

Caring and Collaborating across Cultures?

Migrant Care Workers' Relationships with Care Recipients, Colleagues and Employers

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ABSTRACT The literature on migrant care workers has tended to place little emphasis on the multiple relationships that migrant carers form with care recipients, employers/managers and work colleagues. This article makes a contribution to this emerging field, drawing on data from qualitative interviews carried out with 40 migrant care workers employed in the institutional and domiciliary care sectors in Dublin, Ireland. While the analysis revealed generally positive carer-care recipient relationships, significant racial and cultural tensions were evident within the vertical and especially the horizontal relationships in the care workplace. The article argues that these findings highlight the need for additional research on the relationships formed in the long-term care sector and further theorizing on the meaning and importance of the affective components of care work within increasingly commodified care markets.

KEY WORDS care workers ♦ domiciliary care ♦ gender ♦ institutional care
♦ integration ♦ long-term care ♦ migration ♦ multicultural workplaces ♦ racism

INTRODUCTION

Analysis of the long-term care workforce encompasses the issues (and intersections) of gender, class and migration status. Dual labour market theory, which emphasizes the segmentation of the workforce into the 'primary' and 'secondary' sectors, can be applied in explaining the presence and expansion of the migrant long-term care workforce (Redfoot

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and Houser, 2005). The dual labour market theory underlines the division of the labour force by class and gender and suggests that public policies can contribute to the expansion of the secondary sector. Migrant care workers – predominantly female – employed in low-skilled care work fall into the 'secondary' sector, which affords little job security and career progression. The policy of relegating care work to the private sphere, or to markets, has in many countries led to the concentration of migrant women in low-wage, often exploitative jobs in the care industry (Anthias, 2000). Policies which promote the employment of poorly paid care workers or assign the provision of care to the private realm of the family can force migrant women to accept conditions of employment (such as live-in care work) which would not be tolerated by non-migrant women (McWatt and Neysmith, 1998).

The relationships formed by *non-medical* migrant workers in the elder care sector constitute a very novel area of enquiry. This is a highly complex area of investigation due to the diversity of the care sector: non-medical care workers can be employed in the *institutional* or *domiciliary* (home) settings. Care workers in the latter sector can in turn be employed either *formally* (i.e. on regular contracts, paying tax and social security contributions) or *informally*, by care recipients and their family members (receiving cash-in-hand and outside the safety net of formal social protection). The relationships that migrant care workers form in these diverse settings give rise to a number of important questions. Do migrant care workers and the (often ethnically rather homogeneous) care recipients interact harmoniously and understand each other's expectations and ways of communicating? Is the multicultural workplace detrimental to smooth working relationships and therefore, ultimately, also the quality of care, or are workers from diverse backgrounds and cultures able to work together successfully? How care workers conceptualize and manage their relationships with clients, managers and colleagues has important ramifications for their motivation, well-being and the quality of care they provide.

Much of the relevant literature on migrant care workers' relationships with care recipients has focused on the experiences of domiciliary care workers (Lutz, 2008; Pfau-Effinger and Geissler, 2005). This literature underscores the challenges confronted by care workers as a result of close and dependent relationships with their employers, often the care recipient or a family member (Anderson, 2007; Degiuli, 2007; Ungerson, 2004). The isolated and intensive nature of the work can lead to care workers developing a very strong sense of duty towards their clients. As Aronson and Neysmith (1996: 62) state, 'the privacy and informality of older people's [own] homes . . . makes the separation of practical and emotional labor and the distinction between formality and informality especially ambiguous and problematic'. While the relationship between a care worker and

her employer/care recipient can be mutually beneficial and positive, these relationships are often highly complex, unequal and discriminatory (Grande and Kerr, 1998; Scrinzi, 2003).

Theoretical underpinnings of formal care are limited in the social science literature. According to the feminist sociologist Usha George (1998), the prevailing normative context of caring, based on the assumption that care is a private issue which should remain in the domain of the family, has prohibited theorizing on the meaning and consequences of care. Feminist scholars have argued that the ideological language which surrounds care work needs to be changed. Leira (1994) highlights how feminist researchers in the 1970s and 1980s deconstructed the meaning of care and questioned the accuracy and implications of framing care work within a discourse which viewed it as a 'labour of love'. Such a categorization, she argues, 'overstates the subordination of the carer to the needs of the care recipient' (Leira, 1994: 189) and is also problematic in contexts where an increasing amount of care work is carried out by formal, paid caregivers. The professionalization of care work does not mean that the emotional aspects of caregiving become irrelevant; indeed our findings show that the emotional aspects of formal care are very relevant, yet poorly understood. However, the normative understanding of care as a 'labour of love' needs to be questioned in order to ensure that formal care work does not become exploitative. This is a difficult dilemma since, as Neysmith (1998) argues, discussions which revolve around the commodification of care can obscure the fact that 'caring always involves relating personally to another human being' (Neysmith, 1998: 237).

Ungerson's (2004) comparative research on *formal* domiciliary care in Austria, France, Italy, the Netherlands and the UK suggests that carers employed through the regulated domiciliary care system tended to have a more 'distanced' and 'professional' relationship with care recipients. However, this 'distancing' or 'depersonalization' of care work may not be possible for many care workers. Aronson and Neysmith (2001) allude to female care workers' sense of moral obligation to provide additional care to their clients. The provision of additional care, they argue, evinces exploitation of care workers because it is not always voluntary and often arises out of a 'moral compulsion', or insecure labour market status which forces carers to acquiesce to their employers' demands. They argue that this moral obligation is greatest in the home care setting where loosely defined contracts can mean that work has the semblance of an informal, family-like arrangement.

Due to the isolated nature of domiciliary care work, relationships between migrant care workers and their co-workers can only develop in the institutional care context. Research on these relationships is at a very early stage. There are some notable contributions to this emerging field, such as McGregor's (2007) study which described the stress experienced

by Zimbabwean migrants working in racialized workplaces in the UK care industry, and Lazaridis's (2007) research which found that work relationships between native Greeks and migrant care workers in the Greek context were imbued with rivalry and racism. In order to hypothesize further on relationships within the care workplace, it is necessary to consult the literature on skilled migrant nurses. While it is unclear whether results of these studies are transferable to migrants employed as semi- or unskilled care workers, we conjecture that there may be some areas of convergence given the similarities of the work environment. With some exceptions (Withers and Snowball, 2003), the workplace experiences of migrant nurses have been shown to be predominantly negative (Allan and Larsen, 2003; Allan et al., 2004; Matiti and Taylor, 2005). Likupe (2006) offers a useful summary of the literature and suggests that communication problems infuse workplace relationships with tension. Allan and Larsen (2003) indicated that some nurses had difficulty adjusting to dialects and accents, while Withers and Snowball (2003) found that overseas nurses speaking in their native tongue were accused of being antisocial and reprimanded by their colleagues. A survey of the National Health Service (NHS) in the UK conducted by Shields and Wheatley Price (2002, cited by Likupe, 2006), suggested that discrimination is rife and may be an entrenched feature of the NHS, with 40 percent of ethnic minority nurses experiencing discrimination from work colleagues and 65 percent encountering significant racial harassment from clients and their families.

Relationships between migrant nurses and their managers are also frequently characterized as negative in the literature. Alexis (2007) found that managers ignored migrant nurses and treated them as invisible, a theme reiterated by Bjorklund (2004), who outlined many migrant nurses' belief that workloads were unequally distributed and contributions not recognized by management. Negative stereotypes of foreign workers have been identified as contributing to racism and discrimination in the nursing sector (Allan et al., 2004). This finding is echoed in research on migrant domiciliary carers and domestic workers, which has found that employers frequently construct racial stereotypes of carers based on their nationality and indicate a preference for nationalities that are assumed to have submissive temperaments (Anderson, 2007).

In this article we analyse two broad sets of relationships that migrant elder care workers develop in the course of their work: (1) relationships with the older care recipients and (2) 'vertical' and 'horizontal' relationships with employers/managers and co-workers respectively. We decided to explore these relationships as part of a project that sought to elicit information on various aspects of the work and lives of migrant care workers. The research was conducted in Ireland, where considerable transformations have taken place in the care of older people in recent decades (Timonen and Doyle,

2008). While official estimates of the presence of migrant workers in the Irish elder care sector do not exist, anecdotal and institution-based evidence (e.g. records of individual hospitals and nursing homes) suggests that in urban areas, in particular, the majority of carers in many occupational categories in institutional, hospital and domiciliary care settings are migrant workers (INHO, 2006; Timonen et al., 2006). Quantifying the number of migrants employed in the 'grey' labour market is by definition very difficult and has not been attempted in the Irish context.

RESEARCH METHODS

Qualitative research methods were adopted because the subject matter, interpersonal relationships, is not easily quantifiable and because there were no sampling frames from which to draw respondents probabilistically. We initially decided against using employer gate-keepers on the grounds that using them would introduce a bias into the sample (employers are more likely to refer compliant workers). We therefore set out to accumulate our sample through migrant organizations. In order to combat overdependence on any one network, respondents were accessed via more than 20 different migrant organizations. When this and networking supplies were exhausted, we were thrown back to the employer route and recruited seven interviewees through care sector employers such as nursing homes, taking care to keep the involvement of employers in the process minimal.

In order to acquire an understanding of the diversity of experiences within the migrant long-term care workforce, we sampled purposively across the three sectors of formal institutional care, formal domiciliary care and informal ('grey market') domiciliary care, and across the three broad regions of Europe, Africa and South Asia (see Table 1). An analysis focused on one sector only, such as the domiciliary or institutional care sector, would have provided a more limited picture of the migrant long-term care workforce. While the inclusion of the three sectors means that the sample size within each sector is small, it provides us with preliminary insights into differences between the care sectors; this is important given the overemphasis in research to date on the (informal) domiciliary sector.

The interview schedule consisted for the most part of open-ended questions, and extensive probing was used to follow interesting avenues opened up by interviewees. However, we used the same set of core questions for each interviewee, and as such the interviews can be characterized as semi-structured. The interviews were audio-recorded and transcribed subject to interviewee's consent, which most of them gave without reservation.

Table 1
Sector of Employment and Region of Origin of Respondents

	Formal institutional carer	Formal domiciliary carer	Formal domiciliary live-in carer	'Grey' labour market live-in domiciliary carer	'Grey' labour market live-out domiciliary carer	Total
African	4	6	–	–	1	11
South	6	–	5	5	–	16
Asian						
European	7	4	–	1	1	13
Total	17	10	5	6	2	40

Note: All interviewees with the exception of four male institutional care workers (three Filipino and one African) were female.

ORGANIZATION OF THE MATERIAL AND ANALYSIS

The method of analysis adhered to the framework approach (Pope et al., 2000). This method of analysis involves five stages: familiarization with the raw data; identification of a thematic framework; indexing the data while applying the thematic framework; 'charting' or rearranging the data in line with the thematic framework; and finally, mapping and interpretation of the data with the use of charts, tables and typologies. This method of analysis yields itself to qualitative studies that commence analysis with the help of some preconceived categories, which are also reflected in the interview guides: in this case, the categories are simply the three sets of workplace-based relationships that we asked interviewees about, in all cases using open-ended, non-directive questions such as 'Can tell me about your relationship(s) with colleagues/your manager/the person(s) you provide care to?' All of the respondents had a reasonable level of conversational English, precluding the need to use interpreters. For the ease of identifying the interviewees' geographical origin, gender and sector of employment, all quotes in this article are referenced, containing information on the sector (INF = informal, FOR = formal, INST = institutional, DOM = domiciliary), EUR, ASIA, AFR referring to region of the world, and M and F referring to male and female respectively.

The remainder of this article is organized under the following headings:

- Relationship with the care recipient(s): institutional and domiciliary sectors.
- Relationship with the employer: institutional sector.

- Relationship with the employer: domiciliary sector.
- Relationship with colleagues: institutional sector.

Discussion of the caregiver–care recipient relationships combines analysis of relationships in the institutional and home care sectors. Workplace relationships within the institutional care context and home care context are discussed separately as they present very different contexts from the point of view of interpersonal relationships in the workplace. Relationships with colleagues in the domiciliary care context are not discussed here due to fact that most respondents in this category worked alone and had no or only very limited contact with other home care workers. Care workers in the institutional context typically have a large number of ‘horizontal’ relationships with co-workers and also one or more ‘vertical’ relationships with managers. We discuss the relationship with the employer or manager separately from the relationship with co-workers: whereas in the former case hierarchies in the workplace and differences in power and authority can play a central role, in the latter the assumption is that, all other things being equal, workers at approximately the same ‘level’ in the occupational structure can relate to each other in a less hierarchical manner. Furthermore, the vertical relationships are currently mostly with Irish managers, whereas the horizontal relationships are in many cases predominantly with other non-Irish nationals. This article does not examine in detail how the nationality of the care worker impacted upon their experience of care work, for information and analysis on this aspect readers are referred to Doyle and Timonen (2009).

RELATIONSHIP WITH THE CARE RECIPIENT(S)

Interpersonal relationships between domiciliary care workers and care recipients tended to be more personal and intimate than those in institutional care settings. This was largely due to the greater scope for interaction available to carers working in the domiciliary context. Nonetheless, the themes that arose in relation to interpersonal relationships were similar among those working in the home or institutional care contexts. In some nursing homes the pressures of work left little time for personal social interaction with the care recipient:

I love them, I sing to them . . . but there are so many things to do that sometimes you can’t afford to be very nice, because of the pressure, but I know their stories and personalities . . . who they used to be and what they achieved and their families. (FOR/INST/EUR/F6)

The impression that emerges from our data is that of overwhelmingly positive relationships between the migrant care workers and the older Irish people to whom they provide care. While a social desirability bias

may have contributed to the positive characterizations of relationships with the older care recipients, the fact that the explication of these positive aspects was common to almost all interviews, and was often extensive and very detailed, lends reliability to this finding.

A high degree of respect for older people was evident in most interviews and carers frequently drew parallels between their experience of looking after their own family members and looking after the current care recipients. Many domiciliary care workers spoke of the fun that the carers and care recipients had together. The importance of companionate care was reiterated and thought to be of great importance to those who were living alone and perceived to be isolated. A number of carers relayed how relationships frequently took on an informal, 'family-like' quality. In such instances care workers performed duties that were highly person-centred and not part of their 'regulation duties', such as massage and checking on the care recipient outside normal working hours.

The development of such intimate relationships was only relayed by a small minority of institutional care workers, who due to the intensity of their workload and large number of care recipients did not have as much time available to cultivate relationships as workers in the domiciliary sector. Indeed, in some nursing homes the pressures of work left little time for personal social interaction with the care recipient. Despite this, however, the majority emphasized the importance of person-centred care and communication with the care recipients and explained how they made an effort to be affectionate and accommodating towards care recipients. In their descriptions, talking featured as an important and integral part of the relationship with care recipients. Even within the stressful environment of the nursing home, several carers accommodated and made time for this need to talk, and saw talking as part of the everyday caregiving process. Communication frequently also took non-verbal forms such as holding hands.

Many of the care recipients in the institutional care settings had severe cognitive impairments that made communication very difficult. Within both the domiciliary and institutional care context cognitively impaired care recipients were in many cases reported to use aggressive or offensive language, but despite the obvious harshness of the experience of listening to such language, this was universally 'understood' and simply ascribed to the person's illness. Given the homogeneity of the Irish population until recent times, it is perhaps not surprising that a number of care workers mentioned that care recipients with cognitive impairments receiving care from them were at times confused. In one instance, a care recipient receiving care from Filipino care workers believed she was in South America; in another, a care recipient threatened to call the police if her African carer who was attempting to bathe her approached. Some respondents felt that

they were treated differently by (non-cognitively impaired) care recipients partly because of their nationality, but also due to the hierarchical nature of the workplace:

Sometimes [the patients] are bossy, especially if they can hear your accent, the attitude could be a bit different. They wouldn't offend you but many of them know who they are talking to, especially in this place, nurses in charge have blue uniforms, nurses have white uniforms, when you are a care attendant you have a green uniform, so they know the position and how they can behave. (FOR/INST/EUR/F15)

Unfortunately some behaviours towards the carers from care recipients without cognitive impairments were undeniably racist. All the care workers who had experienced racism from care recipients were surprisingly forgiving of this and stressed that only a small minority of the older people they had worked with were racist. In the home care context, the care workers did not usually end up working in a racist environment as racist clients were able to 'veto' them at the outset. To bridge the cultural divide between the carer and care recipients in both the domiciliary and institutional care context, a gentle and understanding approach towards the care recipient was generally adopted. Bringing gifts of traditional cooking was used by an Iranian home carer, while humour was used by many carers to bridge the cultural barrier and to put care recipients at their ease. Some male institutional care workers used humour extensively, perhaps as a way of differentiating themselves from the majority of female co-workers.

A possible consequence of a good relationship is dependency. Such dependency was only mentioned by those working in the home care setting, probably reflecting the smaller number of care recipients (often a single one) that carers in the domiciliary sector looked after. This dependency sometimes caused significant stress for home care workers who were called upon in emergencies or to compensate for a lack of contact with family members. As a result of these emotional bonds and concern, carers often worried about the well-being and safety of the care recipients outside their working hours:

You [the Irish] have strong family but they don't come that often and they just come once a while and I think that's a bit sad you know, that just the person gets a bit isolated and that's why as a carer they rely on us even more. More for the companionship than for the duties most of the time. (FOR/DOM/EUR/F29)

Relationships between live-in care workers and their care recipients could be categorized as the most intimate but also psychologically demanding. In some instances the blurring of the boundary between work and personal relationships was evident. Many of these women had worked as live-in carers for more than a decade and had confined their

world for extended periods to the restricted environment of their clients' homes. Such relationships, while close, compassionate and affectionate for some, could be demanding, exploitative and exhausting for others. A number of these carers had been caring for their clients for several years and had seen the health of the care recipient deteriorate. Increases in challenging and demanding behaviours such as unpredictability and aggressiveness were in almost all cases attributed to the care recipient's illness and discomfort, and tended to receive a great deal of understanding. With two exceptions, the carers did not perceive their work as exploitative. The majority of carers focused on the reciprocal nature of their relationship and how they and their care recipient mutually benefited from the relationship.

RELATIONSHIP WITH EMPLOYER/MANAGER

Institutional Context

Interaction with management within institutional care settings was usually infrequent, with several interviewees indicating that they preferred to maintain a respectful and distant relationship with their managers. The nature of the relationship was frequently believed to be dependent on the worker's productivity and the manager's perception of the quality of her or his work. While many characterized the relationship with their manager(s) as neutral or generally amicable, a significant proportion identified negative features in their relationship with their superior(s) in the workplace such as management constantly critiquing their work. Excessive criticism and lack of positive feedback were experienced as demoralizing and unfair:

When she comes you think what will be wrong this time, you're a kind of criminal every time, you never hear good words . . . you still need to do more because this and that . . . with the owner, there is no hello, how are you, is there any problem you would like to share . . . when we go home we have back pain and yet we receive this kind of treatment, it's very upsetting. (FOR/INST/EUR/F5)

Nursing homes which operated in the absence of formal rules and guidelines placed little emphasis on teamwork. Carers in such nursing homes thought management did not pay sufficient attention to the development of supportive relationships between co-workers. One respondent construed the placement of a security camera in the reception area and corridors (ostensibly for the residents' safety) as an infringement of the rights of the care workers. The presence of these cameras constrained the development of relationships among staff members, who perceived themselves as being under constant surveillance by management. For others, the priorities of management were frustrating. Among this group there was a perception that managers were not focused on the care recipients but instead invested excessive energy in the aesthetics of the nursing

home such as its overall cleanliness. Unsafe work practices in relation to lifting and lack of availability of adequate equipment were described by several nursing home care workers. A carer who worked in a nursing home with low standards explained that such nursing homes are usually staffed by migrant workers 'who don't have a choice at all, they have to work, they have to earn money, and they are desperate'.

A small number of respondents mentioned how the nationality of the manager affected the nationality of the broader care workforce within a particular institution. For example, a Filipina care worker relayed how her Filipino manager had employed large numbers of workers from the Philippines, some of whom were directly related to the manager. Another Filipina carer explained that she worked with eight of her relatives. Similar examples of possible nepotism were also mentioned by others, who believed that some workers (generally husbands) had gained easy access into the care sector via their spouse, who was already employed in the institution as a qualified nurse. With the exception of those who had a manager of their own nationality, the majority stated a preference for Irish managers, usually because they were seen to be more impartial and better than other migrants at managing intercultural relationships in the workplace:

. . . it's a good thing that the nurse in charge is Irish, in the private nursing home, there was an Indian nurse in charge, and she couldn't manage this part [relationships between Irish and non-Irish workers]. (FOR/INST/EUR/F15)

Home Care Context

Where the home care worker was employed through an agency and saw the home care agency as their employer, the experiences were in most cases positive. Contact with agency employers, which generally related to the allocation of work hours, was infrequent and was usually over the telephone. In almost all instances agency managers were viewed as treating the care worker with respect and were available to help when they called with a query. Flexibility on the part of the agency employer was highly appreciated, particularly for those with childcare responsibilities. One home carer employed by an agency, however, outlined her experience of communication difficulties with a non-Irish manager and the need to resort to written communication in the place of verbal communication:

[The agency] employ people to the management that don't speak English clearly, they employ foreigners but for example I don't understand people from Nigeria . . . it's not that I am racist, I just don't understand their English, if they want something from me I usually have to say, listen, text me [send a text message to my mobile phone], I don't really understand what you are saying. At this moment it's getting more and more culturally diverse. (FOR/DOM/EUR/F9)

In the live-in home care sector, the de facto 'manager' of a care worker was the care recipient's family. The quality of these relationships varied: while some carers outlined their annoyance at 'interference' by family members, others regarded themselves as working together with the family. Indeed, some of the workers reported that they were treated as part of the family by the 'employer'. Given that the employment and the duration of the work contract of live-in carers are closely dependent on the quality of the interpersonal relationships and the care recipient's (and family's) perception of the caregiver's work, carers sometimes completed additional work tasks not typical of a home care worker such as gardening and favours for family members (for instance ironing):

They just told me to mind their Mam but they were amazed that it is not only minding their mum but I care for everybody. If one daughter comes in to mind their mum, I also do favour, like I iron their clothes, I wash . . . put them in the washing machine. (INF/DOM/ASIA/F3)

Such behaviour is linked to the need that live-in home carers have to formulate long-term strategies for retaining their job and for negotiating time off work. For example, permission to return periodically to the country of origin was often at the discretion of the care recipient's family; the need to work hard and accommodate the families and care recipients was seen as essential. However, such 'strategies' were also embedded within a compassionate worldview and approach to interpersonal relationships. As one carer stated: 'if you give love, you receive it back'.

In the informal domiciliary care context, in addition to their own dependence on the income from and risks associated with the (essentially illegal) work, the care workers were acutely aware of the dependence of the older person on their care and by extension, the dependence of the 'employer' (typically the older person's offspring) on them. The relationship with the employer was usually characterized in positive terms, and included several references to the employer 'looking after' the care worker in a rather paternalistic manner. References were also made to the employer 'feeling sorry for' the carer, and to their gratitude for having such expert carers (in one case, two trained nurses) looking after the parent. The relationship between the informal domiciliary care worker and their employer was therefore multidimensional and complex, incorporating elements of sympathy and gratitude but also mutual dependence.

RELATIONSHIP WITH CO-WORKERS: INSTITUTIONAL SECTOR CONTEXT

In contrast to the relationships with care recipients and the 'vertical' relationships with managers, the picture of 'horizontal' relationships in the institutional care workplace that emerged from our interview data is rather

negative. The difficulties mostly arose from barriers to communication such as poor language skills, but also from perceived differences in productivity and approaches to work. Many of these care workers described their work as physically demanding and intensive and in some instances mentioned how the development of positive relationships with co-workers was constrained in such a stressful work environment. It is therefore possible that the nature of the work environment and workload, as well as lack of action by management, contributed to the development of these negative relationships.

Considerable intercultural and inter-racial tensions in the horizontal working relationships in institutional care settings were discernable. The majority of respondents perceived and classified their colleagues in terms of racial groups and/or nationality and distinct characteristics were attributed to each group. Examples included a Filipino care worker who believed that African carers' 'minds are not on the job' and a Polish care worker who believed that Filipino carers were lazy. The workers usually attached positive attributes to themselves and other workers from their country of origin. For instance, the perception that they are highly skilled and desirable both to their employers and care recipients was widespread among care workers from the Philippines. Where the workplace was dominated by workers from the respondent's own country, their perception of interpersonal relationships in the workplace was usually very positive. However, the picture was not so clear-cut in all cases, with one Polish care worker explaining that competition and tensions can exist between workers of the same nationality.

Where a workplace used to be dominated by the respondent's nationality and had recently become more diverse, interviewees explained that adjustment to different accents and work-styles was difficult. A number expressed a preference towards workplaces which were not dominated by one nationality, since this had in their experience led to carers communicating in their own language and excluding other care workers. While some carers believed a mixture of different nationalities to be ideal, others expressed a preference for working with Irish co-workers rather than with migrant workers of different nationalities. Those who voiced a preference for Irish workers did so because of language and communication problems they had experienced with migrant workers, or because of a belief that migrant carers of other nationalities were unproductive. By and large, the experiences with Irish co-workers were positive; however, there were a number of significant instances where care workers believed that they had been mistreated or deliberately ignored by Irish colleagues. A Filipino care worker who perceived Irish staff to be lazy was reluctant to complain to the managers for fear that he would not be taken seriously.

In contrast to racism on the part of a small minority of care recipients, which was universally understood and forgiven, racism from co-workers was experienced as extremely hurtful and in some cases had led to

complaints to management and even resignation. Discrimination was seen to be both covert and overt. Skin colour was seen as a contributory factor influencing treatment by white co-workers of African care workers who encountered more discrimination from work colleagues than European or South Asian carers. Management's refusal to take corrective action and to reprimand staff who openly laughed at the racist remarks constituted a lost opportunity to deal with undercurrents of racism perceived by this interviewee to be entrenched in the workplace:

A patient once said to me: 'alien, come here' . . . my colleagues heard this and they laughed and laughed and laughed . . . to this date nobody has apologized [despite complaint to management] . . . I don't care about money, but I do care about my colleagues giving me respect. (FOR/INST/AFR/F21)

CONCLUSION

Our findings hint at the existence of a dual labour market in Ireland. A gendered and racialized divide is emerging between the 'primary' and 'secondary' sectors, with many migrant workers employed on loosely defined work contracts in the latter sector. The findings also point towards racial and cultural tensions within the Irish long-term care sector. Within both the formal and informal ('grey') labour markets, many workplace relationships were marred by conflict and tension with employers or co-workers. The tensions discussed in this article, especially if they are shown to be widespread, have ramifications not only for the migrant care workforce, but also for the quality of care, which we hypothesize is influenced by the well-being of care workers.

Our findings suggest that many migrant care workers employed in the domiciliary sector develop close personal relationships with care recipients, which extend beyond the boundaries of formal care. Although care tasks performed in institutional settings tend to be more instrumental, the importance of emotional components of care work is evident in this sector also. The findings relating to live-in care workers corroborate some of the existing literature, which suggests that a blurring of the boundaries between work and personal relationships can lead to exploitation. Previous research has focused predominantly on relationships in the domiciliary care sector; our findings suggest that the paucity of research on relationships in *institutional* care settings is a significant gap in the literature.

Our findings indicate that further research on the affective components of care work in formal paid care relationships is warranted. The intimate nature of care work means that unlike other jobs, personal attributes of the employee (the carer) play an important role in the perceived quality of care from the perspective of the care recipient (Samuelsson, 2000). Many of the interviewees described themselves as altruistic, compassionate and

trusting. Further research needs to explore the interpretations and impact of these traits among the care workforce. Researchers also need to explore further the growing contradictions between normative understandings of care as something private and the contemporary reality of an expanding formal (migrant) care workforce, a development which in many instances is explicitly or implicitly encouraged by long-term care policies.

A criticism that can be levelled at our research is that we have only explored one aspect of the long-term care system. Further studies need to look at the totality of the long-term care system, and explore the experiences of larger representative samples drawn from the formal care workforce as well as the experiences of care recipients and family members. Otherwise there is a danger that research will reveal a one-sided picture of a complex issue; as Seysmith (1998: 232) argues, 'Both the diversity and the continuity of caring in women's lives become obscured as academic disciplines delineate specialized area of interest for detailed examination and/or social policies and services are restricted to specific population groups.' In future studies, attention needs to be given to the intersections of gender, class and ethnicity and the importance of emotional labour in the long-term care sector. Care work is interactive in nature, and cannot be depersonalized. Researchers and policy-makers need to gain a better understanding of both the affective components of formal care work and the relationships within care workplaces if the well-being of family members, care recipients and (migrant or non-migrant) care workers is to be increased.

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