced critical theory

and anti-oppressive social justice theories that were part of her undergraduate course work in women's studies. It wasn't just about meeting others needs, but about making a difference through political work that involved supporting others with dignity and independence. While Nora was very critical of the gendered division of labour that sees women taking responsibility for care, when she started in the field, she didn't initially see the care that she provided – which was about friendship and advocacy – as the kind of care work that comes with real costs and consequences for women. While Nora noted that women ended up “performing more of the emotional labour” at the organization that she worked at, she said, “But, in a way, I think that's kind of what I loved about the job. I really liked being with the people we supported. I liked spending time with them and getting to know them and learning about them and communicating in different ways and being present and being there.”

Nora felt lucky to have had the opportunity to connect with others, noting that there weren't many other employment opportunities for in her small city. She said that she felt like she had hit the “jackpot” when her other friends had to leave town to find work. She wasn't just cheap feminized labour. She wasn't a woman stuck in a kitchen. There was something there for her – something seductive about care that seemed to offer a source of power, community and meaning, as well as a way to stay in town. She felt part of the local social justice community scene where she lived. She framed it as a political commitment to a way of life, hinting that she had been “choosing” it. Her position was a contradictory one to be in, as even with her radical feminist approach, she *still* experienced a gendered division of labour similar to that described by women in other generations or life positions (England, Budig & Folbre, 2002; Baines & Armstrong,

2019). She was still working in a sector where “assumptions about under-valued gendered skills and gendered job ghettos (Daly, Armstrong, & Lowndes, 2015; Laxer, 2015)” (Baines & Armstrong, 2019, p. 4) had taken hold. As her account suggests, paid care work was low waged, entry level work that came with the promise of intrinsic rewards or moral worth instead of wages or benefits (Glenn, 2010, p. 4; Stacey, 2011). Part of what bound Nora to the work was her commitment to going above and beyond the job description or the organizational policies to support the “fullness and complexity of what someone might be going through.” Care was framed in her account as a counter-cultural resistance project centered on friendship, advocacy and personal growth. It offered a way to claim power, express herself, and live out an ethical life trajectory. She also noted that it was hard to say “no” to people who she bonded with and as part of an organization that framed itself as a “community” without “boundaries.”

“So, there was always this point, like, ‘Watch your sister,’” Carrie said, laughing and poking fun at how she had been funnelled into care from a young age. As an Indigenous woman in her mid 30s when we spoke, her story offers another example of the narratives circulating among her age-cohort – a narrative that both was shaped through her life circumstances and that reflects and shapes a different political, economic and social period. Carrie said, “Some pedophiles groom children for that abuse, my mother groomed me to be a caregiver for my sister.” She had a flippant way of putting it, but she too framed her mother as an anti-model and engaged in care as a resistance project. Taking aim at maternal or familial projects of care, she was critical of the way that care responsibilities fell to her as a young girl. She recalled providing direct daily care from age two on. “I was two years old and I did all [my sister’s] feeding. My mother

says she couldn't—that she only knew that my sister's diaper was dirty because I told her," Carrie said. She noted that her Mom would talk about how only she knew what her sister wanted. "Some magical intuition!" Carrie said, laughing as she spoke. Carrie narrated finding self-worth and meaning in care that she was mandated to do. While she noted that didn't have an option and had to care, she also found a lot of meaning in the work. "Cause at 12, *laughs* I've always been like very industrious. You know, babysitters club! Here's my business model, you know? *laughs* It worked for me!" Carrie noted that caring offered her a way to launch herself on the path to redeem herself as a "responsible," "industrious" caregiver who could "get her own money" in relation to parents who weren't "responsible," "never had money," and hadn't been able to meet her care needs. She positioned herself as taking a counter-path in relation to irresponsible parents.

In situating and contextualizing Carrie's narrative, I took note that her entrance into care was shaped by her life circumstances and by the lack of public supports for her family living in poverty and with limited access to other social services or other social or material supports. Informal care work offered a way out and put her on a path to social status or security in the face of social or economic conditions threatening her own and her family's survival. She indicated that caring presented a clear path out of hardship – a way to alleviate disempowerment and sustain herself. Babysitting was easy money, acquired because – without public or collective options – people need someone to care and buy cheap girls to do it, which, for girls, is often their first money of their own. As Carrie put it, "that first twenty bucks I made, I bought groceries for the family." She also described being on call to care for her younger siblings. As a young teen she remembered getting

phone calls from her siblings who lived with her Mom, with them saying, “Can you drop off a roll of toilet paper? Mom’s gone. We don’t have this or that.” It’s worth noting that social justice discourses were less apparent in Carrie’s descriptions of orienting to care. She went to university *after* she started work as a care worker, so the insights that she later developed on power or anti-oppressive work weren’t ones that she described as motivating her entrance into the field. In fact, she talked about taking a job at an Indigenous women’s shelter, where the workers had previously stolen all her stuff while she was a resident. So, while she had a similar contemporary sensibility in that she rebelled and positioned her mother as an anti-model, it’s notable that the figure of the “rebel”—that signified a particular classed project in the narratives of some—isn’t a figure that’s inflected the same way for everyone. People need capital to buy into certain figures or to constitute themselves through the practices that make up such a figure (see Dosekun, 2020).

Taken together, the narratives of participants in the younger cohort reveal some of the societal conditions shaping their caring pursuits. They called attention to precarious working conditions and labour market relations (e.g., contract work, job insecurity, lack of job opportunities or few opportunities outside of care work), and to cultural or political movements that emphasize social justice approaches such as feminism or disability politics. Unemployment and underemployment are common experiences for young adults, who often delay starting a family due to precarious or uncertain work, including work in part-time contracts without benefits (Kanai & Dobson, 2020; Worth, 2015). Those in the younger cohort described histories of work in precarious positions in a threadbare sector, including at organizations with low wages, low worker retention and

conditions of overwork, where they were made to feel responsible for the people they supported. It was against this backdrop that most participants both emphasized their lack of interest in making money through professional work, and rejected orientations to caring that involved either subordinating oneself in relation to a man or claiming power from above as part of a charity project.

My point isn't that the approaches of participants in the younger cohort were more "relational" or "mutual," but that my analysis of their talk made visible how much they emphasized those dimensions in drawing on discourses of friendship and social movement activism. Backed by social and cultural movements, and in an era of deinstitutionalization, participants in the younger cohort made links to feminism and disability politics in describing their unique orientations to care. They didn't talk about conventionally feminine ways of caring to meet the needs of individual family members, but about caring to contribute to society, which speaks to their life situations, to cultural dynamics at play, and to the critical resources that helped them to understand or frame their experiences. Participants in the younger cohort positioned themselves as doing rare or unique forms of care. "It's not that," they all seemed to say, positioning people who cared to be good and were presumably more burdened by it as an anti-model. They described a different sensibility, with care as a self-empowering practice centered on advocacy and relationship building. In some ways their approaches to care align well with the cultural sensibility of post-feminism, which declares women now free or empowered, and clears space for women to return to normatively feminine pursuits without compromising their empowerment (Dosekun, 2020). Albeit with a small sample, my analysis suggests that there has been uncoupling of ideal images of care and notions

of good mothering, with more emphasis on advocacy or friendships in care relationships that are sources of meaning and connection for carers themselves.

The set up: Care wrapped in gendered, moral coercion

the social organization of care has been rooted in diverse forms of coercion that have induced women to assume responsibility for caring for family members and that have tracked poor, racial minority, and immigrant women into positions entailing caring for others. (Glenn, 2010, p. 5)

This chapter was about the “set up.” I highlighted the different ways women positioned differently in Ontario’s care economy narrated orienting to or being oriented to care, making links to the social and historical circumstances of their lives. As we have explored, participants described finding self-worth and meaning in the work they were sentenced or obligated to do and even resented doing, which connects to Stacey’s (2005) finding that home care “workers have a conflicted, often contradictory, relationship to their work” (p. 832). There is no question that participants faced expectations to care for others and at times felt coerced to provide care with limited options *not* to care.

Participants described being socialized into what they ought to and should do. They learned early that caring for others has moral significance; it is a practice that is morally salient and tied up with ideas about who is a good girl/woman/worker/mother/daughter. That said, by putting participants’ stories in context, I have also tried to show differences in how they evoked images and ideals of “care” or described orienting to or being oriented to care. The “set up,” which is about how care gets “in” or the ways one’s moral sense of self is implicated, was described differently by women in different social locations. Such a finding speaks to how different groups are coerced in different ways; it

also speaks to the need for structural changes that might limit coercion and promote care as a democratic responsibility.

Across Ontario, participants described taking on care responsibilities, as they were pressed to care in relation to limited public supports that frame care as an individual (family member or employee) responsibility, not a public or collective one. All participants talked about growing up in households where women and girls, their mothers in particular, took responsibility for care work and housework, which speaks to broader social patterns around the gendered division of labour. This work of care extends beyond supporting health or medical needs to include emotional, navigational, and relational work (Barken & Lowndes, 2018; Dalmer, 2020). Participants seemed to be socially sanctioned, invited and expected to care, with strong gender norms and social expectations enticing them. In different age cohorts, women were expected to be caregivers in their families, in the community and, for some, in paid work. They described a similar gendered division of work, with women taking on more emotional or moral responsibility. Julie joked about a male co-worker who “would kind of throw his hands in the air” at the first sign of an “emotional crisis.” As she put it, “He just didn’t know how to develop the emotional relationships that I had been able to do.”

Participants in the older cohort were more likely to draw on their mothers as models, while those in the younger cohort were more likely to frame their mothers as anti-models. Both drew on mothers. Care (with its surrounding scripts, stock positions and scenes) seems to say, “come with me, you can be good” to some or “come with you, you can rebel” to others. It’s worth noting that participants were speaking from different vantage points; younger participants primarily reflected on more recent experiences of

paid care work, while older participants reflected on more recent experiences of family care provision. Although not all choices are available, people choose and innovate with what is available. Similar to images of “dutiful daughters and undemanding mothers” in Aronson’s (1998) study, the images that participants evoked were supported by and shaped through family structures, formal and social services, and symbolic and structural relations. They variously brought about and resisted dominant gendered discourses and relations of care, with gender relations enabling and constraining their practices. Notably, even in evoking images of “good girls” or “rebels,” there were important intra-generational differences in how women described inhabiting the role, which speak to the range of ways that women are implicated in “care” as they make up their lives.

As I have explored, class relations were also a crucial filter with women having different options or constraints. Participants’ stories bear clear markings of their social histories and of structural inequities. With regards to material conditions, lower-income families, who often experience intensified, extreme and inflexible work commitments or hours, often rely more on children’s household work to sustain the family or manage household needs, which is sometimes referred to as “adultification” (Dodson & Luttrell, 2011). That said, I also acknowledge critiques of the romanticization of childhood or the ways children are encouraged to self-realize as productive workers, while being excused from age-appropriate care responsibilities. My main point is that the family is a site of socialization with classed dependency relations making a difference in how participants described orienting to care. Dale’s earlier identification as a “caregiver” seemed to have been tempered by life circumstances (or lack of access to ‘objects’ of care) as she could hardly recall babysitting for others, while Gina narrated growing up with “sick, sick,

sick” family members, as she was handed care across her life with limited options to share responsibility. For Gina and others in contexts of material disadvantage, care was framed as presenting a way to survive, sustain themselves or others, or put groceries in the fridge. Some participants described being able to pay rent, with questions about how they would if they didn't show up for work. Classed, dependency relations provided different rhetorical infrastructures for the stories that participants told about care (see also Mora, 2006; Peltola et al., 2004).

Concluding remarks: Socially conditioned work in the care economy

My analysis of participants' narratives reveals patterns in the institutionalized production of caring femininities, arguing that the social relations that construct care as a moral, feminine activity are in *some ways* different for women in different social and historical locations, but with women *still* set up to care or to negotiate responsibilities for care. Women's stories are not idiosyncratic, but speak to how they come to care, as well as to conventions for narrating care beyond and across particular paid and unpaid care contexts. Women in different age cohorts are “called upon to invest in particular expressions of gender” (Irving, 2017). As I have illustrated, they had patterned ways of constituting their caring femininities—variously evoking images and ideals of “good” or “rebellious” caregivers, while taking on particular moral, gendered positions in relation to “care.”

With different ways of putting it, and different social and historical relations mediating their lives, women in the younger cohort were more likely to frame their mothers as anti-models or to narrate caring to “resist,” with those in the older cohort

framing their mothers as models and describing caring to be “good.” Younger participants can be read as distinguishing their approaches from the conventionally feminine ones described by some participants in the older cohort. The accounts of younger participants seemed to reframe what it means to be a “good” woman or caregiver. That said, they were still implicated just as strongly in the gendered care economy and in historically inequitable gendered arrangements. They too described orienting to care as a moral project or adhering to gendered, moral expectations to care in ways that served similar social functions. So, even with the emergence of different narrative patterns or different circulating discourses to draw on, their stories were still stories about the direct or indirect coercion of girls and women into projects of care, with gendered moral coercion taking different forms in different life contexts.

Practices and meanings of care are deeply institutionalized and historically and culturally variable. As women make up their lives in the care economy, their practices are shaped through *symbolic and structural relations* that assign care to women. It is notable that participants in different social locations were socially sanctioned to care, with strong gender norms, as well as social and political relations funnelling them into the work. Their stories speak to what Aronson (1998) calls the “normative ordering of responsibility and gender relations” (p. 123-4). Limited public supports that make care an individual family responsibility, not a public or collective one, were conditions most visible in the accounts of family care providers in the older cohort. Labour market opportunities in recessionary conditions, as well as social and political currents framing care as a way to speak back to the societal devaluation of certain groups were most visible in accounts of paid care workers in the younger cohort. For participants across

cohorts, neoliberal processes centered on privatizing care or cutting state provisions for care seem to have intensified demands for *individuals* to provide care or to take individual responsibility. My analysis suggests that relationships between women and the care economy change over time and in different social and historical periods and with people's efforts. As some practices and meanings of care are contested, new ones emerge, creating different social relations enabling and constraining women's work and lives (see Shotwell, 2016, p. 154).

The chapter made visible how women are still doing and negotiating the work of care, with commonalities in gendered expectations and divisions of labour over time. In fact, women's care experiences were quite similar, with their interviews showing some continuities in terms of their investment in the work of care. So, while participants in the younger cohort had some alternative ways of framing the work or orienting to care, they were still faced with care responsibilities, with different ways of describing being bound to it. Across generations, gendered, and moral injunctions to care have a strong hold. With that, this is by no means an optimistic account of shifting dynamics in the care economy or of the development of more "relational" or "mutual" ways of approaching care as a form of friendship or activism. What I have tried to show is how the association of caring with conventional *and* unconventional femininity and with moral traits was obvious in many accounts. Not only do "good" women care at all costs, "rebels" do too. Care can be thought of as an "ethical ideal central to projects of transforming and remaking moral subjectivity" (Zigon, 2013), and women are "set up" to negotiate gender relations and expectations that propel or mandate them to care.

Moving forward, chapter four takes up an inquiry into how participants described negotiating moral dilemmas at the limits of care. Having elaborated on participants' socially and historically conditioned work in relation to care as they reference particular figures of the ideal caregiver, I will now explore their moral work to negotiate contradictions. Class, gender and conditions in the care economy not only funnel or coerce women into care, but also contribute to creating dilemmas that they negotiate in practice.

**CHAPTER 4: AT THE LIMITS OF CARE: EMBODIED BREAKING POINTS
AND MORAL, FEMININE ACHIEVEMENTS**

“Nobody would have been able to care the way that I did,” Gracie said. As she told story after story about excelling at caring for others, I wondered why she had signed up to participate in my research on the limits of care if she was only going to emphasize the positives, and if she didn’t seem to identify with the recruitment criteria of having reached her limits. Finally, after 80 minutes in conversation together, she mentioned that her mother’s major heart attack and recovery process had rattled her son to the core, and I sheepishly interjected to ask, “Did it rattle you as well or do you remember—?” I squeaked out the question. I felt like a shit-disturber for asking, as though I was posing a threat to the narrative that she was telling herself and others—messing with her self-image. I struggled with how to broach the topic without undermining the story she was crafting about who she was. Caring for others seemed to be the accomplishment she was most proud of, and one her family still praises her for. In response to my question, Gracie elaborated that she was at her “wit’s end” from sleeping with the baby monitor on and “living one big adrenaline rush all day and all night.” But, from there, as if not wanting to go one bit further, she underscored that she came through “well and whole and in one piece.”

I had a similar experience struggling to broach my research topic in conversation with Judy. Eventually, after 90 minutes, I asked, “One of the things I put on the poster was about reaching your limits. Can you relate to that in any way?” I passively attributed my interest in the limits of care to the recruitment poster: “On the poster I sent, it says ...” Judy responded that the *only* time she reached her limits was when she wasn’t allowed to

visit her husband after his surgery – when the nurse said, “no more visits tonight.” While my question about limits was purposefully vague in that I hoped to open up or invite different meanings, I didn’t expect such a question to be used to reinforce a narrative about how she excelled as a moral, caring subject who just wanted to care more. Similar to Gracie and Judy, other participants only reluctantly or briefly elaborated on reaching their limits after being prompted by me (including after 80 minutes for Rhonda, 55 minutes for Marilyn and 35 minutes for Sheila). I learned that reaching one’s limits can be hard for some to talk about, particularly when one’s capacity to care is supposed to be able to withstand any conditions.

That said, in other life history interviews, I hardly had time to turn on the audio recorder before the person I was speaking to interjected with a story about reaching their limits. Carrie rushed to put that part on the record. With a crass, entertaining, rip roaring account of how life kept throwing her people to care for, Carrie vented about how she had been “groomed ... to be a caregiver” from a young age. She didn’t delicately dance around her experience of reaching her limits, as she remembered that it was “humiliating,” that she felt “dumb,” and that a friend had said to her at the time, “You’re crazy. *Wow. You’re fucked.*” Carrie wanted those details on the record. Hitting her limits was a critical piece that was central to her narrative.

On the surface, the stories of Gracie and Judy seem to contradict or contrast Carrie’s narrative. For Gracie and Judy, reaching their limits was framed as a little wee blip in life histories of caring well for people they loved. It seemed to go against the narratives they were telling. At first it was hard to see any commonalities in their accounts. That said, analyzing and situating participants’ stories enabled me to identify

commonalities and patterns in the rhetorical work they did that often served a similar social function. While speaking in different registers, and reporting on different situations and circumstances, there were conventions for telling these stories, as well as patterns in *how* women told these stories. We can learn from their narratives about the conditions of their lives. As I will argue in this chapter, reaching the limits of care is a moral experience that participants – as agentive subjects – negotiate through rhetorical “moral work” to establish their moral sense of self and to negotiate moral expectations to care. The conditions of care in which participants had lived and worked set the stage for moral dilemmas that they negotiated. They made choices in how they made up their moral life trajectories and made sense of expectations about what they ought to do.

The notion of what is moral is contextually specific with different understandings or dimensions of morality in different contexts. Doucet (2006) writes “a moral dimension enters in that women feel that they ought to do it in a certain way and may feel judged adversely if they do not” (p. 182). Women and girls are socialized into what we *ought to* and should do. As we learn early, caring for others has moral significance; it is a practice that is morally salient and tied up with expectations about who is a good person/woman/worker/mother/daughter. Participants’ stories have a moral dimension in that the requirement to care for others is something that many expressed having internalized with reaching their limits loosely understood as a way of transgressing or no longer fulfilling that social expectation. What could be thought of as a pejorative state of demoralization, I read here as a moral dilemma that women negotiate in practice through “moral work,” which I define here as work to re-establish a moral sense of self and negotiate moral expectations (e.g., to care at all costs) in relation to oneself, intimate

others and circulating narratives. I examine how paid and unpaid carers actively negotiate social expectations to care and normative ideals of femininity that “formalise and entrench a set of unviable subject positions” (Ringrose & Renold, 2010).

With a focus on women's relationship to themselves and on how they make choices, I argue in this chapter that reaching the limits of care is a moral experience that occasions narrative, “moral work” through which women negotiate both their moral self-narratives and expectations around care. This work is observable in participants' narratives and tells us about the contradictions produced in Ontario's care economy. Shaped by class, gender and conditions in the caring economy, participants were speaking of choices they made, as they recounted negotiating contradictions at the limits of care. First, I present a socially contextualized interpretive analysis of how participants framed reaching their limits as: (1) an embodied breaking point; (2) a moral, feminine achievement or outcome of having sacrificed; and (3) a source of guilt or shame. Along the way, I also show how they variously constituted and positioned themselves as moral subjects, while negotiating gendered or moral expectations for women to care for others. To close, I elaborate how their narratives of reaching their limits can be thought of as responses to the conditions in the care economy; they tell us about how social relations of care are organized and brought about.

Women claiming feminine, moral power through accounts of reaching their limits

“I don't know how to make wine out of water anymore,” Troy said, in speaking of paid work at a homeless service center. As if following suit in putting it paradoxically, Gina recalled caring for her mother, saying, “I guess none of them [siblings] could do that.

Because I did. They were not willing to give up their life for her. None of them.” With powerful statements to really land the sentiment, they both expressed reaching their limits as a breaking point, as well as an achievement or outcome of having done the (moral, feminine) impossible as direct carers. They weren't alone in making paradoxical assertions of power through tales of disempowering conditions, nor were they alone in presenting and positioning themselves as moral subjects through their narratives.

Participants narrated encountering hazardous and ethically fraught situations, with some describing intimate losses or life-altering, traumatizing or demoralizing experiences. Many described themselves as overworked and burnt out, with some not having had time off for weeks. Reaching one's limits was often a result of not having the option to share responsibility (e.g., with adequate staffing levels or options to share the care of a family member) or not having the time, resources or supports needed to do the work, recharge or otherwise sustain oneself. Nora emphasized “how brutal it was and how much it ruined” her to have been set up to fail. Troy said that it “felt really shattering” to have been overworked to the point of losing their capacity to care for others. Troy didn't anticipate morphing into “the worker that no one wants.” Like Troy, participants described negotiations with one value (e.g., that of caring for oneself) supplanting—or seemingly sneaking up on—the other (e.g., that of caring for others).

The body says ‘no’: Reaching one's limits as an embodied breaking point

That participants' moral subjectivity is wrapped up in their expressions of reaching their limits was clear when they emphasized how they didn't have any choice – that they wanted to continue caring but that *their bodies* just said no. Some participants powerfully

expressed reaching the limits of care as a breaking point—narrating life-threatening bodily or physical experiences, as well as relational conditions that led them to reach their limits. For some participants, as they told it, their ingrained moral expectations of what makes a good woman or caregiver—or what was expected of them—were so intense that it was only when their bodies physically started coming apart that they felt that they had sufficient moral reasoning or justification to step back from care, ask for help or go against the grain of what they had thought made a good person.

For many participants, at least as they told it, it wasn't that they didn't want to care or didn't want to live up to the social expectations that they had internalized; it was that they reached a physical limit. Nora, a former paid care worker said, "I was in such bad shape, like I couldn't have physically or emotionally even been there anymore. ... My body literally, you know, gave out on me." As she put it, "My mental health wasn't good, but even then it was—it was still so hard to leave." Like Nora, participants called attention to a range of occupational injuries or physical signs, including exhaustion, depression, anxiety, weight loss, high blood pressure, dizziness, spinal injuries, sciatica, back pain, chronic pain and chronic headaches. As Troy said, "My body has been telling me in bizarre ways: 'No, you don't have energy for this; go take care of yourself.'" Troy called attention to their body, while also linking their "burnout and frustration" to the devaluation of social services and to their "work with folks who are really not seen as people and are really devalued because they can't contribute to society in a capitalist way." Gina also remembered that it "took three months to get back" to being able to sleep without "waking up listening for her [mother] breathing." Gina's description of resetting

her body after care speaks to how the social relations of care had made demands on her body.

Like Nora, Troy and Gina, others elaborated on reaching their limits as a breaking point with embodied and relational dimensions. Some scholars have referred to care as compulsory altruism (Rozanova, Keating & Eales, 2012; see also Armstrong, 2013, p. 110) or exploitation under the guise of compulsory altruism in situations “where the carer has no choice but to keep on caring, despite her/his own preferences, health problems etc. (see Parker and Clarke, 2002: 357)” (Kröger, 2009, p. 410). Anne, Carrie and Gracie offered compelling examples. Speaking of their experiences in different roles and contexts, including paid care work and family settings, they called attention both to the embodied (physical or emotional) dimensions, as well as the particular social or material conditions shaping their experiences.

Anne narrated reaching her limits as a breaking point, as she described a “major problem in the system itself.” Her narrative was a political advocacy tool (Panitch, 2018). She recalled how her son with a developmental disability “aged out” of social services support at age 18 and was no longer eligible for publicly funded support, although he needed around the clock care. Anne noted that she and her husband were sleep-deprived, stressed and burnt out from their direct care responsibilities, as well as from advocating, asking for help and going up the echelons. She underscored it was a “three-year wait list to get an assessment.” This wasn’t a blip, but a matter of social organization in Ontario’s post-welfare state. Throughout her narrative, Anne raised questions about contemporary conditions of care in Ontario, where care has increasingly shifted from a collective/public responsibility to the responsibility of individual families. She didn’t outright say that she

had concerns about moral expectations around how she ought to live, but she did go to some lengths to justify why she couldn't uphold expectations to care. She elaborated that she feared for her son's life. She also depicted her life-threatening health status as if relaying symptoms to a medical professional:

I had a blood pressure – 220 over 115, and, you know, normal blood pressure is like 120 over 80 or 90. So, I was up into the area where you can get a stroke, brain aneurism, heart attack. Quite frankly, I was petrified of my own health.

In presenting her case, and in noting that they tried everything and had no other option, Anne did rhetorical work to produce herself as a moral subject in noting that the burden of saying 'no' or setting limits on the care that she could provide was unbearable or impossible, that is, until her own body gave out. She focused her concerns not only on her own health, but on her son's life, which was a way of doing moral work. She said, "At the end of the day, you have to do what you have to do to get your kids' needs met – to make sure they're safe and sound." With a crafted narrative in an empowered register, Anne also called attention to marginalized folks or to others who had it worse, while raising questions about conditions for caregivers. She asked, "I think that it's really important to focus on the health of the caregiver, because, what happens when the caregiver dies before the person who they're looking after?" There was a moral connotation to this other-oriented practice of advocating for other carers or valuing their lives. Rather than caring for the so-called most vulnerable, marginal or worthy – those typically designated as "care recipients," Anne took on a moral position in a particular classed register as she advocated for fellow (women) carers, which is a practice that the moral experience of reaching her own limits seemed to have invited.

“It was almost like waking up after being in a cult, like I finally snapped the hypnosis, or whatever kind of veil I’d been living under,” Carrie said. In a different context, Carrie also framed reaching her limits as an embodied breaking point although she presenced and positioned herself in a different way, cracking jokes and entertaining. She described an intensely physical experience and extreme situation that led to her reaching her limits. She framed it as a “life or death” situation in which she underwent a “mental break” and experienced her entire life grinding to a halt after years of caring for people who “didn’t have their shit together.” At the time she had been working 90-hour weekends at a shelter doing outreach on top of raising her two kids and going to university full-time. She said that, like many “native front-line workers,” she was “so fed up and struggling as though [she] was a client.” As she put it, “like you’re two pay cheques away from being a client. You’re juggling your own program materials, because you need food too.” Ahmed (2020) writes, “A body can stop functioning. A body can announce a complaint.” Carrie said, “I was disassociating *really*, really bad, like, going to groceries at Walmart, and waking up with strangers in my face, ‘Are you okay?’” She said, “I also passed out in my house with my dogs licking my face.” Carrie’s bodily complaints were measures of seriousness and indicators of stress in a care sector that can be disabling for care workers, who are often women working “double duty” with other care responsibilities off the clock. Intersecting work/family relations across Carrie’s life were central, as she had been exhausted from everything she “navigated from being a homeless kid or like, before that, a kid living at home with parents who didn’t care.” She referred to her experience as a “breaking point,” where she “recognized that [she] was super burnt out” and “said ‘no’ to shifts for three weeks. Such an extreme, unique, wild

story of a denigrating experience served to establish Carrie as a moral subject—making the case that she had indeed invested, before transgressing the expectations she held of herself at an absolute, extreme breaking point.

“It rattled me terribly; it did. That was the very first time in my life that I ever went to see a professional counselor myself,” Gracie said, in speaking of burning out while caring for her mother. “My hands would shake without me telling them to,” she said. She noted that her ability to support others was overworked to the point where she lost control of her hands. She also narrated an embodied breaking point at the limits of care, but framed it as something that helped her to care *more* in the long run. She fit the memory into a particular narrative of herself. That said, it is still notable that, with caring as a moral responsibility central to who she was, she was required to negotiate the dilemma that she faced and to (re)establish her moral sense of self. She elaborated that she was at her “wit’s end, very overwhelmed, very sad,” and very exhausted from “living one big adrenaline rush all day and all night.” Gracie recalled going to see a counsellor as “beneficial,” saying, “She told me that she was really, really glad that I had come when I did come, because she felt that I was probably on the *verge—on the brink* of having, like, a serious, you know, mental health collapse or issue of my own, right?” (emphasis added). As Gracie put it, “I think that she really made all the difference in me coming through that *laughs* well and whole and in one piece.” Perhaps as not to appear selfish, Gracie expressed pride that she kept her issues to herself and a counsellor without burdening her husband or friends who had “all of their own issues,” which was a way of doing moral work. Noting that “our bodies are built to provide us with what we need,” Gracie emphasized that struggling had strengthened her. She said, “And it made us just

be stronger and like more in love and like more caring for each other and for the kids too.”

Emphasizing an absolute breaking point in an extreme situation serves a social function; such an articulation in participants' narratives serves to position them as moral subjects who wanted to continue caring, but didn't have a choice. Telling such a story offers a way to underline one's commitment to normative ideals and expectations, while moving in a different direction. The moral experience of reaching their limits set the stage for this rhetorical work. Like Anne, Carrie and Gracie, many participants called attention to life-altering health experiences or embodied signs in narrating reaching the limits of care, with some (including Nora, Annie, Carrie and Troy) framing their own depletion or near-death health crisis as their *only* ticket out of care work. Their accounts make clear that caring involves managing and maintaining the body, and that with the way care is organized in different paid and unpaid settings, carers have embodied, physical experiences. As they told it, only when their bodies literally shut down did they have sufficient moral reasoning or an argument that was strong enough to go against their socialization of what made a moral person. Their narratives speak to the strong hold of gendered expectations or assumptions about what women should do. Good girls ought to care at all costs. Participants called attention to the idea that women *should* care – that care work is obligatory, and that they themselves would have kept caring had their bodies cooperated. With how they had been “set up” or how care got “in,” telling it this way was a way of crafting a moral sense of self and negotiating gendered, social imperatives.

Participants' insistence that they cared and cared until an absolute extreme situation or breaking point – until they had no other possible option – seems to uphold

expectations around care. Their stories speak to “female disposability” observed in feminist studies of the workplace (Wright, 2001). That said, it is notable that their stories didn’t straight-up uphold the “cultural dictate of womanhood from which there was no escape” (Campbell, 1984, p. 266). By virtue of telling their stories of being harmed, they challenged idealized histories of care that hinge on “good” girls caring for others indefinitely, against all odds, at the expense of themselves, regardless of working conditions. They lived to tell the tale, exercising agency and claiming power in telling these stories.

People that care the most: Reaching one’s limits as an accomplishment

In speaking of “very caring people” who “want to help people” and “want to make a difference,” of which she included herself, Nora said that “the people that care the most end up getting the most fucked over.” Nora questioned whether or not caring for others would have been so meaningful had she set boundaries, kept herself safe or closed herself off. In other words, she elaborated on how she had embodied care by sacrificing her own needs and personal well-being for the benefit of those she cared for. She saw meaningful care experiences as a sort of self-sacrifice. Her story was one example of how women claim their feminine moral power through accounts of reaching their limits.

As I will illustrate, participants narrated reaching their limits as a moral, feminine accomplishment or outcome of having invested or made a sacrifice. While many no longer occupied the traditionally feminine role of primary carer, they emphasized how much they had cared and how well meaning they had been, including as they were narrating how they had reached their limits. Gracie, a family carer, said, “Mom said the

reason she beat the odds is because I took such good care of her.” In speaking of caring for her mom, Gina talked about a shift from being someone who couldn't get enough of kids – who used to take her daycare everywhere, including to zoos and parks and concerts and shopping malls and restaurants – to someone who could hardly spend an hour with her own grandkids. She joked that she had to get out and away from her Mom or she would have killed her. While there were multiple examples in my research, I focus here on the narratives of Troy and Sheila, who framed reaching their limits as an achievement and natural outcome of having sacrificed while doing the (moral, feminine) impossible.

Troy emphasized that they had blacked out and hadn't even been aware of what they were saying or what was happening to them when they resigned. They didn't frame it as a choice or as a decision they made. “It just felt really shattering—like I can't do this,” Troy said, adding, “I don't have the energy or emotions. I can't even take care of myself. So, I went and talked to my doctor. And she's like, ‘You're not going back to work.’ *laughs*” Doing moral work to exemplify their caring commitments through an account of reaching their limits, Troy said, “My approach and my caregiving roles are different from a lot of co-workers. *laughs* But I think it also explains why I'm kind of burnt out now.” Conjuring up images of the idealized, youthful, relational care they used to provide, Troy reminisced about going above and beyond with trips to parks, playgrounds and the beach. They remembered how they used to “get told how young and bouncy and fun” they were, how they had been “kind of like Mary Poppins,” how they had been “attached” and like “family” to the people they supported. In telling stories of reaching their limits, Troy also emphasized how much they had cared, hinting that others would burn out too if they cared as much as they did.

It's notable the contradictions that they experienced – that came with real threats to their self-narratives – were shaped through their working conditions in the care sector, as well as through the wider conditions of their lives. The hazards of contemporary life they pointed to went beyond the work (Standing, 2010; Grenier et al., 2017). They identified other “structural things in [their] day” shaping their life such as “all the transphobia and homophobia and sexism and ... poverty ... [and] ridiculous student loans.” They recounted being mis-gendered and concerned for their physical safety when harassed by strangers threatening to throw them in front of the bus. As Troy said, “I don't think any of that stuff has ever been taken into consideration. It's like ‘Oh you just didn't do enough self care.’”

Troy experienced their own limits as an embodied experience. Quoting Troy:

I normally will sit with someone I'll be there for five hours straight. I forget to eat and forget to go to the bathroom. I'm just there and totally present with someone. And that [last day at work] my body was like, ‘You need to go get food, you need to go to the bathroom, you need to go for a walk,’ which was so out of character for me.

With a hint of bravado, Troy reminisced about disembodied, self-sacrificial care they used to provide, as they had disciplined their body to adhere to the work and organizational pressures. In storying reaching their limits, they emphasized how much they had cared and invested in a meaningful way – through the performative rituals of forgetting to eat. Telling it this way offered a way to produce and maintain a caring sense of self. Their narrative produced them as a moral subject who honourably went in “with

[their] whole self all the time.” In telling their story, they attached moral significance to caring in a way that they used to be able to pull off and still desired for their life. Not being able to care *any longer* was linked to a history of caring well.

In speaking of caring for her mother, Sheila also framed caring as a moral, feminine accomplishment. In a different context, she also did moral work, as she narrated reaching her limits. “Well, it was the combination, as I say, of often needing two people do to the transfer, and there weren’t always two of us in the house to do it, the exhaustion, and the worry about [my husband’s] health,” Sheila said, offering a point-form run down of her experience reaching her limits while caring for her mother. She elaborated that her sleep had been broken, and that her mother was getting to be more work as she needed support with getting in and out of bed, toileting, or other aspects of daily living. Sheila infused her account of reaching her limits with examples of her moral, feminine commitments. Similar to Troy, her narrative was loaded with examples of having meaningfully and lovingly invested. Sheila said, “Did I take too good of care of her?” She also recalled that her family doctor had said, “your mother wouldn’t have lived this long if it hadn’t been for you.” With the conditions of Sheila’s life, reaching the limits was a “moral experience” that seemingly didn’t pose a significant threat to her moral sense of self. Her narrative easily reconciled reaching her limits with her self-conceptions as a moral, feminine subject; there was no tension there. Flagging her accomplishments and how much she had invested, she made clear links between her history of caring well and her experience reaching her limits. Framing it this way enables her to do “moral work” to (re)moralize or (re)establish a moral sense of self, following an experience that seemed to invite such work.

Troy and Sheila both framed reaching their limits was a moral feminine achievement, loading their narratives with examples of how caring they were or had been. In different social conditions with Troy clocking in at work and Sheila supporting her mother both at home and in a private retirement residence, they took on moral positions in relation to care, using their experiences of reaching their limits to underscore or re-establish their standing as good people. While they took on moral positions in different ways, they both flagged their own investment in care, while claiming their status as caring subjects. Not being able to care any longer was linked to histories of caring well – of investing in feminine, moral projects. As my analysis indicates, caring, even as it produces hazardous and ethically fraught situations, can be a source of power. Even accounts of experiencing exhaustion, overwhelm, harm or injury can be used to establish oneself as a good caring subject as though the more pain one is in the better person one is. Caring is still highly esteemed, and women express a commitment to care, which speaks to the pervasiveness of caring ideals or expectations around care in their lives.

Guilt on top of that: Reaching one's limits as a source of guilt

With the way that moral “oughts” around caring for others are socially held or internalized by others, calling attention to one's guilt can be thought of as both a way of signalling that one is cut off or signalling that one is aware of moral or social expectations to care. Guilt has long had an association with care or with maternity or good mothering in particular (Forna, 1999, p. 360). As Forná (1999) puts it, in speaking of motherhood, “the guiltier the better” (p. 76). As my analysis makes clear, participants' guilt-ridden narratives of reaching their limits have clear moral dimensions, conveying the tremendous social pressure they felt in relation to moral and feminine imperatives to

care for others at all costs and at the expense of themselves. For participants who internalized social expectations to care, reaching their limits presented a dilemma that they then negotiated through “moral work” that we see in their stories. Expressing guilt is a way of taking a moral position in response to a moral dilemma that gendered conditions of care and of life produce.

With few exceptions, and with “caring about” strongly equated with “caring for” (Davidson, 2015), participants talked about feeling guilty about reaching their limits and no longer being able to care for others anymore. Judy talked about how she’d feel guilty leaving her Dad in long-term care while she went home to support her husband who had cancer. Julie, a paid care worker, wondered if her co-workers didn’t feel as guilty as she did as they hadn’t connected to the extent she did. Giving a concrete example, Julie noted others would just never do the pampered bath routine that she did. As she put it, “I don’t think they felt guilty because they would just never do it and they never really would notice the difference.” She expressed that she “felt guilty” as she had initially had the pleasure of “notic[ing] the difference” in the person she supported. “I still have a lot of guilt around that,” Troy said, making a clear link to their burn out and their inability to support others. While some participants expressed being less affected by what others thought, everyone acknowledged the social expectation for women to care or the harsh judgements on women who can no longer care. Two clear examples of how reaching one’s limits was framed as a source of guilt were in the accounts of Gina and Nora.

In speaking of reaching her limits, Gina expressed feeling like she had done something wrong that was worth feeling guilty or ashamed about. She recalled reaching her limits while providing 24/7 hour support for her Mom for eight months straight in her

Mom's apartment. With a resentful "must be friggin' nice" undercurrent, she simultaneously complained and bragged about having reached her limits and lost her patience. She expressed both that her siblings "left [her] there stranded with no help" and that "none of them" were "willing to give up their life for her" like she had. She said they were "crying and falling apart," couldn't "do Mom," couldn't "handle" her, so she did. Gina said that she cared for a woman who couldn't stand the sight of her: "stranded with no help" for "eight months 24/7," "caregiving with *no* break", sharing a bedroom in her Mom's one-bedroom, geared-to-income apartment. Gina elaborated on the poor relationship with her Mom, hinting that it was fraught and in turn more of a sacrifice. She remembered how her Mom monitored how much and what she ate and how her sister would come to help out but couldn't bear to be in her mother's presence so would run errands, and stiff her with the relational work. There was a heaviness to the way she told her story. She described it as mentally and physically a strain. Continually calling attention to guilt seemed to be a way for Gina to sustain a sense of herself as a moral person. As she put it, "I should want to do that, but I don't." Gina was still fuming and still felt guilty—"totally guilty," "extremely guilty" as she narrated no longer being able to care for others, including her grandchild. Something was called into question, and she made up a story to negotiate it. She said:

I could not do that now. I just I can't do it anymore. I don't know why. And I don't understand that but that's who I became. I feel horrible saying that. Just saying that makes me cringe, because I'm supposed to want that. It's my job to want that. But I don't want to do much as a grandmother. I just I don't want to do

it. It's 24/7 caregiving again, and I don't want to do it. It sounds horrible, doesn't it? The more I say it, I feel horrible.

There was an intensity to Gina's account. For Gina, making up a life through care had been something she wanted and had embodied – a particular kind of ethical trajectory that was central to who she was. Not being able to care was a horrible, horrible experience of transgressing a moral understanding that she had worked hard to embody. It was framed as a failure or a loss, and was something she put a great deal of interpretive, narrative, moral work into processing. At the time of the interview, Gina was still working through guilt and wrestling to reorient to herself or to expectations she previously held. The moral experience of reaching her limits set the stage for this work. Guilt can be thought of a moral emotion that serves a social function and is backed by cultural norms and feeling rules (Donath, 2015); its articulation in Gina's narrative serves to position her as a moral subject who wanted to continue caring, but didn't have a choice. She upheld social and moral dictates that women *should* care, acknowledging the moral 'oughts' accompanying being a good woman. Investing in and publicly projecting guilt offered a way of getting out and flagging her commitment to normative ideals and expectations, while moving in a different direction.

Ringrose and Renold (2010) write that "femininity calls upon girls to perform niceness" (p. 584). For women narrating their lives in the care economy, this "niceness" is routinely reserved for particular objects of care – not for everyone in the vicinity. In speaking of reaching her limits, Nora said, "I definitely felt used," before adding, "That was, again, the organization and structure, management stuff, not the people we supported." Like others, Nora funnelled her "anger and resentment" toward the uncaring

organization, maintaining a caring persona in relation to the people she had supported. She wasn't alone in expressing that care took a toll or got heavier over time, and she suspected that the toll added up over four and half years of working at an organization "without boundaries." Similar to Troy above, she attributed reaching her limits to organizational bullshit and to the wider societal devaluation of disabled people. She recalled quitting her job at a residential group home in 2013 when, with chronic pain, it became physically difficult to walk, get through the shift or do the bare minimum. Nora talked about the "toll over time" that she experienced as a paid care worker, noting that it had been a horrible experience to lose her patience and capacity to care over time. She said that she "just wasn't in any capacity."

Caring for others was an ideal for Nora that had been part of her moral life trajectory and central to how she constituted herself morally. Throughout her account and in different ways, she emphasized how guilty she felt with reaching her limits and no longer being able to care. She said, "I still felt so guilty and so tied to it. ... I didn't really know who I was without it." She attached moral significance to caring as something to feel guilty about not doing. While Nora spoke in an authorial and first-person voice when describing caring for others, she at times hedged, trailed off or addressed as "you" in speaking of reaching her limits as "almost," "sort of" and "kind of" like when "*you*" would "just [be] kind of shitty" – when "*you*" are impatient or stressed. She blamed her unruly body, while emphasizing her guilty feelings or heartfelt desire to care more. With care as a moral responsibility central to her life path, the way that she told her story offered a way to respond to a situation that she saw as perceiving some justification. She framed reaching her limits as a brutal experience of being estranged from herself. She

grieved the loss of her caring self, constituting herself as a moral subject through her narrative as someone who cares enough to feel guilty about not caring. The experience also set her on a moral trajectory to find other outlets for her empowerment such as by advocating for carers and those who need care alike. In speaking of “feeling used,” Nora said, “All the sort of resentment and anger and all that, I feel like it’s the people we support that probably pay the most for it, other than us.”

In her study on regretting motherhood, Donath (2015) found that participants’ accounts of regretting motherhood “indicate the intensity of the social and cultural mechanisms that institutionalize the path toward good womanhood and good mothering” (p. 345). The intensity of Gina and Nora’s accounts suggest that they too had internalized the social expectations for them to care. In framing reaching their limits as a source of guilt, they hinted that they could no longer live up to the social expectations that they had internalized or to the gendered roles that had been assigned to them. While their accounts of caring in different roles were differently emphasized or articulated, they both expressed feeling guilty about reaching their limits and no longer being able to care. Gina referenced expectations for grandmothers, while Nora referenced her desire to live out disability politics by sharing power and listening and learning from people with developmental disabilities. Gina’s account was laced with sarcasm and punchy quips, while Nora’s account was packaged in a critical discourse that alluded to power and privilege, as well as the odd joke. Their registers were different, with their stories serving a similar social function. They both attached moral significance to caring and framed “care” as something that was integral to them that they felt guilty about not doing. With the way that they had internalized expectations, reaching their limits produced

contradictions that they actively negotiated through moral work to make sense of their experiences and reorient to their sense of selves. Articulating their guilt was a narrative strategy. It was a way of (re)moralizing or (re)establishing moral sense of selves following experiences that made them question it.

The paradox at the limits of care

Reaching the limits of care is a moral experience that presents a contradiction that women actively negotiate through practical and conceptual work to make sense of the experience and of their selves and self-expectations. The moral work that participants do in their narratives tells us about what's possible to say or do in the social and historical conditions of their lives. The fact that reaching one's limits was paradoxically narrated as a breaking point *and* as an achievement speaks to how women were implicated in care relationships, as well as to the grip of ideals about care as an ethic. Building on a finding in chapter three that participants found self-worth and meaning in work they are obligated to do, this chapter has explored how they claimed power through stories of disempowerment. As my analysis shows, one's moral sense of self was at play, and implicated, even when speaking of experiencing physical or emotional harm.

In different contexts, participants narrated *becoming* entwined in the lives of people they supported – made to feel as though others were dependent on them for survival. Care needs of the “I-need-YOU-in-particular” variety shaped their lives, and were part of the story as women described conditions that made them so vulnerable. As their stories suggest, being “irreplaceable” or the “only ones” made it hard to share responsibility, and seemed to create the conditions for moral confinement. Betty was the

link to the world as a family carer, and Troy was the “one person” as a paid worker. Such experiences weren't about carers' own volitions or whims; they were institutionally produced. Conditions in the care economy blocked exits or options to share responsibility for paid and unpaid carers alike, giving rise to contradictions that carers had to negotiate.

Through their stories, participants reoriented to their sense of selves and negotiated expectations for women to care at all odds regardless of conditions. Faced with life experiences that seemed to “threaten” their moral subjectivities, they framed their stories of hitting their limits in ways that reaffirmed their commitment to their moral life trajectories. They variously negotiated, upheld or resisted social imperatives for women to care or the normative conventions of femininity that link women to care. Their stories show how gendered, moral expectations for women to care have a strong hold; even in speaking of their own vulnerability, participants took on moral feminine positions and emphasized care's moral dimensions. Their statements both reveal a profoundly moral terrain and raise questions. How telling is it that women do moral work, even in talking about being harmed or violated to the point of no longer being able to walk? Where do we get the idea that our inability to care for others at all costs, regardless of conditions and at the expense of ourselves is a moral weakness? How could we change that?

Concluding remarks: Moral work in the care economy

This chapter analyzed participants' narratives of reaching their limits, elaborating how they made choices in negotiating the circumstances of their lives. I detailed how they took on moral positions in relation to care, with their practices for doing so shaped by

how they were situated, as well as by gendered, moral expectations. There are real social and organizational factors that contribute to psychological health and safety hazards and lead carers to reach their physical and psychological limits (Braedley et al., 2018), and these conditions need to be transformed to support and ensure the safety of those who provide care and those who need care. Some attribute burnout to carers' emotional labour, while others have found it can be attributed to the "suppression of a workers' emotional labour" (Stacey, 2005 p. 852). Carers' experiences are more complicated than usually acknowledged in analyses that explicate working conditions or uncaring organizational or structural dynamics. Participants described intimate, closer-in attachments or entanglements in care relationships of which they were a part. No one told a straightforward account of simply being violated, invalidated or alienated from their sense of self. They told both/and stories, elaborating the "uncaring conditions" as other researchers and advocates have, while also signalling moral dimensions *that were important to them*. The limits of care was narrated paradoxically, including as an embodied breaking point, an achievement or natural outcome of having done the moral, feminine impossible, and a source of guilt. Participants' narrations often reproduced and reinforced dominant discourses of care even as they tried to subvert them at the individual level.

In regard to what exactly has a hold, I have brought into view the relational care economy at the level of *institutionalized relations*. The relational care economy is a profoundly moral terrain with women negotiating moral dilemmas at the "limits" of care. Albeit with different expectations for people in different care roles or contexts, responsibilities for care have intensified across formal and informal settings. This applies

to parents or other family members (Kittay, 1999; Hays, 1998) and to paid care workers, who take on extra responsibilities or engage in overwork to make up for gaps (Baines & Armstrong, 2019; Stacey, 2005). Participants' expressive and embodied practices weren't idiosyncratic, but socially and conceptually located. As their narratives show, care relationships, as they are organized in Ontario's care economy, are often fractured and too often sources of violence and harm for people who need care, as well as for people who provide care (Klostermann, 2020c). In different care roles or contexts, participants reported that they had been set up to reach their limits or to fail at caring for others, with real costs and consequences. Care relations can be thought of as "greedy institutions" (Cosser, 1974) in that people aren't held to such commitments through physical force or constraints, but voluntarily comply, commit or show loyalty through their work and, crucially, their words. What is notable here is that "moral injunctions, not to act unfairly toward others, and *not to turn away* from someone in need" (Gilligan, 1982, p. 20, emphasis added) are quite dangerous when lived out or pushed to the limit in wider conditions of social neglect or without options for carers to share responsibility.

Women negotiate moral dilemmas in moral conditions, engaging in a range of agentic practices at the limits of care or in rejoinder to such limits. They are implicated as agents, and active in the process, with care experiences occasioning creative, agentic, narrative "moral work" to respond to the contradictions of their lives. In different circumstances, and with differently framed and emphasized accounts in different gendered and classed registers, all women (to varying degrees) engaged in "moral work" to produce and position themselves as moral subjects and to negotiate moral expectations to care. They took on moral positions through their life history narratives, claiming

particular types of subjectivity and rethinking dominant moral expectations that presently and historically define women as caregivers. It's not just that care obligations were shoved on some women and had to be redistributed. What I am arguing is that conditions in the care economy involve intrasubjective relationships. Cultures of caring institutions variously get into people's sense of themselves with care intertwined with one's expressed moral subjectivity. Questions like "why didn't you just leave?" miss something about how interwoven or implicated carers are.

Connell (1987) writes, "practical transformations open up new possibilities which are the tissue of human life. But they do this by creating new social pressures and risks" (p. 77). While Connell hesitates in using the word "progress," as she notes that shifts may generate other limitations or forms of subordination, she insists that social change *does* happen – that potentialities and possibilities do open up. For participants, hitting their limits came with an invitation to improvise, move around or work through it. This isn't just about resigning or walking away from a particular role or relationship, but can involve renegotiating one's sense of self and self-narratives. Participants' practices bring about new relationships, inviting new practices and meanings, as I will further explore in the next chapter that considers how people narrate opting out of direct care responsibilities. But, first, to give a taste of where I'm going, I will introduce "the flinch factor" – a creative reflection and interlude – that reflects on how, with the structuring conditions of my life, I was "in" care in a different way than others with seemingly lighter relationships to care as a moral, feminine project.

FLINCH FACTOR: TOUCHING FEARS ABOUT CARE [INTERLUDE]

It's an understatement to say that my personal story about resigning from care work hit a nerve when I performed it as a part of a sociology conference. The purpose of the event was to showcase alternative, artistic works or polemic sociological interventions. Yes, polemic. It seemed like the perfect venue to share my early thinking on the topic of "exiting" care work as I was working on the proposal for my doctoral research. I wanted to raise questions about how accounting for the perspectives of former care workers – those who reached their limits and no longer wanted to care for others – might shift sociological research and thinking on care that at times centers well-meaning, hard-working carers who want to care more, but just can't catch a break in the uncaring organizations where they work. At the time I struggled to see my own experience reflected in the literature. I was skeptical of work that framed those who need care as more vulnerable, marginal or morally worthy than care workers, and by work that undertheorized care workers' unique vulnerabilities and the conditions giving rise to them. I didn't recognize myself in accounts of care workers who were lumped together or represented in pull quotes of the "A care worker said" variety. I was left wondering, what about the artistry, subversiveness, and joy of it? What about exploitation, betrayal and disillusionment? What about care wrapped in moral coercion? What about the limits of care?

For the arts-based event and storytelling show, I performed a story about my own experience living and working as a care worker, before attempting to facilitate a conversation. I was proud to share my story, as I felt like I had done a lot of work to process and situate my traumatizing experience, writing with compassion for myself and

others. In the prose piece that I performed, I reminisced about moving into L'Arche, an organization where I lived with and supported people with intellectual and developmental disabilities. I shared that I had been drawn to care work to listen and learn from others and build community with disabled and non-disabled people alike. I noted that I had initially enjoyed spending time with the people that I supported, jogging alongside them on adaptive bike rides. "There was something there for me," I said. From there, raging with pain, and without a clear sense of what I was taking aim at, I shared about how devastating it had been, over time, when I lost my capacity to care, to even make eye contact with some of the people that I supported. Grieving for my past self, I shared that I had felt so vulnerable and that it had been a slog to claw myself out of the work after several years in the field, as it felt like opting out of an ethical way of living – walking away from my "goodness." I asked how we might cultivate conditions of care that honour care workers and people who need care alike, contributing to valuing and investing in care as a collective responsibility – not a moral, individual one. I asked whether a story like mine could help the cause.

As soon as I finished presenting, a full professor and world-renowned feminist sociologist interjected with an emotionally charged critique of my storytelling piece. "You escaped," she fumed before adding that the care workers who supported her mother were trapped. They couldn't get out; they had chains around their ankles. She said it like it was supposed to sting, emphasizing the phrase "*chains around their ankles*" as though slowly clapping out syllables to a toddler. She hinted that I was too privileged to be taking up space – that, if my experience as a care worker had been bad enough, I would have died on the job. The care workers worth learning from are the ones

still working. Another full professor and feminist sociologist interjected that I should have known that the care home where I worked was a dump when I first arrived and that I should have known well enough to set boundaries. She pointed out that the summer she worked as a care worker, she knew well enough to take breaks, smoke cigarettes and crack jokes about the people she supported.

My voice squeaked as I responded saying that surely she could appreciate that care work is different in different contexts – that her summer job a few decades ago was different from mine. She nodded, but fired back by critiquing my focus on my own experience – how my account made it sound like I was the only one producing value. She said that I didn't reveal the social in the way that she would have, for example by looking at value production or at the financialization of care. A student around my age in the room raised her hand to mention that she could resonate with my story. She said that she too had struggled to set boundaries at the social service agency where she recently worked. I appreciated her speaking up, but could hardly register her words. I was too busy noticing one of the experts gritting her teeth and flashing a restrained smile at me. I was too busy sitting in my shame. Then, as I stood chatting with the chair after the event, I was mid sentence, when one of the profs stepped in front of me to stand with her back to me to talk to him—physically edging me out of the conversation. *Ouch.*

“What the hell was that?” a woman said to me in the bathroom afterwards, poking fun at the two elite profs who critiqued me. We took turns trying to put a finger on why they had taken such a run at me. She wondered if reflexive accounts about care work, or at least the ones from care workers themselves, aren't supposed to circulate. I joked that perhaps they both thought they had the care sector by the balls – that they had it all

figured it out, so it was awkward to entertain a perspective they hadn't considered. She said that she agreed with my point that the devaluation of care workers goes hand in hand with the devaluation of those who need care. She too was mad about how hard it had been for her to set boundaries or say no. "I, ugh, guess it's not hard for all women, though?" I said, puzzled. "Yeah, if they know the trick to boundary setting, they should tell us!" she joked.

I laughed in the bathroom, but it was hard to keep up the comedy beyond that. I mostly felt raw and vulnerable, as I had expressed that I had suffered and they had responded by playing their moral cards. "Honey, aren't you one of the happy-go-lucky-good girls?" they seemed to say. It was hard to make sense of what felt like such a profound lack of compassion or failure of the imagination. I couldn't understand how two well-resourced pros who had studied care and who had access to a professional discourse were caught off guard to the point of critiquing a junior scholar personally and sharing their own memories to counter mine. Neither bothered to situate or contextualize my perspective. I was hurt that their responses seemed to position me as smug, self-absorbed and privileged, or to place blame on me for not having navigated the situation properly. It was painful to have devoted so much energy to thinking about the topic, and to finally take the stage in such a momentous way—articulating something so close to home—only to be criticized. I thought that I was speaking to the 'we' – to others with a relational approach, only to have them respond with emotionally charged, personal critiques of *me*, my work and my life path. It was painful to feel so misunderstood and rejected. I felt like I had a busted story that didn't translate.

There was something destabilizing about the experience. Shame-spiralling, I too wondered why I hadn't known the care home was a "dump" when I first started, why I hadn't set boundaries, kept myself safe, or resigned from paid care work sooner when I had been so miserable. Why had I pursued such a stigmatized, devalued path to begin with? Why had I got stuck? It was easy to get stuck in an individualized story about what had been a traumatizing life experience. But, I also found myself asking, if it had *just* been job at a "dumpy" work site, wouldn't I be over it by now? Why did I feel like care still had a hold on me or like I was still in it? It also hit me that I was researching and exploring a touchy subject, but that I didn't know where the edges were. I felt confused about the rules of the game. There was a flinch factor there, but what was it?

Conversations with friends, mentors and my therapist helped me to process. "I swear to god—she actually suggested smoking and joking," I'd say, getting some mileage out of it. I also tried to learn from the experience. "I don't know how I provoked them," I said to my supervisor Susan. She didn't miss a beat in countering that *I* wasn't the problem. She suggested that it was provocative material – that the story itself was provocative, but that it wasn't *me* who was provoking. She credited me for getting their attention, inviting them to consider a perspective they perhaps hadn't fully explored. She thought I must have hit on something. My therapist suggested that people need to voice their traumas. She elaborated that, when people are triggered, they often respond by sharing raw, unprocessed emotions, or by making connections to their own histories, as the pros had. She suggested that my story had hit too closely to their own lives or fears. She didn't think it was me either, but that my story was touching fears.

Considering how I had been hitting on something and touching fears helped me with unpacking in a different way. As I reflected on the backlash that I received, I suspected that my story hit a nerve when services for care are so thin and when people have real fears about who will care for them. It can be threatening to suggest that care has limits, or to hear from someone who doesn't want to provide care, when we rely on services and when being denied or refused care is such a threatening experience. With threadbare services, and with people's lives valued on the basis of age, ability or care needs, telling an earnest-rip-roar-of-a-story about walking off the job almost seems like a way of devaluing or neglecting the lives of those who need care. We need ready and willing good girls to care. We don't have time to talk about consent. As I thought about it, I also suspected that it was hard to admit that, as care workers or would-be care workers, we ourselves may not be able to keep ourselves safe or set boundaries with the way care is organized. Perhaps my story was an uncomfortable reminder of how vulnerable we all are.

CHAPTER 5: GETTING OUT? CARE REDISTRIBUTION AND THE NARRATIVE REFORMATION OF CARING SUBJECTS

There's pressure from her, there's pressure from your siblings, if it's your mother. There's pressure from the outside to do right. And then the pressure on the inside and the physical and mental pressure you put on yourself to do the best. – Gina

Yeah, it's kind of—there is a feeling like potentially all of you is for use. And it's like, 'No, I don't really want that. I do want some boundaries,' but it's hard when you have this identity – Dale

Gina elaborates what holds carers in inequitable care relationships, drawing attention to dimensions at different levels of social organization. She points to social pressures to care in relation to one's sense of self, people who need support, others relying on you, and broader social expectations. She points to a culture of caring institutions that gets into people's sense of themselves. As if responding to her directly with a "Yeah, it's kind of—" Dale elaborates on the feeling that comes with it. She also says 'no.' "No, I don't really want that," she says, making central her agency in negotiating social expectations to care. In our conversation, Troy remembered having a plastic folding chair pressed against their neck. They had to negotiate that situation, just as they had to negotiate the contradictions that came with caring for others in the context they were in. They had to say something, do something, contort themselves in a certain way, engage in real work to move on or get "out."

With a focus on choices that women make in telling their stories, I consider in this chapter how participants' narratives of renegotiating or stepping back from care tell us

about intrasubjective conditions in the care economy and about the strong hold of gendered, moral expectations for women to care which extend beyond particular care roles or settings. This chapter has three key sections. *First*, I trace some dominant tropes apparent in participants' narratives, bringing into view accounts of heartbreakers leaving paid care or "writing off" their relatives, as well as horror stories of those who leave facing severe costs and consequences. *Second*, I consider how, and under what conditions, women redistribute care across their lives, detailing the range of work involved in doing so. *Third*, I detail how participants had diverse ways of reconciling their care histories or positioning themselves as caring subjects following life experiences that variously seemed to "threaten" their sense of moral subjectivities or call into question their commitments to gendered, moral caring ideals. With a focus on participants' performances of self in their life stories, I present portraits of participants (1) framing themselves as finding "flow" or (2) framing themselves as wading through "swamps" or *still* struggling to move on or step back from care work. I then close by further theorizing the care economy by accounting for the intrasubjective, "intra-active" (Barad, 2007; Doucet, 2013) work participants did in relation to their sense of self-expectations.

Heartbreakers leaving or "writing off" with real consequences: Caring tropes

Many feminist theorists note that there is a strong, normative, persistent link between women and care, with some tracing discourses that present women as providing boundless care at all costs and indefinitely. Care is understood in dominant conceptions as an intrinsic feminine capacity centered on (good, moral, women) carers willingly self-sacrificing in service of others and at the expense of themselves (Baines & Armstrong,

2019; Baines & Daly, 2015). As the story goes, good, moral women say ‘yes,’ while “women who abandon family values and selfishly pursue new lifestyles of their own” face criticism (Ezawa & Fujiwara, 2005, p. 46). These dominant discourses seem to bind (moral, feminine) carers in direct care relationships indefinitely and as a life sentence; they are to care against all odds and regardless of conditions. In Western cultural contexts, caring is associated with goodness, responsibility or relationality, while not caring is associated with being selfish or privileged. Such formulations have roots in Judaeo-Christian perspectives claiming “the obligation to care for others is in conflict with selfish desires” (Hollway, 2006, p. 113). We can see traces of these dominant discourses in participants’ narratives, including of (1) heartbreakers leaving; (2) women “writing off” their relatives; or (3) women being shunned for not caring.

First, the phrase “heartbreakers leave” offers a clear example of discourses that frame opting out of or redistributing care as a selfish, uncaring act. In speaking of care workers walking off the job after a COVID-19 outbreak at a Markham, Ontario group home, Premier Doug Ford said, “What happened in Markham is heartbreaking. We just can’t abandon the most vulnerable” (Delitala, 2020). His comment is an example of the moralizing language around stepping back from care that is also evident in media coverage promoting ideals of servitude, heroism or feminine devotion. As a director of care at an Ontario-based LTRC facility said to me, “You can’t instill empathy into a soul who doesn’t have that sort of thing, but those people end up leaving.” The common social expectation is that care workers “will work as long as it takes to get this work done” (Baines & Armstrong, 2018, p. 9), with many workers themselves expressing a desire to “care more” (p. 11). With dominant or disparaging views of old age such as those

framing older people as a burden, long-term care as a prison, or aging as a problem, crisis or tragedy (Chivers, 2013; Grenier et al., 2017; Swinnen, 2019), care workers who leave are perhaps seen as (or see themselves as) contributing to the devaluation of those who need care.

Walking away from a care responsibility was also framed as an uncaring, privileged, selfish act in some participants' stories. Julie told a story of Joe, a person with an intellectual and developmental disability, that she supported as a live-in care worker (aka assistant) at L'Arche:

I was talking with Joe's stepdad and I was like, 'I think I've finally tapped into Joe, like I think we're finally friends!' And then his stepdad was like, 'Yeah, until you leave him just like everyone else does. He's actually a smart guy and he wasn't connecting with you, because he was protecting himself.' I remember being like, 'Oh, my god! I'm one more person who's going to break his heart, and he just doesn't know that yet. He thinks that I'm probably in it for the long haul.'

Julie differentiated heartbreakers who leave from those in it for the long haul, noting that Joe had been taught to close himself off or become more guarded with live-in assistants. Her story speaks to how dominant understandings of care are handed to people in practice or in specific organizational contexts. There was no ritual closure. While Julie recalled being touched by this conversation, her story suggests there are limited social scripts or rituals to support carers in opting out of care responsibilities or in articulating their experiences in more complex ways such as by exploring how carers may also become attached or heartbroken themselves. Such an idea – that good, moral, women don't leave,

along with the expectation that they should or might be in it for the long haul – is harmful for carers and those who need care alike. It seems to limit carers' agency or social mobility, making a claim on their lives. It also positions care recipients as those "impacted," rather than as agentive subjects who might be able to make meaning of or negotiate such transitions. Accounts of heartbreakers leaving frame caring as moral work that women should do indefinitely, while framing opting out of a care relationship as an act of betrayal.

A second related trope in the context of familial care was "writing off" one's family members. That is the kind of thing a heartbreaker does. In speaking of growing up, Gina talked about family members with mental health issues, and noted that "back then" – decades ago – they wrote people off as "crazy" and sent them to the "loony bin" without more comprehensive understandings of, or supports for, "mental health issues" or of the "situational or social or what's going on in someone's life." As Gina said, "You were just written off." The idea here is that not providing care in one's family/home is a way of "writing off" a person. Such an ethical stance is informed by an awareness of the conditions of care in large-scale institutions. It also places the onus on individual family members to provide direct daily care. It relies on an 'if not this, then that' logic, for instance by idealizing non-Western cultural practices around care for older adults rather than pushing for public supports for communal or congregate care that might enable families to share responsibility and might support people who need care in just, equitable, meaningful, joyful ways. The idea that not providing direct daily care was a way of not caring about a person (Davidson, 2015) was visible in participants' stories of placing their relatives in institutional care, as well as in critiques they faced for doing so. Anne

recalled one journalist referring to her as “selfish” and as a “line jumper” when she dropped her son off at developmental services. That said, with a deadpan delivery, Anne didn’t exactly seem bogged down by weight of the moral scrutiny. “You know, she’s really entitled to her opinion,” Anne said, with a nonchalant and unfazed presentation of self. Some got it, others didn’t. As Anne told it, she was aware of the social expectations to care, but had agency in negotiating them.

Some participants also expressed concerns about “writing” people off if they were to leave. If paid care work is a gendered form of resistance (Baines, 2015) or a way to “contest uncaring management, governments and larger society” (Baines, 2015, p. 205), it makes it hard to step back as stepping back seems “uncaring” or like a way of devaluing the lives of people that one set out to value. Family carers also had concerns about keeping their relatives safe or alive. For instance, Betty described how there was a lot motivating her to continue providing family care. She first said it was out of “loyalty and bonding” after 40 years of marriage that she came in daily from “11 o’clock in the morning, [to] 7 o’clock at night” to support her husband at a long-term care facility. She framed herself as a loving wife, caring for a husband who had always been “high maintenance.” As Betty said, “he sees me as his link to the whole wide world, thinks that I can solve all the problems, that I can fix everything, that that’s my job.” She also said, “I’m afraid if I’m not here, nobody’s going to really take care of him.” She felt the organization was stretched thin and couldn’t meet his needs with paid care workers who had a “mindfulness missing.” The way she was positioned was supported by dominant ideologies of “family responsibility” that rely on women to take responsibility for care for their dependent family members “for free, on the basis of love and affection and

reciprocity (Glenn 2010)” (Levitsky, 2014, p. 7). Further, with discourses that frame the nursing home as a “repository for cultural fears” (Chivers, 2015, p. 135), Betty devoted herself to her husband out of “loyalty” and “bonding” and so that he would not become a “non-entity.”

Third, in addition to the common sense understandings that heartbreakers leave or “write off” others, were participants’ horror stories of carers who *do* leave, and experience real social and material costs and consequences. Many participants challenged the idea that it was a privilege to exit, giving examples of women who lost everything when they did leave. Carrie mentioned that her family stopped speaking to a trans family member when he stepped back from care responsibilities that he had previously provided or had been socialized to provide living as a woman. As Carrie said, “They don’t speak to him because he stopped meeting all their needs.” Carrie’s own life experience helped her to claim solidarity with her uncle, facilitating an ethical relationship with someone who didn’t want to care, as opposed to exclusively with those who are conventionally deemed most worthy of care (such as their family member with cancer who Carrie’s uncle had been pressured to support).

Taken together, these tropes make up and are backed by dominant circulating narratives at a social and historical moment in which responsibilities for care are framed as the individual responsibility of individual workers or family members. For instance, Marilyn emphasized that decades ago home care used to provide more supports to families, with the state taking more responsibility. She noted that with the way those services have been clawed back, the onus now falls on women in the family to provide those supports. Something as simple as the number of hours of care provided per day

makes a difference in whether women are put in morally fraught situations. It makes a difference whether one has financial resources or access to other private or public sector supports (such as respite, home care or residential care options), with others or the state taking on some of the duties. It also makes a difference whether or not opting out lets down a co-worker, puts others' lives or health in jeopardy or puts oneself at risk for being criminalized or losing housing or income. It matters whether someone has access to social services or other supports (such as WSIB, employment insurance). These conditions matter, and are what produce the moral dilemmas that people negotiate in their narratives. As a matter of design, the way care is organized places the onus on individual women to care, which in some circumstances creates an ethical demand for women not to break hearts or dump others or face the costs or consequences of doing so. The term "heartbreaker" points straight to affective dimensions here. It signals someone irresponsible in emotional relationships to the point of causing others distress. It makes leaving seem like a rare or unexpected occurrence – something to be let down by. Such a storyline gets in the way of organizing equitable care relationships that both support carers' mobility or agency, and give people who need care options about who will support them or how they will be supported. In these narratives the onus lies on individual good women to keep caring.

Lives in context: How and under what conditions women get "out" (depends)

As evident in participants' life narratives, part of how the relational care economy operates is that people *do* set limits, step back or redistribute responsibilities for care that previously fell to them. There are practices for doing this, as well as conventions for talking about it. Learning from women about how they are *already* doing this can support

with broader calls to redistribute care from women to men or from individuals to the state. Participants told stories of renegotiating or shifting tasks or their workload; opting out, exiting or resigning from particular care roles; and ending or taking a break from care relationships. All participants either directly or indirectly reported setting limits on or stepping back from a direct care responsibility in different paid or unpaid care settings over the course of their lives, with different experiences occasioning different narratives. In this section, I will critically reflect both on how and under what conditions women get “out,” as well as on the practical and conceptual work involved in renegotiating responsibilities for care.

The stories that women tell about leaving tell us about the conditions of their lives. Past studies of nursing and teaching have found that some workers leave their professions due to moral distress, with some leaving to preserve their sense of moral integrity or moral self-conceptions (Corley et al., 2005; Kelly, 2002; Santoro, 2015). Conditions matter, as Duffy (2011) notes:

The historical story of domestic services describes jobs that women leave when they can. One scholar of nineteenth century domestic service [Sutherland, 1982, p. 61] observed: “In most cases only people in desperate financial straits, those who considered service a brief interlude to better things, or those who could not find employment elsewhere became servants” (p. 33)

She calls attention to the social and material conditions for making a life. While the phrase “women leave when they can” seems to suggest that they didn’t want to be there or only stayed as long as they had to, my research puts a different spin on the phrase in

raising questions about how and under what conditions one can opt out. In doing so, my analysis calls attention to how gendered, moral expectations for women to care make a claim on women's lives. In her analysis of sex work, Rivers-Moore (2018) describes a focus on individuality and efficiency at an evangelical organization supporting sex workers in stepping back from the work. She writes, "This approach demands that individual sex workers change, while the context in which they turned to sex work in the first place does not" (p. 863). She refers to the wider political and economic conditions that restricted women's employment opportunities and led them into sex work in the first place. Her comment is relevant to my analysis of participants' narratives and life trajectories. What Rivers-Moore gets at is the practical and material conditions or the options for one to sustain oneself materially, for example with housing and employment. Further, a key finding in my work is that *intrasubjective conditions* also matter, as those conditions not only led them to care or shaped their involvement in care, but also shaped their options for remaking their lives. "Care" makes a claim, and participants' work to reconstitute their narrative selves is central to "care redistribution" or to how the caring economy operates.

It's important to state that the practical and material circumstances of one's life shape the 'choices' or options one has to renegotiate responsibility. Wajcman (2000) notes that people's "choices" are "heavily conditioned by structural social arrangements that impose limits on what women can do" (p. 188). I want to emphasize that the stakes are different in different contexts. Providing an example of a decision to step back from care that was criminalized, Anne remembered police officers in tactical gear threatening to charge her and her husband with abandonment after they had dropped their son off at

developmental services. There are different normative expectations around abandoning family members or abandoning clients or paid workplaces. Further, the extent to which people are constrained varies, with working class women have fewer life options outside of care and fewer options for opting out once they are there (Dodson & Lutrell, 2011). One example of that from my study is how Nora both felt like she had hit the “jackpot” when she started as a paid care worker with no other work opportunities in the town where she lived. When recruitment into paid work happens in the context where people choose between working and starving (Irving, 2017), those wider relations also impact one’s ability to renegotiate responsibility.

In regard to how context matters, some participants detailed real costs and consequences for setting limits or opting out of care responsibilities. Nora narrated being “exiled” from her community, losing her job, community, friends and housing. Julie shared one example of her grandmother’s cousin who had devoted her life to service and caring for others as a nun, only to be left “essentially homeless” when she left the convent. Julie also noted that she herself had been “fine financially” while in a live-in care worker position, but was “faced with this harsh reality of financial burden, after having dedicated [her] life—a year of [her] life—to something.” Troy also mentioned that there were costs to leaving when they talked about the “policing and paranoia” at the organization where they worked and where they had been afraid to tell anyone why they had to resign. As they put it, “when you’re forced out of the role itself, you’re seen or made to feel a little bit crazy – discredited in the same way our clients or discredited.” With care offering people a way to sustain themselves, participants emphasized that leaving came with real social or material costs.

In some participants' accounts, practices of redistributing care involved little by way of justification or were well supported by broader narratives or social relations. Donath (2015) notes that one's justifications or back story "may indicate the intensity of the social and cultural mechanisms, which are hard to undermine due to their institutionalization" (p. 360). In participants' stories, unremarkable transitions (such as resigning from babysitting or camp counsellor gigs) demanded little by way of explication or meaning making. Participants gave countless examples of exits that were no big deal. Gina shared an empowered account of kicking a kid out of her daycare who had intentionally peed all over her bathroom – covering the curtains, towels, toiletries, sink and floor. As she put it, "To put it bluntly, [he] was an evil child. ... I said, 'please don't bring him back.'" Rhonda laughed as she talked about retiring from her work as a nurse at age 73: "I said, 'Bye!' and my colleague said, 'You have to give two weeks notice.' I said, 'So fire me!'" She had already put in her time, and it made for a funny story. Troy said, "I left town as quickly as possible when I turned 18, my younger sister had to pick up the slack of caring for the kids [in my Mom's home daycare]." Dale also recalled setting limits on a friend, who Dale supported on a care team, while out for dinner: "I told her that her anger toward me was something I needed changed in order for me to continue supporting her, and everything ground to a halt." These stories seemed easy and fun to tell. There were no back stories or elaborate explanations, and no need to slow down to unpack one's sense of self or moral worth to justify one's decisions. Redistributing care was just part of life.

Participants also described some situations where organizational processes played a role or where such decisions (e.g., to share responsibility or step back) were dictated by

the system or out of one's hands. Noting that "[t]here was good team support and good management support when [she] worked in home care," Marilyn said, "we gave as much as could and then had to stand our ground and say, 'No, that's, all we can give.'" Others recalled conversations with professionals, including doctors, social workers or home care workers, who advised them it was time to redistribute responsibility. Rhonda shared, "It was CCAC [Community Care Access Centre] that said, 'we can't do this anymore.' It wasn't my decision [to place him in long-term care]. ... I understood I had no power." She also noted that this had been for the best. "You've got to do this, you gotta look after yourself" others had said to her. Gracie also recalled a situation that was out of her hands when her Mom recovered from her health issues and no longer needed Gracie's support as a primary full-time family carer. She recalled her Mom "launching back into the world" and saying that she did not need her anymore.

As participants told it, redistributing care variously involves a range of practical work such as: (1) trying to make it work; (2) making arrangements to sustain others; and (3) working to sustain oneself. Several participants talked about *trying to make it work* as a key stage before stepping back. In emphasizing how hard it had been to leave, Carrie talked about coping with food, while Troy also recalled that "not eating" became their "coping mechanism" to get through the shift and to be able to listen to "traumatic stories." In speaking about the context of family care, Betty also talked about how she tried to make it work. She said that she was at her limits, sharing that she had had the flu a few times one year and had had hip surgery, with her own health needs getting in the way of being able to care. But even still she struggled to leave and tried to make it work. She also joked about others asking her, "Oh Betty, how's your weekend?" to which she'd

deadpan, “What’s that?” Several participants talked about making arrangements to sustain others to be able to leave. Anne recalled identifying a suitable place to seek out care for her son, dropping him off at developmental services where he would have access to care providers who knew him and could support him. “John is still part of our family,” she said, “As long as we’re alive, he always will be part of our family.” Participants also described a range of work to sustain themselves, including by seeking out other employment, securing housing or engaging in intensive work to recover physically or emotionally. Julie talked about applying for other employment opportunities such as in care research, only to be referred by a care scholar to another direct care position that was “part time, patchwork hours here and there.” Some participants talked about taking significant time off work to recover, with one talking about having to pay out of hand for medical expenses (for procedures she felt too “guilty” about pursuing while working). Still others talked about work to negotiate their sense of subjective dislocation.

As I have explored, participants’ stories speak to how redistributing care is deeply structured by access, inequalities and resources. They all told stories of renegotiating responsibilities for care across their lives, with many identifying conditions that made it easier to leave (such as having a long-term care spot or options to offload care or share responsibility). That said, I at times struggled to connect participants’ narratives (or expressions of dissonance) to their material circumstances or life histories. While I initially anticipated that care norms make a greater claim on the lives of some whose material conditions force them into care more strongly, several accounts complicated this assumption. What makes it “easier” or “harder” to leave (e.g., with different associated expectations or norms in different care situations) was hard to measure. For instance,

some participants framed all encompassing primary care responsibilities as “easy” to move on from, while others talked about how they technically could have resigned from a job with the resources or supports needed to, but that leaving felt like a crisis of self or something that they were still wrestling with.

Participants framed their care histories in different ways, and how and under what conditions they got “out” of care really depended. With that, my analysis isn't about what care situations were actually harder to leave, nor is it about participants' internal states, motivations, or the ‘actual’ subjective processes facilitating leaving. Caution is also needed around participants' ability or willingness to elaborate in a narrative or introspective way. What I do get at, however, is how they framed their accounts in relation to dominant social norms. They engaged in work to frame their lives, reconciling their care histories and caring subjectivities through the stories they told.

Care limited: Narratives of renegotiating responsibilities

In a study of how social inequalities mediate people's practices of workplace change, Siltanen and colleagues (2009) distinguish between people “flowing through” workplace change and getting stuck in a “swamp” or transitioning in ways that are “comparatively more belaboured” (p. 1016). The distinction between “flows” and “swamps” offers a useful way to categorize two patterns that I identified in analyzing participants' accounts of stepping back from care responsibilities. With different presentations of self, some described finding ease or flowing through processes of redistributing care, while others framed themselves as getting hooked or stuck, as they expressed that they were still “in” it or still working through questions of care. Making links to gendered conditions in the care economy that extend beyond any one job, I consider both how expectations to care

for others variously made claims on women's lives, as well as how they variously engaged in the narrative reconstitution of their selves. In particular, I show how some seemed to be establishing a caring self that went *beyond* care in framing leaving care as easy to do, while others were presenting a caring self through accounts of still being "stuck" or wrapped up in questions of care. Participants engaged in narrative work to reconstitute their moral subjectivities after life transitions or experiences that variously seemed to threaten their expressed moral sense of selves or self-expectations.

Flows: I backed out of that one pretty quick

Marilyn described turning down a request to care for her mother-in law, who had some heart issues, saying, "It was felt by his [my husband's] side of the family that I should get a babysitter for the children, so I could spend my days with her, and I backed out of that one pretty quick! I was not about to become her maid." While it's notable that she was wrapped up in other care responsibilities at the time, the phrase "backed out of that one pretty quick" speaks to an observation I had that some participants' narratives seemed to easily reconcile their caring life histories. When it comes to getting "out" of care, some participants told stories of "flowing through" or redistributing care, which offered a particular way to constitute a moral, caring subjectivity that went beyond a particular care role. In these narratives, care was described as easy to get out of when 'caring about' someone or 'being caring' didn't equal 'caring for' them. As Gracie said, "I *had* a relationship with [my Mom]. ... I still *do have* a really good relationship with my Mom."

Sheila told a story where her sense of self as a caring subject went beyond caring for others. Looking back on the experience of caring for her mother, she spoke in the

'we' and without regrets: "We were coping with a lot at that time. It was just starting to be a bit overwhelming." She didn't say that she herself was overwhelmed. *They* were coping and *it* was starting to be a bit overwhelming. As she put it, "I realize I made sacrifices. But I wouldn't have done it differently." For her, the example of redistributing care was when she put her mother in a nursing home. She hated the phrase "put her in there," but there seemingly wasn't a contradiction there. As narrated, her worth or purpose went beyond caring. Part of this was that she was well-supported in caring: welcoming her mother into her own home, hosting her mother in a granny suite, and supporting her mother in a private retirement residence. As a well-resourced woman, she had back-up in sharing responsibility as she hired "the cleaning lady" to provide one-on-one support and had support from her husband who pitched in. 'Caring about' was different than 'caring for' when others were able to help. In her story, she didn't load up care with meaning, nor did she frame it as central to an ethical life project. So, while she was physically exhausted, and it was an experience of overwhelm and of hitting physical limits, she didn't describe a sense of subjective dissonance.

Marilyn gave an example of a flowing pattern in speaking of caring for her parents. There was no contradiction there. She didn't narrate herself as having overly identified with or invested in the role. She said, "So that was [20]09 until 10, 11, 12, 13, 14, 15, 16, 17. So for eight years, he continued living at [private retirement residence], but they changed his care level three times" as he needed more support over time. In three sentences, she elaborated that she supported her father with his exercises and with medical appointments, before saying, "So that's the caregiving history with Dad!" That was it. With a brief, condensed summary of her Dad's medical needs, she was on top of

it. What Schein (2008) refers to as the “how and why” of a story, and the “emotional interiority necessary for their exploration” (p. 172), were absent in most of her account as she focused on the “what” of it. It was a short interview with point-form responses to most questions. When I asked her to elaborate on any other “stories or memories” related to care, she said, “Ah, I don’t think so. I think I gave you a fairly good impression of what it was like.” “At the time” was a distancing refrain as she summed up her past care experiences without identifying with the role. In her story, the speaking “I” wasn’t all ‘caregiver.’ Questions about negotiating responsibility for care in relation to her (moral) sense of self or life weren’t part of what she was unpacking. When I asked whether she’s had to discern whether or not to be there for her family members, she shrugged and said, “sometimes the need gets dictated” for instance when her daughter “needed somebody to be with her [for] a day surgery.” Her sense of self or moral life trajectory seemingly wasn’t on the line. There was a material basis to a story like that; Marilyn shared about her elite family who was upstanding in the community. She also mentioned that she had shared the responsibility with her siblings, and that they divided the time as they supported their parents at the private retirement residence that was a phone call away. With care work distributed among many, it was just life. Redistributing care seemingly didn’t come with major social consequences for sustaining herself or others.

“I just remember by the end,” Julie said, “I wasn’t super excited. So, I finished my contract [at L’Arche] without having my next job lined up and moved into an apartment with a friend.” While she remembered becoming closed off to relationships, and that she had been “depressed,” as well as “emotionally fatigued or socially fatigued,” she didn’t describe any moral qualms about leaving. She said, “I really value [the work of

direct care], but it doesn't mean that I want to be involved in it." She didn't detail an experience of subjective dissonance, nor did she describe scrambling to reorient to her moral subjectivity or life trajectory. Her story offered a clear example of how the dynamics *between* people and their contexts make a difference. L'Arche provided structures of meaning that infused care with particular spiritual, communal meanings or invited particular embodied performances. As part of a live-in community, workers can be thought of as "hidden in the household" with their work and housing conditions limiting their engagement with the local community (Stasiulus, 2020, p. 38). Yet, against this backdrop, Julie emphasized her agency, as she said, "The expectations of the community didn't really align [with my own]." As she put it, "I was ready to give a lot of time and energy, but the expectations of what that meant didn't really line up with what the community wanted me to give." As Julie told it, she left when the contract was up, and didn't elaborate on feeling like a horrible person or like she should have cared more or indefinitely or longer. Her story speaks to how it is about the dynamic or "intra-action" between a person and the conditions of their life. Everything was seemingly in place for Julie to tell a slog of a story about wading through a swamp or struggling to recognize herself on the other side of care, but she didn't. Intra-subjective conditions matter, and she was claiming a particular caring femininity in the moment.

With empowering stories to tell, some found flowing patterns in narrating, which offered a particular way of establishing a moral sense of subjectivity in relation to care. Notably, it wasn't that these participants didn't identify with the role, but that their expressed sense of what made them a caring subject went beyond the role or beyond the work of providing direct care for others. Sheila and Marilyn both framed themselves as

good, moral caregivers, describing care as a force in their lives that they positioned themselves in relation to. Similarly, Julie had wondered if her coworkers hadn't felt as guilty as she had as they hadn't cared to the extent that she had to begin with. Care was framed as part of their sense of selves. That said, in these accounts, 'caring about' or 'being caring' wasn't equated with actively or currently 'caring for' others. So, while gendered, moral expectations to care were still at play, participants claimed caring subjectivities that extended beyond particular roles. There wasn't a contradiction there. With that, it's also notable how intra-active or situational framing oneself as "flowing through" is – even with seemingly all the right conditions to frame oneself as having got "stuck" or bogged down, some participants found other ways of putting it.

Swamps: Well, then who am I? Who am I, then?

Akin to "wading through swamps," some participants engaged in comparatively more belaboured narrative work in reconciling their care histories – unpacking contradictions, remaking their moral sense of selves, and breaking down or detaching from "care" as an ethic. Family carers and paid care workers alike expressed that they felt like they were still "in" care. With bulging, sprawling stories, they revisited and reworked memories of care, taking side angles and processing experiences close to their hearts.

In speaking of resigning from paid care work, Nora made clear that she had a savings account and family to stay with *and technically could have left*. What was at stake in struggling to leave was about who she was as a person. With care work as part of a moral project, she described and undertook a lot of work to redefine her sense of self and remake her intimate relationships. In speaking of being "forced to leave," she

recalled having to move in with her mother and take a full year off work after burning out as a direct care worker. As she put it, “I went from looking after people with disabilities to becoming kind of disabled myself—from being a caregiver to someone who needs care.” She described “all the pain and the fatigue and the depression and stuff. And also all the loss: like losing a job, losing a home, a community, kind of thing.” She didn’t simply chalk it up as a learning opportunity in her younger years, as Julie had. Speaking to the intrasubjective, intimate relations, Nora said that she was “immersed in it,” that it was “part of [her], a part of [her] identity.” It wasn’t just that she was no longer well enough to go in for her shifts. There was more to it than that. Her story is an example of a deeply internalized discomfort or subjective dissonance. “Well, then who am I? ... Who am I, then?” she asked, noting that she “didn’t really know who [she] was.” Caring gave a sense of purpose: “I felt more empowered or more capable, or had something to say, had something to give, you know, at least more than I’ve ever felt in my life.” To leave or step back from a care responsibility was to diminish, compromise or erase the self. This was a horrific experience that left her scrambling to reorient to her sense of self and self-expectations. She was still working through it in the stories she told at the time we spoke.

Nora was still grappling with its loss, and what leaving care meant for who she was. Stepping back, as Nora narrated it, involved an incredible amount of work from caring for herself to accepting care and processing her experience in therapy and in conversation with friends. “I’ve thought about it so much over the years and have talked about it so much too,” Nora said. She did a range of work to unpack her sense of self and to unpack care as an ethic—reflecting on her commitment to care, on how her care history had played out, and on what this painful experience meant for her life. “That’s

interesting. ... Yeah, that's interesting," she said, as she spoke, thinking through her positioning in relation to care as she went. This was work that she was doing at the time of the interview, as she wondered if she had been susceptible to burning out as the "oldest child" or if she had always been "drawn to other people's pain." She also talked about working to recover from the experience or from a sense of "unworthiness or neglect."

Quoting Nora:

I think care is something that's really devalued, that's really gendered or really kind of whatever, but it's something that's so integral and important. And it's one of those, 'Oh, if we all cared for each other more, life would be better.' But at the same time, care is something really unhealthy and really controlling and really traumatic and really just debilitating. ... I guess it's just something that's really complex. ... So, is there a way, instead of making it this dichotomy—care is good, care is bad—can it be both? Can it be?

Nora can be thought of as putting a great deal of energy into rethinking her romanticized attachment to care as an ethic, breaking down the associations between care and morality that had had a particular grip on her life. She was still trying to make sense of it and figure out where to put the emphasis. Hers wasn't a straight-forward story about listening and learning and connecting and then moving on. For instance, she wrestled with why she had stayed past the point of reaching her limits. Struggling to describe why, she said, "Yeah—again—I think it was—I don't know if—it was a slow process—I think I knew for a long time that I wanted to leave, but I just couldn't for a lot of ways. I convinced myself I didn't need to." She remembered thinking, "I'm doing such good work. I'm such an integral part of this organization. I'm part of this community. The work I do is so

meaningful.” As she emphasized, “Not in an egotistical way, but, like, ‘It’ll be hard to replace me,’ kind of thing.” Part of the work she was doing in our conversation together was to make sense of her life and her caring orientation. She said, “I think that I can let go of that idealized version of myself—untangle myself from that romanticized version of it.” She made such a compelling point both in noting that she was still attached and tangled, and in noting that it could be otherwise – that she could “let go.”

At the time of our conversation, Gina was also still struggling to make sense of who she was or what it meant for her life that she was no longer able to care for others. No longer having “what it took” was a tough pill to swallow, as she had attached moral value to caring as something she was supposed to want – an expectation she was supposed to uphold. Working through it in her narrative, Gina told multiple stories that seemed to speak to the coercive, dark or absurd side of care. She alluded to a pattern of self-sacrifice across her life, drawing comparisons between her experience as a direct carer and her past experiences of both being “pawned” off for marriage and experiencing domestic violence. In speaking of her ex-husband, she said that she could find herself “pushed into a wall with a fist in [her] face” if supper wasn’t on the table or if her husband saw “any signs of any children ever.” She also noted that people often ask “why did you stay in an abusive relationship” to which she replies, “you have to be there to understand what it’s like.” In other instances, Gina seemed to poke fun at the sanctity of care. She laughed when mentioning that she sold her car so she wouldn’t have to be on call to run errands or take care of her mother. “Yeah, yeah. I’m glad you got rid of the car!” I said, laughing. I also laughed when she shared that, for eight months on every dog walk and pee break, she hung her own cane on the back of her Mom’s wheelchair and the

dog with the heart condition sat on her Mom's lap while the other one shuffled along beside her. She painted one hell of a scene, as though theatricalizing the sanctity of care—revelling in the absurdity of it. These stories seemed to serve the social function of both trying to understand how she had been trapped in such inequitable situations, while easing the moral burden she had carried for no longer having the patience to care in ways that had been important to her sense of self worth.

Gina storied her way out of her relationship with care, for example in telling a story of sharing responsibility. She remembered hosting a pool party, where she “had no desire to spend [her] whole day doing stuff with” her great granddaughter. She described the child, saying: “She was lovely. She's a very well-behaved little girl. Sweetheart. Cute as a button.” Gina also recalled how she set out craft supplies for the child, and “let her Mom and Dad do the crafts and stuff with her.” She expressed that the old Gina would have been right down on the floor, hanging out with the child the whole party. Gina's story wasn't one of selfishly stiffing others with direct care work, nor was hers an account of a privileged next step. Instead, inhabiting an ethical position in relation to care, she painted a scene of the pleasures of care – of loving parents crafting with their little sweetheart at a family pool party. She also emphasized that she knew the extent of what was involved in caring for someone, but just wasn't able. She framed it as a loss or as something she was missing out on, emphasizing that it hadn't been a privilege. She maintained a caring self, saying “I cannot give the proper care. ... I'm literally, like I said, burnt out. I can't do it. Maybe in a few years down the road. I've never stopped caring for people; I just can't do it 24/7.” She told stories that helped to shift responsibility, finding a way to lean on others. After decades of being the first to jump up

to respond to the needs of others or the one who would be on the floor the whole party, finding space to tell it (and live it) another way was expressed as incredibly significant in the context of her life and relationships.

Carrie narrated getting out of “care” by both resigning from paid care work and setting limits on family support she provided. Caring for others had been a foundational life experience and part of a life-long commitment, which raised the stakes for leaving. She shared that she relinquished her vehicle and started growing her own food to save money. She did physio exercises to recover from occupational injuries that resulted in chronic pain, and went to therapy where she was diagnosed with PTSD and supported in making sense of her experience as a care worker. She said, “I worked on mental health, developed my self worth, started noticing toxicity in relationships.” Carrie noted that therapy had helped her to see that there was “nothing wrong” with her. As an Indigenous woman, Carrie also reflected on the consequences of being cut off from her community or feeling like she was neglecting them. As Polys notes, “Separation, alienation from their own Indigeneity, those are all ways that guilt can creep in” (as interviewed by Smith, 2020, p. 41). Carrie shared that she felt as though she had been kicked out of the community – left out of intimate family happenings such as the opportunity to feel her pregnant sister’s stomach when her baby kicked. At the time of our conversation, Carrie was wrestling with how an experience like hers fit in with the tradition of “intergenerational care” that was important to her. She valued practices of living “with generations within the home” or of living “communally” not in “little factions.” She also saw the importance of tenants to “stick together.” Redistributing responsibilities for care wasn’t something that Carrie took lightly; she still wrestled with it. Yet, she also

expressed the significance of valuing her own life or “look[ing] out” for herself, something that she noted that women often have to do. She felt for those (women) in her family who she said had:

worked, had to work, so hard to get out from under the care of others—to get out from under caring for others. ... You have to go through fire. Get shunned first. You get hated on. ... Everybody and the cat is going to talk bad about you. ... That's the price to pay to get out from being their caregiver.

With a unique and unexpected way of putting it, Carrie called attention to the work of getting “out from under caring for others.” She emphasized that it's a slog to get out with real costs and consequences; it isn't as easy as just leaving when you can. She certainly wasn't reminiscing about a learning opportunity, nor was she quickly summing up a chronological account of caring for others.

In our conversation together, Carrie was actively unpacking what her care history had meant for her life. In a way that I related to, mocking her past commitments to care seemed to offer Carrie a way to distance herself from them. She poked fun at her historical self who found it meaningful or who used to love supporting people “in the fire.” She said “in the fire” as though to sound pretentious or ‘hoity toity’ or to hint that caring *used to be* something she would brag about. She told countless stories that seemed to offer a way to release herself from care as a moral project. For instance, she shared that she had been processing how caring for others had been a way to keep herself safe or “soothe [her] own stress.” She recalled that if she was “experiencing distress or conflict,” it's easier for her to say, “Oh, forget about that! How are *you*? Oh, you don't have

enough groceries for a week?" or "*Oh*, I can get him jeans that'll fit. Don't worry!" She laughed as she spoke, and how she narrated this was central. She said that caring came with an "affirming validation" before speaking in the voice of a casting director to say, "Look! At! You!" Just as Dale noted, "you have to call it by some other name if you're gonna call it," Carrie did a lot of rhetorical work to revise projects and meanings of care that she had been handed. Circling back to the jeans, Carrie said:

My Mom started this thing with my brother, because she would only ever have 20 bucks for back to school clothes for him, which I mean you can't even get a pair of running shoes at Walmart for 20 bucks. She would go on and on about how he would only buy clothes with me. 'Well, I try to take him shopping Carrie, he won't buy anything.' Well, for 20 bucks, what do you expect? But I had grown up like that. Back when Value Village was actually a cheaper option. *laughs* Now, it's like I may as well go to Walmart! *laughs* So, I would go, '*Ohh*, only I connect with my brother.' She would exploit my wanting to be connected. I'd take my brother shopping for a whole weekend to all these discount places and we'd find him cool clothes that he was okay with. We found cool—I'd find them for six dollars a piece and I'd probably kick in about 50 dollars of my own money, because I didn't want him to go through what I went through.

Carrie relayed that her moral desire to be good or to connect had been exploited in a context of material disadvantage. Such a perspective was developed following her experience of subjective dissonance at the limits of care and after years of processing, unpacking and reckoning with the experience. Telling a complicated life story, Carrie felt for her historical self who wanted to connect and who didn't want her brother to "go

through what [she] went through.” She also made light of the way caring for or sustaining someone had been framed as a moral practice that only she could do, as though she was uniquely equipped for it. Rolling her eyes, Carrie said, “From a small, small age, my Mom would talk about how I knew what my sister wanted before anybody else did.” “Some magical intuition,” she said, repositioning herself in relation to care and claiming a particular form of narrative power.

“There’s something there that needs to be unpacked!” Troy said with enthusiasm, as we talked about the phrase “I couldn’t do your job,” which was a “compliment” they often received as a paid care worker. Troy was actively unpacking their care history in our conversation together, with that as one of several examples. They described having to un/think or un/do the ways they were made to feel “crazy” for no longer being able to care, which was part of the work they did to get out. They had to unpack and reorient to moral, gendered self-expectations to care that they held. Part of how Troy seemed to do this was in coming to see resigning from care as an act of care – a way not to become the “worker no one wants” like their “hard and jaded” co-workers who would “just half-ass” it or “do the bare minimum” or “set boundaries” or “delegate” without really helping anyone. More than simply walking off the job, they described rethinking their own life path, as well as breaking down associations of care as moral work.

Troy said, “It’s so ingrained in my identity and my career and I’m really scared if I step away from it completely, like what does that mean, like how do I identify? ... What type of person does it make me?” They described actively wrestling with what no longer working as a care worker meant for their life. Having dedicated their life to anti-oppressive work, they had come to think of anything other than direct care as “selfish,” as

it had “been so ingrained that you put everyone else first that it’s hard to even fathom.” To give one example, Troy found it hard to *even talk about* resigning, speaking of a “you” that has to leave or a “you” that reaches their limits. Emphasizing that it hadn’t been a choice but that they had “blacked out,” Troy said, “When I filled out the WSIB paperwork and incident report, I wasn’t even present enough to figure out what was happening in the moment. I went to my boss’s office, and I just kept saying, ‘Please don’t hate me, please don’t hate me, please don’t hate me.’” In the context of Troy’s life story, the phrase “please don’t hate me” wasn’t just a throw-away comment that slipped out, but something they were actively making sense of. Not caring, as they had come to think of it, had felt like a way of being cut off from their life-sustaining relationships. Troy unpacked and wrestled with how they had been caring to connect.

Doing rhetorical work to break down care as an esteemed ethical project that had a hold on their life, Troy told a story about volunteering as a university student at a community service agency and going to visit the home of a woman they supported. They remembered thinking, it’s either “going to be the worst thing I’ve ever seen in my life or it’s going to be like ... dusty rose paint on the wall with Royal Doultons” – “very like grandmother sweet kind of home.” Troy set up the story, before pausing to say, “I had no concept of how bad it could be until we opened that door. *We were shocked*. Everyone was just like, ‘*Oh my god*.’” Troy described the “conditions as toxic,” with “tin cans filled with urine and feces,” and things “soaked in blood.” Troy said, “That day I realized, like what I was really getting into.” They elaborated that their work in social services had often involved being put in hazardous and violent situations. It was the norm. They said that other people “can’t even comprehend the state of the places that I’ve

gone into. And how do you really convey that? For so long that was just normal, like this was just part of the job and now—.” One social function that Troy’s story seemed to serve is that of highlighting how ‘care’ doesn’t do what it says. They worked to demystify care or release themselves from their initial romanticized attachment to it.

Redistributing care was perhaps framed as more painful for those who had “fully internalized the requisite feeling rules but [could not] live up to them” (Erickson & Grove, 2008, p. 717). With the way that care made a claim or demand on their lives, some didn’t simply describe packing up their bags or resigning from jobs at so-called “dumpy” care homes. Instead, they engaged in interpretive, narrative work to unpack and reorient to their sense of selves and self-expectations or to break down or shift associations of care that they had previously held or attached to. Their concerns weren’t just about whether there was another job available or options to physically exit. Following Berlant (2020), part of this slog that some described can be thought of as an experience of “losing your object” or breaking your “referential relation to the world.” They hit existential impasses after having attached and engaged in care as a moral, feminine life project central to their sense of self.

Restorying/redistributing care

Women need options and avenues to renegotiate responsibilities for care, as well as narrative resources for talking about it. Gendered, moral coercion is a historical process that we can see in women’s life histories. It’s obvious in their accounts of being funnelled into care, but we can also see it in their accounts of care redistribution; stepping back or setting limits can be hard to even talk about. The analysis in this chapter further speaks to the strong hold of gendered, moral expectations for women to care, while also showing

differences in how women engaged in narrative work or claimed particular forms of narrative power through their stories.

Participants' stories served a purpose at an individual level by helping them to reconcile their care histories (e.g., by framing oneself as okay with 'exiting' or pulling back). That said, as was the case in the way Troy distinguished themselves from workers who "just half-ass" it, participants at times drew on and reproduced dichotomies or stereotypes about "types" of (caring or uncaring) people, while also individualizing their solutions rather than tackling broader gendered structures. The kinds of 'redistributions' that participants described often centered around shifting responsibility (e.g., to organizations or to the state), rather than challenging the gendered division of labour.

As my analysis illustrates, participants' discomfort suggests a "recognition of dominant expectations about care and gender that were not being followed and therefore required explanation" (Aronson, 1998, p. 124). The dissonance they expressed can be linked to internalized norms they had accepted in a context that individualizes care or wedges people in self-other care relationships in which they are the "only one." Even the idea of leaving was described as painful for some, as caring was interwoven with their sense of selves in contexts where "job titles do not distinguish the worker from the task" (Daly, 2013, p. 35) and where caring is seen as an intrinsic capacity, as opposed to skilled, remunerable work (Armstrong, 2013; Palmer & Eveline, 2012). It's clear in some participants' accounts that "caring activities are connected with caring identities which provide self worth and a sense of self" (Funk et al. 2019, p. 6). As Day (2013) notes, "care workers also feel compelled to perform this work due to a sense of self-identity as a "good person," and see the provision of care outside of their official contractual

obligations as a way of fulfilling the altruistic care ideal” (p. 27). With care framed as central to an ethical life trajectory, participants engaged in intrasubjective, narrative work to negotiate contradictions or get “out.” As part of their performances of self, some framed themselves as looking back, while others framed themselves as still stuck as they worked to unpack and redefine their sense of selves or to reposition themselves in relation to “care.”

Concluding remarks: Intrasubjective, intra-active work in the care economy

The redistribution of care is a central societal concern, with many pushing for shifting the division of caring labour from women to men (to evenly distribute it) and from individuals to the state (with the state taking more responsibility). Noting responsibility has shifted to individuals through privatization and marketization and broader austerity or neoliberal agendas, feminist scholars have looked at how care is distributed among individuals, households, the voluntary sector, markets, and the state. In this chapter, I examined women's narratives of moral obligation and choices related to redistributing care. I considered how their narratives and narrative practices were shaped by (intrasubjective, intra-active) conditions in the caring economy that extend beyond particular paid or unpaid care realms.

With a focus on how concepts are remade in context (Doucet, 2020), and on embodied and expressive practices and narratives at the micro level (Kontos, Miller & Kontos, 2017), this chapter raises questions about whether care as an ethic should apply to the level of individual women's lives. As we've explored, participants variously engaged in work through their life narratives to reconcile their caring histories –

unpacking moral contradictions, reorienting to their moral sense of selves, and breaking down or detaching from care as an ethic. Having been sold the idea or socialized to “fulfil a vision of ourselves as good only when we attend to the needs of others” (Kittay, 1999, p. 24), part of redistributing care was the work of finding alternative narratives or ways of framing one’s life, for instance in making sense of choices or transitions that seemed to pose threats to one’s subjectivity. Some seemed to ask, Am I a horrible person? Am I morally unworthy? Are there other ways to make a life? When care is an activity or moral life path – a way to constitute oneself as morally worthy, it needs to be unpacked. Participants reconciled their life histories and crafted new conceptions of care. They found work-arounds and kept going, for instance in telling stories about the the dark, absurd or unexpected sides of care. Making up one’s life in the care economy, as my analysis makes clear, involves the ongoing narrative reconstitution of self.

In a study of films about escaping from nursing homes, Chivers (2015) writes that “constraints compel the escapes that propel the remaining points of each film” (p. 137). Her observation has helped me to think about how the different ways that care is interwoven with one’s sense of self relates to the work involved in getting “out.” Processes of redistributing care involve a different range of practical and conceptual work for different people in seemingly similar care roles or contexts. Some participants framed themselves as “flowing” through, while others framed themselves as *still* struggling to get out of “swamps.” Connell (2005) writes, “an active process of grappling with a situation, and constructed ways of living in it, is central to the making of gender” (p. 114). The work that participants did to grapple with the existential impasses or contradictions of

their lives tells us about those conditions.¹⁸ Participants' stories tell us about how they were in it – about the structuring moral conditions of their lives that they variously “intra-acted” (Barad, 2007; Doucet, 2013) with and negotiated. One's social location and structuring conditions matter, and part of those conditions are about having liveable story structures or access to narratives that can help to justify leaving, sustaining oneself or imagining otherwise. Prior chapters explored women's historically conditioned work and moral work, while this one brought into view what can be thought of as micro, intrasubjective, intra-active work in that it focused on the (moral) grip of care for people in different situations. I further elaborated how women are variously positioned, and how they reposition themselves vis-à-vis the relational care economy. I reflected on what exactly has a “hold,” and how women lessen the grip.

Moving forward, chapter six, “Why Janna doesn't care,” further contributes to a conceptual reimagining of care by reflecting both on the stories we tell and on the nature of care relationships as we variously inhabit, embody and resist them.

¹⁸ Schein's (2008) analysis of Peace Corps volunteer memoirs offers examples of such impasses, showing how some volunteers' narratives didn't follow the expected trajectories of (promised) self-growth or self-mastery or of realizing oneself as morally coherent, but instead detailed subjective dissonance or incoherence.

CHAPTER 6: WHY JANNA DOESN'T CARE: A REVISED MEMOIR

I spent a while stuck in a story about care. For that while, the only part of my care work history that I wanted to tell was how much I had been violated as a care worker. I think that I told it that way because I needed to. It was a part of the story that I was trying to validate. At potlucks or dinner parties, at the first sign of someone valorizing, romanticizing or mystifying care, I'd interject with a counter story, as if sneaking up from behind to hit them with it. Defensive and snapping back, I'd pelt out a story about getting my ass handed to me after wanting to be good. I was unable to imagine the person I was speaking to as someone who might be willing to care for me.

I'd share with them – whoever they were, that I had a miserable, slog of a time as a live-in care worker at L'Arche, where I lived with and supported people with intellectual and developmental disabilities. "I went from jogging alongside the people I supported on adaptive bike rides to hardly being able to make eye contact," I'd say. I'd tell them, that after a few years of work, I confided to a middle manager that I was suffering and burnt out, and asked if I could reduce my hours and reduce my pay, to which she giggled, smirked, and denied the request. "She thought my labour was worth more than my personhood," I'd add, proud of the insight. I'd elaborate that she had advised me that my discontentment was about my relationship with God and that I wouldn't need space or time to myself if I had a spiritual life. Others at L'Arche had advised me to forfeit my freedom, relinquish my ego, and break up with my partner to invest more in community. Whipping out what felt like "my side" of the story, I warned others about the shit society throws at women, grieving for the woman who had to move

into L'Arche when I moved out. "That organization that made my life a living hell," I'd fume.

These days I hardly know where to put the emphasis, when speaking about my past work as a care worker. As I've been learning from women as part of this research, I've been struck by the incredible range of ways that others work up their care histories. Much like them, I have a lot of material to work with. I worked as a direct care worker in social services for several years, including for a year at a homeless service center where I worked as an urban service corps volunteer, a couple years at a residential group home where I supported people with intellectual and developmental disabilities, and two and a half years at L'Arche. At the Canadian L'Arche community I lived in, there were six to eight people per home (including people with and without developmental disabilities) in eight different homes in the community.

Being in conversation with others has helped me to be able to access, entertain or articulate other parts of my story. Don't get me wrong—I'm still mad about how care is organized and imagined, and mad that my moral desire and duty to be good led to my own exploitation and harm. But my story feels fuller somehow. I've found a way to validate it. I don't always have to pelt it at people anytime the word 'care' comes up. I seem to have more stories – more options.

This vulnerable, intimate, cool thing

When I first started speaking with Anne, she mentioned that she worked at a group home, and I commented that I had also done so, enthusiastically noting that I used to enjoy "jogging beside people on adaptive bike rides, coffee shop visits, making meals together,

hanging out.” It was a way to put it when we first sat down, but as the conversation went on, she elaborated on how exhausting caring had been. “Yeah, yeah,” I said, fessing up that I too had burnt out, but that a story about jogging and enjoying it is the kind of thing you lead off with. She burst out laughing, and it felt like we found new ground together – like we could see each other.

Nora warned me that before I tell people that she experienced harm as a care worker, I should first begin by mentioning that I am aware of power, privilege and ableism. Perhaps sensing there was a flinch factor in the way I was framing my work, she seemed to uphold dominant discourses of care in her advice to me – framing care recipients as the most vulnerable. *What if I'm okay provoking?* I thought. *What if I understand there's no greater risk in society than identifying with women (Rudy, 2019), but that I might have it in me?* But Nora also resisted dominant conventions to center the “most” vulnerable or to play a moral card in other parts of her story. She helped me to remember a part of my story that I hadn't thought to put on the record, when she said that landing a job as a care worker felt like hitting the “jackpot.” She noted that her friends had to move out of town for work with limited options in the labour market. I let out a supportive “Huh,” as I listened to her. I remembered how I had been funnelled into care work by recessionary conditions when the only other job that I could land after university was at a donut shop. That was a part of the story that I didn't usually put on the record.

I was annoyed that Nora advised me to (re)center those who need care, but as I analyzed the interviews, I noticed that I employed a similar narrative convention. I'd start off a sentence by making a run for it – talking about honouring my own needs or desires or about my own passion for storytelling and the arts, and *then*, as if not wanting to get

accused of being selfish, I would wrap up the story by speaking of my collective interests or commitment to social justice work. To Troy, I responded to something they said, saying, “Yeah I resonate with that; it felt like this major crisis of self, because it was the life’s work, the sense of community, the sense of purpose.” But, as if afraid of letting a comment about how I had suffered just hang there, I trailed off by noting that my concerns were also about “the devaluation of people we support” whose “survival or wellbeing” depends on care. I couldn’t simply mention I had suffered without noting that the people I supported had too. “I mean, you want to affirm your own desires and honor your own ideal vision for your life,” I said to Nora, “but you still have this understanding of how some people are more devalued than others, you know, this real responsibility to be in relationship with others, you know?”

Writing in the margins on an earlier draft of my dissertation, my supervisor Susan questioned if carers are “modern day nuns,” with nuns in short supply. I cheered at her comment, as it named something about how I had been handed care – how I had entered into it as a vocation, as a way to nourish and sustain my sense of self through the work and relationships. It hadn’t just been a job. At L’Arche, I felt like I had found my purpose. I enjoyed jogging alongside others, initiating outings or offering to drive when others made plans. Co-workers and I raced to the punchline, pretending to fake groin injuries or to doze off mid-conversation only to have others wake us up. I once waltzed into work dressed as a bunch of grapes with 25 purple balloons tied to me. I tapped into a funnier, light-hearted side of myself, bringing that out in the people I supported. When I first started in social service work, I remember meeting two people who spoke ASL and only knowing how to introduce myself by signing my own name. ‘J A N N A’ was all I

knew. It felt symbolic. Much like how former Peace Corps volunteers narrated themselves as infantile, dependent, ignorant or helpless upon arrival (Schein, 2008), I often called attention to my own incompetence and ignorance, emphasizing that I was there to listen and learn from the people I supported.

Some of my coworkers had sentimental approaches, lighting candles and playing classical music as they supported with personal routines. I remember saying, "I wouldn't want anyone making a sacrament of me." It was meaningful for me to find what I saw as more mutual ways of connecting. I turned up my nose at others' fun and flirty, wholesome, Disney princess-y approaches to care. With Holly, a woman I supported, we eventually found music that we both liked. We also had fun hitting up music festivals and sipping virgin margaritas. It felt to me like a way out of the dominant narratives we were both funnelled in to. Troy also resonated with finding their own rebellious groove, revealing their "true" self through the work. They dramatized hanging out in playgrounds and parks, and turning even the most mundane tasks into celebrations such as by throwing "laundromat parties." They talked about a person they supported, saying, "He thinks I'm hilarious and he'll call me out on things." We both prided ourselves that our paths were different from our coworkers. No one could care the way we did.

I took pride in taking a rebellious counter-path toward self-formation, growth and community. Needless to say, I nearly started cheering when Troy talked about how they had been drawn to care work, noting that other lines of work didn't seem soul-fulfilling. Neither of us mentioned wanting a baby or a bungalow. Dale expressed a similar sentiment, saying, "You know, there's no mother. There's no—I'm not a mother." As she put it, "If you don't fit into social narratives about caring, you know, parenting or

mothering or whatever, you kind of have to make it up, right? ... You have to do it some other way if you're gonna do it, you know? Or you have to call it by some other name if you're gonna call it, you know?" Together, we turned up our noses at maternal, heteronormative or professional ideals, perhaps priding ourselves that the traps we fell into were different. We weren't moral overseers.

In conversation with Gracie, it hit me how talking about money or the everyday work involved doesn't make for much of a life story. Initially I was critical that she hardly mentioned a whiff of the work involved as she talked about operating a home day care. She described it as a "fabulous job," noting that "if you have more kids than you have hands, it doesn't really matter how many more you have." Sheila did the same in speaking of supporting her mother. She detailed family skits and trips to the cottage, saying, "We mostly just say, 'If Granny were here, she would be doing—.' you know, depending on what the situation is." I felt like they were both mystifying care – keeping women from knowing the stories of our lives. I distinguished my bad ass, rebellious approach from their sentimental ones.

In telling and retelling my care history though I've realized that, much like Gracie and Sheila, I hadn't exactly been leading off by telling others about how I supported with personal care, incontinence care, administering medications, making meals or otherwise running a household. I've rarely told anyone about the complex care needs of the people I lived with and supported, who had been diagnosed with autism, schizophrenia, down syndrome or other disorders. I too had been making it sound better or more nourishing than it was through tales of ripping it up on the dance floor at community events and

hanging out in sports bars, coffee shops and parks. "Did I tell you about the time that we loaded up a van and went ten hours north?" I'd ask.

It was Rhonda, a participant, who jogged my memory of how meaningful some of the intimate tasks had been. In speaking of caring for her husband following his stroke, she talked about finding a strategy to transfer him in and out of his wheelchair that worked better for him and for his body than the strategies the home care workers used. She was proud of knowing him, and her story had me thinking about how something as simple as learning how to carefully use a Hoyer-lift to move someone in and out of bed had felt meaningful. I enjoyed advocating, noticing things that could be done differently, and discerning whether or how to speak up. I was building relationships and actually making a difference. I can remember accompanying a person that I supported while he was in the ICU with breathing tubes and IVs and tape all over him. I held his hand and put Chapstick on his dry lips. It felt like a privilege to be with him and so fully in the moment. *No where else to be, no where else to go.*

Coworkers and I intellectualized our urges, supporting one another in finding more equitable or mutual ways of connecting. We chatted a lot about how to cultivate relationships that respected difference. This was something that Judy also framed as being meaningful. In caring for her husband who had cancer and her Dad who lived in a long-term care facility, she remembered attending workshops on empathic care and advocacy, and remembered focusing her advocacy on care workers' behaviours not on them as types of people. At L'Arche, coworkers and I talked about how to make space for people. I can remember helping to put a stop to condescending pet names or to coworkers ordering lunch for the people we supported without involving them. I intervened

when an 18-year-old young assistant purred “*Aww*, honey, you know everyone loves you right?” to an older woman that we supported. I can also remember a co-worker holding me accountable when I tried to cheer up a person we supported; she helped me to see the value of making space for the range of emotions people experience, without trying to control others. There was a lot of pleasure in the learning curve.

I can remember feeling drawn to the work when I interviewed for the position at L’Arche – a position that involved working split shifts, mornings and evenings, sixty-odd hours a week for room, board and a small stipend. I had applied for the job after reading a couple books about intentional community life. I remember that I had wanted to live ethically and connect with others. I loved the spiritual invitation to share life, build mutual relationships across difference, and connect with people in all of their diversity. I felt special in the job interview – like I mattered to them. They asked about my favourite books and movies – about who I am and what I desired. They complimented my comic sensibilities *and* my spiritual commitments. They hinted that they could see me like no one else could see me, and that L’Arche would be an ideal space to make myself vulnerable and express my unique capacity. They prodded at my desire to be good, pointing me in the direction of moral worth. Virtuousness was used as a recruiting device; it was part of the set up.

I wasn’t the only care provider to feel hooked, nor was I the only one to mention how good or well-meaning I had been when I started. Others loaded up their stories of entering care with significance, moralizing or idealizing them (albeit in different ways). Nora, Troy and Julie talked about their social justice commitments, while Gracie and Sheila talked about their family ties. Dale refused to use the word care altogether and

instead called attention to mutual support relationships threaded across her life. Nora, a paid care worker, remembered thinking, “I found my purpose; I found something I’m really good at that’s really meaningful.” I gasped and said to her, “It did almost feel like this magical space with what was possible with relationships – this vulnerable, intimate, cool thing, you know?” I shared with her that I too had felt like I was “bringing something that felt unique,” like “space had opened up or this was what I was meant to do.” As I put it, “I remember when they first assigned [me] a one-to-one [a person I was responsible for overseeing the care of] I like felt *so* flattered or like, ‘Wow, they see something in me’ you know?” “Totally!” Nora exclaimed, before I shared, “And then, by the end, you just feel like, ‘They were just desperate,’ you know?” Others remembered a sense of purpose as they rushed to the hospital to support their family members, or as they embraced the learning curve when a family member’s needs first changed. Gina took pride that she was the only one in her family who could keep her mother breathing. There was something there for us as we saw ourselves in new ways.

At L’Arche – the live-in community where I lived, I didn’t feel like I was on a ship of fools searching for that which cannot be found. It felt like a worthwhile next step. The beer in the fridge felt like the perfect example. It didn’t seem like an overly polished, prefigurative community, but that there might be space for something ‘real’ – space to connect with people from around the world who were trying to commit to an ethical way of life. It was a weird feeling, and hard to describe, but I can remember feeling contained or held in place when I first started. To get to my bedroom, I had to go through the laundry room and past a utility sink, stand-alone shower and second fridge. The room had low ceilings, bare walls, a twin bed, a bite-sized desk that I couldn’t write at, and a view

of a 10-passenger wheelchair van in the driveway. As a 6'3" woman, folding into such a tiny room felt symbolic. It felt like I was stripping everything away from my life to commit to what matters – switching from a showboat-y “Janna show” to humble, moral work in community. There was a clear map on how to live ethically – a routine to hold me in place. I could catch on.

The care junkie who didn't notice red flags

“Oh, wow, yeah. You certainly have me thinking about the toll that it takes on the body, or how exhausted you are the year afterwards or how it's not sustainable, so then you end up having to pay the cost, whether it's paying out of pocket for dental work or— And, even not even the option to call in sick had you needed a mental health day or something!” I blurted without taking a breath, after hearing part of Julie's life story. I know that I came on strong. The truth is—I was excited to talk to her, as we had both worked at L'Arche, although in different communities. I was particularly keen to speak, as I was still processing my traumatic experience there. I still felt absolutely disgusted with the organization, and with the fact that – when I moved out, someone else had to move in and occupy the twin bed. I was critical of the power structure and of the ways young adult workers were used for labour – shouldering the work, while elite leaders wrote books. Needless to say, I brought a lot to the conversation, and was caught off guard when Julie narrated her experience in such an empowered way.

“I noticed red flags that were very disenchanting. I knew it wasn't going to be a comfortable place for a long-term commitment. Knew it wasn't my version of community,” Julie said. As she put it, “the expectations of the community didn't really

align with what I wanted to give.” Her account seemed like a slap in the face. *Must be friggin’ nice*, I thought. It seemed to me like she cared with one foot out the door, kept herself safe, knew there wasn’t anything there. I was attached to the idea that I had been duped as a care worker – that the experience had been a violation. It was painful to speak to Julie as she underscored, at least in the way that she framed it, that she didn’t fall for it – that she got out of direct care and got out quick. It was as if she was saying, “Oh, you got raped at that party too? For me, it was a learning opportunity.” As I licked my wounds, she made meaning through the discourses of academia, raising questions about how to “govern a community with policy.” She talked about how *the team* was stretched thin, how she sometimes wondered about it, and how she noticed red flags from the start. She emphasized that she was young. It was a learning experience. It was her first job after university. She was only 22 and “value[s her] own health and wellness differently [now] than [she] did before, when [she was] more susceptible to guilt trips.” Hers was an empowered story that I didn’t know how to tell. And at the time I felt like my story was the only one I had.

“So sometimes, I think, did I take *too* good care of her?” Sheila said, giggling in the interview that I conducted with her. I had put that it was a study about the limits of care on the recruitment poster, so was surprised to hear her emphasizing how much she had thrived while caring for her mother. Whatever caring capacity I had couldn’t withstand conditions that didn’t support it. I felt like Sheila was maintaining the pretence of the caring institution – upholding a culture of secrecy. She had hinted that it had been totalizing care, letting it slip that she had slept with a baby monitor on. Why was she radiating gratitude? Eventually, after working up the nerve, I asked Sheila, “I ended up

feeling quite resentful when I reached my limits, and I'm wondering if there was—if you felt that?" My hands shook as I asked the question. The question had an ethical demand; it felt like my way of asking whether Sheila could imagine what it was like for me or appreciate how I felt as though I had been set up. Demure, fluttering her eyelashes, or as if the thought hadn't occurred to her, she responded, "[You're asking] if I had felt resentful? No. No." She said that she realized that she made sacrifices, but wouldn't have done it differently. Her response hurt. It felt like we were both set up, and set against each other. It was hard to see past my own pain.

Gracie seemed to 'one-up' me too as she upheld strong gendered feeling rules. When she said that she made it out "well and whole and in one piece," I couldn't help but wonder why I had been left bulging out of the seams. Her comment felt like a critique of my own work and life – of how I hadn't quite managed to pull off the moral, feminine ideals to which I had aspired. It was hard to hear her claiming power and flaunting a moral position through a narrative that I could no longer pull off. I felt like I had been kicked out of the club after having tried so hard to live in an ethical way. I also felt like I was getting in trouble the second time that I chatted with her. By way of hello, Gracie went from talking about snuggling an "absolutely, gorgeous, content, well-loved baby" to distinguishing her loving approach to care from mine. "I just think it's *interesting* sort of where people's sense of commitment comes from," she said. *Uh oh—where is she going with this?* I thought. She said, "It was an obligation, and 'sure' that's true. To a point. But, *for me*, when I was doing any of the things I was doing, it was always from a place of love. The obligation part never really came to mind for me." "So same deal," she added, "you know, all the caring, you have to be selfless ... But just totally different

feelings about it. Like I felt satisfied and content and rewarded for what I was doing. It made me happy, right?”

As Gracie spoke, I felt as though she was scrutinizing and disciplining me for stepping out of line with my area of focus or for failing to uphold gendered expectations to care out of pure love or without any expectation of getting something in return. I sensed that I had asked one too many questions about whether she was rattled. Truth be told—in listening to her, I felt inadequate, and part of me wanted back in. I wanted to show that I was moral, too. I wanted to redeem myself from what seemed like moral allegations put against me. In response, as if to show that I valued moral, feminine ideals, I said to Gracie, “you used the term ‘soothing souls’ where you were really connecting in a meaningful way. It wasn’t just, ‘alright, what’s the job that needs to be done here?’ Just a different quality to it.” It was my way of trying to acknowledge that the questions I had been asking might have been threatening to her self-narrative. It was also my way of trying to redeem myself by showing that I was moral enough to notice her moral approach. I too had a lot at stake in the conversation. I too wanted to be good. *Really, Janna, still?* I thought after, realizing I couldn’t just let her comment about how good she was hang there without implying that I was good too.

Midway through analyzing the research, my therapist suggested that I had reactivated the trauma that I had experienced as a care worker. Maybe she said inflamed old wounds. Whatever it was, it was hard to set down the story or snap out of it. I couldn’t shake the idea that there were two “types” of former carers: those who got out unscathed like Julie and those, like me, who were damaged by it. I felt like one of the dupes or care junkies. I also thought back to my year of service as a volunteer in the

urban service corps in Los Angeles the year after I finished undergrad. It stung to think that I had slid into a job at a group home afterwards while most of my service corps cronies used their year of service to get a leg up on applications for law school, med school or MSW programs at top tier universities. I wondered if their elite parents had tipped them off that there was nothing there for them in pursuing care as a life path. “It was almost like this weird—I don’t know like—hoax!” I said to Nora, as she talked about how she too had struggled to understand how such invigorating relational work had led to such an experience of exploitation and harm.

It was hard to re-story it. In the early stages of the study, I could hardly refer to my research topic without someone pegging me and my proposed research participants as “privileged.” I hadn’t once been accused of “researching up” when I interviewed visual artists and curators as part of my Master’s research. But several colleagues credited me for researching up, researching privilege or researching those in power in this study. Some even advised me to first mention that I most want to improve the lives of *working* care providers before I tell people about my topic. When I submitted my ethics application for this study, the university ethics committee responded saying that they thought the project was ethically sound, but that I should redesign my study, *not* to examine the privileged, but to center the *most* vulnerable or *most* marginalized – care recipients and care providers who are still doing the work. It was as if they said, “In case you didn’t think of it during your course work, your comprehensive exams, your dissertation proposal or conversations with your committee, it’s not too late to be a good girl.” When I distributed my recruitment poster, a researcher asked whether I’d consider researching marginalized people, hinting that my recruitment criteria of former care

providers excluded them. With how I was situated, I grieved for my historical self and felt betrayed by the organization I worked for. Leaving care work hadn't felt like a privilege.

In conversation with others, part of what I was wrestling with was how I had navigated the situation. I had a lot of shame, and it was hard for me to shake the idea that it's a 'type' of person that burns out – a woman who just can't hack it. When I first started conducting research, a feminist sociologist noted that looking at former carers' life stories might help me to show that it's a type of person – an oldest daughter, with an alcoholic Dad, passive Mom and early experiences of childhood neglect who is susceptible to burning out. Even with a PhD in Sociology, she located the problem with the care sector in the flaws, deficiencies or developmental wounds of women like me. A long-time union worker did the same. When I told her about my experience at L'Arche, she suggested that *I* had been the problem. She argued that someone like me who went to university should have had the wherewithal or class resources to navigate the care sector – to set boundaries or resign from the work before I burnt out. "You shouldn't have let it get to that," she said, putting the onus on me as an individual. It perhaps made it comforting to think it couldn't happen to her; that there was something about *me*. Her comment stung, but it was also hard to shake. Part of me suspected that she was right and that I didn't have a decent excuse for burning out. I had captained my university basketball team, graduated from university, and am an accomplished storyteller and performer. I felt duped or like I had dressed up, looking for it.

The limits of care and the toll over time

Carrie talked about lateral violence and about toxic working conditions at the organizations that she worked for. Betty, who recalled supporting her husband at the long-term care facility where he lived, spoke out against the organization's public relations strategy and the "subtle pressure to get on the band wagon" and "spout the party line" about how residents are "getting the best care" that they possibly could. She said that she felt "traitorous" seeing things in a different way. In a different context, I also developed a critical analysis in conversation with co-workers. After a while, even invitations to listen and learn from the vulnerable started sounding similar to the "belief that women are obliged to let men fuck them" (Bryant & Scholfield, 2007, p. 332). At L'Arche, we made stove top popcorn and sipped wine, as we critiqued the conditions of our work and the racist, classist and sexist structures of the "community."

I remembered a co-worker remarking that we were like servants on Downton Abbey, before I noted that it would likely be easier to serve if we had the cultural resources, power, prestige and elite family lineage of L'Arche founder Jean Vanier. We fumed that – under the guise of friendship and fun – L'Arche undercut other agencies and underpaid assistants, failing to value the skilled work involved in "living" in community. Some of our critiques felt subversive. We joked about getting our tubes tied or sourcing out abortions, noting that to reproduce the community we could not reproduce ourselves. When a co-worker popped a blood vessel in his eye, I teased in a team meeting that we should all pop a vessel in the name of the care – throw out our backs in the name of community.

We were critical that L'Arche exploited racialized immigrant women who worked over nights and were referred to as "night ladies." One older woman of colour had worked overnights in the home I was in, sleeping on the couch for 20 years. Speaking with some fellow assistants, we wondered, was she tired of dozens of young adults passing through on the way to something better? Did she think we were too smug? We worried about how she was pit against *us*, occasionally mentioning how organizational structures played a role. The job title "night lady" erased the skilled work. She herself was excluded from team meetings or decision making. Brochures about community life didn't mention her or any of the other older women of colour who were essential to the running of the homes and community.

L'Arche's philosophy promotes mutual living, while overlooking the real work and skill involved in supporting people with complex needs. The power structure sets elite, well-educated spiritual leaders who *live out* apart from live-in young workers, including women, working-class, racialized or migrant workers without citizenship status. L'Arche leaders with Master of Divinity degrees coached us on submissiveness, coaxed us to forfeit our power, and cued us to say that we got more than we gave. They treated us like stage props in their performance of community. They wrote books and sermons, while we worked in bathrooms, bedrooms and kitchens. The L'Arche elite proudly flaunted that they could have social citizenship, a public life *and* care for others. I don't remember anyone acknowledging their class position or the critical resources they had access to that helped them in saying the so-called 'moral' thing. Nor do I remember anyone advocating to value care as labour or to support migrant care workers. With low wages, low worker retention and conditions of extreme overwork, workers are vulnerable

to labour exploitation, as well as to spiritual, psychological, physical and sexual abuse. Many are reluctant to speak out, particularly when dependent on the work for housing, income or residency status. The culture spiritualizes sexism and debases feminized work.

“Everyone kept saying I don’t know how you do the work you do,” Troy said. I nearly pulled a muscle rushing to tell them how I resonated. I thought of how elite women used to charge up to me in public spaces to tell me that I must be an angel and that they couldn’t do my job. I can remember being proud or even saying, “Oh, lucky to hang out with them” then by the end of it, it was like “Oh, *yeah?* I bet you’d never consider a job like this.” By the end, I felt a bit unhinged. I could no longer let on that I got more than I gave, that it took more skill and effort from the person I supported, or that the people I supported were the “angels” for putting up with me. Similar to some of the Peace Corps volunteers in Schein’s (2008) study, serving others in the context I was in, didn’t lead to “the reconstitution of a self that has been tried and stretched” (p. 184), but to an experience of “incoherence, incommensurability, and disjuncture” (p. 185). I felt disconnected from myself. Dramatizing her dissolution, Carrie talked about waking up with her dog licking her face when she passed out from the stress of care. I talked about how I couldn’t hack it – how I had been black out drunk a few nights a week. We told it that way. We didn’t chalk it up as a learning opportunity or frame it as part of a professional narrative, although perhaps we too could have crafted it that way. We emphasized the abject, detailed our denigration, let it all hang out. As entertainers who valued landing a sentiment, perhaps we too were up to something. Perhaps our critiques were an act of care, a way of staying with the trouble. Perhaps there was pleasure and agency in our stories too.

At L'Arche community meetings, I distributed handouts that I made challenging the myth of "servant leadership" (Eicher-Catt, 2005) and how the notion can be appropriated to maintain power divisions. With support from others, I started calling attention to the skilled labour involved in supporting people with complex medical and psychological needs, and to the ways the ideals of "servant leadership" normalized the abuse and exploitation of assistants. I questioned the assumption that the way society structures a person's worth or non-worth was *only* about disability, as though by virtue of not having intellectual disabilities, assistants were coming from places of power. It was fun coming up from behind. I poked fun at a L'Arche leader who expressed that L'Arche "teaches assistants how to love" as though we were empty vessels with nothing to offer. When a community leader gave a lecture about how the *only* job for assistants is to listen and learn and open themselves up to others, I raised my hand to ask how much time he thought should go by before we'd be allowed to dialogue or contribute as speakers or teachers. *Should the advice to forfeit one's freedom really apply to L'Arche assistants who are migrant workers sending remittances home?* I wondered. I loved seeing him (at least performatively) take pause and think it through in a deeper way. I felt like I was making a difference.

"I was a grown woman; I didn't need my Mother telling me what to do," Gina fumed, remembering how her Mom controlled every aspect of her daily routine when she lived with and supported her following her Mom's stroke. Gina's story reminded me of how petty, passive aggressive and defensive to criticism I had felt as a live-in care worker. She made a point of keeping those details in, and I resonated. After having invested so much of myself in the work, I felt defensive or on guard at even the slightest

critique from others. “Can’t you see how much I’ve given?” I’d wonder. Similar to others that I interviewed, I started taking breaks in the bathroom and getting in power struggles with some of the people I supported. I can remember yelling at one woman to stop screaming for five minutes so that I could think. I just wished that something would give.

My lowest point was on vacation with my grandparents. As I shared with Betty, “When I was kind of in the heart of the care work, it was even hard to go on vacation with my parents and grandparents, who I really love and connect with, but I felt like, ‘Oh gosh, I don’t even know how to crack a joke or bond over mundane things.’” I didn’t tell her that I remembered thinking, “If I have to hold one more fucking door, I am going to snap,” but I got the point across. Betty also relayed that she had closed herself off from friends. “I don’t want to be someone’s sort of pity case, you know?” she said, “I feel that my life is quite uninteresting so in a relationship – in the social give and take – you bring something to your togetherness, and I don’t feel that I have a lot to contribute now.”

For me, another low was when my L’Arche housemates sang happy birthday to me. It shouldn’t have been a big deal. They were trying. But for whatever reason, at that moment, the disillusionment sunk in. It’s hard to describe the violation of subjectivity that I perceived. It was painful not to be recognized or cared for in a place where it felt impossible to be known or to exist in any real way. I resonated with poet Alice Notley (1998), who writes “for two years, there’s no me here” in speaking of motherhood. At L’Arche, I couldn’t locate myself. I resonated when Julie noted that she wanted more “reciprocity” in care, before giving the example of “even just being asked how [her] day was.” We both laughed that it was something as simple as that – something as simple as having someone in the vicinity that might be able to ask how she was doing.

“And the exhaustion,” Gracie said in our conversation together, “like the exhaustion from ... living one big adrenaline rush all day and all night.” She remembered that she couldn’t turn it off when she supported her Mom following her Mom’s heart attack. *Aw—she felt it too.* She also remembered that her husband, friends or family couldn’t care for her. She was on her own. Although in a completely different context, it was a feeling I knew well. Once, for three months straight, my coworkers and I did not have the option of calling in sick or taking a mental health day. After a few years of buckling every seatbelt and holding every door, I was exhausted from constantly being tethered to others. It was hard to giggle at toilets clogged with washcloths or to respond to the same question forty times. It was hard to see a man that I supported break down in tears after a massage, as I wondered if it was the first time he had been touched in years. It was disillusioning to find myself in the midst and reality of suffering, among others with unmet care needs, and implicated in fractured relationships that were a matter of design. I felt as though I had been up to neglect the people that I supported without the needed resources or supports to be able to care or to pull off the moral project that I had aspired to. It was hard to see the people we supported herded around in the ten-passenger mini-van and sitting at a table set for a crowd. It was hard to see some of them turned in on themselves or hungering to have their needs met with limited options for intimacy or a public life. It seemed like we all did “things [we] did not want to do out of a sense of commitment to a shared community” (Aubrecht & Keefe, 2017, p. 223). Projecting onto the people that I supported, I figured they were in as much pain as I was – as dependent and powerless as I felt. It was painful to be there.

At my lowest what I most needed was art. I wrote poems about mopping up the messes that bodies make and shouldering the weight of an unjust system. I wrote every single afternoon, filling pages with rants and one-liners to process the experience. My poems were all pretty heavy-handed with titles like “the psychological cost of learning to care,” “How to speak for God,” “The song and dance,” and “Explanation for termination of employment.” They weren’t pretty, but I worked hard on the craft. I wrote and drank and drank to cope. I just wanted to get fucked up and not think about it. “Okay, yeah, to numb or not to think about it for a second,” I said to Carrie, when she talked about how she had also coped with food. I felt like I was constantly holding myself and others up on a day-to-day basis, whereas drinking felt like letting myself be held. I was often hungover and irritable.

When Troy questioned if they cared for others because for whatever reason they didn’t feel cared for, I couldn’t help but relate. I too had individualized it, wondering what it was about *me* that had put me in such a mess. As soon as the phrase left Troy’s mouth, though, they interjected laughing that I was probably going to analyze their comment. “Oh my gosh!” I roared, giggling. So, more than a story of the “type” of person they were with a distancing analysis from me to follow, we were both in on the joke – both finding some common ground in coming to see that *we* had not been the problem. Perhaps we were both working through the shame that was supposed to keep us quiet. We were both sticking around to tell the stories of our lives, hinting that we deserved to be cared for *regardless*.

When I worked as a live-in assistant at L’Arche, spiritual and emotional manipulation were part of the job. The organization read my vulnerability as weakness

and exploited it. I still feel sick that the organization exploited my desire to be good, blamed me for burning out, and denied my request to reduce my work hours when I hit an emotional breaking point. I regret that I wasn't able to leave sooner. I regret that I went in hungry and looking for something – that I didn't do more to keep myself safe, set boundaries or say 'no.' I regret that I stayed long enough for the fantasy of myself as a caring, moral person to feel like a joke. I regret that I stayed long enough to develop disgust or resentment toward the people that I cared for, with my body sending strong signals for me to get the hell out. I also acknowledge that it's hard to say 'no' in a wider context where 'good' girls are coerced to care for others at the expense of ourselves and to the point of depletion. It's hard to say 'no' without an option to call in sick for months on end. It's hard to say 'no' without other options for community or connection lined up. It's hard to say 'no' when others deserve to have their care needs met. It's hard to say 'no' if your moral, feminine worth is hanging on it.

The great escape, with stories we can tell together

Needless to say, while I was a care worker, I started having strong urges to leave. I wanted more than a small room with a twin bed and three hours off in the afternoons between shifts. I wanted time to myself, space to write and to think. The impulse hit when I visited a friend at grad school and stayed up all night talking about ideas. It hit when my partner wrapped his arms around me, when I overheard a young family planning a pool party, and when I walked empty-handed through IKEA while a friend sourced out stuff for her new apartment. The impulse also hit when a L'Arche community leader barged into my bedroom as if to try to catch me in bed, and when a professor encouraged me to apply to grad school. I still remember that my house leader

told me to make a run for it – to build a life around words and ideas. “Good, moral women leave all the time,” she said, cheering me on with a message that I desperately needed to hear. It was meaningful to hear about how women had cultivated soul-fulfilling lives after L’Arche.

When I announced that I was moving out and announced my engagement to the people I lived with at L’Arche, it seemed to be taken as a blow by some of the people I supported. One man, who was nonverbal, collapsed in his seat, excused himself to his room and sulked for a couple days straight. Another woman that I supported started yelling “FUCK OFF! I’M GETTING MARRIED!” then and almost every time she saw me for a few weeks after that. It’s hard to tell how they felt. Betrayed? Rejected? Worried about who would care for them? I guess I just know that I felt sheepish or like I was leaving them stranded. It felt selfish to leave. Other carers related. Gina felt like a horrible person. Troy didn’t know who they were anymore. Nora asked, “Well, who am I then?” For some of us, it felt like a crisis of self – like we were walking away from an ethical way of living. The institutional structures of care, as we had deeply internalized them, seemed to leave us with limited other scripts or storylines to affirm our worth or build a life around.

“So, do you think you’ll go back to caregiving? Or do you feel like you have to step away from it for like a really long time?” Troy asked. Their question grabbed me by the neck. “Yeah, um, it’s, um, yeah, I guess lately I’ve been or like for a while felt like I needed to like get away full stop or like could hardly even face it or even with my—I like felt—” I stuttered to respond, before giving a half-baked answer about building a radical life around care through art and storytelling. From there, I trailed off to mention that I

also felt selfish and had a lot of guilt around not caring, but that I also know that I couldn't physically sustain it – that I had been blackout drunk a few nights a week as a care worker. “Obviously, I couldn't hack it!” I blurted. At the time I didn't realize that the lines about my body and about the guilt were tropes that participants also relied on – ways of doing moral work to re-establish a moral sense of self. Answering Troy's question was a slog. Five years after resigning, I still didn't have a solid answer. I was still wrapped up in moral, feminine ideals. I was still in it.

A friend suggested that the reason I was so miserable as a care worker was because I knew I wanted to be a writer, knew that I was capable of it, but that I didn't have the needed supports to build such a life. The word “miserable” used to pop for me. So did the fact that I got stuck at a time when I didn't see my life getting better if I left. I pictured myself living in my parents' basement and working back at Country Style donuts. When people have asked why I didn't leave sooner when I had been so miserable, it's been hard to come up with a decent answer. The question misses something about the moral conditions of care – about what actually keeps women in inequitable care relationships. When asked such a question, the way that I hesitate, pause or otherwise hmm-and-ha seems to tell me something about gendered, moral relations that I too contribute to making. “It's because you can't leave,” Gina said. She got why paid care workers get stuck, and why family caregivers get stuck, and why it's hard for *any* woman to leave. She seemed to grasp how you could build a life that you're resentful and bitter about, and how you might need to shift gears. What strikes me now though is that we did in fact renegotiate. We engaged in creative, soul-sustaining work to pursue a different kind of life.

I can remember talking about Mary Oliver's poetry with a fellow care worker. We wondered what we should do with our "wild and precious" lives (Oliver, 1993). We cheered at Oliver's (1992) advice: "You do not have to be good. / You do not have to walk on your knees for a hundred miles through the desert repenting. You only have to let the soft animal of your body love what it loves." Her words felt like a reprieve, although neither of us thought it was as straightforward as it sounded in the poem. We couldn't help but talk about the soiled sheets and unattended needs that would be left in our wake. We noted that the people that we supported wouldn't be able to get out of bed, that we'd be screwing over our co-workers, and that it wasn't as easy as folding up shop or letting the soft animal of our bodies love what they love. Just as unsettling, I think, was the moral dilemma and loss of "goodness" that felt like a crisis. With how we were set up, "leaving" or "just quitting" meant erasing our sense of selves and self-expectations. It felt like an intimate loss.

Women I interviewed talked about still being "in" it too. Carrie said, "It's just always ongoing work to define caregiving and make sure it's not sacrificial." As she put it, "Even now, I'd drop everything and run; I have to watch that." She spoke of staying vigilant, saying, "It's constant measuring and reflecting, because, you know, it's so easy to go back to being a doormat." Troy also indicated that care still had a "hold," as they teased about recreating or living out similar 'care' dynamics even after resigning from the work. They joked that they were trying to stop yelling "I'll go with you!" when others ask them to help. They were staying vigilant in trying to notice when they had "urges" to care, which they noted felt like an "unhealthy relationship" or "addiction" they were recovering from. I felt the weight of Troy's words, and responded, saying, "I resonate

with stepping back from one organization or feeling like it's a clean break and then still having all these kind of caregiving dynamics in other areas, you know. It's hard to shake!" Resigning was part of getting out – a huge part – but it wasn't *just* about resigning.

It was just over three years after I officially resigned from L'Arche that I further released myself or detached from care in a powerful way. It was in the second year of my PhD in 2016 when I was gearing up to write a comprehensive exam related to theories of care when I was both diagnosed with Marfan syndrome – a connective tissue disorder – and told that I needed an immediate major open-heart surgery for an aortic aneurysm. It was a whirlwind experience that further and rather dramatically shifted my relationship to “care,” as I found an incredible sense of pleasure and meaning in slowing down to take care of myself without delivering myself to others. It was powerful to be so completely in my body with a slow recovery process that saw me walking two minutes the first day out of the hospital and four minutes the next. The experience shifted my perspective. It seemed to provide whatever ‘permission’ I thought I needed to release from one-sided relationships or burdensome responsibilities or areas of life where it felt like I was living out similar “care” dynamics by being of service to others. I truly felt worthy of the care that I received with more space to say ‘no’ or to honour what I needed. I also found a lot of space and support for creative writing and storytelling and for taking the stage at different storytelling festivals and events. It felt like I was writing with a sense of urgency, honouring my own needs and desires.

As I have continued to unpack, I can see how much I had internalized and individualized my care history. I'm proud that I have been able to claw myself out after

having gotten to the point of thinking that the people I supported were the problem – that it was something about *them* or how much pain *they* were in or how draining *they* were that had been my problem. It's hard to connect now to the sense of helplessness and powerlessness I felt, and I can appreciate how it's hard for some people to resonate with how a woman (like me or my Mom or my grandma or Gina or Nora or others) might build a life she's resentful and bitter about, and then build something else if the conditions are right. It's hard to articulate what it is like to be that “in” it, but I have compassion for those who do or who are unpacking or working through it or, as Carrie put it, trying to “get out from under caring for others.”

“I think we need to stay mad and say more, say more and never stop,” a friend said to me, as we chatted about the news of L'Arche founder Jean Vanier being credibly accused of spiritual and sexual abuse against six women, including live-in care workers at L'Arche, under the guise of spiritual accompaniment. I expressed my rage, frustration and disgust – at what I saw as yet another example of how the organizational structure harms women. She also expressed that she just felt ripped off or like she would have followed Vanier anywhere, and she hadn't even worked at L'Arche. We both felt sick about how some women are lured into care and written off while there. We were also disturbed by public accounts that wrestled with the downfall of a charismatic spiritual leader or rushed to distinguish the sex scandal from the good, moral work of L'Arche communities worldwide. In some opinion pieces, the writers expressed relief that the people who were sexually assaulted were care workers, not people with developmental disabilities. They seemed okay with a version of “community” in which only some are

violated. “Let’s not get too carried away humouring the women were abused” they seemed to say.

On the one hand, with the news of the scandal, I felt like I could finally take the duct tape off my mouth after years of flinching when people described Jean Vanier as a living saint or L’Arche as heaven on earth. On the other, I also worried that by speaking out I was transgressing social mandates for women to be good or not upset anyone. I was worried that my work was too provocative. Yet, when I used the word “provocative,” my friend used the word “integrity” to describe the work I was doing. Speaking to her, I started into a rant about how I still grieved that I was no longer able to cash in whatever cultural or moral accolades would come with being one of the happy-go-lucky good girls. I then stopped mid-sentence, and said, “Ugh, you know what? I think I’m actually okay out of the club – that my self worth or moral worth or whatever I’ve thought I lost doesn’t actually hinge on only ever being of use or of service.” *Boom.*

There was “something” there in conversation with her and in the weeks and months that followed. For instance, the op-ed that I wrote in response to allegations of abuse by L’Arche’s founder Jean Vanier (Klostermann, 2020c) resonated deeply with care workers and advocates who reached out to share their stories. Several workers across North America shared with me that they had used my piece to ignite conversations in their workplaces, with three workers focusing on issues I had raised about how to support more vulnerable, racialized and migrant women workers. I’m grateful for how many women I have supported and how many women have supported me both at L’Arche and afterwards. We’ve shared poems, swapped stories, talked about our lives, and found ways

to help one another out. We've worked hard to notice and advocate for care workers and people who need care alike.

“Alright. Okay. We're rolling. It's July 24th and we're chatting about care!” I announced to Nora in a sportscaster voice when I first turned on the audio recorder. With the recorder on, Nora teased that now “we had to perform and say all the right things,” but that I could “edit the awkwardness out.” “Totally! Like a bad reality tv episode!” I joked. Just as I tried to connect, I am grateful to participants who cracked jokes and claimed solidarity with me. Some told stories as though they were landing jokes in stand-up comedy sets. There was a lot of vitality, humour and joy in our conversations together. Nora joked that she didn't get a goodbye party, laughing to insist on her own need for recognition and care, while hinting that no one goes out gracefully – that there were no goodbye parties for care workers milked for all they are worth. I shared with Nora that I had been questioning whether I could stop first telling people how good and well-meaning I had been when I first started as a care worker, before mentioning that I burnt out and had to resign. I noted that the more that I moralized or idealized my entrance into care, the further I had to fall off the care cliff or to narrate my downfall, framing it as a violation and betrayal. It seemed like an “aha” moment to her as well, as she said, “I think that I can let go of that idealized version of myself—untangle myself from that romanticized version of it.”

“I mean, do you have to almost die before you start taking care of yourself? To me that's wild,” Gina said. Anne also made a point to remember care workers rendered disposable on the job, including a woman with a concussion who was no longer able to work and another woman who left work on a stretcher. She put those stories on the

record, facilitating an ethical relationship with other carers. Together we enacted what I would call a “radical care politics,” asking questions that went beyond caring for those deemed most vulnerable or worthy of care. While a normative understanding of “belonging” might suggest that it’s for women actively engaged in care relationships, our conversations felt like spaces of belonging. It felt like we were making something together. We broadened understandings of who should count as the most vulnerable or morally worthy of being cared for. Together, and in conversation, we found cultural footing for telling it otherwise. As Nora put it, “Our stories change over time.”

At a more recent conference, I received yet another “gotchya” response after presenting a paper on stepping back from care. A woman raised her hand to ask why I hadn’t centered and focused my research on disabled people – the people who she felt were most worthy of scholarly attention, most likely to be abused and most worth learning from. I felt like a different person, as I listened to her, and didn’t feel defensive or as reactive as I had been in the past when people suggested that I redesign the study to focus on the *most* vulnerable or worthy. Somehow, listening to her, I wasn’t as “in” it or reactive. I wasn’t worried what she thought of me or whether I would come off like I’m not paying my fair share or not being a good girl. Her comment didn’t feel like a threat to my moral, feminine worth.

Answering her, I just said that, for me, researching women’s caring stories is how I thought I could most contribute and best respond to the contradictions of my life. I had a lot of peace of mind that the project was my way of showing up, paying attention, contributing in a way that I can contribute. I also told her that I too was concerned about how relationships have become so fractured – how people with disabilities are pit against

the people who support them. I said that my point wasn't to privilege one group over another, but to learn more about how it operates – how we're all set up. I think it's a testament to how healing this research has been that I stuck around to chat with her afterwards. Through this research, I have been able to think more coalition/ally, situating my own and others struggles or knee-jerk responses in the social relations of which we are a part. I'm okay being misrecognized – okay keeping the conversation going.

It was at the end of a long three-hour conversation with Carrie just before I turned the recorder off when she shared about some of the patterns of “tending and befriending” others that she had been relying on and trying to change. It seemed like by recognizing them she was getting somewhere. She had been saying ‘no’ to others or to certain ways of relating. Responding to her, I said, “Okay, maybe that's what that is, maybe we don't have to carry it. Maybe we don't have to.” Carrie paused before smiling and saying, “That's kind of the worst, too, after all that fronting, and you're like *awwwwwhh*.” She laughed and sighed a full body exhale with the word ‘*awwwwwhh*.’ It was like we could release. It was like maybe we could get ‘out’ together.

Key contributions: Seeing with fresh eyes

revision—the act of looking back, of seeing with fresh eyes, of entering an old text from a new critical direction—is for women more than a chapter in cultural history: it is an act of survival (Rich, 1972, p. 18).

It's interesting. When we were in the work and doing really well, the stories we told were more empowering and then when we were burnt out, the stories we told were soaked in pain and resentment. But, it's interesting now being able—at least,

for me, I can tell both sides, you know? I guess I have a little more distance from it now. Our stories change over time. *Yeah*, that's interesting. – Nora

Engaging in the act of revision, and taking seriously that our stories change over time, I deployed feminist political economy and narrative analysis in this chapter to provide a reflexive account of how I came to know through the life history research that I conducted. I drew inspiration for my chapter title from a journal article written by Schaffer (2019) entitled, “Why Lucy doesn't care: Migration and emotional labour in *Villette*.” In reading Schaffer's article, I sighed with the relief of recognition when she wrote, “But the story of *Villette* is, in part, the story of Lucy gradually managing to imagine a different type of reader. It becomes possible for her to narrate her story because she comes to believe in a reader who is like a lover, not like an employer” (p. 86). This observation resonated with me, as I also noted a shift in conducting this research from me feeling quite alone in my experience towards being more open to what others had to say or to the creative possibilities that might come with thinking through it together. Writing within the event, my goal here was to elaborate on the research process, with a focus on how my own involvement in the research shaped the co-production of knowledge and shifted my own understandings of care and of my own life story.

Steedman (1987) writes, “Certainly, the political analysis my mother possessed and the political language she used suggest to me that her vision of the world had been organized in this way, at some point” (p. 119). Just as participants' analyses or the language they used had been organized at some point, so too had mine. Attending to the unique and unexpected ways we told our care histories has helped me to find some new ways of putting it and new patterns of relating. I've come to see that my “own

perspective—[my] way of naming the world—[is] not unique but one among many possibilities” (Weiser, 2009, p. 142). My conversations with participants helped me to produce clarity and to rethink both my own care history and my analysis. I learned from my own and others’ knee-jerk responses and from how our stories settled in the room. I also came to shift my perspective, orienting to myself and to ‘care’ in new ways.

Throughout the process of conducting this research, I’ve rethought my own trajectory of “going over the care cliff” and the ways my story intersects with others. As I said to Marilyn, “I also had a bit of a template or trajectory in mind. Mine was a pretty romantic one: service corps, care work, went downhill, burnt out, stepped away. So, a pretty clean narrative in terms of writing a movie! You have the climax.” Continuing the thought in conversation with Betty, I said, “It’s been really powerful to talk to people who have different relationships or trajectories or where it’s maybe not as straight forward as what I had in mind.” I’ve also come to appreciate how the study didn’t just start with the problematics of my life or with my own sense of moral or personal failure; my own structuring context, referential memory and classed, racially coded assumptions about “care” shaped how the conversations went and how the project developed. My imaginary of care was not only different from some participants, but from others who weren’t in the room and perhaps didn’t identify with the recruitment criteria of stepping back from a care responsibility to begin with.

As someone with a strong affinity for the care provider role and a familiarity with the patient or care recipient role, I had a lot of stake in the life history research that I conducted. Interviews were alive for me too as dialogical encounters involving participatory telling, attentive listening and meaning making. As I have revealed, some of

the conversations with participants were uncomfortable, coming with the invitation for me to rethink my own internalized social expectations and my own ongoing investment in a particular narrative of myself as a caring, moral person. Some conversations helped me to unpack my own care trajectory, decision to leave, and sense that I was lacking morally. In her study of institutionalized weight-loss programs, Heyes (2006) asked, “How can I speak from my normalized position as a dieter simultaneously with my critical position as a diet resister?” (p. 127). Throughout this process, I found myself both upholding normative positions, while also engaging in critical work to resist inequitable gendered norms that I had internalized. For instance, while I was both critical of the way Gracie seemed to valorize her experience or only focus on the positives, I also found myself jostling for moral position, wanting her to know that I have indeed tried hard to live my life in an ethical way. In situating and contextualizing our stories, I came to appreciate further how we were “set up,” with gendered, ethical expectations to “care” interwoven with our sense of selves. I explored what gets “in” and what makes it hard to leave, as well as some of the ways I was able to get (some of the way) “out” by unpacking my sense of self and moral worth. I situated and contextualized our perspectives and structuring contexts, further raising questions about whether ‘care as an ethic’ should apply at the level of women’s lives. As I have argued, there is an intimate politics to redistributing care involving our sense of selves and the expectations we have of ourselves. We can see it in our stories.

Recognizing that “social practice continuously brings new social reality into being” (Connell, 2012b, p. 866), this revised memoir has offered an expanded view of how new realities are brought about through *narrative practices* in particular. Just as the

work of revision “open[s] us to new possibilities for relating and living” (Rice & Mündel, 2018, p. 229), I am hopeful that my work here contributes to expanding the conversational tools needed for fostering empathy and solidarity between researchers and participants, as well as between carers in different age cohorts and social locations. Federici (2013) writes, “We need to put our lives in common with the lives of other people to have movements that are solid and do not rise up and then dissipate.” As I have illustrated, telling the detailed, historicized stories of our lives—attending to differences and particularities—provides a useful way of engaging in communal action and resistance and of examining and remaking everyday, everyday life.

CONCLUDING REMARKS: WHERE WE CAN GO TOGETHER

The stories we tell about care, as well as *how* we tell those stories, tell us about the conditions of our lives and the circulating narratives we have access to. In this dissertation, I examined Ontario's care economy through a contextual analysis of the narratives of women, including those who reached their limits and stepped back from care work responsibilities. I theoretically drew on feminist theories of care, as well as social theories of gender and morality; and methodologically mobilized a feminist narrative approach that used life history and arts-based methods. I analyzed women's narratives, situating and contextualizing how our lives were shaped, as well as how we reshaped them. Now, I want to share key insights and implications, thinking about how my work informs scholarly and public conversations on care work/family relations.

The 'how' of the study: Responding and opening to creative possibilities

Through life history and arts-based narrative research involving myself and differently situated women, I have tried to be accountable and take responsibility in the "production, circulation, and acknowledgement of claims to know" (Code, 2006, p. viii). Recognizing that researchers hold social and political responsibilities, I responded to "obligations to answer for oneself/ ourselves" (Code, 2006, p. 93). That said, the project wasn't simply about taking responsibility or being responsive, accountable or otherwise of service. It involved inviting the world in and opening myself up to creative possibilities. Barad (2007) writes that questions of responsibility and accountability are "not about representations of an independent reality but about the real consequences, interventions, creative possibilities, and responsibilities of intra-acting within and as part of the world" (p. 37; see also Doucet, 2013). Centered on creative-critical research, my work involved

relating, imagining and striving to enact what I call a radical care politics. As Doucet (2018a) writes, “If multiple worlds or wordlings are possible, then the researcher’s role is not to *represent*, but to contribute to bringing new stories, relationships, and worlds into being” (p. 749-750). We said one thing to say the next, riffing and responding.

Using reflexivity as an analytical and artistic strategy was incredibly generative. Like a stand up comic learning from the laugh of the crowd or from the knee-jerk responses of oneself or others, I came to appreciate the utility of putting myself out there or making an offer, opening myself up to the unexpected and learning from my own and others’ responses (Klostermann et al., 2020; see also Berlant & Ngai, 2017). This was the case in the “flinchworthy” performance, in the life history interviews that I conducted, and in other public interventions that I made. Notably, I wasn’t just hitting a nerve or touching fears, but was producing clarity through moments of connection and disconnection. The utility of this approach has me motivated to further develop my capacity for using storytelling, performance or conversational forms as modes of inquiry. For instance, launching a “good girls care” spoof campaign to give advice on how to lure women into care, may support with igniting “catalytic” (Baines, 2007) conversations, working out and shifting commonly held conceptions of “care” or otherwise spurring change.

Putting my own life “in common with the lives of other people” (Federici, 2013) was central to my approach here, as was dialoguing or being in conversation with others to unpack and revise conceptions of “care.” With a focus on how concepts are remade in context (Doucet, 2020) through embodied and expressive practices at the micro level (Kontos, Miller & Kontos, 2017), I didn’t simply look at practices that people narrated,

but mobilized and extended life history research as a method by analyzing how participants' stories were told in the relational encounter of the interviews. Attending to representational, non-representational, performative or ontoformative dimensions of narratives in my analysis enabled me to learn about practical and conceptual, classed and gendered relations that we actively make up. It also helped me to appreciate more fully how care as an ethic or organizing principle is part of my own and other women's lives.

What the research reveals: Care, gender and what exactly has a hold

With a focus on the limits of care, this dissertation looked both at women reaching their limits as carers, as well as at the limits of conceiving of care as an ethic. Looking more closely at women's agency as we renegotiate responsibilities for care *across our lives*, shines light on the stories we tell, and the moral work we do, while also contributing to research and thinking on the relationship between women and care in the "care economy." When it comes to the redistribution of care, my study makes visible how it's not just about a division of labour, but about a division of labour *over time*. It's about time to care. We need time to take turns caring, as well as time to sustain ourselves or time off all together. Care work needs to be considered in light of opting in and opting out. The redistribution of care is about how we make up and put together our lives.

Recall that I asked: How do women narrate negotiating responsibilities for care across our lives? The study elaborated the range of ways that women make up our lives in relation to care with a focus on the narrative work involved in renegotiating gendered, moral expectations to care. Motivated by the need for alternative accounts of how care plays out or what it ends up being about, my study wasn't just about carers at work or

care in practice. I engaged in narrative research with women situated differently in relation to Ontario's care economy. With a focus on *orienting to care*, my research made visible socially and historically conditioned differences in how participants in older and younger cohorts drew on different discourses and evoked different images, while variously undertaking the work of care. Good girls care; rebels do too. With a focus on *reaching one's limits*, I showed how participants narrated reaching the limits of care as an embodied breaking point, a moral, feminine accomplishment, and something to feel guilty about. They engaged in moral work to negotiate contradictions in relation to intimate others. With a focus on *stepping back*, I made visible how participants variously engaged in intrasubjective work to reorient to their moral sense of selves and self-expectations. Getting out of care was framed as easy for some and a slog for others, with women finding different ways of reconciling their care histories. How these stories were told tells us something about how "care" has a hold. Participants can be thought of as *caremakers* – engaged in practical work and activities of care, as well as in conceptual work to remake meanings of care.

I asked: How do women shape and how are we shaped by class, gender and conditions in the care economy? Aiming to contribute to research and thinking in feminist political economy, I theorized the care economy through an interpretive, narrative analysis of how women inhabit, embody and resist broader intimate and extended structures of care *across our lives*. Engaging diffractively, and drawing on the work of Braedley (2015) and Connell (2002, 2005), I developed a working definition of the "relational care economy" as the constellation of social relations through which care relationships, *and the contradictions that come with them*, are inhabited and negotiated,

including (1) symbolic and structural relations; (2) institutional and organizational relations; and (3) micro, intimate, everyday relations. The framework supports with theorizing how people are positioned in inequitable care relationships, and how people negotiate contradictions that come with them, including in relation to their sense of selves. While some desire to care or don't mind, and it has benefits, including with meaningful affective relationships, it is still inevitably wrapped up in coercion at the level of (moral, feminine) self-fashioning.

Exploring women's narratives of paid and unpaid care work was revealing. I tracked rhetorical conventions for speaking about care in different contexts, considering how meanings and projects of "care" are shaped through social relations of care and gender that extend beyond any particular care role or setting. Interrelationships between women positioned differently in the care economy are incredibly important. Just as Betty was coming in to support her husband in long-term care from 11am to 7pm daily, Carrie and other paid care workers were clocking in early or staying late to make up for organizations stretched thin. Paid workers talked about picking up the slack for family members, while family carers talked about making up for gaps in relation to workers run off their feet. Participants' accounts of care in a range of paid or unpaid settings had many commonalities with challenges in boundary-setting or in negotiating gendered, moral responsibilities for care. Had I focused on family carers, a simple solution might have been that paid workers need to step in, but there were no easy solutions here. Thinking together about paid and unpaid care work has helped in making links to a broader political economy of care and in considering how the way "care" makes a claim extends beyond particular paid or unpaid care roles or realms. My research can be used to

support efforts to bring women together around a broader political agenda or to build coalitions amongst carers in different contexts.

With the aim of contributing to an alternative conceptual imagining of “care,” my work presents a challenge to the ethic of care framework. I acknowledge that work in the tradition makes a significant contribution in arguing that women’s social location has them come at life differently and that morality takes on different forms. Theorizing care as moral work that needs to be taken seriously is an important contribution, particularly when women have been excluded from notions of what counts as moral or what counts as contributing to political life. Further, the care ethic makes sense as a political philosophy, as care is socially necessary labour and we need social policies and arrangements that ensure the democratic provision of care for those who need it. The care ethic works well as an orientation similar to how the ethic of justice was intended. That said, in working to conceptualize care through the narratives of women positioned differently, my study raises questions about the experiential underpinnings of care as an ethic: how care is constituted at the level of individual women’s lives. My analysis suggests that “the moral injunctions, not to act unfairly toward others, and *not to turn away* from someone in need” (p. 20, emphasis added) are quite dangerous when lived out or pushed to the limit in wider conditions of social neglect or without options for carers to share responsibility. As I have illustrated, the body says ‘no,’ and care has limits.

Participants did an incredible amount of work to rethink their moral sense of selves or to break down moral, feminine associations with care in reconciling and presenting their care histories. With the way moral feminine ideals circulate and inform how care is organized and understood, the women I interviewed had to loosen the moral

chains around their hearts as they navigated relationships in the care economy. Our stories indicate that moral dimensions contribute to inequitable situations, making carers and the people we support vulnerable. With that, I ask: Can we insert some fine print on care as an ethic? Should we distinguish care as an orientation from care as work or a life project? Should we note that framing care as a conveyor of moral values or as an act of resistance to patriarchal forms of oppression (Gilligan, 1993) may lead one to feel morally unworthy if opting out? Is it worth noting that not everyone has the luxury of reading ethical ideals of care as an orientation or political philosophy without having them make a claim on their subjectivities or lives? Should we mention that *turning away* from someone who needs care is a practice central to sustaining oneself and others? In asking these questions, I want to note that my point here is quite different from one articulated in recent works that challenge the care ethic for granting moral status to those who care as though carers are oppressing or wielding power over others from on high. I believe that it is indeed the case that care relationships can be oppressive to those who need care, but I also note that women need to claim power or find worth and value somehow, and providing care can be a way to do this. Taking seriously questions about care redistribution means ensuring women have other worthwhile, legitimate ways to make a life or make something of ourselves outside of care. We need liveable lives, and how society structures our worth or non-worth beyond care and across our lives is part of the story.

Now, what? Moving forward, enacting a radical care politics

How can we engage with vulnerable, exhausted, angry, and worn out populations to cultivate equitable socio-economic relations that value the contributions that all lives bring? (Irving, 2017, p. 176)

Attending to how women position ourselves in relation to care contributes to the ongoing, collective work of challenging our decollectivized everyday lives and internalized responsibilities. For sociologists working from a feminist perspective, further research could consider how people are positioned differently in relation to care, including people loosely understood as needing care, shouldering or shirking the work of care, or resisting and revising care responsibilities. Research could look at developing remoralization strategies or ways for people to build connections or networks with others actively grappling with moral concerns and negotiating moral dilemmas. In particular, having illustrated how the inequitable redistribution of care leads people to actively engage in work to remake their lives or find other legitimate ways of living, it would be worth detailing in more specificity the activities that people engage in to loosen or break down moral, feminine associations around care. How do people find ways of living otherwise?

Moving forward, research is also needed that critically reflects on the right (not) to care as it involves having the right to provide or not provide some forms of care work, and to receive or not receive care, with conditions that make those rights possible and even rewarding (Armstrong, 2019; see also Armstrong & Klostermann, in press). Future work is needed to consider the right (not) to care as a matter of gender and intersectional inequities, with gender, racial, class/income and citizenship relations not only shaping

access to care (with some not being able to afford care), but also shaping who is tracked into care roles or prohibited from caring altogether. Looking at other hierarchies of difference or learning from racialized, immigrant women might support with illuminating femininity and moral worth differently or bringing layers of settler colonialism or racialization into view such as with a focus on how racially coded language (e.g., around “good” immigrants) produces contradictions that women negotiate.

My research also has invitations for shifting understandings and arrangements of care, particularly given that calls to recruit and retain workers into the sector, to date, outnumber calls to ensure care relationships are consensual or to support carers in exercising agency. As we have explored, carers' own lives need to be sustained, and carers need to be supported. With dominant tropes about “heartbreakers leaving” and with gendered expectations linking women to care, there is very limited public dialogue on ritual exits or on how to ensure care relationships are consensual. “How come I didn't get a fucking goodbye party? *laughs* or like a card?” was a question that Nora asked after resigning from care work that I think comes with an invitation to consider how women can be supported in moving on rather than simply disposed off. As we have explored, creating truly caring relationships, involves more than simply ensuring someone has the needed supports to turn towards or meet another's needs. In turn, beyond improving public support for care or improving working conditions or standards so people can be able to care, we need conceptions and configurations of care that enable carers to resist or renegotiate inequitable care work arrangements as needed. If relationality or interdependency were taken seriously, carers would have the option to discern or to withdraw or suspend their care work without guilt or shame. Being able to leave is an

indicator of equitable care relations; conditions should be good enough to ensure people can leave or are free to go.

To come full circle, this project opened up and critically reflected on a tension: care work is socially necessary labour central to social life and we need to ensure the democratic provision of care for those who need it, yet the gendered, moral coercion of girls and women into care (that extends beyond any one particular care role or realm and is visible in people's ongoing interpretive work) needs to stop. I explored how this tension plays out in the individual lives of women as we are fixed to care, set up for contradictions at the limits of care and as we engage in an incredible range of practical and conceptual work in relation to care *across our lives*. With socially and historically inequitable conditions in the care economy, and with the way that socially necessary work to survive under capitalism is assigned to individuals, care is wrapped in gendered, moral coercion, and it is hard for women to say "no."

Relatedly, to date, operational definitions of care do not include any limits or boundaries. For instance, Glenn's (2010) definition of care work involves three interrelated activities, including providing direct care, maintaining physical surroundings and fostering social relationships (see also Black, 2020). Underscoring the need for making "care" more equitable for carers and care recipients alike, my research suggests we need a definition of care work that is collective in the broadest sense of the word – one that moves beyond describing 'recipients' of care or the tasks involved in caring to include other intersecting, structuring relations, as well as limits and boundaries. "If you're going in alone, don't go" is a phrase that comes to mind when I hear of individual women (workers or family members) being funnelled or wedged into self-other,

individual care relationships of the “you’re the only one” variety. I would argue that such individual arrangements aren’t actually “care” and that going “in” or taking on such responsibilities isn’t “caring.” Such conditions are dangerous, unacceptable and a testimony to the failure of the welfare state and to our failure to imagine or organize care in equitable, sustainable ways. There are real consequences for not taking care very seriously (Folbre, 2010), and we need alternative conceptions and configurations of care – radical ways of sharing responsibility and sustaining ourselves for the long haul.

With a focus on the limits of care, I set out to undertake a disruptive project and to make a deep, cutting critique of structures of care. On the surface it was a project about how to leave or get out of care work. But I’ll also admit that it was a project about what it means to stay with something. Like a dog with a bone, I’ve stayed with the trouble, writing with anger and optimism, and pushing for something more. Moving forward, I push for new ways of conceptualizing and organizing care beyond those that alienate us from ourselves and others or set us up for contradictions that we spend years negotiating. We need ways of loosening care’s moral grip or weaning ourselves off “care” as an all-encompassing ethic or life path. We need tough conversations about what we expect of ourselves and others, how we can stop setting women up for such intimate losses, and how our lives and relationships can be otherwise.

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Appendix

Recruitment Poster

THE CARING LIFE HISTORY PROJECT

Participate in a study that honours the life stories and memories of diverse (past or present) care providers.

The aim is to tell new stories about care and the limits of caring in Ontario.

Who is invited to participate?

People with experiences *reaching their limits* and/or *stepping back from* a care responsibility or position in Ontario in some way (e.g., by sharing responsibility, finding other supports, resigning or opting out).

As a former care worker, I am interested in learning about people's experiences with diverse forms of care (e.g., paid, unpaid, family, volunteer, private/companion, etc.) in diverse settings (e.g., homes, hospitals, group homes, long-term care facilities, social movements, social service agencies, L'Arche communities, etc.). I am excited to speak with past or present care providers (e.g., activists, PSWs, live-in carers, direct care nurses, support workers, family members, etc.) who have stories to tell about the limits of care.



What is involved?

The study involves participating in at least one confidential interview of approximately two hours. Ideally, we will meet three times over the course of 2-3 months. In the 'life history' interview(s), you will be invited to share your memories of caring. (Interviews can be conducted in person, by phone or by Skype. The study is voluntary; you may withdraw at any time during the interviews and up to 90 days after the interviews.)

How can you find out more?

For more information on "The Caring Life History Project," contact Janna Klostermann, a former care provider and PhD student in Carleton University's Department of Sociology: janna.payne@carleton.ca or 613-807-5581. *The ethics protocol for this project has been reviewed and cleared by the Carleton University Research Ethics Board (#109030). If you have any ethical concerns with the study, please contact Dr. Bernadette Campbell, Chair, Carleton University Research Ethics Board-A (ethics@carleton.ca).*