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ARTICLE

More than a visitor? Rethinking metaphors for family care in long-term care homes

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Abstract
Recent public and policy interventions aim to recognise formally the contributions of family care-givers to long-term residential care in Canada, with some arguing family carers are more than visitors and should be recognised as essential care-givers. These developments call for reconsidering how family care roles are understood and operationalised. Drawing on ethnographic research conducted in three care homes in Ontario, Canada, we present an in-depth feminist rhetorical analysis of the narrated lives and work practices of 12 unpaid family carers. Specifically, we explore how unpaid family carers themselves draw on broader discursive 'ruling metaphors' to interpret their roles and activities (*e.g.* as essential care-givers, visitors, team members), and how these metaphors invoke, organise and/or give rise to particular practices, responsibilities and relations. We contrast the stories of a family member who positioned herself as an essential care-giver and expressed a more onerous sense of individual responsibility with the stories of people who enjoyed the pleasures of visiting, who contributed as team members in ways that went beyond caring for their own relatives' care needs, and who embraced the possibilities that came with volunteering and with being able to influence change. Our analysis situates and contextualises participants' stories of their involvement and unpaid work in relation to their everyday material conditions and circumstances. We elaborate how different ways of understanding caring roles shape the nature of carers' unpaid work, as well as their options to share responsibility or set limits on that work. We also raise questions about the organisational conditions needed to help enact care as a shared collective responsibility.

Keywords: family care; feminist care scholarship; long-term residential care; unpaid work; volunteering

Introduction

There has long been an awareness of family carers' role in facilitating care for older adults, and of how their unpaid work is connected to the restructuring, deregulation and reduction of public services (Skinner, 2008; Joseph and Skinner, 2012;

Barken *et al.*, 2016). Across Canada, long-term residential care (LTRC) facilities rely heavily on the unpaid work of family/friend carers and volunteers, which we understand as a subtle form of privatisation (Armstrong and Armstrong, 2019). This phenomenon has been illuminated through the unfortunate and unintended effects of visitor restrictions in LTRC in many Canadian provinces during the COVID-19 pandemic, and has also been an issue globally (Chu *et al.*, 2021; Hugelius *et al.*, 2021). In 2020, a military report detailed inadequate care, neglect and examples of abuse in private Ontario LTRC homes (Mialkowski, 2020). In response, considerable public attention and advocacy has pushed to recognise formally the contributions of family/friend carers within congregate care settings. Advocates have argued that family carers are more than 'idle' visitors, and should be understood as designated and essential care partners (*see* Drury, as interviewed by CBC Radio, 2020). Such calls respond to urgent needs for even basic care in these settings. This advocacy has been prominent in the province of Ontario, which passed the 'More than a Visitor Act', as well as nationally with groups petitioning to recognise that 'family caregivers are more than just visitors' (Canadian Hospice Palliative Care Association, 2020).

Growing attention to the concept of essential care-givers in Canada calls for considering how this concept and other terms used to characterise unpaid family care work operate as 'ruling metaphors' (Braedley, 2018*a*), structuring how we make sense of things, what work we do, and how we relate to ourselves and others. While advocates and professionals often invoke the terms 'care-giver' or 'carer' to facilitate access to formal supports and programmes, there have also been targeted critiques of these terms for invoking unidirectional and altruistic support, being polarising, and not reflecting how people see themselves and their roles and relationships (*e.g.* Molyneaux *et al.*, 2011). Indeed, the concept of care-giver seems to supplant other terms preferred by many such as those associated with the nature of kin or spousal relationship or friendship (*see* Funk, 2019). Some argue in favour of the term 'care partner', as a way to recognise the agency of people who need care (*see* Bennett *et al.*, 2017). Others push for terms that help counter the strong hold of gendered familial ideologies, opening up possibilities for further mobilising unpaid family/friends in broad cross-sectoral movements to create structural changes in the care sector (Levitsky, 2014).

This article makes three interrelated contributions. First, we analyse the possibilities and limits of particular ruling metaphors of family care (*e.g.* essential care-givers), as they might invoke, organise and/or give rise to particular practices, relationships, responsibilities and orientations to work. In doing so, we consider the implications of particular role framings for broader collective action around care as well as for carers' rights and choices not only about being involved but also about setting limits, saying 'no' or stepping back. Second, we trace the range of unpaid work that family carers do by exploring both how unpaid family carers themselves draw on broader discursive 'ruling metaphors' (Braedley, 2018*a*, 2018*b*) to interpret their roles and activities, and how carers inhabit and at times renegotiate their caring roles in these settings. Third, we explicate forms of social organisation in LTRC, including intimate and extended relations that organise boundaries between paid and unpaid work. We raise questions about the organisational conditions needed to help enact care as a shared collective responsibility or to support carers in being able to advocate, share responsibility with others, or make choices about the level or range of care they provide (or not). We ask: How can we promote conditions that support people in enacting relationships that are consensual for all involved? What metaphors or meanings of family care roles, and what ways of inhabiting or enacting them, might support people in being able to 'let go', share responsibility or lean on others?

Such a line of inquiry is motivated by our recognition both of the importance of choice for unpaid carers in the amount, type and limits of their work and circumstances under which they provide care, as well as their ability to exit or cease care and to mitigate risks for their wellbeing (Herd and Harrington Meyer, 2002; Funk *et al.*, 2020; Klostermann, 2021). It is also motivated by our recognition that dominant ways of caring intersect with organisational relations and care constraints within LTRC settings to pose challenges in these regards. We contribute to feminist research that moves beyond a focus on recruiting and retaining workers, and beyond helping carers to cope with their roles, to consider the right of carers not to care (Klostermann, 2021; *see also* Armstrong and Klostermann, 2023). This is an important consideration, particularly since care relationships can be oppressive, burdensome and even unsafe, when carers do not have options to step back (Klostermann, 2021).

Drawing on ethnographic research in three LTRC facilities in Ontario, Canada, we present narrative portraits of a subgroup of unpaid carers, selected for how their stories prompt us to think about different metaphors for family care. To begin, we provide a brief introduction to Ontario's LTRC sector, survey existing research on unpaid carers' roles and responsibilities in LTRC, and introduce our feminist theoretical and methodological approach that offers a generative way to explore concepts/metaphors, while accounting for the critical role of everyday material conditions, histories and relationships.

Locating LTRC

In Canada and other welfare states, facility-based care homes (also known as LTRC homes or 'nursing' homes) are a vital part of social infrastructure, providing live-in, 24-hour support and accommodation to people whose care needs extend beyond that which can be provided in the community. A recent report by the Royal Society of Canada notes, 'For the many older Canadians who will need this high level of care, a nursing home is a good choice *if we do it right*' – that is, being able to 'consistently deliver high-quality and holistic care and support a good quality of life, a good end of life and a good death' (Estabrooks *et al.*, 2020: 6). Currently, however, LTRC is an increasingly precarious sector that employs a workforce of mostly women, including racialised, immigrant women (International Labour Organization, 2018; Das Gupta, 2020). During the COVID-19 pandemic, reports and public commentaries highlighted innumerable crises within LTRC that are connected to diminished public-sector supports. The restructuring and devaluation of this care sector, including but not limited to the Canadian province of Ontario, contributes to intersubjective tensions and scandals (Banerjee *et al.*, 2012; Lloyd, 2014; Funk *et al.*, 2020). Paid care workers and unpaid carers alike are exposed to physical and psychological hazards (Braedley *et al.*, 2018; Grey *et al.*, 2018). Increasingly, we hear stories of acute staffing shortages, of care facilities that are closing or unable to open, of inadequate care levels or long waiting lists for care, of escalating violence, accident and injury rates, and of high death rates in care homes (Grigorovich and Kontos, 2020; Gil, 2022); all of which are highly gendered, considering the majority of residents and workers are women.

LTRC is considered non-medical/non-hospital, and thus public funding is not guaranteed under the Canada Health Act. Nonetheless, Canadian provinces and territories each provide some public funding for these facilities, accompanied by oversight and regulation through accreditation. While facilities operate either on a for-profit or not-for-profit basis, other ways of privatising care have generally been increasing over time (Armstrong and Armstrong, 2019; Marier, 2021). In this regard, Müller (2019) documents how some elements of care work are relegated to the private sphere, which she frames as a condition of capitalism that has real impacts on those providing and accessing care. The creep of neoliberal agendas and forms of privatisation in LTRC have marginalised and limited social aspects of care and increased reliance on unpaid care (Barken and Armstrong, 2019). The delivery of public services relies on the voluntary sector, as well as on communities, households and individuals, which is a form of privatisation (Armstrong and Armstrong, 2019). Further, staffing has generally not kept pace with these increased needs for complex care with a changing resident population (Rosen, 2021; *see also* Manitoba Nurses' Union, 2018). In turn, some well-resourced families have turned to hiring paid companions or supplemental private care (Daly and Armstrong, 2016), and facilities have often sought to develop their volunteer base (Funk and Roger, 2017).

Ontario offers a fitting case study with applications to other contexts (*see* Miller and Barrie 2022; Leontowitsch *et al.*, 2021). Tensions in LTRC are also evident internationally, with studies linking tensions or even scandals to the dangers of privatisation or inadequate public-sector supports (Lloyd, 2014; Lopes, 2016; Armstrong and Armstrong, 2019) or to ageism and other forms and relations of oppression (Jönson, 2016; Faghanipour *et al.*, 2020).

Existing research relevant to family carers' roles and contributions in LTRC

Just as LTRC plays a vital role in social and political life, forms of paid and unpaid care work have tremendous economic, social and political value (Folbre *et al.*, 2021; Klostermann *et al.*, 2022). We engage with, and aim to contribute to, research and thinking on the unpaid contributions of family carers, on the ways family carers understand and orient to their roles, and on the ways the 'choices' of family carers can be constrained.

Many now recognise the important unpaid contributions that family carers, who are mostly women, make to LTRC. Research identifies the variety of unpaid work that family and friends continue in these settings. Although the broader concept of family involvement is increasingly welcomed in rhetoric or in principle for enhancing quality of resident care (Hovenga *et al.*, 2022), family members have traditionally been understood as transitioning away from the daily burdens of 'hands-on' forms of care towards other (*e.g.* emotional) forms of support. Assumptions that family carers return to their 'previous' role identities as wives, daughters, friends or so on after a LTRC transition still arguably underpin not only the perspectives of many facility staff, but also government policies which restrict access to family/friend care-giver benefits or similar supports after a person moves into LTRC.

In a classic paper, Twigg (1989) exposed important contradictions within existing policy in the United Kingdom, highlighting how social care agencies tended to conceptualise informal carers not only as clients (*i.e.* when the goal is to intervene to relieve carer strain), but also as resources for the delivery of care and/or co-workers (*i.e.* co-operative relationship). Similar contradictions manifest in the current political and economic context of LTRC. Barken and Armstrong (2019) found families increasingly feel compelled to take responsibility for care yet are still viewed by many staff primarily as 'visitors', 'interlopers' or recipients of care themselves in these settings (*see also* Baumbusch and Phinney, 2014). Similar patterns have also been noted with respect to LTRC volunteers, who tend to be even more restricted in their formal roles, contributing to feelings of being unable to address care gaps (Funk and Roger, 2017; Sangild Stølen, 2021). Although research highlights some family members' feelings of powerlessness and alienation, as well as tensions with staff, in reaction to these expectations (Hertzberg and Ekman, 2000; Ryan and Scullion, 2000; Hennings *et al.*, 2013; Holmgren *et al.*, 2013, 2014), we should not necessarily conclude that family have homogenous preferences for a uniform kind of role in LTRC.

The contributions of critical Canadian scholars have emphasised how patterns of expectations and unpaid work are shifting in the context of increasing human and financial resource constraints in LTRC (Baumbusch and Phinney, 2014; Barken *et al.*, 2016; Puurveen *et al.*, 2018; Armstrong and Klostermann, 2023; Streeter, 2023). Family carers' work often goes beyond supporting their own relatives to include supporting other residents, advocating and contributing to the running of LTRC facilities (Barken *et al.*, 2016; Puurveen *et al.*, 2018). Bereaved family members also at times continue as volunteers after resident deaths, further blurring the distinctions between 'family member' and 'volunteer' in these settings (Funk and Roger, 2017). In these and other ways, unpaid labour that is typically performed in the private household extends into what was previously or is often conceived as a public site of paid care work. As noted, the importance of family carers' high levels of involvement in hands-on care work in LTRC was starkly evident with its absence during the pandemic (Coe and Werner, 2022). The pandemic also gave moral and political weight to the metaphor of the essential care-giver, which can be contrasted against what tends to be viewed as an arguably more peripheral 'visitor' role.

We contribute to Canadian and international research that has examined the contradictory ways that family carers understand themselves and are understood by others, including with attention to choice and to the structuring role of kinship and power relations in this regard (Dupuis and Norris, 2001; Davies and Nolan, 2006; Lloyd, 2006; Hennings *et al.*, 2013; Holmgren *et al.*, 2013, 2014). For instance, family care work is often viewed as unskilled and as the natural responsibility of women who will do it for free (Armstrong, 2013). Some research also highlights the agentic, interpretive or rhetorical *positioning work* in which care-givers engage, including the fluidity and situational contingency of care-giver self-identification processes (O'Connor, 2007; Stajduhar *et al.*, 2008; Morgan *et al.*, 2021).

We also follow scholars in looking both at family carers' choices and at the ways they are constrained (*see* Aronson and Neysmith, 1997). Pointing to family relationships, life histories, gendered and cultural expectations, and diminishing public care resources, scholars raise questions about the extent to which family carers' unpaid work is entirely voluntary, including whether family carers have options to say 'no', set limits or step back (Funk, 2015; Klostermann, 2021). Indeed, even the notion of choice in 'volunteering' has been problematised, as women often volunteer in unpaid care when they lack labour market opportunities (Overgaard, 2019). Further, coercions into care are often about a lack of alternatives, and are shaped through political and economic relations (Glenn, 2010; *see also* Aronson, 1992; Rozanova *et al.*, 2012). In LTRC, Barken and Armstrong (2019: 216) explore limits to family members' autonomy, including their ability 'to decide if and how they want to participate'. Taken together, this scholarship suggests broader gendered norms, expectations and inequitable distributions of caring labour shape dominant interpretations and performances of unpaid care in LTRC (Holmgren *et al.*, 2014).

In this article, we extend knowledge on family care by exploring how the unpaid work that family carers do, and the range of ways they understand and inhabit their caring roles, are shaped through, and contribute to reshaping, the embodied organisational relations of care homes. In our analysis, we conceptualise family carers' advocacy[1] work as itself a form of unpaid work, and we elaborate how family carers' differential positions shape the unpaid work they do in these poorly resourced settings.

Examining 'ruling metaphors' using a feminist rhetorical approach

In this article, we mobilise a feminist rhetorical approach that analyses narrated examples of unpaid work as well as carers' rhetorical (social) practices in research-related conversations (Klostermann, 2019, 2021). With a focus on how participants express or draw on ruling metaphors of family care, we are inspired by Braedley (2018*a*), who extends the work of Smith (1999: 49) to examine 'ruling metaphors' for nursing homes (hospitals, homes or hotels) as manifestations of forms of ruling relations or social organisation which shape people's 'assumptions, vocabularies and ways of knowing the world'. In the present study, we expand this sensitising concept of ruling metaphors to look at the embodiment of interpretations in practice, considering how forms of social organisation in LTRC shape imagined possibilities around unpaid family care. Recognising that social and material relations can shape available forms of subjectivity, agency and imagined possibilities (Hallenbeck, 2012; Braedley, 2018*a*), we attend to language in use and to rhetorical activities as they are shaped through, and potentially reshape, the social and material relations of our lives (*see* White-Farnham *et al.*, 2019).

Looking at how people talk about orienting to and 'inhabiting' particular roles helps us to explicate intimate and extended relations of power, including those that organise boundaries between paid and unpaid work. The word 'inhabiting' calls to mind embodied practices of dwelling in, living in or residing. In later stages of our analysis, mobilising the term as a sociological concept helped us to account for how people make choices as they evoke particular metaphors and enact particular roles and relations, with different ways of engaging, participating and even negotiating. It also gave us a way to analyse conditions shaping how or whether family carers engage for a time, indefinitely or with options to move on. The concept of inhabiting calls to mind being able to leave, as well as being able to enter to begin with, which is another important consideration with recent news of carers fighting for access to care homes (Nicholson, 2022).

The project: rapid, team-based ethnographies in Ontario care homes

This analysis draws on team-based, rapid, site-switching ethnographic research conducted at three non-profit, municipal and unionised care facilities in central and eastern Ontario (a large Canadian province), prior to the COVID-19 pandemic (for additional details on sampling and recruitment, *see* Baines and Cunningham, 2013; Armstrong and Lowndes, 2018; Doucet and Armstrong, 2021). The research was conducted as part of Pat Armstrong's 'Changing Places: Unpaid Work in Public Spaces' study, a broader project examining the social organisation of paid and unpaid work in LTRC. Through ethnographic research, the team (including JK) conducted participant observations and 68 semi-structured interviews. Interview participants included ten care home residents, 12 family members, 22 staff members in different roles (*e.g.* care aides, nurses, recreational therapists), 15 managers or administrators, eight volunteers and one private companion. Located in Ontario, the three municipal facilities included one urban facility (with approximately 450 long-term care beds), one rural facility (with approximately 70 beds) and one in a mid-size city (with approximately 250 beds). In all three homes, the team heard reports of staffing shortages or of workers 'working short'. We also learned about promising practices with examples of things going well (*see also* Barken and Lowndes, 2018).

The project was approved by York University's Research Ethics Board, and involved developing and applying a collaborative, team-based 'ethical research praxis' that extended beyond the formal review process (*see* Braedley, 2018*b*). This relational, feminist approach involved teamwork, continuous learning and democratic decision-making (*see* Doucet and Armstrong, 2021). To navigate the specific ethical conditions relevant to research with long-term care residents, the team interviewed residents and family carers together or individually depending on their preferences and capacities to give informed consent. The team's collaborative work also provided built-in accountability and support, as well as space to discuss ethical issues before conducting research, at each site, and in team meetings that followed. Pseudonyms are used below. It is also worth noting that the team opted not to collect demographic information during interviews.

In the three sites, recruitment involved visiting the facilities to distribute posters and brochures and to tell people about the study (including at two family council meetings). From there, site visits at each facility lasted for three days with the interdisciplinary research team covering different shifts from 7 am to 12 pm daily. The interviews with informal care providers (from which our subsample was drawn) were semi-structured and lasted approximately one hour, with questions focusing on participants' relationships with others, involvement in the care home and any unpaid support they provided. As part of the primary data collection and analysis process, the team recorded detailed field notes and analytical memos (Emerson *et al.*, 2011) and worked collaboratively to analyse materials and to reflect on early findings, engaging in the feminist work of situating and contextualising people's everyday work within the organisational relations of Ontario's LTRC sector. Sharing our initial observations and works in progress helped to ensure research trustworthiness, and to reflect on the contextual specificities of care in these particular homes. This also helped us with identifying emergent metaphors, as our conversations often drew on and expressed circulating narratives about family members as visitors, essential care-givers or team members with cultural representations or stories we had access to such as in Canadian news media.

In this particular qualitative analysis, we applied feminist rhetorical and narrative analysis tools to explore how the 12 family carers in particular framed their roles, and engaged in rhetorical work in interviews, which helped to reveal circulating narratives or discourses (Funk *et al.*, 2019; Klostermann, 2021). We also analysed observational field notes, considering how family carers enacted particular role metaphors in the everyday routines within the facilities. Following Smith (2005), our goal was not to generate codes or key themes, but instead to index a range of unpaid work (including rhetorical work, advocacy and other tasks), as it is institutionally mediated, and shaped by broader gender and intersectional inequities (*see also* Klostermann, 2019). This involved going through and labelling people's practices that they told us about (such as shopping), and that we witnessed through our fieldwork (such as joking around or connecting with others) or in the space of our conversations (such as hedging or laughing). We identified examples that offered a clear sense of how participants invoked or enacted metaphors of family care.

Findings: inhabited roles and relations of family care

In what follows, we consider the possibilities and limits of particular metaphors, trace the range of ways that family carers interpret, inhabit and negotiate caring roles and relationships, and explicate how local dynamics of unpaid care work are shaped through embodied material relations (*e.g.* in relation to people's care needs and to socially mediated 'care shortages'). To start, we elaborate the breadth of family carers' contributions, with an emphasis on gendered dimensions of this work. From there, we present our analysis of ruling metaphors of family care. In doing so, we examine how people told stories of their positioning in care roles and relations, and how they engaged in rhetorical work to position themselves in particular ways in conversations.

Family members' co-ordinated work in LTRC

In Ontario-based care homes, families provided a range of personal, social and co-ordinative support for their own relatives; they contributed to the running of these facilities and advocated for change therein. Family carers described supporting with the initial transition into the facility (doing paperwork, moving, setting up rooms), helping with basic activities (eating, bathing, dressing) and instrumental activities (supporting with laundry, meal preparation, shopping, banking) of daily living, supporting health (*e.g.* assisting with walking, physical therapy and medical appointments, monitoring and/or responding to changes, attending training), and facilitating residents' participation in activities internal to the facility (accompanying to on-site choir, bingo, *etc.*). It was also common for families to pay out-of-pocket for care supplies or for residents' hair or nail care. Some also hired privately paid companions to be with their family members full- or part-time, an option only available to those with economic resources.

While paid care workers' job descriptions see them providing task-based body care, some family carers detailed more relational work of visiting and sharing stories, celebrating holidays, supporting their family members' emotional or spiritual wellbeing, and connecting residents to their lives and identities outside the facility such as by organising and accompanying them on outings. Family carers talked about bringing in coffee and doughnuts, or wine and cheese. Some hosted movie nights or brought in photos or photo books. Family carers also spoke of organising or setting up schedules for their other family members to visit or assist with care work.

By helping to provide care and to maintain their family member's wellbeing, family carers were supporting the operation of the LTRC facility. In addition, participants spoke of additional unpaid work targeted at supporting the facility at a broader level, such as by assisting residents other than their own family member (*e.g.* portering residents to and from meals, putting on bibs, helping to serve dinner). They monitored other residents' physical needs and raised concerns about safety. Some described mopping floors, making beds, watering plants, socialising with residents and staff, co-ordinating and hosting events, and organising fundraisers to raise money for the facility (including to buy medical equipment).

Families' advocacy work in LTRC functions at different levels. Some reported seeking help for their relatives or other residents when call bells were not answered, ensuring residents have appropriate medications, and calling upon the government to increase funding for LTRC and fight privatisation. In one facility, family council members told us they had advocated to cancel the corporate food contract, successfully bringing the food services back in house. Individually, families supported residents on the units, around the facility and collectively, through family councils. For example, one woman took pride in the 'good things that they had done' as part of the family council, including creating community space. Some participants raised concerns about staffing shortages or about organisational policies. In one home, family carers' complaints about intake processes led them to develop a 'transitions volunteer' programme to have family carers/volunteers accompany residents and families on their day of arrival.

Importantly, family carers' unpaid work is shaped through gendered relations of LTRC that distribute certain forms of work to some more than others, while shaping carers' interpretations of the meaning and value of their contributions. Work in LTRC is highly gendered, considering the majority of residents and workers are women. In our research, the majority of family carers were women who expressed feeling responsible as daughters and wives. That said, it is also notable that not all participants enacted or understood their roles in conventionally feminine ways. Margit, a family carer whom we will introduce below, said, 'I'm told I'm the most regular on that floor (laughter). I don't know, do I get a star at the end? What happens when that – do I get a star? (laughter).' Similarly, when asked whether she finds caring for others rewarding, Betty, another family carer, responded, 'Well, I never wanted to be a nurse, I'll tell you that.' As we further illustrate below, family carers made choices as they negotiated their work and relationships.

Ruling metaphors of family care

In analysing family carers' work in LTRC, we identified three emergent metaphors of note: essential care-giver, visitor and team member. We start by looking at some constraints experienced by a woman as she inhabited the 'essential care-giver' role, before looking at the possibilities and limits experienced by carers inhabiting the roles of visitors, team members and advocates. While carers did not always position themselves fully within one role or metaphor, what was striking was that different metaphors seemed to invite different practices or orientations, as well as different possibilities and limits for understanding and enacting care, including, for instance, care as a collective, interdependent endeavour.

'He only has us': essential care-giver metaphor

The term 'essential care-giver' has gained visibility more recently in Canada by care-giver advocate groups seeking to reinstate family members' access to LTRC and other institutional settings during the pandemic. As a metaphor, essential care-giver denotes the importance of family care provision, expresses dyadic relationships to individual family members (with carers positioned as part of a pair or in relation to that person), and evokes certain expectations and responsibilities. These dynamics are evident in the story of Josie. Josie supported her brother Mark, who had been diagnosed with dementia, and who had moved into a rural facility a few months prior. She mentioned that she had supported him most days from 10 am to 3 pm daily since he moved in. Before that, Josie and her sister had been providing direct daily support to Mark in his apartment over the last four years. She expressed that she and her sister knew that Mark 'needed 24-hour care' when he 'couldn't even make a cup of coffee' using a Keurig machine.

'But that's me' was a refrain throughout Josie's story as she strongly identified as a care-giver and expressed caring out of a sense of obligation. She said that she took responsibility for 'mother[ing]' Mark when their mother passed away, which Josie believed was her 'mom's wish' since Mark 'didn't have a wife'. As Josie put it, 'he only has us'. Josie expressed surprise at how much support Mark still required after moving into LTRC. She said that some may 'think because he's in a home and looked after, it's okay if you only come once a month', but she emphasised that the nature of Mark's condition meant that he still required a lot of support and overseeing. As she said, 'I still have to sort of take care of him and take him out and say, "can you put on shoes?" or "sit here".' Josie talked about monitoring Mark's physical needs or concerns about safety, responding to his emotional and spiritual concerns (including with conflicts with residents and with his fears about mortality), providing social support (such as by taking him for coffee or on outings), and advocating or complaining to hold staff accountable. Josie said, 'I need to be here to see changes.'

Josie focused relatively less on her sense of enjoyment, the quality of their connection or on Mark's own contributions. Her stories suggested a one-way flow of care from her to Mark, without a sense of shared learning or connection. Josie at one point compared the thought of abandoning Mark to 'bringing [her] dog in to get fixed and just dropping him off and you feel bad 'cause you're not there – they're alone'. For Josie, Mark's declining cognition meant he was 'not the same person' as he once was, and she referred to certain behaviours (like him trying to leave the car while she was driving) as 'like playing mind games'. From a disability perspective (Barken and Martino, 2020), her limited imagination for care or disability relations is apparent. That said, our point is not to pass judgement on her approach, but to instead note that the way she came to inhabit the role – with such a sense of individualised responsibility – seemed to close off opportunities for her to connect in fuller ways, trust in others or share responsibility.

Rooted in guilt and a sense of responsibility, and as part of a pair with her brother, Josie's advocacy seemed to focus on getting Mark's own intimate needs met, with relatively less focus on the needs of other residents. For instance, she shared about individual issues pertaining to his care and about wanting to ensure he could sit with residents with the same 'mental capacity' or same ability to participate in conversations. Directing her attention to her brother's individual care needs, Josie at times conceptualised other residents or staff as the problem. Josie herself even seemed to acknowledge the potential narrowness of her concerns: 'Maybe it's just 'cause he's my brother and I know him so well … I don't know if I'm just biased because it's him and I'm wanting the best for him.'

Josie's story raises questions about the conditions needed to help enact care as a shared collective responsibility, trusting in others to notice and respond to one's care needs. While her sister helped out and care home staff also provided her brother's care, Josie expressed a clear sense of individual responsibility. With its emphasis on being essential to one person, the essential care-giver metaphor seems to inadvertently serve to limit options for women to consent, say 'no' or share responsibility within a broader collective. Josie seemed to express having limited options to express her own needs or to enable her to set limits on the care she was providing. Josie referred to having to resist the urge to tell Mark they were 'just sticking [him]' in the facility because the care required of them was too great. As she said, 'We always tried to make sure we never said "oh, we were so tired, I can't".' She also noted that she felt guilty and unable to step back, as to do so would be to abandon him or treat him as less than human. Such a limited way of conceptualising her care role had implications for her ability to set limits or trust others to support him; it was also closely tied to the institutional structures of care (and her understanding of them).

This metaphor, as it was enacted by Josie, draws on, stems from and further reinforces a sense of obligation and feeling like the only one available. In the case above, Josie's sense of being essential was underpinned by her lack of trust that others would pick up the slack. Moreover, backed by familial ideals (*see* Levitsky, 2014), Josie's advocacy was primarily about one resident, with less concern about others, which speaks to the way that being essential to someone, or turned right in on them, may limit other ways of seeing, noticing or situating. With that, it is also worth considering how to promote choice or recognise the skills family carers bring or desires they may have to provide and be involved in all aspects of direct daily care, without tethering them to the work indefinitely.

‘Even if it’s only for five minutes’: the visitor metaphor

Despite existing critiques of the ‘visitor’ metaphor that have amplified during the COVID-19 pandemic, in both interviews and observations in LTRC facilities, the team heard and witnessed several examples of carers embracing that position. Some family members described the pleasures and rewards of visiting, reading, going for walks, going on outings, accompanying relatives to special events, sneaking in pizza, beer or other treats, or spending time with their relatives, other residents and staff. In one home, JK met a family carer, Karen, along with Karen’s mother, Helen (a resident) and their friend Lou (another resident). Karen affectionately introduced Lou as the ‘den mother’, saying that Lou ‘keeps tabs’ on her mother, and ‘let’s [her] know how she’s doing’. They shared that Lou (resident) won ten dollars in bingo and insisted on using it to treat Karen to lunch when she came. Karen also talked about hosting Lou at her house for Christmas dinner this past year. Karen jokingly said, ‘I kept asking her, and she finally said yes.’ Lou also shared that Karen had bought a sweater for her. For participants such as Karen, there was nothing wrong with being a visitor. Two examples below provide additional illustrations.

Margit, a woman from eastern Europe, shared stories about the pleasures of visiting Vince, her husband of 51 years who was a resident with dementia. She was one of several carers who mentioned that moving into LTRC was a relief, as prior to that she was unable to stop worrying about his health, safety and wellbeing at home, especially as he tended to leave the house to go out on to the street. Margit said, ‘It became increasingly clear that I couldn’t look after him. He wandered out. He wouldn’t take his medication. It was just – I couldn’t, couldn’t really handle it.’ Margit talked about dropping into the facility daily, ‘even if it’s only for five minutes’. In speaking of enjoying visiting, she described bringing in pizza and non-alchoholic beer to share with Vince in the garden. She added:

> And when I come in, I hug him all the time. The nurses get embarrassed. I hold his hand. I hug him. I kiss him. And they kind of get embarrassed but I don’t care. My only job is to make sure he knows he is loved and to know he is cared for.

Margit’s engagement as a visitor had clear links to material conditions of care, including the nature of Vince’s condition, that seemed to underpin her orientation to her role. She shared that it was hard for her to connect with Vince for longer periods of time. This was in part because he was constantly walking the halls, and her knee troubles meant she could not walk with him. She also noted his cognition, which had ‘worsened’ over time, had shaped her involvement. She said, ‘he still knows me but it’s for an instant, it’s a flicker of recognition’ on his part. Margit also mentioned that due to his constant walking, Vince was assigned a one-to-one behaviour support worker who provided eight hours of support daily (provided by the municipal facility). Although Margit mentioned several times that she enjoys showing affection to Vince and updating him about her life, she ultimately relied on, and generally trusted, staff for his direct daily care. Moreover, Margit did not get involved with the care of other residents or attend family council meetings (which conflicted with her bridge club).

The evolving nature of Vince’s care needs, as well as the high level of support provided to Vince in the facility, shaped Margit’s interpretation and enactment of her role, as well as her subsequent advocacy efforts. Although she did share one complaint in the interview ('I do worry about him when I see him unshaven'), she framed herself as having a fairly easygoing and hands-off approach to advocating for Vince, which perhaps also offered a way to avoid appearing to be over-bearing or making trouble. Margit made light of and downplayed her advocacy in imitating herself lecturing staff, saying, 'blah blah blah'. She seemed to foreground her relational connection with staff, and spoke of bonding with workers. In Margit's story, caring about Vince did not equate to providing all aspects of direct daily care for him. She seemed to have a choice in the nature of her involvement, and did not express feeling overly burdened by navigational, advocacy or other forms of care work in the facility. Instead, as noted, she reminisced about visiting and dropping in, 'even if it's only for five minutes'.

A final example of enjoyment in visiting was observed at a bingo match at an urban care home. Four residents sat with one privately paid companion, Fanny (supporting a resident named Ralph) and a family member, Catherine (Richard's wife). Throughout the game, Fanny and Catherine were quick to engage with the other two residents at the table, asking about their day, where (in the large 450-bed home) they live or how full their cards were. Catherine pointed to a number to show Richard which one was called and then moved the card down to him. She held the card in front of Richard, slowing down to point and pausing to let him in on it. Along the way he made eye contact and smiled at her. When JK asked if they split the money since they play together, Fanny laughed and said, 'no'. She also said, 'We're not allowed to play without our guys; they get us in the game so we're grateful.' Catherine was also smiling and laughing throughout the game, at one point even affectionately teasing Fanny for taking an interest in her husband. They all laughed along and spoke with great affection. Fanny even stayed to finish the game with others after Ralph had fallen asleep, and throughout the game, Catherine interjected with humorous, light-hearted comments. 'Race ya!' she said to another resident (when they were both two numbers away from a full card). Catherine, like Fanny, seemed to derive pleasure or meaning from what might be perceived as more of a social hangout or visit. There was joy in visiting.

In the promising examples above, we can see how visiting as a way of orienting to care implicitly involved relational care or having a sense of shared responsibility for care, with paid care workers handling the direct daily care. What we glean above is that the visitor role might at times reflect and reinforce a sense of choice, trust in staff and enjoyment. Tentatively, we might also consider whether such a metaphor may be associated with more social or humanising forms of interaction with residents, if not focused on responding to care needs or providing essential services. That said, it also may limit the nature of family carers' advocacy, perhaps without people building up knowledge of the running of the facility to be able to push for change.

'Most people think I do work here': team member metaphor

In one facility, when a housekeeper passed by, a family member yelled to her, 'Should I water her plants?' to which the housekeeper responded nonchalantly and without stopping, 'I watered them yesterday.' Watching such choreographed care play out prompts us to think further about family carers' contributions. Indeed, 'part of the team' was an expression used by some family carer participants (like Betty, below) to describe not only their work supporting their own family members, but also supporting other residents and contributing to the running of the care home. In this way, the metaphor of 'team member' seems to signal the skills and expertise of family carers while recognising contributions that extend beyond 'their' individual residents, thereby invoking a sense of interdependent or solidaristic relationships with a variety of others in the facility, including staff. While the metaphor has not gained traction publicly, it does align with how some participants framed and interpreted their roles. Several family carers insisted they were not 'watching over' staff, but had good rapport and were working together as part of a team.

Betty, an 86-year-old Indigenous woman, arrived to the interview with handwritten notes about her involvement. She talked about a life immersed in the everyday care of her husband Walter and other residents. She had moved within walking distance of the urban facility, and described working daily there – covering two shifts – to support her husband and other residents (including a resident who needed help with meals), from 11 am to 7 pm daily. She also volunteered on the admissions committee and on the family council. Expressing her complete immersion into the daily life of the facility, Betty stated, 'Most people think I do work here.' Hamming it up, she re-enacted a staff member asking her, 'how was your weekend?', to which she replied sarcastically, 'What's that? What's a weekend?' Much like Josie above, Betty referenced caring out of 'loyalty and bonding' and expressed feeling guilty if she did not come in. Indeed, responsibilities tied to caring identities and concern for the wellbeing of others (including staff) can create conditions that make it difficult for individual family carers to limit or scale back their unpaid work commitments that develop over time, especially in the under-resourced conditions of LTRC.

Betty's own complaints and advocacy work were linked to concerns for both residents and staff in the context of care shortages. Positioning herself as part of the team, Betty understood that if a care aide was checking on her husband Walter, it meant they were not checking on someone else. She was concerned about Walter's individual needs, but not only with his needs. The examples of advocacy that she shared centred on confronting organisational problems, and looking out for others on the floor. She said, 'You'll hear the workers saying to [residents], you know, "I'll be right back. I have to go see so and so." [Residents] will say, "Well that's what you always say; you never come back" (laughs).' Betty recognised this problem as a matter of work organisation and staffing shortages. In speaking of trying to push for changes on the floor, she said:

> You have to think carefully when you want to broach these things. You can't be barging in, you know, a typical bull in a china shop, because it's not going to accomplish anything. People are just going to become defensive and arm themselves.

Betty (now retired) also had previous professional experience in government and with policy, which informed her approach to advocacy. Her deep engagement in the care home, along with her background in social policy and her access to critical discourses about work organisation shaped her advocacy work. She referenced organisational policies that see workers checking on residents every hour. She also indicated her awareness of what was going on and why, her dissatisfaction with the lack of formal support her husband was receiving, and her careful consideration of how to broach it. Betty's nuanced strategies for advocating included gathering information 'at the ground level', analysing why particular policies are not working and identifying ways to fix policies. Betty distinguished her assertive approach from other members of the family council, noting that she does not view her role as entailing being 'friends with the CEO'.

The way Betty positioned herself seemed to create space for her to help make changes in the facility that went beyond supporting her husband. Her struggles 'bumbling around' and trying to 'find out how this whole business [works]' when Walter first moved in led her to collaborate with others on the family council to transform the intake and admissions processes for other residents, and to serve as a transitions volunteer, accompanying residents and families on their day of arrival. Albeit a form of further unpaid work for Betty, it was also an example of how being part of the team or taking responsibility in a broader way can help to reshape the social relations of LTRC. Her scope of work went beyond visiting and beyond providing essential care to a particular person.

In Betty's story we see a more active attending to interdependence and the collective, a recognition and application of her own skills/expertise, and a desire to create change at higher levels rather than meeting the needs of individual residents or blaming individual staff. She offers some promising examples of how to inhabit a family care role. That said, although such an example opens up space for solidarity and collective action, it also involved an incredible amount of work, and does also raise questions about how to ensure carers can have choices in their level of involvement. Further, the metaphor of 'team member' also seems to overlook that most family carers do not have the same training as staff and may struggle to understand the work of staff, which can result in inappropriate demands (Armstrong and Lowndes, 2018). Such a metaphor might also contribute to further blurring of the distinction between paid and unpaid work.

'Just two old ladies that have come to volunteer': volunteer as outsider metaphor

Although our focus in this paper is on family carers, analytic juxtaposition of the family interviews with the accounts of two volunteers highlights the extent to which family members can become immersed in caring roles or relationships, as well as the possibility of other ways to orient to the work. As an illustrative example, we focus on the interview accounts of Cynthia and June, who had for a long time held formalised volunteer roles in one urban facility, and who talked about their collective engagement in advocacy work. Their stories not only show the power of collaborative work, but the value of engaging in LTRC spaces outside the ways outlined above.

Cynthia and June, two volunteers of 19 years, used 'people first language' – referring to themselves as 'just two old ladies that have come to volunteer'. Perhaps in part because of this (as well as not having a family member receiving care in the facility), they both expressed having more choice in the support they provided, and mentioned that they 'did one day a week'. The stories they told were also laced with the word 'we' – they spoke of always coming and going and working together. Their solidarity seemed to be a source of power, as they both spoke about their work together and with staff.

Whereas several family members foregrounded the importance of not being viewed by staff as a 'complainer', and thus needing to 'pick their battles', volunteers Cynthia and June talked about being in a unique position to advocate or respond to issues in the facility, as they were not dependent on the organisation to meet their own family members' care needs or to support their livelihoods. Together they advocated for residents, staff and for meaningful social activities that benefit all involved. As Cynthia, a retired nurse, said, 'We can step in and say something, but [the staff] can't.' This was a theme throughout the joint interview in which they both participated:

June: We are volunteers.
Cynthia: We can vent all we want.
June: Well, I said, 'if you want to fire me, go ahead!'
Cynthia: But we can say things that [the staff] wouldn't be able to…
June: You know, [staff are] afraid for their job and they don't want to get that other person [in trouble].

June and Cynthia riffed with and responded to one another. Bound with a sense of affective kinship, they seemed to offer a hopeful 'vision of late-life friendship rife with possibilities for creativity and empathy' (Chivers, 2021: 163). In speaking of the changes they made in the dining room, June said, 'Then it changed. It really did change and they thanked us for it.' Cynthia added, 'And the staff thought we were great … they figure we are the miracle workers now because we had, we have made changes for the whole floor.'

Cynthia and June both spoke fondly of their connections with multiple residents and with staff. They also seemed to note how, with their freedom to move from floor to floor, they could connect with some residents more than others. 'And it's interesting, like Bob gets along better with you than he does with me', Cynthia said, before noting that 'you match up to different' with residents. Continuing the thought, June said, 'There are certain residents you click with, others you don't.' Notably, neither of them was assigned as the point person or 'essential care-giver' to a particular resident, and thus their sense of affiliative 'kinship' differed from that of the family care-givers. 'We just come and go', June said. 'We just switch around', Cynthia stated.

Being able to 'switch around' was central to why they seemed to find pleasure, some lightness and a sense of possibility in their roles. They both seemed to have a choice in it. They noted that they used to do more than one day a week or volunteer when they were asked 'to do something special' such as 'wrapping presents' or helping with events, but they have scaled back a bit, and quit a particular job of 'greeting' others. 'We sort of slowed it down a bit', June said. Cynthia also mentioned that she quit volunteering altogether for six months, after losing 'five people inside of a week and a half that [she] was very attached to'. She stated that she could not 'stand it, went home, and then … tried again in a month and it was fine.' Hers was a promising example of how giving someone options in their level and type of involvement shapes the quality of their contributions and relationships. At the time of speaking, she seemed to have found a way to inhabit the role that worked for her, which involved work and thought on her part as well as the material conditions to make it happen.

Cynthia and June's role positioning, particularly their somewhat more informal or nonchalant approach to the volunteer role, was a source of agency and collective action. They had knowledge and skills from being embedded in the facility's daily life for such a long time. As volunteers working within LTRC spaces independent of specific care or employment relationships, they expressed being in better positions to be able to advocate. While the volunteer role has associations with community service, selflessness, and the altruistic free giving of time and friendship, it is notable that obligation may even develop for those in volunteer roles, particularly in the context of the increasing formalisation of these roles (*see* Funk and Roger, 2017). However, what was most striking in our study was the ease with which Cynthia and June inhabited their roles. Offering promising examples, they seemed to find a way to be 'in' it without being immersed right 'in' it or 'turned in on it'.

Discussion: unpaid work as a rejoinder to care shortages

This article assesses the possibilities and limits of particular metaphors of family care, while uncovering interpretations of unpaid family care roles as they are shaped by, and contribute to reshaping, the embodied organisational relations of LTRC. Our aim was to explore how unpaid family carers themselves interpret their roles and activities, and how the metaphors they use invoke, organise and/or give rise to particular practices, responsibilities and relations. As has been detailed elsewhere (Davies and Nolan, 2006; Barken *et al.*, 2016; Dalmer, 2020), family carers' work often (but not always) goes beyond visiting or supporting 'their' relatives to include other care and management tasks and responsibilities. This unpaid work can be viewed as a rejoinder to inadequate public-sector supports (*see* also Armstrong and Armstrong, 2019). Relatedly, demands for more collective care and better conditions can, in turn, be undermined by unpaid care that hides the gaps in care and the skills required in the work (Aronson, 1992). As such, it is important to consider the implications of how carers interpret and inhabit caring roles. Although not a wholly comprehensive examination of all possible metaphors (on 'care partner', *see* Bennett *et al.*, 2017) or of all possible ways to enact these metaphors, our analysis calls attention to the importance of choice and of having options to share responsibilities. As such, it supports previous studies which highlight the diversity in how family roles and involvement are understood and operationalised after a transition into LTRC (Dupuis and Norris, 2001; Reid and Chappell, 2015), as well as how these roles involve complex combinations of choice and obligation, and are tied to social positionality and power (Holmgren *et al.*, 2014).

In the present study, we contrasted the stories of a family member who positioned herself as an essential care-giver and expressed a more onerous sense of individual responsibility with the stories of people who enjoyed the pleasures of visiting, who contributed as team members in ways that went beyond caring for their own relatives' care needs, and who embraced the possibilities that came with volunteering and with being able to 'switch around', 'slow down' and influence change. Some challenged conventionally feminine ways of enacting the role, while enacting more solidaristic, collective and even consensual ways of orienting to care relationships.

In providing illustrations of a range of ways that informal, family carers describe participating in and inhabiting their roles, we contribute to research and thinking that aims to rethink the terms, conditions and expectations of family carers' work (*see* Streeter, 2023) and that engages with and promotes stories that broaden our imagination 'beyond, without rejecting, dyadic care relations that trap caregivers and care receivers alike in their narrow perspective on who does the work of care and of what care work comprises' (Chivers, 2021: 173). Carers need other ways to live and other stories to reach for, and our aim is to share promising examples in late-life family care relationships.

The context of LTRC shapes the nature of the metaphors invoked and enacted by family carers, when they describe their unpaid work and advocacy in these settings. While much can be said about how these metaphors – of visitors, essential care-givers, part of the team – position and 'set up' family carers and residents alike, it is also notable that people's approaches or ways of inhabiting or enacting those roles varied. Margit's story would have looked very different had she been viewed by staff as, for instance, a jealous or judgemental visitor. Similarly, as Josie seemed to take on the role of essential care-giver, she perhaps could have found some relief had she been able to lean on others or trust in staff to support her brother. Further, the way Betty inhabited the role of team member seemed quite demanding as a full-time, all-encompassing undertaking. While the terms, conditions and expectations of family carers' work vary and change over time, as people are pressed to care and make choices about how to do so, our research has helped us to consider the implications of these metaphors – for relations with care home residents, and for carer choice (to care or not to care) and citizenship – all of which have potential for envisioning care as a broader collective endeavour.

Our research suggests some metaphors might draw on and further reinforce particular understandings of, and ways of relating to, older and disabled persons. The essential care-giver metaphor might, for instance, inadvertently contribute to and further reinforce ageist or ableist understandings of residents in that it seems to assign an individual 'point person' to oversee care, rather than ensure care is distributed collectively or that people who need care have a choice in who provides that care over time. While some examples of visiting above involved bringing in pizza and beer or coming to hang out, it is notable that institutional structures of care, including reported staffing shortages, often give rise to forms of hands-on care and assistance with residents in the facility, with potential to undervalue relational forms of care (Seaman, 2018). Relatedly, having energy to participate meaningfully often depends on having adequate conditions (*e.g.* paid staff availability) or the financial resources to be able to sustain oneself.

Our analysis also prompts consideration of how the ways that people understand their roles can shape their ability to set limits (*see also* Klostermann, 2021), which is often bound up with being able to envision care as a collective or shared responsibility. We asked: what metaphors or meanings of family care roles, and what ways of inhabiting or enacting them, might support people in being able to 'let go', share responsibility or lean on others? With such a focus, the stories above speak to the importance of people having choices in the care they provide or in having metaphors to inhabit that align with their identities and comfort levels. The essential care-giver metaphor has been particularly helpful during the COVID-19 pandemic to help advocate for family carers' access to residents in care homes by prioritising their right to care and acknowledging their contributions. That said, there is a risk that extended reliance on this metaphor in public discourse might inadvertently further embed institutionalised *expectations* for family care in these publicly funded settings. Moreover, the metaphor invokes more clinical aspects of care rather than social or relational ones, and limits more collective ways of thinking about care or sharing responsibilities, especially in contrast to the 'team member' metaphor. With that, there may be cause for further reflection about the value of being 'just a visitor', being part of the team or being one part of a duo of 'two old ladies who have come to volunteer'. Recognising differences between families in their preferred amount and type of involvement has implications not only for resident care, but for carers' citizenship and ability to make choices.

Our study focused on public facilities in one jurisdictional context. Without a national LTRC agenda in Canada, it is worth considering provinces, and indeed countries, with other funding structures or ways of organizing care. It would also be worthwhile to learn from contexts with different terms, conditions and expectations for family carers (*see* Skinner *et al.*, 2021), and to explore divisions between paid and unpaid care work within for-profit care facilities. Lastly, while our focus here is on the agentic practices and perspectives of family carers, future research is also needed that considers how these are shaped over time, in various local contexts, through everyday interactions between families and both residents and facility staff, with attention to both the power hierarchies and the affective aspects of kinship (including fictive kinship) involved in those interactions.

Concluding remarks

The strength of this research lies in its in-depth and theoretically informed analysis, as well as the broad conceptual understanding of 'unpaid care' that extends to include advocacy work. We offered a feminist, relational approach to exploring concepts/metaphors that accounts for the critical role of everyday material conditions, histories and relationships. We examined family carers' co-ordinated work that contributes to the running of care homes, with a focus on how they evoke, inhabit and enact ruling metaphors for family care. In doing so, we contributed to understandings of how social imaginaries of care organise relationships and responsibilities. Envisioning care as a collective endeavour requires structural supports, and crucially involves rethinking relationships with our sense of selves and others. Beyond 'caring for the carers' to ensure they can continue their work, we considered the importance of promoting conditions that support people in enacting relationships that are consensual for all involved. Carers need options to share responsibility, just as residents should have the option to rely on or to be able to trust in a team. As metaphors for family care have evolved with the pandemic, we reach for ones that promote consensual and equitable forms of care or that leave room for the odd pizza and movie night, without always equating 'caring about' someone with providing direct care for someone indefinitely. Examining and expanding metaphors for care in this regard can help us to rethink gendered societal expectations around care, and reimagine care work policies. We need inhabitable care roles and relations, and insights from Josie, Margit, Betty, Cynthia and June can point the way.

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Note

1 Advocacy as a form of unpaid work involves rhetorical and practical activities,that respond to and confront individual or social struggles. This can include identifying specific barriers, targets or demands for organising, building relationships or establishing solidarity for political action, contributing to public dialogue, or engaging in political organising or activism such as through direct action demonstrations or campaigns (Hurl and Klostermann, 2019; Klostermann and Hurl, 2022).

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