Unseen and Unheard: Experiences of Immigrants Who Work as Low-Level Healthcare Providers

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“I used to work at a nursing room with two white nurses on my shift. One of them used to go inside the patients’ rooms and hide their dentures, then she will say it’s the Haitian workers that take them to go sell in Haiti. I never paid her any mind until one day. So, there is this racist patient who does not want to work with any black people; in fact, his family said that. So, this patient put on his light, and I decided to go to his room to know what he needed. He said, “How come they sent me a black person? Get out of my room, nigger! I can’t stand black people!” Then he slapped me. The nurse that I mentioned above was passing by at that time; she didn’t say anything; she didn’t even make a report. She came to the patient’s room to take him out, and she was laughing. I spent two weeks with a swollen face. The Director of Nursing (D.O.N) didn’t know about what happened.

Later that month, I went to the patient’s room to take care of him, and he didn’t want me to be there. I left immediately, and, fortunately for me, the D.O.N was there, so I took the opportunity to talk to that white nurse. I ask her why she keeps allowing the patient to insult me when she knows that he doesn’t want black people to enter his room. I told her that Martin Luther King died so that I didn’t have to go through all this. I went to the D.O.N. and told her that if she doesn’t take any measures I am going to write a letter to the President (Obama) so that he knows what’s going on at the nursing home.

Whenever something happened to the black workers at the nursing home, the head nurse and D.O.N. never found out. I wanted to speak for all the black workers because it seems like they always stay silent when something happens to them. So, I told the D.O.N. everything that happened to me and what I observed since I started working at the nursing home. She told me that she didn’t know I was that mad. She was shocked that my face was swollen for 2 weeks and I never told her. She said that I should have spoken to her and filed a report. The nurse didn’t get fired because it’s not easy to find nurses who want to work in nursing homes. What do you think they did to her? They just give her a warning. Because of that, I left the job after 3 months.”

Story told by Marie, an older CNA from Haiti.

The story above comes from one of fifty interviews I conducted in the summer of 2017 with an ATP Summer Grant. I interviewed immigrants who work as caregivers in the health field, mostly as Certified Nurses Aids (CNAs), Personal Care Assistants (PCAs), and Home Health Aids (HHAs). Immigrants, especially those from the Caribbean, are heavily employed in the low-skilled but high-demand caregiving fields. According to the U.S. Bureau of Labor Statistics (BLS), there were 2.1 million immigrant healthcare workers in 2015, and 24 percent are employed as low-skilled direct care workers (Altorjai et Al. 2017). The number of immigrant workers continue to increase. I wanted to learn about their experiences because while our health system depends heavily on them, current political rhetoric about, and administrative action toward, immigrants is making their lives more insecure.

I began with Marie’s story because this brief shows what so many of my interviewees discussed: indifference, outright racism and hostility, even physical violence experienced on the job. Though Marie was physically marked by the patient who hit her, her supervisor never found out. It is easy to blame Marie, as the D.O.N. did in her story above, for not reporting the incident immediately, but low-status healthcare workers have few job protections and fear losing their jobs. This may be even more true for immigrants.

1 All names used in the paper are pseudonyms.
who are often supporting people back home as well as in the U.S. The majority of care workers I spoke to are not protected against false accusation and abusive behaviors, whether it is the use of vile language, insults, and lies against them, or racial discrimination. This story reflects the work culture of many caregiving jobs as described by my respondents.

Sociologists try to push against our taken-for-granted understandings of the social world. By doing research with immigrant care workers in low-status healthcare jobs, I am making the contributions of these immigrants more visible and pushing against taken-for-granted and, often, very negative assumptions about low-status immigrants. For instance, in January 2017, President Trump made disparaging remarks about immigrants from Haiti and Africa, the population I worked with, during a meeting on immigration reform. This study enhances understanding of immigrants’ significant contributions to the lives of the elderly and disabled for whom they provide care. Ideally this information will be useful to people who work in the healthcare field as well as BSU as it tries to serve all people in our region.

IMMIGRATION AND THE HEALTH FIELDS, SOME BACKGROUND

Direct care workers (caregivers) take care of the disabled and the elderly as home health aides, certified nursing assistants, or counselors. Care workers play a major role in the health care sector; their job responsibilities and tasks involve activities of daily living (ADL) such as dressing, bathing, using the toilet, shopping, cooking, and maintaining a safe environment (Meyer 2015). Their daily work is different from those who do not perform entry level tasks. For this reason, they are considered frontline care workers.

Because baby boomers are aging, scholars have studied the role of immigrant workers in elder care, but relatively little research has focused on the lower-skill employment of frontline caregivers. Most research has instead emphasized high-skill employees such as RNs or health care technicians. There is a lack of research that focuses on the experiences of immigrant care workers. My research adds to our understanding of: contributions of low-skill immigrants to the lives of aging and disabled Americans and their families; immigrants’ feelings about these jobs; and other aspects of their lives such as balancing work and family. Although the prevalent themes that I found in my data were low wages, job instability, racism, and other forms of discrimination, additional findings include issues of emotional management, personal attachment, conflict management, religiosity, and patient care.

METHODS

This paper is a small piece of a larger analysis of my interviews. My research investigates the experiences and aspirations of low-status immigrant healthcare workers in the state. Massachusetts’ low-status healthcare positions are disproportionately filled by Caribbean and African immigrants, so my sample was mostly comprised of Haitian, Nigerian, Ghanaian, and Cape Verdoan respondents. All my participants were asked the same sets of questions whether in English or in Haitian Creole. It is important to hear from immigrants who fill this crucial role in our economy and health field, but who are often rendered invisible and often experience considerable anti-immigrant and racist political ideologies.

To get an idea of their stories, I conducted semi-structured interviews. Semi-structured interviews use one interview guide for all respondents but give interviewees a lot of freedom to focus on the things that matter to them. My broad interview questions were intended to lead each discussion, but participants had flexibility to bring up topics that are most important to them. I asked questions such as: what motivated you to do this job? What aspect of the job do or don’t you like and why? What relationship do you have with your coworkers, the family members of your care recipients, and your care recipients themselves?

I started by reaching out to contacts I already have, then used a snowball sampling method, asking interviewees to recommend others who could speak to me. Snowball sampling is useful for difficult to find populations because each respondent
helps you widen the research field. I conducted all interviews over the phone, recording them, then transcribing them. I conducted 50 interviews in all—seventeen in Haitian Creole. I interviewed thirty-eight female careworkers and twelve male careworkers. While most of the interviewees live in Massachusetts, a few of the participants live Florida, New Jersey, and New York. They mostly work as CNAs, PCAs, HHAs, although I interviewed a few nurses as well. My sample was equally divided among workers older and younger than 30. Though my small sample size means we cannot generalize their experiences to all immigrants, my respondents’ stories align with the literature and tell us very much about immigrants’ experiences in the low-skilled U.S. healthcare field.

It is important to note that I have a personal connection with this research. First, having immigrated from Haiti in 2010, I am passionate about immigrant rights, and, secondly, I am surrounded by people who do the particular jobs that I am studying. From family members to friends, to church members and classmates, I could lose count of how many care workers I have met, but I know that these stories matter.

JOB SECURITY AND EMOTIONAL LABOR

In general, care workers are employed by for-profit organizations, which means that they are not unionized. Workers who have union representation get organizational support, can hold their employers accountable, and benefit from social safety nets such as health insurance, social security, and unemployment. For example, Mercy, a young Kenyan who used to work as a residential counselor, was wrongfully terminated from her job after the parents of her client falsely accused her of abusing him. Because her case went to court and her employer “washed their hands clean,” she had to deal with her legal proceedings by herself. She mentioned that if she was part of a union organization, they would have referred her to a lawyer. Her narrative demonstrates that non-unionized workers are put at an extreme disadvantage.

When workers are not represented, it also affects how they respond to work-related abuse, as was the case for Marie, whose interview began this paper. Even though reporting an abusive incident depends on individuals and their knowledge of their rights, for immigrants, scholars have found different reasons why they do not report incidents of work-related abuse. Studying help-seeking behaviors of Filipino migrant home care workers in Israel, Ayalon and Green recorded that 70% of the respondents’ reasons not to report was because it “takes too much time and effort” and because of the belief that “things cannot be changed” (Ayalon and Green 2016). These findings demonstrate that it is hard for workers to end the cycle of exploitation, even when they know it’s wrong, like Marie clearly did when she referenced Dr. Martin Luther King Jr. The small portion of the workers’ sampled who did report abuse did it through informal means such as family and friends.

The daily job of care workers involves both physical and emotional labor. The notion of emotional management or emotional labor was first defined by Arlie Russell Hochschild, a sociologist, in 1983, and focused on flight attendants, but is very useful to understand the day-to-day work of immigrant healthcare workers. Hochschild defined emotional labor as “the process of managing feelings and expressions to fulfill the emotional requirements of a job.” (Hochschild 1983: 184). In other words, emotional labor requires people to hide their real emotions or show emotions that they don’t really feel in order to keep their job, like the saying “fake it until you make it.”

Among paid care occupations, lower-skilled care workers are the most influential direct care workers because they have the most contact with care recipients. Working in often fast-paced settings, these care workers need to be physically and mentally ready in order to provide sufficient care. Moreover, they have to deal with certain stresses in the workplace. Although my respondents have different job titles, my data shows that care work in general is a job that involves constant emotional management, especially in times of conflict or during racist situations. They have to manage their personal feeling so that they do not interfere with the way that they do their jobs.
EMOTIONAL LABOR AND ITS CONNECTIONS TO RACE, GENDER, AND CLASS

Imagine a situation at work involving another person when you feel angry, frustrated, or humiliated about what happened. Instead of expressing those emotions, you keep them to yourself in order to maintain a positive perception of yourself as a worker and to satisfy the other person’s needs. In the book *Global Woman*, Barbara Ehrenreich and Hochschild tell stories of immigrant women in first-world countries who work as nannies caring for the children of wealthy families, leaving their own kids behind (Ehrenreich and Hochschild 2002). They end up being attached to these children to the point that some say they love the children that they care for more than their own kids. Even though this statement might seem genuine, the workers say it while fighting their distress and guilt.

Kang (2003) goes further with the concept of emotional labor. She personifies different dimensions of emotional labor and shows how race, gender, and class help to shape its performance. She argues that emotional labor relates to gendered bodily display in service interactions. Hence, she defines body labor as work involving the exchange of not only body-related services, but also physical and emotional labor, for a wage (Kang 2003). Nail salons remain a niche for Asian immigrant women in the United States, and, daily, these workers have to deal with many emotional stressors that come with customer service. Her ethnographic study involves nail salons that serve white middle-class customers, those that serve working class, mostly black, customers, and those that serve lower income mixed-race customers. Depending on where their work is located, the manicurists have to be aware of their customers’ emotional attentiveness, the customers’ preferences, maintain interactive conversations, and have high technical skills (Kang 2003). These are necessary in order to satisfy customers’ needs and earn tips.

Given that my research is immigrant focused, I draw a parallel from Millian Kang’s research from 2003. Kang informs readers about the everyday interactions of Korean immigrant women workers in New York’s nail salons with different types of clients. Using quotes from my participants, I demonstrate factors that shape immigrant care workers’ feelings. I examine the interactions of respondents with their care receivers as well as their superiors. It is important to mention that gender is less relevant than race and ethnicity for this discussion. Though my male participants mentioned that some places prefer to assign male workers to work with combative patients, the themes found in my data resonate with both genders. Emotional management is a component of many jobs and I found three sub-themes in my data which are part of the overall conversation of emotional management. These sub-themes, including relationality and personal attachment, the workers’ perspectives of their care receivers, and religiosity, help to explain the interactions between the care workers and their care receivers. Moreover, I discuss their encounters with other healthcare workers and superiors.

FINDINGS

Race, Ethnicity, and Emotion at Work

Despite the low wages and the physical demands of care work, low-skill health care workers understand their employers’ expectations regarding emotional behavior. They have to suppress their real emotions and at times, keep silent, in order to please everyone around them. To begin, workers learn not to bring their outside problems into the job. When they enter a patient’s room they are told to smile, say “Hi,” and have a little conversation with the patients and their family members if they are present. They have to keep a positive attitude or the family members might say that they are “rude” or they were uncaring, or they were speaking in their maternal tongue to another care worker in the family’s presence. This is why a lot of my interviewees think that when the family members come to visit the patients, either at the nursing homes or the hospitals, they come to cause trouble for the care workers. Anette, a young Haitian who has been working as an HHA for three years said, “This job can be very stressful, you will feel like you want to quit. The Americans always say ‘don’t make
your problem my problem.” Considering the population that they are working with, the last thing that they can do is lash out at the patients. The interviewee went further to say that if someone does not like the job that they are doing, they will be better off not doing it.

In this line of work, immigrant health care workers often find patients who call them names, make racist comments to them, or even hit them. In my data, 43 of 50 interviewees mentioned that they have experienced racism, either directly or indirectly, at work. Despite the emotional rewards that come with care work, being a person of color and an immigrant greatly influences their experience of their work environment. Those who work overnight shifts and have fewer interactions with the patients or clients praised their shift choice. Apart from doing routine checks in every room, the only time that they face the patients is if patients call them for something (by putting the call light on) which means they are less at risk of racist and demeaning comments. This is common for workers who work in private homes as well as for those who work in institutional settings.

One thing that my participants commonly said they do not like about the job is finding racist care receivers who see them simply as workers. Betty, an older Haitian CNA who has been working at the Veterans Affairs hospital (VA) since 2003 compared her job to that of bayakou in Haiti. Bayakou is a Haitian Creole word which describe a job that involves manual labor to empty septic tanks and pit latrines. Given the societal views of this job, referring to someone as a bayakou is most undignified. Betty said “You will find patients who tell you that they pay you to clean them so do your job. As a result of that I call the job bayakou. When someone talk to you like this they really consider you as a bayakou.” The reason behind her claim is that because the job involves tasks such as “wiping people’s behinds,” as Anna, a Cape Verdean HHA, said. Society views this job as disgusting, low-down, and dirty. Even when the patients can do a task by themselves, they would rather call the CNAs to do it for them. Usually the tasks are those that no other health care workers would like to do or would help to do.

For example, Betty, the Haitian CNA that I mentioned above, was explaining her frustrations with some patients at the VA who would call her just to clean them up. They would tell her that she should do as they say because they put their lives on the line for the country [as prior military personnel], and she did not. These cases usually happened between white care receivers and immigrant care workers of color, both in nursing homes and in hospitals. Since that is the case, we should consider the elements that help the workers to control certain situations and not respond to the care receivers. Many times we hear about elder abuse which is often caused by workers’ frustration about something the care receivers might have said or done. This why it is important to study emotional management in care work.

The U.S. is not alone in tending to fill the dirtiest, hardest jobs with minorities. For example, in Italy, domestic workers who are mostly women of color and immigrants, are supposed to scrub the floor on their knees instead of using a mop on the floor (Parrenas 2001: 174). As immigrants, workers are often belittled for their skin color, their language skills, and sometimes their potential. Although not every worker might experience discrimination firsthand, it is something that they might see in their work environment. Interestingly, depending on a care worker’s country of origin, some employers might treat them differently. For instance, there were two direct care workers employed at one house, one from Brazil and the other from Haiti. Cecilia, the Brazilian direct care worker narrated the story as follows: “the family members treat the Haitian girl bad; they are very racist; they will say things like, ‘I should have hired you to clean my bathroom,’ ‘I should have hired you to clean the house.’ The girl will get mad and then go off on them.” I proceeded to ask the interviewee why she thinks the family members treat her differently, and she quickly responded that she believes it is because of the color of her skin, noting that she has fair skin like many Brazilians. However, she mentioned that as an immigrant you can get discriminated against anywhere you go, because, no matter your skin color, your accent will show that you are foreigner.
Relationality and Personal Attachment

One thing that is very distinctive about care work is relationality (Armenia et al. 2015). Care workers have a genuine relationship with the people that they care for. In a study conducted by Meyer (2015), who interviewed immigrant workers in the care work sector, immigrants reported that relationships with both clients and their family members were essential for rewards and positive experiences. Being a care worker requires more than providing close, physical attention. Paid care work is a job which facilitates workers to give their undivided attention to someone else. Care workers’ main duty is the act of “pouring love” (Parrenas 2001: 183) In my data I find that one thing that makes immigrant care workers overlook whatever the patients might say or do is relationality. In African countries as well as Caribbean countries, people are taught to respect their elders and not to talk back at them. In those cultures, the elders have significant importance. Moreover, back home, many of these immigrants took care of their elderly parents and grandparents, who most of the time lived with them. Now, even though they are taking care of complete strangers, they still hold the same ideologies. A younger Haitian HHA named Fabiola described her relationship to her patients this way: “I always tell people that, just treat them just like you will treat your grandparents, think of them as your grandparents because I don’t think anyone will treat their parents or grandparents bad.” Many immigrant care workers share this sentiment. If you treat the elderly badly, you will definitely face the consequences, because my respondents strongly believe that they have the power to curse you.

Some care workers feel more connected to the job when they are taking care of their own family members. Not that it happened consciously, but because it’s very personal to them, they put in more work. Khadra, a young Somalian female HHA who was motivated to get her HHA certification in order to take care of her disabled brother, mentioned that there is a very big difference when she is working with her brother compared to strangers: “For my brother, I go above and beyond because I want him to get the best care. I do want the best for everyone … where for other people I just do what is on the paper.” Even though she mentioned this personal element, many care workers said that they can only perform the tasks that they are assigned to do for the patients. They cannot exceed their job’s requirement because that might put their jobs in jeopardy. For example, if a client requests to drink some juice and the care worker gives it to them while it is not written in their work assignment, they will be held accountable for anything that happens to the client.

Workers’ Perceptions of Care Receivers, Fate, and Religiosity

Many of the care receivers that the immigrant care workers work with suffer from dementia, Alzheimer’s, and mental illness. People with these issues do not act the same way as people who have only physical disabilities. Care receivers who have mental illness have diminished brain control. There are different behavioral and psychological symptoms of mental illness, including aggression and violence, and many can be verbally abusive. Veronique, an older CNA from Haiti, mentioned how she was frustrated by something a patient told her and went into detail about what he said: “‘How come all Haitians, when they come here, they either work as CNAs or nurses?’ He asked if we got selected to do these jobs before we got into the boat to come to the U.S.” For anyone else listening to this, they might decide not to work with that particular patient anymore because of the way he insulted them. However, Veronique mentioned that although at that time she was mad, they all learn that the patients might say and do things they don’t really mean when they are not in their “normal state.” Ines, a younger Cape Verdean who works as a residential counselor said, “It’s not them acting willingly, but it’s because of their sickness, that is why they are acting like that. So, you got to be patient with them.”

Equally important is the notion of fate. Everyone who is born will one day get old, and, therefore, may experience any illness related to aging. Immigrant care workers believe that the way they treat their care receivers will dictate how they will be treated in their old age. Both the older and the younger workers express that no
matter what the patients do to them, what’s important is the care that they are providing to them. Many of these care receivers need assistance to do the activities of daily living such as cleaning, eating, and combing their hair because they are unable to do it themselves. While the patients can be difficult to work with, the care workers I interviewed remind themselves that one day they will be in that same position, and, therefore, they should be kind and considerate towards their care receivers. A younger Ghanaian male named Obeng who worked both as a CNA and HHA said, “We all need to get the best care or we will want to get the best care so, in order to have that, you need to give that care out to someone that needs it, so you receive it.” He realized that by being there for his care recipients and giving back to them, in return, he will receive much more in his old age. There is a saying “you receive what you give,” and this is why most care workers see their work as an opportunity to shape their dying years.

Immigrants tend to be more religious than the U.S born population (Pew Research Center 2013). For religious people, all aspects of their life are impacted by their faith. I did find a connection between some care workers’ faith and how that helped them manage their feelings. An older Haitian CNA named Lourdes, who works at a nursing home, told me about an experience she had with a patient and how she struggled with her own faith. The patient needed to smoke, and Lourdes decided to bring him. However, she was very busy, so the patient became impatient and started to swear at her. Lourdes got mad and didn’t want to bring the patient to smoke. As a result, the patient put feces on his bed and lied to the nurse manager, telling her it was Lourdes who put it there. Knowing that she was innocent, Lourdes wanted to defend herself and to confront the patient. Throughout her years of work, she said this was the one thing that she would never forget. She said “I know that God says that we have to forgive, so I try to forgive the patient. There are certain things that you can forgive, but you can’t forget.” In order to work with that particular patient Lourdes had to get rid of all her bitterness and anger and relied on her faith to help her.

Religion offers guidance on how people should work and live with one another. I did not ask any questions about the participants’ faiths, but many of them mentioned “God” or talked about their beliefs in the interviews. Two other Haitian female interviewees stated that God would reward the care workers depending on how they treated their care receivers. They believed that they should put their hearts into the job, not just when a supervisor was around, but at all times. There are multiple Bible verses that urge followers to excel in the job that they do because, in the end, their labor will not be in vain.

Conflicts between Care Workers

I was interested to see how immigrant care workers deal with conflict, especially when it is with their superiors. Many of my interviewees mentioned that they get belittled by the nurses who want the CNAs to be busy at all times. One older female CNA from Nigeria called Ngozi said this about the nurses who work at her nursing home: “They think that they are the boss, they want to control you. They boss you around, they want you to do this, and they want you to do that.” This was not relevant for those who provide care at the client’s residence because there are no other health care workers around when they are working with the clients. Two older male nurses told me that it is very common to see disputes between the nurses and the CNAs at the hospitals and the nursing homes. What usually happened is that, unlike patients, they report each other to the manager who most of the time is the head nurse. Some of the CNA interviewees complained that judgements are never fair because, most of the time, the managers are white and are nurses as well. Therefore, the CNAs do not really feel like they have a voice. This shows why race and ethnicity are important in how we view care workers.

I interviewed two head nurses, the first was Jean, an older Haitian male, and the second was Gloria, an older Bajan female who first started as a CNA in the 1970s and now works as a head nurse. They both mentioned that they practice fairness and that whenever they cannot settle a dispute they hand it over to someone
who is their superior. Surprisingly, Gloria did mention that she has had some misunderstandings with CNAs. One time, she asked a Haitian CNA to shave a patient but the CNA did not want to do it because she believed that the head nurse could have asked someone else to do it and from there the situation escalated. Gloria said, “She said that I personally don’t like certain people at the job which was definitely not the case. I get along well with all Haitians, in fact, my daughter’s godmother is Haitian. I never let where someone is from be a problem.” As can be seen, the issue between the two Caribbean workers was not about race but, rather, power. In every health care institution, the nurses are at a higher level than the CNAs. They have the power to delegate different tasks to the CNAs. For those who were once CNAs too, they try not to abuse their power.

CONCLUSION

My research shows that frontline caregivers experience a great deal of satisfaction from their jobs but, even more, experience racism, fear of job loss or mistreatment, and general insecurity at work. Many of their stories are difficult to hear. While I was doing this research, some of the participants asked me if this research would bring any changes to their experiences. I found this question very difficult, because while I am increasing people’s awareness of these workers and their struggles, it’s not like I am creating any policies to raise their wages, or change immigration laws, or mandate that all employers provide Workers’ Compensation to help them when they are injured at work. All of these are very significant issues for my participants. Still, working toward making these changes is also very important to me.

In November 2017, the Trump administration announced that Temporary Protected Status, or TPS, will not be extended for Haitians who have come to the U.S. legally seeking protection from the tremendous social and economic issues at home. According to the New York Times, among the 320,000 people who benefit from TPS, by July 2019 more than 45,000 of them who are Haitians will have to leave the country (Dickerson et al. 2018). Recently, it was announced that many other immigrants from nations who were initially granted TPS (Salvadoreans, Syrians, and Somalis) may also not be able to renew their status. These are people who have contributed to the economy and have established a life here. Moreover, given today’s healthcare costs, health care facilities are downsizing, restructuring, and cost cutting in order to deal with smaller budgets. What this means is that those that need the help the most, the elderly and people with disabilities, will be more vulnerable because there are not enough funds and workers to assist them. It is important to learn about and understand immigrants’ contributions to our health care institutions, our economy, and their experiences at work.

Immigrant healthcare workers are vital to the U.S. economy, their patients, and their local communities, and we should be looking for ways to help them stay and take care of the most vulnerable, rather than trying to push them out. The stories these interviewees tell can help policy makers make informed choices when it comes to laws regarding immigrants. A current narrative surrounding immigration, though, is that immigrants depress wages because they arrive without employable skills. In reality, there is no federal mechanism that assesses immigrants’ credentials, leaving new arrivals with few employment options. Despite other challenges that they have to face outside of work, these workers devote their work to the betterment of the elderly and aging population. This research allowed the voice of immigrant care workers to be heard.

I want to thank all the 50 participants who dedicated their time to participate in this study. All of my participants were helpful and without them this research would not have been possible. Some of them were interviewed after midnight, some of them were interviewed while on break at work, and others were interviewed during their commute from one job to another job.
About the Author

Daniela Belice graduated in May 2018 with majors in Sociology and Political science and minors in Spanish and Civic Education. Her research was completed in the summer of 2017 under the mentorship of Dr. Norma Anderson from the Sociology Department: it is part of her honors thesis. Her research was funded by an Adrian Tinsley Program for Undergraduate Research and Creative Work summer grant. Daniela presented this paper at the National Collegiate Research Conference (NCRC) at Harvard University and the Midwest Political Science Association in Chicago, IL. She has been awarded a Fulbright scholarship and plans to pursue her Masters in Canada.